DEPARTMENT OF HEALTH

REVIEW OF PSYCHIATRIC HOSPITALS AND HOSPITALS FOR THE INTELLECTUALLY HANDICAPPED

REPORT TO HON DR M E R BASSETT
MINISTER OF HEALTH

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1 REVIEW TEAM MEMBERSHIP

This report has been compiled by the departmental review team comprising:

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Additional material has been supplied by Dr D M McLellan and associates from the department's Design and Evaluation Unit.

2 INTRODUCTION

A variety of comments and reports, some public, have over recent years, raised concern regarding the quality of care available in the country's psychiatric hospitals and hospitals for the intellectually handicapped. Your predecessor, the Hon A G Malcolm requested the Department of Health to undertake a comprehensive review of these facilities. The specified objectives of the review were:

(1) to gain an overview of services being provided at psychiatric and psychopaedic hospitals;

(2) to examine standards and procedures in place;

(3) to gain information that will provide the background for service planning nationally and regionally;

(4) to examine the functional aspects of psychiatric care and to identify any shortcomings;

(5) to survey the present building stock to ascertain to what extent buildings in the larger historical psychiatric hospitals should be abandoned, renewed or replaced elsewhere.

This report represents a synoptic overview of services, and of standards and procedures, as envisaged by the first two terms of reference.

In response to objective 5 of the Terms of Reference, the Design and Evaluation Unit of the Department surveyed all psychiatric hospitals and hospitals for the intellectually handicapped to assess their functional suitability and physical status. The unit's report is summarised in the section on hospital facilities in this report.

Basic mental health data make it clear that psychiatric hospitals have undergone something of a transformation over the last two decades. In particular, hospital size has been reduced, individual patients' length of stay has shortened and a "revolving door" policy has been adopted. There are now, proportionally, fewer persons resident in psychiatric hospitals than at any time since 1877.

These changes are clearly reflected in many aspects of psychiatric hospital function, and in the motivation, energy and sense of professionalism of many staff at all levels. Each hospital has its own areas of special development about which it is justly proud.

What is apparent today, compared to what existed 20 years ago, is highly laudable. These aspects of the service will be described fully in more complete and detailed reports to hospital boards as soon as the material can be assembled.

It will be seen from the following observations and general criteria that many specific deficiencies remain and have been identified. In concentrating on these deficiencies the report attempts to respond particularly to the latter part of objective 4 of the terms of reference.

More importantly, however, it is considered that it would be very misleading to present a favourable view of the situation as a whole.

A combination of circumstances has led to a situation which in many respects is critical. Major and important changes have occurred in the philosophy and techniques of treatment and care of the psychiatrically disabled and intellectually handicapped; and an increased awareness has developed, world wide, of the need for new standards to be applied to the care of such patients. These have arisen against the background of a generally unfavourable economic climate and the need for cost containment. Thirteen years ago, the administration of psychiatric hospitals was decentralised excluding Lake Alice Hospital and for the last eight years these hospitals have had to compete for scarce resources within board regions. The introduction of the population - based funding formula has added a new dimension, the implications of which have not always been perceived in ways favourable to the mental health service. Such factors have made it difficult to continue the earlier progress.

Whilst the achievements described and the continued dedication of those responsible for operating the service are acknowledged, it is clear that a plateau has been reached, and that energy and resources must be mobilised anew to achieve standards acceptable in the 1980's and beyond. Unless this is done, progress may not only be halted, but standards may actually decline. On the other hand, the present situation could be used as a time of opportunity to build on the gains already made towards the development of an exemplary mental health service for New Zealand.

3 PROCEDURE

To undertake the review as set out in the terms of reference described above, a departmental review team was formed comprising members from the disciplines of psychiatry, nursing, occupational therapy, physiotherapy, social work and dietetics, and from administration.

In drawing up criteria for the review and in designing the checklists used, the team had considerable assistance from the department's Management Services and Research Unit. The format used was derived from international studies and tailored to meet New Zealand conditions.

The checklists were further developed and refined during a "pilot" visit to one psychiatric hospital and agreement on qualitative criteria guided the review team in its subsequent visits.

The criteria developed and used by the review team reflected the following general considerations:

(1) Did conditions in individual wards facilitate respect for the individual's privacy and ability to exercise some choice, or otherwise influence the basic elements of living style, environment, and daily or weekly routines?

(2) In terms of their health status, were patients adequately assessed at regular intervals to ensure satisfactory monitoring of progress including review of their disability and current treatment?

(3) Was the accepted range of modern treatment methods available to those patients who needed them? Were there sufficient staff competent to administer them?

(4) Did the hospital as a whole and its component units have clearly understood written philosophies and objectives; were these regularly reviewed?

(5) Did staff members demonstrate a sense of purpose and direction? Did they function as a cohesive group whose contribution was valued and whose opinion was sought? Were their individual professional expectations satisfied by the tasks they were required to perform?

(6) Did the resources in general appear adequate; were they efficiently and effectively managed; how did the management of resources impact on patient care?

The team visited all psychiatric hospitals and hospitals for the intellectually handicapped between June 1984 and March 1985.

Prior to the review team's visit professional and administrative questionnaires were sent to each hospital board and to individual hospitals. The returned questionnaires were

used with the standard on-site checklists when reviewing each hospital and in the compilation of field notes and reports subsequent to the visits.

For its visit to each hospital the review team comprised representatives from each of the disciplines of psychiatry, nursing (2), occupational therapy, physiotherapy and social work and from administration.

The review of dietetic services was conducted by the department's advisory dietitian subsequent to the main review.

The review of each hospital covered the following areas: philosophy and objectives, hospital organisation and administration, support services, practitioner and professional services, patient management and care, and community services.

Within each of these areas services were reviewed on a consistent and pre-determined basis. For example, in the area of patient management and care the factors considered comprised admission criteria, assessment, treatment planning, standards of treatment, information and consent, standards of daily care, and discharge and follow-up procedures.

Before each visit the psychiatrist, nurse and administrator on the team met with the hospital board's management team, and then the full team met with hospital management to explain the purpose of the review and how this would be carried out in each hospital. At the end of the visit the team's main findings and concerns about each hospital were conveyed verbally in further meetings between the same groups.

The department is in the process of preparing detailed written field reports for each of the hospitals visited, which are being despatched for comment to the respective hospital boards. Following receipt of their response, it is intended that a comprehensive report on each hospital will be made to the respective boards.

Within each hospital the review process itself generated discussion and data which are already proving to be most valuable to the individual professions involved. Many aspects of the review cut across individual professional areas; indeed in recognition of the considerable overlap which exists between professional groups, and which is indeed essential in the provision of effective patient care, the team itself operated in a co-ordinated, multidisciplinary fashion.

4 FINDINGS

(1) PATIENT CARE

(a) Philosophy and objectives

The formulation of a background philosophy, and the setting of goals and objectives are fundamental to the provision and maintenance of good patient care. While these are to be found within some professional groups in some hospitals, they are seriously lacking at the hospital and unit levels with consequent blurring of focus and direction, and thus of leadership and co-ordination of the services provided by various professional groups. It is believed that addressing this deficiency would make a significant contribution to remedying the inadequacies encountered.

(b) The patient population

The patient population currently resident in our psychiatric hospitals comprise a number of groups with differing needs, including those with acute mental illness, longer stay psychiatric patients, those patients requiring conditions of restriction, the intellectually handicapped and psychogeriatric patients, etc. It was beyond the brief of this review to discuss the future role of the psychiatric hospital, but the indications are that there will continue to be a need in the foreseeable future for hospitals to provide long-term care for some patients. Nevertheless, it was apparent to the review team that there are currently a significant number of patients in several hospitals who do not need full hospital treatment and who could more appropriately be cared for in a non-hospital environment if professional support and facilities were available. This is dealt with more fully in sections 4(1)(g) and 4(1)(h), and a numerical analysis is the subject of a separate investigation upon which a further report will shortly be made.

(c) The range of treatment

International trends in patient care in psychiatric hospitals demand that a broad range of treatments, as individualised as possible is available to meet differing needs.

In most psychiatric hospitals in New Zealand the range of treatment options available is inadequate so that patients with very different needs are often treated in the same ward and with the same programme. The necessary range of treatments is deficient, with particular weakness in the psychological (psychotherapeutic) approach to

treatment. This serious lack coupled with staff shortages and the lack of individualised assessment, treatment and rehabilitation programmes tends to lead to undue reliance on drug therapy and various forms of custodial care; and to seclusion.

Given the general over reliance on medication, the choice (appropriateness and range) of drugs and dosages prescribed are generally satisfactory in most wards. However, it is occasionally compounded by idiosyncratic prescribing, including the prescription of large numbers of different drugs to an individual patient with no apparent justification and by poor drug recording.

Significant numbers of patients continue to be given drugs for lengthy periods without review. Such lack of review of individual treatments is of particular concern as many of the drugs, if given over prolonged periods, are capable of producing serious side effects. Current medical shortages decrease opportunities for peer review including prescribing practices.

(d) Seclusion

Facilities for seclusion and restraint are often Dickensian. In the main, rooms used for seclusion are bare and stark. The phrase "low stimulus" therapy is creeping into use, sometimes appropriately, but more often it can only be a euphemism to describe barren walls and door, a mattress on the floor of a cell and loss of control of such amenities as light, heat and ventilation.

Hospital staff agreed with review team members that seclusion would often be unnecessary with improved staff numbers and staff training. When it is required, however, there is no reason for it not to be dignified with appropriately designed and constructed furniture, and with toilet facilities.

An issue of comparable concern is the use of "time-out" boxes and cupboards in some wards for the intellectually handicapped. The stated purpose of using time-out in this situation is to modify behaviour in the scientific sense, but the review team and many hospital staff consider that it must be seen as a frankly punitive measure.

(e) Staff deployment

Because of staff shortages, hospitals tend to concentrate resources in acute areas. Even so nowhere can it be said that staffing levels in acute wards are excessive; indeed on occasion they too are inadequate.

Thus the long stay areas are by any reasonable standard most seriously depleted resulting in less effective or non-existent treatment and rehabilitation programmes and often in deficiencies in dignity and in the basic elements of appropriate care. In the longer stay areas, nurses are often the only health professionals providing care, and those few available nurses are attempting to compensate for the lack of other professional services.

(f) Treatment planning and review

Assessment of the patient, treatment planning and patient review are inadequate to a greater or lesser extent in all hospitals particularly in longer stay wards including those for the intellectually handicapped.

There appears to be a need for further education in the purpose of treatment planning. There is also a lack of sustained, integrated and informed medical input into an overall treatment plans for longer stay patients.

Where reviews of longer stay patients are undertaken, they tend to involve medical and nursing staff only, and are often poorly documented. The lack of reviews and periodic summaries make it impossible to obtain an overview of the patient and his problem. In long stay areas there is also a lack of regular physical assessments of patients. They may be carried out when the patient is admitted but rarely routinely afterwards.

There are some energetic attempts at multidisciplinary team work in some acute wards and specialist units but in some of these it is still not fully integrated, with individual disciplines often functioning independently of each other.

Lack of enthusiasm for the multidisciplinary team approach seems to arise from failure to resolve problems of poor role definition, overlap of responsibilities, and from poor acceptance of another discipline's role, resistance to change by some staff, and issues of authority.

(g) Rehabilitation Programmes

Some hospitals have comprehensive community-orientated rehabilitation programmes. Others have excellent facilities but lack well planned, coordinated programmes strongly supported by staff. In some hospitals rehabilitation programmes are rudimentary only.

Rehabilitation often comprises ad hoc efforts with few overall plans or objectives. This deficiency is related to the lack of treatment planning, the limited range of treatments offered, and the lack of multidisciplinary input to patient care.

Greater recognition should be given to the fact that most patients have potential to benefit from rehabilitation programmes to attain or maintain their optimum levels of functioning even within the hospital. In some long stay areas routine day to day care is all that is available. The picture of under-stimulated, under-occupied, under-noticed patients standing or sitting aimlessly in stark, crowded, smoke-filled day rooms has not been totally eliminated.

A number of patients, not requiring full hospital treatment yet who would be unable to function satisfactorily in the wider community, are not adequately catered for at present. There is a pressing need for on-campus facilities which parallel those in the wider community, but which are geared in pace and purpose to the realisation of the individual resident's potential. Such a therapeutic community would meet the needs of some patients who may ultimately be discharged in addition to normalising the lives of those who remain indefinitely.

(h) Community Services

The review team is aware of the pressures on hospitals and on staff to move towards increased care in the community. Where the value of rehabilitation is recognised, the acknowledged benefits of de-institutionalising psychiatric care and the reality of inadequate community support services create a serious conflict for hospitals and staff. The mixed motives of humanitarianism and economy are often incompatible, ie. there is some resistance to pursuing a policy which in the absence of resources, and allocated responsibility and accountability leads less to community care than to community neglect.

Good rehabilitation programmes tend to go hand in hand with good community services. These latter range from being well developed in a few areas to virtually non-existent in others. Overall it is clear that many more patients than is the case at present could be supported in the community. However, it is recognised that most hospitals are unable to find sufficient, suitable accommodation in the community in a diversity of locations which do not place too heavy a demand on community tolerance and support, and on professional resources. The situation has been reached in

several hospitals where good rehabilitation programmes have been nullified by the lack of these community resources resulting in the patients concerned slipping back into custodial accommodation within the hospital.

There is an overall lack of coordination and leadership in the provision of community services. Despite some good, innovative ideas community services even within an individual hospital board have developed without coordination and without clear objectives and policy guidelines.

The development of community services is further limited by the poorly-developed interface at national policy-level with other agencies providing funding and support, and between professions.

In summary, suitable patients are unable to move into the community because of the lack of preparation, the lack of community support and tolerance, the lack of coordination, and the shortage of suitable accommodation and professional support.

(i) Multicultural issues

Recognition of differing belief systems is particularly important in the mental health area. There is a need for such cultural sensitivity, however the degree of emphasis varies between hospitals and is to some extent dependent on the cultural diversity of the population served by each hospital and from which hospital staff is drawn.

There have been some local initiatives towards meeting the needs of Maori and Pacific Island patients and other cultural groups. Some hospitals maintain a list of staff who are multi-lingual and use them as interpreters or resource people as required. Several hospitals have a list of Maori traditional healers who are able to be contacted for those patients who would like to use their services. Maori cultural support groups have been set up in some areas or links have been established with local marae.

There is however, a widespread lack of formal recognition of cultural needs in many aspects of patient care. Where positive developments are taking place, they sometimes appear to be over-dependent on individual initiatives and the good will of a few resource people whose services are not always adequately supported.

(j) The Community's Relationship with the hospital

The involvement of local communities in patient care within the hospital is variable. The geographical isolation of some hospitals is often a barrier to closer community ties.

There is often considerable difference in the extent of community input in different areas of the same hospital. For example community, church and cultural groups make an extensive contribution in some wards, while in other wards such contributions are non-existent.

The value of links with the community needs to be recognised and fostered for the positive contribution they make to the overall treatment and rehabilitation of patients.

(2) STAFFING

(a) The Shortage of professional staff

There are major shortages of professional staff, throughout the mental health services. In varying degrees different hospitals experience serious shortfalls of psychiatrists, qualified nursing staff, physiotherapists, occupational therapists, social workers, speech therapists (particularly in hospitals for the intellectually handicapped) and psychologists. In particular there is a shortage of training positions in psychiatry. Of any medical speciality, psychiatry suffers by far the greatest shortage of numbers nationally. The low level of recruitment of men into psychiatric nursing is a relatively recent problem, and is a matter of growing concern.

The level of morale and the recruitment and retention of well-motivated health professionals are mutually reinforcing variables and they have a major impact on hospital staffing. Low staff levels resulting from both low establishment and failure to recruit, leading to overwork, low job satisfaction and low standards, together with poor physical resources, and professional, administrative and geographic isolation, contribute to a lack of status for psychiatric hospitals. These and other factors adversely affect the recruitment and retention of high calibre staff. Until this cycle is broken, the problems are self-perpetuating.

Staff shortages and low morale seriously affect patient care and the availability of alternative methods of treatment, and lead to lack of awareness and general acceptance of substandard conditions.

In situations where interpersonal relationships should form the very essence of treatment, and directly influence the well-being of patients, staff often appear defeated and convey an air of resignation.

(b) Nursing staff mobility

The rapid rotation and lack of continuity of nursing staff in wards was the most common complaint made to the review team. While recognising that nursing staff must provide 24 hour cover and that rostering must inevitably create continuity difficulties, the team found it difficult to isolate additional factors which compound the problem. Possible causes include inadequate numbers of staff available, the constraints of the negotiated roster system, inappropriate management, and the practice of providing a variety of work experience for all staff.

The constant turnover and lack of continuity of nursing staff often compromise patient care by inhibiting the development of individual patient and ward programmes. The system also inhibits the introduction of progressive nursing methods such as primary nursing, impedes participation in inservice training, and contributes to poor staff morale.

(c) Opportunities for continuing education

In most instances there is only one major psychiatric hospital in a board area, and many staff tend to have irregular outside professional contact if any, leading to a feeling of professional isolation. This situation emphasises the need for continuing education inside and outside the hospital, but there is a lack of awareness of its importance by some individuals and professional groups.

In general, hospitals do not have a policy on inservice training, although most professional groups provide this for their own staff. The nursing inservice department is often the only unit with its own facilities and resources. Its supervisor frequently assumes the responsibility for orientating all new staff to the hospital and for organising and/or providing training on topics of general application, e.g. cardiopulmonary resuscitation. There is little evidence of an interdisciplinary approach to co-ordinated inservice training.

Opportunities to attend educational programmes outside the hospital are hampered by inadequate staffing, limited funding, and the perceived

marginal relevance of course topics for psychiatric hospital staff, particularly nurses and occupational therapists.

(3) HOSPITAL MANAGEMENT AND ADMINISTRATION

(a) Philosophy and objectives

The value of a philosophy, and of goals and a set of objectives, is not always recognised, and there is a widespread lack of written statements of philosophy and objectives at hospital management level. They may appear to be a luxury if one is under intense pressure of work; yet they comprise vital elements in the planning process, inviting thought and discussion about current procedures and practices which as a result can be questioned and changed. Objectives also sharpen activities so that efficiency is enhanced and effectiveness measured.

Some individual services and professional groups have developed excellent philosophies and objectives but these are not necessarily supported by the hospital administration. This results in a lack of coordination between services provided by various professional groups and contributes to poor staff morale and lack of job interest.

Some senior management staff state that they have objectives but that they are not written down. They are, therefore, unlikely to be known by staff. Regular reviews are not undertaken to assess achievements and to produce current objectives. Opportunities are often lacking for personnel at the work-face to contribute to the formulation of philosophies and objectives, with consequent frustration and a sense of impotence.

(b) Quality assurance

Quality assurance is very poorly developed with a general lack of formal programmes. Some individual health professions are introducing quality assurance within their own departments, but there is a lack of coordination between disciplines. Overall there is a lack of informed leadership and direction from hospital management in this area. The development of appropriate measurement tools is hampered by the absence of objectives for the hospital and heavy clinical workloads, and a lack of appropriate experience.

(c) Administration

A feature of the hospital board service is the lack of interchange of senior administrative staff between general hospitals and psychiatric hospitals.

An improved interchange of health professionals and administrators would do much to improve communications with the hospital board, lessen the effects of physical remoteness, increase the awareness of the substandard conditions existing in many psychiatric hospitals, and improve understanding of the function of psychiatric hospitals within the board and in other board institutions.

It needs to be understood that the management of a psychiatric hospital is a complex matter, demanding the same levels of skill as the management of a general hospital. In fact, the level of resources made available by boards to psychiatric hospitals probably places greater demands to exercise managerial skills if these are to be successfully operated. The increasing emphasis on community care and the gradual reduction of inpatient numbers also call for skills in the management of change, for a more flexible approach to care.

It could be that increased attention to training in modern management techniques would greatly benefit management practices in psychiatric hospitals.

(d) Communication within the hospital

The quality of communication within hospitals varies from one institution to another, and senior hospital management often appear isolated from staff. The level of communication is directly related to the standard of care since the implementation of new policies relies primarily on the dissemination of information. As with the development of a philosophy and objectives, the importance of formal consultation and involvement in the decision making process as well as written communication between all levels of management and staff is not recognised.

(e) Official visitors and District Inspectors

The procedure by which official visitors are appointed appears to be unsatisfactory because it is not widely known or understood. A further problem is a lack of understanding of the role of the official visitor both by the appointee and by hospital staff. The meeting of official visitors held in June 1985 appears to have gone some way towards overcoming these problems, and will have served to strengthen the positive contribution the official visitors can make to patient care. Official visitors are generally enthusiastic about their role and accept their responsibilities concerning the lay aspects of day-to-day patient care.

The role of the District Inspectors, related as it is to their professional work, is more clearly understood. The official visitor and District Inspector form an important resource for both hospital staff and patients, and provide a vital link with the community.

(f) Support Services

Many boards have centralised support services, eg, laundry, maintenance, and transport, providing services for a group of hospitals.

Few psychiatric hospitals are satisfied with such services. For example, in many hospitals the laundry services are seen as unsatisfactory. There is a widespread feeling that a centralised laundry service does not meet the particular needs of a psychiatric hospital. Patients in psychiatric hospitals are increasingly encouraged to wear personalised clothing and often such clothing is unsuitable for processing in large centralised laundries. Consequently clothing is washed in the wards, and nursing staff are assuming a very large non-nursing task indeed. Some hospitals also complain of the slow turn around in the laundry they do send to the centralised laundry. For example, at one psychopaedic hospital at times patients may have no underwear for several days.

In some cases where there are centralised services, staff who were previously used to having control over their own services, make little attempt to cooperate with the centralised services. They are, however, remote from those providing the service and feel a sense of isolation.

Hospitals boards with centralised laundries need to examine just how appropriate are the systems for handling patient clothing from psychiatric hospitals. Questions need to be addressed such as whether separate handling of such clothing at the main laundry is possible, or whether more attention needs to be paid to more effectively laundering clothing on the wards.

(4) HOSPITAL FACILITIES

(a) Design and Evaluation Unit Report

During 1984 the department's Design and Evaluation Unit surveyed all psychiatric hospitals and hospitals for the intellectually handicapped to give a general assessment of present buildings.

This "screening evaluation" is intended to give a general appreciation of the situation. It must be stressed that the condition of individual buildings

should not be taken out of context and that if there are proposals for the development of particular buildings, further detailed evaluation is necessary to determine the most appropriate course of action.

The assessments are based on standard preliminary evaluation procedures used by the unit which categorise buildings into four groups:

<u>Category A</u> - Providing very good standards of accommodation for the function for which it is used, whether it is purpose built or upgraded.

<u>Category B</u> - Providing adequate facilities and standards of accommodation for the purposes for which it is used.

<u>Category C</u> - Requiring adaptation, replacement or essential additional facilities to provide adequate accommodation.

<u>Category D</u> - As for 'C' with conditions so bad that the unit will cease to function it steps are not taken in the near future.

As all buildings do not fall neatly into one of these four categories, further simple sub-division of this classification has been used where appropriate.

Of the total of 244 in-patient units, 54% are classified 'A' to 'B' inclusive and provide adequate to very good standards of accommodation; 33.7% are 'B-C' to 'C' inclusive and provide accommodation which will require adaptation, some replacement or additional facilities at some time in the future; 12.3% are 'C-D' to 'D' inclusive suggesting that their future useful life is very limited.

There are approximately 311 other buildings or complexes of different types and function within the estate of these hospitals. Of these 76.9% are classififed 'A' to 'B' inclusive. These are in very good condition and suitable for the purposes for which they are being used. The remaining buildings or complexes in this group are not in a satisfactory condition and will require some upgrading, alteration or replacement if they are to continue to be used.

The Design and Evaluation Unit gained the impression that since the previous survey in 1978, there has been a significant amount of upgrading undertaken. However, a considerable amount of work

of this type remains to be done as there are still important functional and environmental deficiencies. There are no grounds for complacency, particularly when the basic facilities are compared with those available in general hospitals.

The unit also noted the changing emphasis in psychiatric hospitals with a tendency towards community care with a consequent reduction in inpatient numbers. The dependency of those remaining in hospital is tending to be higher and increasing, reinforcing the need to plan for changing requirements.

(b) Review team comment

While accepting in general the structural and functional suitability report of the Design and Evaluation Unit and acknowledging the adequacy of the grading criteria used, the review team was sufficiently concerned about the standard of facilities, to comment on a number of matters.

Overall many wards are bare, unattractive and depressing. Although many of the buildings are old this should not necessarily account for their appearance. For example, some wards in old buildings had been imaginatively decorated to create a bright, home-like environment. It is also of concern that although it is possible to build well-designed facilities, too often the design of new or renovated facilities perpetuate the problems of those they are replacing.

For example, with regard to individual privacy and dignity, there is often a lack of cubicles and curtaining in dormitories, and, for longer stay patients, some toilets and bathrooms have no doors either through lack of maintenance or so the few nursing staff can more closely supervise patients. In some wards for intellectually handicapped residents, there are toilets of a bench type in open corridors and communal showers. These conditions were seen in recently upgraded facilities. In other wards toilet and bathroom facilities are inadequate in number and design. In many wards there is little space for personal possessions. Facilities such as these have an impact on staff attitudes, behaviour and expectations, and ultimately affect the quality of patient care.

The size of the wards is also a matter of major concern. Units containing more than 40 beds are common. The review team is strongly of the view that for personalised care and rehabilitation, admission wards should have no more than 15

patients and no ward should exceed 20. Most long stay wards should be small enough and designed in such a way as to provide a home-like environment.

It is a disturbing irony that the mental health service actively creates mental health and behavioural problems, through institutionalisation in large wards. The present size of wards plus the rostering system mean that in many instances staff do not know patients, their backgrounds or current problems.

(5) COMMUNICATION WITH HOSPITAL BOARDS

Communication between individual psychiatric hospitals and hospitals for the intellectually handicapped, and hospital boards is often seen as satisfactory from the board's perspective while almost everywhere it is seen as unsatisfactory from the hospital's point of view.

We believe this comes about because senior board management may not always have a clear understanding of the work of psychiatric hospitals, and input on matters seen by the hospital as critical to its day-to-day management is often not solicited by hospital boards. There is a widespread belief among hospital staff that the needs of the psychiatric hospital receive a low priority at board level. The geographic isolation of some hospitals hinders communication.

It is also true that the management groups at psychiatric hospitals do at times fail to draw to the attention of senior board management deficiencies and problems with which they require assistance.

Few hospital boards have a service plan for psychiatric services as a whole. Where plans are being developed, hospital staff are often unaware that such exercises are being undertaken. Hospital staff at various levels are given little encouragement to contribute, and when they do, feedback from the board is limited.

A consequence of poor communication is uncertainty about the future role of the hospital contributing to low staff morale.

Any apparent lack of understanding by hospital boards may reflect a lack of personal experience in a psychiatric setting and thus less than full appreciation of the special functions and needs of psychiatric hospitals and of what can and should be achieved by a modern psychiatric service.

(6) FINANCIAL CONSTRAINTS

The level of funding is a contributing factor to maintenance of many of the problems which exist in psychiatric hospitals and hospitals for the intellectually handicapped.

The funding levels are set by hospital boards sometimes inappropriately using the funding formula which is based on historical funding patterns.

The population based funding formula provides for a separate allocation of bed-day equivalents for mental illness and mental handicap. Also included is an amount to cover the cost of care for an identified number of old long stay patients.

The net effect of providing this separate allocation of funds is that funds allowed by the formula for mental services are a predetermined proportion of total funds, in fact, 20% of total funds available to hospital boards.

The figure of 20% is not reached by chance. In past years, it was found that about 20% of expenditure nationally for hospital board services was spent on psychiatric services. Because of a lack of adequate cost data this proportion of expenditure was used as the basis to determine a weighting for mental illness/mental handicap bed days. It was not intended that boards should spend exactly 20% of their allocation on psychiatric services. Board are free to allocate resources as they wish.

Nevertheless, providing a separate calculation of the allocation of bed-day equivalents for mental illness/mental handicap may be interpreted as a bench mark for boards to decide what should be spent on these services, and to try and keep to the 20% figure. This is unfortunate as the 20% figure is a carry over from the days when psychiatric services were under-funded and very much the neglected area of the public hospital system. The funding formula appears, therefore, unwittingly to have provided a mechanism to perpetuate this situation. Not all boards have taken this approach but we are aware of some boards that appear to have funded psychiatric hospitals in this way.

The review team believes that the funding formula needs to be revised. If weightings are to be used in the formula it could be more appropriate to use the various categories of patient which hospitals serve e.g. acute, short stay, long stay, etc. If a separate weighting continues to be provided for mental illness and mental handicap, it is unlikely that more resources will be directed into this area, and consequently there is little chance of services being upgraded to an acceptable standard.

5 SUMMARY

The problems of the country's psychiatric hospitals and hospitals for the intellectually handicapped arise from a combination of a variety of factors, many of them historical. The fact that the situation has improved is unduly consoling and must not be allowed to detract from the advances still required.

Many patients remain in hospital who could be more appropriately cared for in other environments. There is insufficient emphasis on strengthening community resources, so that rehabilitation and community care may be realised.

Because of lack of personal experience, hospital board personnel cannot always fully identify with the goals of a modern mental health service. Thus few individual hospitals have stated philosopies, goals or objectives. Communication between hospital management and staff is another issue of concern.

Serious staff shortages, the relative concentration of staff in acute areas at the expense of long stay areas, the rotation of nursing staff, and the lack of attention to quality assurance are contributory factors to often inadequate levels of patient care. Staff frequently have to use inappropriate interventions and are able to provide only basic care; in particular, conditions and lack of specific training lead to under-use of psychotherapeutic approaches to treatment. Patients often do not have individual treatment plans and in many instances patient reviews are infrequent. Multicultural and family issues are increasingly recognised as major influences affecting patient care, but the response to cultural issues remains undeveloped in certain areas.

In many instances hospital design including ward size, and bathroom and toilet facilities seriously hamper personalised patient care.

The management of support services vital to the smooth operation of a hospital need attention.

Finally, financial constraints influence the problems summarised above. There must be recognition that if services for the mentally ill and intellectually handicapped are to be significantly improved, then there must be a willingness to pay for such improvements. However, this should be complemented by more effective management of the limited resources available.

It could be said of the country's psychiatric hospitals: It is a cruel paradox that the least is provided where the need is the greatest.

6 RECOMMENDATIONS

(1) Standards of Care and Quality Assurance

Many of the inadequacies in patient care stem from a lack of national minimum standards of care and quality assurance programmes.

The review team recommends:

(a) that the department prepares and promulgates a mental health policy paper;

(b) that the department gives the highest priority to the formulation of mental health service planning guidelines for hospital boards;

(c) that the department takes immediate steps to ensure the development of minimum standards of care in collaboration with health professionals directly involved in the provision of services;

(d) that the department assists hospital boards to develop interim standards of care. (The review process has used transitional standards, and departmental staff are available to assist hospital boards to address this question);

(e) that the National Health Statistics Centre updates the mental health statistical data system;

(2) The Patient Population

In addition to the need for standards for patient care as outlined above, another major factor contributing to inadequate patient care is the number of patients who remain inappropriately in hospital, and inappropriately placed within hospitals.

The review team recommends:

(f) that all hospital boards be encouraged to establish service development groups for mental health as a mechanism for involving other agencies concerned with the provision of community services;

(g) that such service development groups give priority to the development of community services, if necessary with assistance from the department, utilising the findings of the 1984 survey which categorised patients according to their capability for independent living;

(h) that bridging finance be made available where necessary to hospital boards to enable them to develop a range of facilities and services aimed at de-institutionalising patient care;

(3) Finance

As outlined in this report, until the funding base is changed from an historical funding pattern using bed day equivalents for mental illness and mental handicap, to weightings which ensure acceptable modern standards of care for various categories of patient within the service (e.g. acute, short stay, long stay), psychiatric services will continue to receive less than their fair share of resources.

The review team recommends:

(i) that the Advisory Committee on Hospital Board Funding with additional members co-opted from the mental health service, be asked to examine the funding formula with a view to changing the allocation base as it currently affects psychiatric services;

(j) that hospital boards be urged to review the priority given to psychiatric services, and to recognise the need to upgrade standards of care by appropriate budgetary allocation. If it is clearly not possible for boards to re-allocate resources in this way, it may be necessary for the Government to consider allocating additional resources.

(4) Management and Administration

The lack of philosophy and objectives, and the effect of this on leadership and accountability at individual hospital level preclude the effective and efficient management of resources.

The review team recommends:

(k) that hospital boards and individual institutions under their control be encouraged to formulate a philosophy for mental health services with written goals and objectives which are annually reviewed;

(l) that hospital boards encourage individual institutions to set up mechanisms to ensure greater consultation between the various levels of hospital staff and wider participation in the decision-making process;

(m) that hospital boards direct attention to the efficient and effective management of resources through individual accountability and fiscal recompense for hospital managers;

(n) that, in particular, hospital boards consider the establishment of user committees to advise on the operation of centralised support services;

(o) that hospital boards should evaluate the advantages of a regular interchange of administrative staff between psychiatric and general hospitals.

(5) Personnel

The serious shortage of professional staff, the sometimes inappropriate use of those available, and the problems associated with nursing staff rotation have serious implications for patient care and adversely affect staff morale.

The review team recommends:

(p) that the department be asked to report as a matter of urgency on measures that can be taken to remedy the identified problems of workforce requirements for the mental health services;

(q) that a working party comprising representatives of the employing authorities and employee organisations be set up to examine the implications of the negotiated rosters and current practices in their implementation;

(r) that formal appraisals of staff performance should be undertaken regularly for all staff in professional areas and should be available for use as a basis for individual development and promotion;

(s) that hospital boards be encouraged to initiate personalised staff development programmes, and to operate co-ordinated inservice training for all professional staff to assist in meeting the need for improved continuing education;

(t) that the department seek discussions with those responsible for professional and continuing education with regard to course content, noting especially the need for improved psychotherapeutic skills and the requirements for participation in multidisciplinary teams;

(u) that regular and systematic training on management techniques be considered by boards for psychiatric hospital managers to ensure their management skills are continually updated.