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# Correspondence

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## Contents



## Splitting in-patient and out-patient care, and why it has succeeded

The debate on splitting in-patient and out-patient responsibility[1] coincides with the 20th anniversary of John Dickson Ward, which pioneered acute in-patient care as a specialist service separate from community care at Guy's Hospital, and has since moved to the Maudsley.[2] Being reassured to see Baggaley, in debate with Burns, quoting our work, it was natural to write to support his views.

Burns claims that the split is not evidence-based, nor could he find any theoretical basis for it. We decided to separate in-patient from community care as a pragmatic and much needed attempt to address the intractable bed crisis and unremitting pressure on services that followed the closure of Victorian asylums and mental institutions. The pre-existing model, where a single consultant provided both in-patient and community care to a designated catchment area, was simply unable to cope with the challenge – and was crumbling.[3] There was in fact little evidence – and no theoretical basis – to support the intrinsic superiority of the previous model *per se*, and its survival owed more to tradition than to any tangible advantage it could offer to our patients. The sad reality was that mental health professionals were difficult to recruit and retain, and retired early as soon as they could. Worse, acute wards were overcrowded and understaffed, chaotic and inefficient – the true Cinderella of the National Health Service (NHS). Talking of 'continuity of care' was a platitude when the very provision of any care was in doubt.

Probably the best evidence that the functional split has been successful is that we did resolve the local bed crisis. Our unit managed up to 500 admissions a year.[2] We reduced duration of stay by ensuring high standards of care.[4] Our model has since been widely adopted, most likely a result of the practical solutions it delivers in everyday practice to both patients and teams. This is because, rather than being an academic or centrally imposed construct, it emerged as a genuine bottom-up response of mental health services to patients' most pressing needs. Indeed, turning acute care into a specialist service has raised standards of patient care, as exemplified by the implementation of accreditation systems, dedicated multidisciplinary teams and care pathways, which do include effective and well-organised ward rounds. In-patient psychiatry has become an attractive career choice that requires an increasingly specific set of skills (http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/whygetaccredited.aspx).

The split has offered local solutions to local problems, an indication that mental health services can be responsive to the community that they cater for and structure themselves accordingly. If rates of bed occupancy are any guide, the need for in-patient care will probably remain unabated, particularly in inner cities. In any branch of medicine, in-patient care is an organised, multidisciplinary and interpersonal service where, to secure consistent care for patients, strategic priority should be given to staff stability and education in order to build teams with collective competence and a shared ethos of responsibility. We have been doing this for the past two decades, and so have many other in-patient teams in my own Trust and across the country.


1 Burns T/Baggaley M. Splitting in-patient and out-patient responsibility does not improve patient care. *Br J Psychiatry* 2017; **210**: 6–9.

2 Dratcu L, Grandison A, Adkin A. Acute hospital care in inner London: splitting from mental health services in the community. *Psychiatr Bull* 2003; **27**: 83–6.

3 Marshall M. London's mental health services in crisis. *BMJ* 1997; **314**: 216.

4 Dratcu L, Walker-Tilley T, Ramanuj P, Lopez-Morinigo J, Huish E. Metropolitan acute hospital care in psychiatry: measuring outcomes. *Eur Psychiatry* 2012; **27** (Suppl 1): P-1227.


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**Author's reply:** Dr Dratcu and his colleagues at Guy's are to be congratulated on providing what was clearly a very successful 'local solution to a local problem'. The 1990s were, as he points out, a particularly tough time for mental health services, particularly in London.[1] Had Dr Dratcu cast his gaze just 6 miles to the south-west, he would have observed St George's in Tooting taking a radically different approach to the same problem. There, the emphasis was explicitly on strengthening continuity of care with declared consultant leadership and clinical decision-making in integrated sector teams. Throughout that decade, not one general adult admission was sent out of area, nor was any acute admission delayed. Senior posts could be filled, and the Department of Health referred to St George's at the time as the only mental health Trust in London not in crisis.

None of this, of course, tells us whether Guy's got it right or St George's got it right. What it does show is that commitment, energy and strong leadership produce impressive results in mental healthcare. The pioneer effect is a well-recognised and powerful force in mental health service development. The impact of enthusiastic and charismatic leaders needs to be distinguished from the impact of any structural changes if generalisable and enduring benefits are to be achieved. This requires reflective and sophisticated enquiry into the different models of care. Such enquiry (or even careful debate) has been singularly absent in the roll-out of the functional split.

In my contribution to the debate, I was advocating for a rigorous and open-minded critical approach to this enormous service change.[2] Obviously, my belief is that, on balance, it has been a mistake. But trading enthusiasms and convictions will not move us much forward on the substantive questions. I know this only too well, to my cost! Twice I have carefully researched my own strongly held enthusiasms – assertive community treatment (ACT) teams and community treatment orders (CTOs) – to find that I was wrong and I have had to change my opinion as a consequence.

Continuity of care is no trivial matter to be discounted. Wherever in the world patients have any real power to shape their care, they opt for continuity – just look at any private or insurance-based system. We know it matters to them, just as it matters to us. It is not something to be lightly abandoned without clear evidence of significant clinical benefits in return.

To end on a brighter note, let me reassure Dr Dratcu about at least the feasibility (if not desirability) of continuity of care. Our 3-year follow-up of patients from the OCTET trial[3] found that, with or without CTOs, ordinary CMHT staff achieved a