HIGHLAND USERS GROUP

ADMISSION TO HOSPITAL

The Views of Highland Users Group on Best Practice when being admitted to a Psychiatric Hospital

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HIGHLAND USERS GROUP

The Highland Users Group (HUG) was established on 11 June 1996.

Its aims are to:

1. Represent the interests of users of mental health services living in the Highlands.
2. To identify gaps in services and to find ways of improving services for mental health service users.
3. To provide information about mental health issues to users living in the Highlands.
4. To participate in the planning and management of services for mental health service users.
5. To pass on information and news amongst mental health user groups in the Highlands and to interested parties.
6. To increase knowledge about resources, alternative treatments and rights for users of mental health services.
7. To promote co-operation between agencies concerned with mental health.
8. To promote equality of opportunity and to break down discrimination against people with a mental health problem.

At present (July 2001) HUG has 246 members and 13 branches in:

- Caithness
- Sutherland
- Easter Ross
- Wester Ross
- Nairn
- Inverness
- New Craigs Hospital
- Lochaber
- Skye and Lochalsh

Between them, HUG members have experience of nearly all the mental health services in the Highlands including Child and Adolescent Services and Services for Older People. However, our reports mainly reflect the views of 'adults' with experience of mental illness.

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WHY LOOK AT ADMISSION TO HOSPITAL?

The Highland Users Group (HUG) decided to look at this topic for a number of reasons:

- In the summer of 2000 the old psychiatric hospital, “Craig Dunain”, was closed and a new hospital, “New Craigs”, was opened.

- A patient at the new hospital, whilst trying to find out her “rights”, discovered that there appeared to be no admission's policy. This provided encouragement to members of HUG to look at the subject.

- At the same time there were anecdotal stories that it was proving much harder to get admitted to the new hospital than the old one, although the environment of the new hospital was said to be infinitely better than the old hospital. This gave an incentive to establish criteria for admission or to find ways that would prevent the need for admission from a user-perspective.

- Lastly, a sub group of the Adult Service Development Group, (established by the Highland Primary Care NHS Trust) had been set up to develop an admission's policy. A member of HUG was involved in this group and used examples of our discussions to inform the development of a policy. The original intention was that this report could be produced before the admission's policy was produced. Unfortunately this did not happen, but we hope that the views expressed here will be of use when looking at admissions and hospital care.

- The discussions were held in the branches of HUG in September 2000 and involved a total of 70 people. The report itself was sent out to the 26 members of the HUG Round Table to check its accuracy and that it continued to reflect the views and experiences of members. In addition, some members of HUG discussed the new hospital in their meetings in June 2001, which confirmed many of the issues mentioned here, especially the fact that it appeared to be increasingly difficult to get admitted into the hospital.

- As usual, discussions were semi-structured and involved talking about basic issues, such as what purpose a hospital has, as well as the experiences people had had of admission. Because the meetings were held so close to the opening of the new hospital some of the experiences related to the old hospital, Craig Dunain. We believe that these stories are still relevant when looking at good practice.

WHY DO PEOPLE NEED HOSPITAL?

> **"I just snapped – anything was better than what I had got, anything at all. There were lots of problems in the community. I didn't want to go in, but staying in the community was worse"** - HUG member.

Most members of HUG considered hospital to be a vital community facility - it provides treatment, refuge and asylum. In the words of one HUG member:

> **"When you have been baling out the boat for so long and now the water is coming in too fast – that is when you need hospital."**

And another:

> **"Hospital can act as a route to a new life."**

The main reasons that people considered hospital admission could be needed were as follows:

1. When people cannot deal with their everyday situation, with other people, or are alternatively alone and isolated.
2. When people need treatment to get better (a long-term aim).
3. When people want to learn coping skills (a short-term aim).
4. As a last resort when all other options have failed.
5. When people are too ill to manage in the community or their illness is recurring.
6. When people need protection from abusive and un-supportive relationships.
7. When people are not responding well to their medication and it needs reviewed.
8. When the family situation is breaking up so that not only is one person ill but the whole family is becoming ill.
9. When people have lost control or feel that they are about to.
10. When a person considers that they are a danger to themselves or others, or those around them do.
11. When people need sanctuary and relief.
12. When people have moved out of conventional reality to the extent that they can no longer look after themselves, but may not realise this.
13. When a reassessment and a general checking out are needed.
14. As a form of respite to prevent future illness.
15. As a way of breaking an unhealthy cycle of living, e.g. when every day has become the same or when a person has withdrawn from other people and the world.
16. As a place of safety.
17. Because there is nowhere else to go to, e.g. if the person is mentally ill and homeless or in police custody or prison and vulnerable in these situations.

- However, not all members of HUG feel that they need hospital as an option. For some people it is not relevant. Their mental health does not become so bad that they ever consider hospital to be a necessary form of treatment.

- For other people there is a stigma about the place that discourages any thought that it might be helpful. Some people see it as an oppressive institution that would discourage their wish for autonomy and their need to deal with what can be a very personal problem in privacy.

- Other people see the idea of hospitalisation as a sign of failure and prize the idea of being able to continue to cope in the community however hard the conditions:

  "You have to fight illness all the time. I get awful depression, so much that it can take 3 hours to decide to go shopping. Once you can learn that you can cope and live through it, it can be very good. It is hugely better than hospital. You need to be in the community to fight it. In hospital you are out of the every day, in the community you can learn the skills."

  "…. At other times facing your problems at home is the only route to overcoming them."

- For some people hospital can lose the original purpose that they used it for and, instead, it becomes a place that doesn't help them. They can use it whenever life becomes hard to cope with. For a time it is clearly a place of refuge, but ultimately it can become too safe – so much so that people begin to lose the capacity to cope in the community and the safety the hospital provides becomes an illusion.

- Some people are used to seeing hospital as a place that they are admitted to without any option and for them it is a place where they feel that their liberty and freedom are taken away:

  "Some people don't want hospital, they just want to be left to themselves and to get on with life without interference. I feel like burning all my notes, to put them on the bonfire to wipe out the last 13 years. It has been a pain in the neck."

  "I keep on being admitted to hospital on a section and shunted into the locked ward. I'm always brought in from home always to the locked ward where I am injected and the same old story goes on."

- For such people there was a feeling that the process may never be productive. Unless people agree with what is happening and feel a part of the treatment it may always be counter productive.

KEY ISSUES

The three key issues that were constantly repeated were that:

a.) The home environment frequently becomes impossible to cope with (for instance due to family circumstances, poverty or homelessness) and that as life becomes unmanageable and uncontrollable there is a need to break out of that situation and get relief as well as help in solving the problems at home.

b.) That illness can become so intense that people need specialised treatment away from home.

c.) That on occasion there is a need for a specialised review and assessment of a person's treatment and medication that can only happen in hospital.

WHAT DO PEOPLE WANT FROM HOSPITAL?

There were a number of things that people wished for from hospital:

1. Security – everything is done for you, you have no worries and no bills to pay.
2. A chance to recuperate and feel stronger and more able to handle ordinary life.
3. A chance to learn ways of coping and improving your life away from the pressures of your home situation.
4. Space and time-out when you are vulnerable and not at your best (asylum).
5. People who are always there to give you help and to talk to.
6. It should be a place where you can get access to a resource of expertise.
7. The treatment for the specific illnesses people come in with.
8. Help with other problems that are contributing to the severity of the illness.
9. A chance to learn about your illness, to gain the skills to see the early warning signs, how to gain insight and manage illness.
10. A greater intensity of help than can be obtained in the community.
11. Access to therapies that can't be found elsewhere.
12. Access to the help that other patients can give to each other.
13. To find a space with boundaries that can protect you.
14. To get access to information about illness and services.

15. A chance to relax.
16. A chance to get a diagnosis.
17. A place to be protected from yourself.

People said that hospital should provide a caring, compassionate environment- a place where people can have trust in the people involved in their care.

Unfortunately, some people regarded hospital as more of a place of containment than a place where people could learn about, and manage, their illnesses.

However, the vast majority of members agreed that psychiatric hospital was an essential part of the care of many people with a mental illness. Yet, many people felt that it was not a place where people necessarily got better (which they had believed on their very first admission), but that it was more a place to restock or learn ways of coping with illnesses that may last for years or for life.

KEY ISSUES

The points that were most talked about were the need for hospital to provide:

a) A safe place where people could relax and recover.

b) A place where people could help each other. The assistance that fellow patients give each other was thought to be invaluable.

c) A place to learn skills with which people can manage their illness better.

WHAT SHOULD HAPPEN WHEN PEOPLE ARE FIRST ADMITTED TO HOSPITAL?

Many people talked about how frightened they were about first being admitted to hospital. Hospital does still have a stigma attached to it and many members of the public

still perceive it as a place of bedlam and a place to fear which can influence how they react when they, or people that they are close to, are admitted:

- One member of HUG explained that they were petrified at the image of hospital and that the fear of it stopped them asking for admission.
- They didn't know what would happen to them.
- Many people were affected by negative reporting of hospital by the media.
- Some people had seen people affected by large doses of medication and did not want to see the same thing happen to them.
- Some people thought that hospital signified the end of the life that they were used to.
- Other people regarded admission to hospital as in infringement of their identity, freedom and autonomy.

The actual process of admission can be very traumatic:

> **"You felt that you were being looked at by everyone, you felt that they were telling everyone about you and that everything good about you was being taken away."**

Measures that could prevent this are:

On first arrival: The emphasis should be on being put at ease and being helped to relax.

1. You should be met by someone who is empathetic, caring and understanding; someone with a polite smile and a friendly face and they should stay with you until the doctor or psychiatrist arrives.
2. They should take you to a quiet, comfortable room and talk to you like an individual.
3. When they take you onto the ward they could perhaps make you a cup of tea or something. They should be there from the start, reassuring you that you will probably end up all right.
4. They should introduce you to the other patients.
5. You should be able to put your bags away and see where you will be sleeping.
6. If you are up to it you should be shown around (given a guided tour).
7. You should be told what you can and can't do.
8. It should be possible for a friend or family member to stay with you whilst you settle in (even if this means using a camp bed for the first night).
9. The hospital should have all your information ready and not have to ask basic questions, such as your address.
10. You should be provided with information about the hospital, your rights as a patient and benefit entitlements.
11. You should be given some idea of what to expect.

12. If you are unable to take anything in then you should be given privacy and peace until you are ready to face the ward and other people. Many people have said that on first admission they were unable to take anything in:

    "The first time I was admitted I cannot remember. They took over and took complete control."

    "Being left alone until you are ready to do things is good. When you are ready then you can talk."

Equally, if it is late at night, people should be admitted and allowed to sleep with questions being asked in the morning.

A token of affection would be very much appreciated. On the move from Craig Dunain to New Craigs, everyone was given cards and chocolates. People were surprised and very pleased to receive this. A simple inexpensive gift, such as a flower or a card, can mark a large gesture of respect.

Many members of HUG talked about the problems that they faced in the community before admission had even been considered. Some examples were:

SELF-HARM:

There have been regular reports to HUG that people who are self-harming or in considerable distress, are sometimes not given the help they feel that they need. Doctors can see them as attention seeking or as manipulative and refuse to visit them or only visit with the police. They may also give the impression that such people would be needlessly taking up bed space on the ward.

CHANGING ATTITUDES:

Whilst the attitudes of some professionals can be very negative they can change.

One group talked about how these attitudes change. They had been used to their GP's "brushing off depression", but over some time they began to clearly recognise depression, to the point where:

> **"The GP and the Community Psychiatric Nurse were marvelous – everyone was so good and understanding. It was the waiting time for admissions that was the problem."**

KEY ISSUES

First impressions on admission to hospital can be critical. It is very important that the individual is put at ease and made to feel comfortable. This includes making the journey to the ward as easy as possible and giving people room to settle in.

INFORMATION

As has been said many people have very negative and inaccurate ideas about hospital. Members of HUG were clear that there is a need for comprehensive provision of information that should be provided before, during and after a person is admitted to hospital. The point was made that ignorance breeds fear and information speeds recovery.

Some groups felt that there was little effective information provision at the moment:

> **"When admitted to hospital nothing is explained and there is no explanation for the family. Even when people are very distressed they need basic information on their rights and what to expect whilst in hospital".**
>
> **"Families are not told anything about what to expect, what to do or who can help. Very often they are not told about the illness of their family member."**

The whole community should have a realistic idea of what an admission to a psychiatric hospital involves, what the hospital is like and what to expect. Stereotypes about hospital and mental illness should be challenged:

> **"Getting dragged off to the big house" "They're coming to take you away" were phrases people used as children that affected their feelings about later admission",**
>
> **"I was told, "You need to go to hospital", I was taken by surprise – I saw the doctor and he phoned the ambulance. I didn't know what to expect or why – I had a vision of bars on the windows, of locks and screaming."**

People should have information about:

- The ward itself
- The treatment they will, or are likely to, receive
- Their medication and what being on medication is like

- What they can and can't do
- Their diagnosis
- Their rights
- How to make a complaint about a professional

Relatives should have the situation explained. They should (assuming the user has given permission) know about the illness, the treatment and what to expect. It should be made clear that there is nothing shameful about mental illness.

Children and young people should have specialised information provided to them.
Information should be provided at the right time (finding out what a person's diagnosis is some years after it has been made is not satisfactory).

Information should be provided in plain English and given in an unhurried manner.

The assumption should be that people want information. Some people feel that they were not given information, as there was an assumption that they were asking questions "out of their illness".

KEY ISSUES

a) Information needs to be provided both to potential users, present users and carers. It should have two functions: it can dispel myths and reassure, and it can let people understand their new environment and circumstances.

b) Information should be in plain English and in attractive, high quality formats.

WHEN SHOULD PEOPLE NOT BE ADMITTED TO HOSPITAL?

There are a number of circumstances when people thought that admission would not be appropriate:

1. Sometimes admission can make illness worse. For instance, if a person has a great dislike of hospital and a sharp sense of independence.
2. Admission can have a large affect on family and friends and, although they are not of prime concern, their views, feelings and knowledge of the situation must be taken into account when admission is being considered.
3. When a person's ability to return to the community is affected. A member of HUG talked about how hard it was to adapt to the demands of community living. A prolonged admission with intensive 24-hour support was abruptly changed to an afternoon a week at a day hospital.
4. Occasionally hospital can come to be seen as the preferred route for any upset or problem – this is not always appropriate.
5. People with drug and alcohol problems, but no mental health problem, should not be admitted to a psychiatric hospital. They should have access to specialist facilities dedicated to providing in-patient help for people with drug and alcohol abuse problems. An alternative view was also expressed about this: people with substance misuse problems need to detox in places where their physical health is cared for, but afterwards a psychiatric ward could be very helpful. Some people view drug and alcohol problems as a mental illness or at the very least a sign of poor mental health, and as such people with these problems should be dealt with under the mental health banner.
6. A few people may try to access hospital as a way of avoiding the consequences of crime – where this does not involve illness this is not appropriate.
7. When people are a threat to other patients and staff.
8. Sometimes people are not interested at all. If a person has no interest in treatment, and this is not because they are ill, then they should not be treated.
9. Some people said that people needing respite (which is essential) do not often need it in hospital (although some will) but that until such dedicated facilities exist there will be a need to provide it within hospital.

KEY ISSUES

There was a very clear majority view on two issues:

a) People with drug and alcohol problems, but no mental illness, should have high quality dedicated facilities for treatment, but a psychiatric hospital would not necessarily always be that place.

b) Many people have a great need for respite care to give a break from their situation. Access to this would allow people to maintain an acceptable level of health. However, in most circumstances it should not occur in hospital but in dedicated facilities which people do not have to pay for.

BEING REFUSED ADMISSION TO HOSPITAL

- Within HUG there was a feeling that, although the existence of illness is a very important factor in admission to hospital, so is the existence of distress and no longer being able to cope. In fact, the precipitating factors for hospital admission are often more to do with a person's environment and home circumstances. Trying to distinguish between the distress that is caused by, for example, a person's environment and that caused by illness is very hard, if not impossible, for the person concerned.

Many members of HUG had experienced being refused admission to hospital when they wished to be. Their thoughts on this were:

- It can be very frightening and people can feel desperate and rejected.
- Some people will, as a consequence, self-harm or attempt suicide and end up in the accident and emergency department (in fact there were anecdotes that at least two people had killed themselves after being refused admission to hospital).
- Some people become so desperate that they commit a crime as one route to getting help or one means of expressing how they feel.
- Many people just become more desperate and increasingly ill until they have to be admitted.
- People felt that it indicated a lack of respect for them or their situation.

"Once I went to the hospital as I felt that I needed it. They said I was alright – I felt awful and left."

However, if handled well, people can feel a lot better:

"If a person goes through the options with you in a meaningful and sensitive way, and you willingly go along with the discussion of ideas and possibilities, and a viable alternative is offered then this can be great."

"Some people on being denied admission to hospital can feel a mixture of relief and disappointment."

KEY ISSUES

a) If a person is not going to be admitted to hospital then it is very important that they are helped to understand why and hopefully to agree with the decision.

b) Although a psychiatric hospital has a specific function it has to share the responsibility that society has for caring for, or finding appropriate facilities for, people who are in considerable distress but unable to access help.

c) If a person is not admitted to hospital it is important that arrangements are made for follow-up in the community.

WHAT COULD PREVENT ADMISSION TO HOSPITAL?

There were many views about this, some of which have been repeated in other reports. Generally, people felt that improved community facilities could reduce the need for admission and lead to shorter admissions, by being both responsive to crisis as it develops and able to provide more help in the community on a person's discharge.

However:

People who are living through acute illness at home may make it hard for other people to cope. In fact it can lead to other people feeling unwell too.

It is important that people have support if they are living at home. There must be access to back-up and advice when people need it.

Ideally there would be a short-term alternative to hospital – this might take the form of:

1. A crisis or safe house that people could use in short-term emergencies or as an alternative to hospital.
2. Provision and access to sources of expertise in drop-in centres with room to provide time out.
3. There should be some form of accident and emergency response to people with a mental illness who are in crisis.
4. In New Craigs it may be an idea if one of the wards were specifically for very short admissions, perhaps for a few hours or a day that people could access in times of distress.
5. In areas at some distance from New Craigs, the use of local short-term beds may be a useful option.
6. Preventative admission to hospital may stop a more prolonged admission later on.

Other services which may prevent, or reduce, the need for admission are listed in the Appendix.

KEY ISSUES

Local facilities and preventative work could avert the need for longer admissions. As community facilities develop the need for hospitalisation may remain but may also reduce.

WHO SHOULD DECIDE WHETHER A PERSON SHOULD BE ADMITTED INTO HOSPITAL?

A comment made by many members of HUG was that:

> **"If we are well enough to know we need to go into hospital, we are seen as well enough not to be admitted."**

For people affected in this way the consequence is that they can feel resentful of the way in which hospital admission is handled.

Members were clear that people with a mental illness should have a say in the decision to admit, even to the extent that some provision could be made for self-admittance as long as there were ways of preventing any abuse of the idea.

It was also felt that the views of family members were very important.

Where this didn't happen things could go dramatically wrong:

- One person tried to get admitted in the early stages of his illness, but the refusal by the hospital to provide a bed caused him to lose trust in services. He became increasingly ill and began to lose insight into his illness. By the time the hospital were willing to admit him he would no longer agree to this. This situation escalated until it resulted in the break-up of the family.

- Another person went through the process of being prepared for admission to hospital, giving her time to come to terms with it, to accept it and in the end agree with the decision. However, when she had agreed with this idea no beds were available and

what had been intended as a planned admission ended up in the trauma of an emergency admission.

- Users have sometimes felt they have had to behave dramatically and out of character in order to convince the hospital that they need admitted.

- Other members talked of their growing desperation as they turned to person after person only to be denied the help and support that they felt they needed.

- Members of HUG were clear that after a few admissions users can become very aware of how seriously ill they are and should be encouraged to contact services. Services, in return, should respond and recognise the users' expertise and if necessary arrange for an admission.

The users' views should be celebrated:

> **" We should be aiming for a society where we are prepared to take responsibility to say we need help and for this to be seen as a positive step."**

But equally they shouldn't be judged:

> **"People felt that they couldn't explain why and exactly when they knew hospital admission was necessary (sometimes simply because they were too ill) yet many felt they had to justify to the professionals why they needed to go to hospital".**

People in frequent contact with users were also important; friends, other users, social workers, support workers and CPN's. Their views can be critical in getting timely intervention. The assistance that CPN's can provide by "setting the wheels in motion" was highly praised in some of the groups:

> **"Someone came in, they phoned and arranged for admission. If they know you and your situation and respond to your view they can be very helpful – they know whether you like or dislike hospital, what is a mask and what is coping."**

Ideally the decision should be made jointly by the user and the people concerned with their care.

It is important that, as admission to hospital becomes more likely, the user and family have time to prepare and get used to the idea to the extent of being able to plan their admission and draw up Care Plans:

> **"If you are likely to go into hospital, people should stop and go through it with you. Why do you want to go in? Do you really need to?"**

Preparation can prevent later trauma:

> Admission for one member, **"came like a thunderbolt" and "floored us"**

It is also important that people know your views:

> **"If you have been sectioned you might always agree to go into hospital, just in case they section you again. In this way you keep a little control over your life."**

It is also important to realise that users can cross a line where they can no longer make or agree to decisions. In these circumstances it can be necessary for other people to take responsibility away from you – albeit gently.

> **"People have known that they need to go back into hospital but couldn't bring themselves to pick up the phone. They wait for the doctor to suggest it because they can neither articulate their need or suggest an option. In these circumstances having someone who knows you can be vital".**

> **"I am doing well. I hold down a job and can be seen as stronger than I actually am. You can look well when you are going to pieces inside."**

Ultimately most people thought the decision should rest with the doctor responsible for a person's care.

Although some people thought that if a CPN was in regular contact with a person then giving them the authority to admit a person directly could prevent delays and reduce bureaucracy.

Some people disagreed with this view and said that the ultimate decision should rest with the user. Many people felt powerless when life became hard enough to warrant admission to hospital:

> **"I have complete control over my medication but no control over admission to hospital."**

KEY ISSUES

A variety of people have an expertise in what the user is going through. They should all have a chance to influence the idea for admission. The feelings of users is very important and needs to be recognised. They should be able to influence both admission and refusal to be admitted. However, ultimately the doctor needs to take responsibility and, on occasion, control.

OTHER ISSUES RAISED AS A PART OF THE ROUND OF MEETINGS

DISCHARGE:

Members of HUG talked about the need for support on discharge from hospital. It can be a critical period in people's lives and can be one in which people feel both disorientated and unsupported:

> **"It is vital that people have follow-up from hospital. It is no use getting insight into what you are going through, and ways of coping, if when you get back out there are no resources or people to fall back onto."**

Many people can feel very let down on discharge. They may have had high expectations and still feel bad, which they may feel guilty about. They may also be on high dosages of drugs and find these hard to cope with, as well as feeling let down by staff that they felt didn't understand them. Follow-up is vital after discharge.

One member of HUG had to find her own accommodation on discharge from hospital. This was a bedsit in which she felt there was little hope or help and which she considered led directly to a later overdose.

OUR ATTITUDES

The way that we look at our illness and our treatment can have a large influence on our care:

One member talked about being able to relax for the first time in a long time on admission but, because they then felt so well, they began to feel guilty about being in hospital and discharged themselves only to get ill again when they found that they still couldn't cope at home.

This illustrates the point made many times that it is a person's home environment that can cause problems and which needs changed or adapted to.

DURING OUR STAY

Hospital can be both a refuge and an escape but it can also be a place where very intense and effective therapies can be carried out.

However, this can be at odds with people's experience. People often talk about how infrequently they see doctors and how worried they are that nurses will continue the habit of staying in the nurses' station, as happened in Craig Dunain.

They also said that sometimes professionals don't realise that the habit some people have of hiding away and not communicating is due to the fact that they feel the burden of asking for help is beyond them, even though they would appreciate contact:

> **"The therapy on offer in hospital may be exactly what you need but because you are very distressed it can be a missed opportunity because you can't ask for, or participate in, it."**

> **"You cannot really talk to people you do not know. Talking about such things is based on trust, which has to be built up. You need to pick the people and work out who you feel capable of speaking to."**

> **"If you have been on your own for a long time, it can be very hard to open up. Sometimes you need a little gentle prodding."**

> **"Some nurses are brilliant. They are there for you and for everyone else. They do not stay in the office and are always on the ward. They joke with you, use your language and they do not judge you. They can be a great help."**

Some members felt that there was restricted choice in hospital, for instance, about who treats them, about their medication and other therapies. This can make it hard for patients to participate in treatment.

There was also a feeling that people's whole circumstances were not always taken into account. Some people may have a history of mental illness, drug and alcohol problems and a history of abuse that are all dealt with in separate, different and confusing ways. It is important that one problem is not dealt with at the expense of others.

There is still a feeling that people can be ignored:

> **"In a way hospital encourages bad behaviour. You need to shout or scream, even if quietly to get attention. This is not good."**

A common request was for more opportunities to talk and for greater access to psychological services.

Although we have mentioned that hospital has life-saving functions this does not mean that everyone believes it is a nice place:

> **"It is still a place you want to get out of. Being in hospital is still a grueling case of survival."**

THE JOURNEY

Getting to hospital can be very traumatic for people. Transfer from a person's home to hospital should be quick and safe. In some circumstances the use of an air ambulance might be a sensible option although it could cause people to feel very insecure.

FAMILY

Many people talked of the need for family to be consulted, supported and involved. People talked about the despair that can be felt when they have finally persuaded a relative to go into hospital only to see them treated apparently harshly – this can be very hard for them to cope with.

Relatives should also be encouraged and helped to keep in contact and to visit and share in future plans.

Many people may have mistaken impressions;

> **"Families often do not understand what is going on. They can see you being whipped off and think that you will come out better, but this is often not so."**

KEY ISSUES

a) Friends and family play an important part in a person's care and can be traumatised by the events in their family. They need to be able to get support and know that their role is acknowledged.

b) Staff in hospital need to reach out sensitively to people so that patients feel able to participate in their treatment and in their stay.

THE CRITERIA FOR ADMISSION TO HOSPITAL

Many of the groups made the point that admission to hospital should be determined solely by the need a person has for that form of treatment. Whilst restrictions can

occur because of a shortage of a particular type of bed, policy and ideally practice should not be influenced by this consideration.

THE CRITERIA FOR ADMISSION SHOULD BE:

1. If people are a danger to themselves or others
2. If people can no longer look after themselves in the community – they are suffering from neglect and helplessness
3. They are unable to undertake daily tasks any more
4. They have lost insight and are becoming increasingly ill (although this needs to be balanced against a right to autonomy and self-determination)
5. Where community facilities are unable to provide adequate support
6. If people are in inappropriate places ,for instance, ill and in police custody
7. If there is no other alternative
8. The family or friends can no longer cope with, or support, the person
9. Where people have problems that can only be addressed in hospital – perhaps reviewing and changing medication
10. The severity of their illness justifies hospital treatment
11. People's willingness to go through with treatment should play a part
12. A person's location and isolation
13. They need a break to prevent future deterioration

Some people also thought that there were some people well known to services who would follow a recognised path of illness as they began to relapse. For such people an early preventative admission could be very useful. However, other people talked of their distress as other people appeared to get priority for admission that they themselves didn't have:

> **"There are times that I would have been helped if I had been admitted early in order to nip in the bud, problems that were developing. But I've usually been screaming mad when I have been admitted. If I had been admitted earlier, I would have coped better and stayed for less time….. I have never been able to ask for admission until it has been too late."**

KEY ISSUES

Admission to hospital is a great deal more complex than just an increase in the severity of a person's illness. The conditions at their home and their community also play a large part, as does the existence of supportive, accessible services close to where they live.

CONCLUSION

Hospital provides both sanctuary and escape from home circumstances, as well as direct treatment of mental illness. It can be seen as both a place of safety and place of imprisonment.

Many people wishing for admission do so mainly because they need a break, without which they would certainly become more ill. It is important that access to this is provided, but whether this would be best provided in hospital needs further discussion.

Hospital provides an ideal place for people to learn skills in identifying and coping with illness in relative safety but many users feel that they are unable to access, or were not offered, such opportunities.

Many users feel that their knowledge of when they need admitted is not sufficiently acknowledged; users and their carers need to have their expertise acknowledged.

With an increase in community facilities, including out-of-hours, more responsive services and crisis services, the need for admission could be reduced.

Some people do need admission but this is something they may only need for a short time; access to safe places or some form of accident and emergency response could prevent later, more prolonged or inappropriate admissions.

APPENDIX

PREVENTING ADMISSION TO HOSPITAL

Below are some of the ideas HUG members thought could prevent the need for admission to hospital:

1. A phone line providing access to people trained in crisis – not necessarily medically trained but with the ability to link into professional services.

2. Increased support from drop-in centres with training provided to workers and users in dealing with crisis.

3. Access to self-help groups where people can get together and support each other; people said that being able to build up trusting relationships with other users is very important.

4. Buddying/befriending or peer-support schemes where users can link up with, and help, each other.

5. Volunteers to provide support to people.

6. Help for the family can be very useful in providing a stable environment - giving the family the skills to cope can help the user to cope too. It can also help users and carers alike to feel less guilty about what is happening.

7. GPs are often the first point of access and can be very good but equally can be seen as less than helpful. Different people can also have different views about the same doctor. There is a feeling that many doctors could benefit from awareness training from users as well as in gaining a greater range of skills in helping people with a mental illness.

8. The continued development of the Community Mental Health Teams would be very useful, especially if users can build up trusting relationships with members of the team. Some people had very clear feelings that, without the support of the teams, they would have spent considerably more time in hospital. There was, however, a call for continuity. People can find changes in staff and support, which, although they may be inevitable, can be very hard to cope with.

9. Some people felt that contact with people who would visit them at home, and provide a gentle jump-start out of their apathy, could be very helpful.

10. A responsive service is very important. As people realise that they are getting ill it is important that services respond quickly to this or to other critical events in a person's life.

11. Some of the causes of hospital admission occur when people can no longer cope. Some people have had sensitive help with looking after the house or their children, which has taken areas of responsibility away and allowed them to cope a little longer or to come through the other side of the crisis.

12. Out-of-hours provision, containing a range of services, could be very useful.

13. Some people may find it hard to ask for help and may become very isolated. Some form of help that reaches out to them may be very useful.

14. The use of information technology could also be very useful, both for tele/video conferencing or access to psychiatry online. It could also be a way of finding out information and accessing support. The Internet is a good way of saying very personal things and yet staying anonymous.

15. Some people travel to Inverness for treatment, for instance to Ross House (the day hospital). It may be an idea to provide accommodation for such people so that they can gain access to therapies and ideas for coping in a relaxed environment without the struggle and occasional trauma of travel.

16. Respite care, both planned and unplanned, can be very important especially if users can access it without charge.

17. Some areas do not have drop-in centres – in these areas people have called for access to places where they can "go and do things".

18. Access to ways of seeing the signs that you are getting ill – e.g. training for users in self-awareness could allow early intervention.

19. Access to support workers can allow people to cope in the community in situations that they wouldn't normally be able to manage.

20. Access and encouragement to use sports, leisure and recreational facilities can be very useful.

21. A phone link to the hospital ward that people could generally use, or to their GP, could provide both security and friendly advice. However, one person reported contacting a ward when suicidal and being told that they were just using it as "a threat to get into hospital" and yet later when they did take an overdose being asked "why didn't you come to talk to us?"

22. Access to an out-of-hours crisis service similar to the Ness DOC CPN service, across the Highlands may help with many problems out-of-hours.

23. The environment that people are in can be the cause of illness. Wider changes to that environment would reduce illness in the community and reduce admission to hospital.

24. Home-treatment is seen as a step that could prevent later admissions.

25. Services may need to be creative – a weekly visit from a CPN may be useful but can become inflexible and perhaps not as important as the ability to adapt to crisis that may be happening if they had smaller case loads.

26. Places like Catalina House (a rehabilitation unit/nursing home) could act as alternatives for some people.

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