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"Set up to Fail": Staff Experiences of Caring for Long-Stay Patients in Acute Mental Health Wards in England

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ABSTRACT

Rising demand for mental health services worldwide has placed increasing pressure on acute inpatient services, where patient lengths of stay continue to grow. Long-stay admissions (> 60 days) are linked to demographic, diagnostic and service-related factors, with the United Kingdom reporting longer stays than other developed countries. National reforms aim to reduce unnecessary inpatient stays, but staff report high strain and burnout within current systems, reflecting systemic issues such as inadequate community support and limited discharge options. We aimed to examine staff experiences of working on acute mental health inpatient wards, focusing on long-stay patients, to drive improvements in care quality and workforce sustainability. Six focus groups were conducted with a range of clinical staff working on acute wards ($n = 34$). Themes were generated using inductive, reflexive thematic analysis, focusing on semantic content while also considering latent meanings. The following key themes were identified: (1) Structural and systemic conditions shaping care delivery, (2) Organisational processes constraining patient flow, (3) Emotional labour and burnout among staff, and (4) The cycle of institutionalisation and dependency. The findings evidenced that acute wards are under significant pressure, with long stays, delayed discharges, and repeat admissions driven not only by clinical need but also by gaps in housing, community services, and care coordination. Addressing these challenges requires investment in workforce development, stronger inter-agency collaboration, and expanded community provision, enabling acute wards to fulfil their intended role as short-term, recovery-focused settings that provide person-centred care for people in crisis.

1 | Introduction

1.1 | Background and Current Provision

Globally, more than one billion people are living with a mental health disorder (World Health Organization 2025). Following the COVID-19 pandemic, record numbers of people have sought support for their mental health, further intensifying pressures on acute mental health services (Centre for Mental Health 2024). Acute mental health services provide intensive, short-term inpatient care for people experiencing a severe mental health crisis or episode. These services aim to stabilise individuals, deliver necessary treatments, and facilitate a return to the community or to a less intensive level of care (NHS England 2023a). They play a critical role in the care pathway, supporting individuals during periods of crisis when community-based support is insufficient to meet their needs.

Although acute inpatient services are intended to be crisis-focused and of short duration, the average length of stay continues to increase. Between 2016 and 2023, there was a 24% increase in the number of people in inpatient mental health facilities, with the latest National Health Service (NHS) benchmark figures demonstrating that the average length of stay in an acute adult mental

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health bed increased from 32 days in 2014 to 39 days in 2023 (The King's Fund 2024). Major policy initiatives have sought to address the long-stay patient problem, but with limited impact (NHS England 2024b). Community treatment orders (CTOs), intended to reduce 'revolving door' admissions, have been shown to be no more effective than previous forms of compulsion, and payment by results has not resolved core issues of inappropriate placement or the lack of suitable discharge options (Poole et al. 2014). Consequently, pressure on available beds is a direct manifestation of missed opportunities within the care pathway and inadequate community support for patients. The United Kingdom (UK) has longer inpatient stays than other developed countries (Moran and Jacobs 2013), making it essential to explore staff experiences of working with long-stay patients in a UK context.

Extensive research has been conducted to identify factors that predict length of stay, including systematic reviews undertaken nationally and internationally (Carranza Navarro et al. 2021; Dima et al. 2024). Research shows that older individuals, those from minority ethnic groups, and those involuntarily admitted to hospital are more likely to become long-stay patients (Phillips 2019), defined as admissions exceeding 60 days (NHS England 2023a). Diagnosis also influences stay length, with psychotic disorders linked to longer admissions (Gopalakrishna et al. 2015) and personality disorders associated with shorter stays (Degli Esposti et al. 2022). However, patients with a personality disorder often experience more frequent admissions and earlier readmissions, indicating a pattern of brief but recurrent hospitalisations (Lewis et al. 2019). Professional stigma, difficulties in forming therapeutic alliances, and perceptions of poor treatability can contribute to the delivery and duration of care for those with a personality disorder (Loader 2017; Ring and Lawn 2025).

1.2 | Service Transformation

Relieving the strain on acute mental health services is a global priority (Phillips 2019) and longstanding concerns around high bed occupancy, inconsistent care quality, and delayed discharges have driven a national transformation agenda. The Royal College of Psychiatrists (2022) outlines a comprehensive framework for how person-centred inpatient care should look. Their standards aim to ensure timely and purposeful admissions, trauma-informed and recovery-oriented ward environments, multidisciplinary treatment planning, and coordinated discharge pathways. These principles underpin the transformation of inpatient services from reactive and risk-driven settings to proactive and person-centred places of care that support short, effective admissions and improved long-term outcomes. They also align with the wider ambitions of the Long-Term Plan (NHS England 2019a) and Mental Health Implementation Plan (NHS England 2019b) to reduce out-of-area placements, improve patient experience, and embed recovery-focused and equitable care. Recent policy developments, such as the 10-Year Flagship Plan (NHS England 2025), reaffirm these priorities and highlight the ongoing need to strengthen acute and community pathways to relieve pressure on inpatient services.

A reduction in long-stay admissions may benefit patients by minimising negative experiences of restrictive hospitalisation and reducing the potential challenges of community reintegration post-discharge (Babalola et al. 2014). It may also benefit staff by reducing work-related stress. Recent research with staff across NHS and third sector mental health services describes a system under strain, in which inefficient pathways, high risk aversion and limited resources result in staff feeling unable to deliver meaningful care, contributing to burnout (Sambrook et al. 2025). Inpatient services currently have higher staff sickness absence rates than community mental health services, as well as higher vacancy and turnover rates (Centre for Mental Health 2024), demonstrating a need to better understand how staff experience and respond to the pressures of working with long-stay patients, and how these experiences influence care quality and workforce sustainability. Recent research (Berry et al. 2025) has explored staff and patient experiences of acute mental health wards, highlighting the challenging nature of inpatient environments, including high levels of stress, competing demands, and tensions between task-oriented care and therapeutic engagement. However, this work primarily focused on intervention delivery rather than specifically examining staff experiences of managing long-stay patients, and staff perspectives remain relatively underrepresented in the literature despite their central role in delivering care and shaping patient outcomes. This study seeks to address this gap, offering novel insight into the challenges and dynamics that influence length of stay and care delivery.

1.3 | Research Aims

This study aimed to understand and describe the experiences and perspectives of staff working on acute inpatient mental health wards (hereafter referred to as acute wards) in the UK, with a focus on long-stay patients (> 60 days).

2 | Method

2.1 | Study Setting

This study was conducted within a North-West NHS Trust across three localities to capture variation in service delivery and contextual factors across different regions. Two localities represent urban areas, while the third is more rural. The Trust provides a range of community and inpatient physical and mental health services, including acute mental health wards.

2.2 | Design and Participants

A qualitative design was employed, using focus groups to explore shared and divergent staff perspectives on long-stay patients within acute ward settings. Focus groups were selected over individual interviews to facilitate interaction between participants, enabling the co-construction of meaning and exploration of differences in perspectives and shared challenges within team-based environments. Purposive sampling was used to recruit participants from a range of professional roles to ensure diversity. Inclusion criteria required participants to be employed by the Trust, working on an acute ward, and able to provide informed consent. No restrictions were placed on contract type or length of service.

A total of six focus groups were conducted with 34 participants (ranging from three to nine participants per group).

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TABLE 1 | Number of participants and their corresponding job titles.

Job title	Number of participants
Clinical Support Worker (Band 2–3)	6
Clinical Lead (Band 7-8c)	5
Ward Manager (Band 7)	5
Occupational Therapist (Band 5–6)	4
Staff Nurse (Band 5–7)	3
Consultant Psychiatrist (Band N/A)	2
Discharge Team Member (Band 4–7)	2
Practice Manager (Band 7)	1
Therapist (Band 5)	1
Student Social Worker (Band N/A)	1
Occupational Therapy Support Worker (Band 3)	1
Registrar (Psychiatry) (Band N/A)	1
Advanced Nurse Practitioner (Band 7)	1
Practice Development Nurse (Band 6)	1

Participants represented a range of roles (e.g., nursing staff, healthcare assistants, occupational therapists, and psychiatrists), with variation in seniority, including different NHS Agenda for Change bandings (see Table 1). All staff approached agreed to participate. This high uptake may reflect pre-existing interest in the topic, the relevance of long-stay patients to daily clinical work, and recruitment via internal Trust channels. However, it also raises the possibility of self-selection bias, whereby those with stronger views or experiences may have been more likely to participate. Focus groups took place during the working day to maximise attendance. No incentives were offered for participating.

2.3 | Materials

Participants were provided with a study information sheet and gave written informed consent prior to participation. A semi-structured topic guide was developed in collaboration with key stakeholders, including Trust representatives, public and patient contributors, commissioners, and the local authority (see Appendix A). The guide was designed to explore experiences of working on acute wards, with a focus on long-stay patients. Participants were asked to collectively identify two long-stay patients to use as case examples. These were selected based on shared familiarity within the group and perceived representativeness of long-stay experiences. Participants were asked questions relating to these cases (e.g., factors contributing to extended length of stay), alongside broader questions about care quality and systemic challenges.

Given the potentially sensitive nature of discussing patient care and workplace challenges, a distress protocol was in place. Participants could pause or withdraw at any time and were signposted to appropriate resources if needed following the discussion.

2.4 | Procedure

Potential participants were identified by Trust staff (PW, MH) and approached by the researcher (LS). Focus groups were conducted between May 2024 and March 2025 on Trust premises, in private meeting rooms with a hybrid option available via secure video conferencing. Sessions lasted between 32 and 50 min (average 44 min) and were facilitated by LS, an experienced qualitative researcher. Participants had no prior relationship with the facilitator. Attention was paid to managing potential hierarchical dynamics between participants of differing roles and seniority.

2.5 | Data Analysis

Focus group discussions were audio-recorded, transcribed verbatim, and checked for accuracy. Data were analysed using reflexive thematic analysis based on Braun and Clarke's (2024) six-stage process, due to its theoretical flexibility and emphasis on the active role of the researcher in interpreting meaning within the data. Analysis was conducted from a contextualist perspective, recognising that staff accounts reflect both individual meaning-making and broader organisational and systemic contexts. This approach aligns with reflexive thematic analysis, which conceptualises knowledge as co-constructed between participants and researchers rather than as a direct representation of an objective reality.

Coding was primarily inductive and initially focused on semantic content, with increasing interpretative depth as analysis progressed. NVivo software (v15.1.2) supported data organisation. Codes were iteratively developed into candidate themes, which were reviewed and redefined through ongoing engagement with the dataset. Rather than seeking consensus or inter-rater reliability, discussions with members of the wider research team were used to support reflexive engagement and deepen interpretation. In relation to positionality, the lead researcher is a clinically informed qualitative researcher with previous, indirect experience of the Trust, who maintained awareness of how prior professional experience might shape interpretation. In line with reflexive thematic analysis principles, the study did not aim to achieve data saturation; instead, emphasis was placed on generating rich, nuanced insights into staff experiences.

2.6 | Ethics Statement

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013. All procedures involving human patients were approved by the NHS Health Research Authority and Research Ethics Committee: Integrated Research Application System (IRAS) prior to study commencement [REC ref. 22/EM/0201].

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3 | Results

Analysis produced four themes: (1) Structural and systemic conditions shaping care delivery, (2) Organisational processes constraining patient flow, (3) Emotional labour and burnout among staff, and (4) The cycle of institutionalisation and dependency. Each theme reflects shared patterns of meaning across the dataset and includes several subthemes.

3.1 | Theme 1: Structural and Systemic Conditions Shaping Care Delivery

This theme explores staff perceptions of how resource and policy-level barriers can impede their ability to deliver person-centred care. Participants described discrepancies between policy and practice, resource shortages, and fragmented pathways that can hinder patient recovery and prevent timely discharge.

3.1.1 | Disparities Between Policy and Practice

Staff reported that acute wards fail to adhere to National Institute for Health and Care Excellence (NICE) evidence-based guidelines, which are recommendations designed to ensure the best possible care. Staff felt that long-term admissions are counterproductive and inconsistent with best-practice standards for inpatient care. They were also concerned about lack of access to outdoor spaces:

> It's archaic, it's against national guidelines. Every mental health ward should have access to an outside space, and our patients don't. It exacerbates symptoms because they're so contained.
>
> Ward Manager.

Staff highlighted that Trust policies state key workers should visit their patients once per week during admission to an acute ward, but that this rarely happens in practice. Staff also reported discrepancies between current acute service practices and NICE guidelines for personality disorder treatment:

> We work with mental health patients; they are at risk of ending their lives, but you're not made to feel safe in continuing and working alongside the NICE guidelines, which are to discharge even aware of the risk.
>
> Ward Manager.

3.1.2 | Resource Shortages and the Erosion of Acute Ward Identity

Limited staffing was discussed mostly in relation to home treatment teams, social workers and support workers, which participants felt impacted in-reach and quality of care. They felt that caseloads have *"grown significantly"* which can be difficult to manage:

> There are not enough social workers, but it's that knock-on effect. It means the patient can't have their assessment for their needs, which means we can't get them into placements.
>
> Support Worker.

Although participants acknowledged that new members of staff have been recruited, one described their ward as *"rarely functional"* at its current staffing levels, which impacts their ability to facilitate escorted leave and therapeutic activities for patients, all of which promote recovery:

> He needs a male member of staff when he goes out. And getting two staff members off the ward at one time is hard enough, never mind needing a male, which impacts when [patient name] can go out.
>
> Occupational Therapist.

Staff reported feeling that acute wards have lost their identity. They voiced frustration that they had signed up for a fast-paced role with high patient turnover, but that this had changed over time:

> When this first opened, patients were here for a lot less time, whereas now, it's more like a rehab, which is not what we are.
>
> Clinical Lead.

Despite this, staff noted that acute wards are unable to offer the same level of care as rehabilitation wards in terms of psychological input; consequently, they focus on stabilising symptoms rather than promoting recovery. Staff also discussed factors contributing to burnout in relation to the ward's identity:

> You watch a patient get better and then dip again. That's frustrating. Then you tend to need more medication to get that person better. But that's not our skillset. In the nicest way possible, we don't want to care for long-stay patients, so staff experience burnout.
>
> Ward Manager.

3.1.3 | Fragmented Pathways and Limited Community Provision

Staff described a lack of appropriate community placements for patients with complex mental health needs, reporting that this prolonged inpatient stays. They noted that community staff frequently adopt a risk-averse approach, attributed to lone working and insufficient training in suicide and self-harm. Nevertheless, they acknowledged that risk is inherent in working with complex individuals, and that such risk aversion can compromise timely and appropriate step-down of care:

> We do have places in the community, but they won't take people. Their requirements are tight, given it is

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> mental health. They won't take people who ligature, who do drugs, who self-harm, and that covers a lot of our patients. So, then we're stuck.
>
> Clinical Lead.

Three participants reported difficulties discharging patients experiencing homelessness. They felt that these individuals were more likely to become long-stay patients due to a lack of placement options. Staff also felt that the refusal of nursing homes to care for homeless patients exacerbated this issue. Two participants discussed difficulties faced by autistic patients:

> There's a massive gap for our patients with neurodiversity. If their primary diagnosis is autism, there is no step down, no placement, no respite of that next step moving into the community.
>
> Staff Nurse.

3.2 | Theme 2: Organisational Processes Constraining Patient Flow

While Theme 1 outlines the structural conditions shaping care delivery, this theme focuses on how these constraints are enacted in day-to-day practice through organisational processes that delay or disrupt patient flow. Participants described how administrative delays, complex processes, and differing professional approaches to risk contribute to patient stagnation and frustration across teams.

3.2.1 | Bureaucratic Delays and Administrative Burden

Participants described how administrative tasks such as arranging Care Act assessments, organising benefits and housing applications, and documenting notes create blockages within the system, due to poor staffing levels and infrequent panel meetings. In some cases, this resulted in patients remaining on acute wards for several months longer than staff felt was necessary:

> One of the biggest things that holds a discharge up is patients' forms. Whose responsibility is it to fill them in? Because these guys haven't got time.
>
> Staff Nurse.

Another administrative issue reported was the requirement to refer patients to placements that are outwardly unsuitable, to demonstrate to the Integrated Care Board (ICB), funders, and Trust executives that all options have been exhausted, despite the delays this will cause to the patient's discharge plan:

> That delays someone being referred to the right placement by two to four months. Even though the inpatient team that looks after the patient 24 h a day are aware of what that patient needs to be a success upon discharge, you have to jump through different hoops to then start looking at the right places.
>
> Ward Manager.

3.2.2 | Divergent Risk Cultures and Professional Disagreements

Staff discussed how differences of opinion within teams and localities can delay patient discharge, as treatment plans cannot progress without consensus from all involved. Most discussions centred around risk, with one participant highlighting how one locality frequently engages in positive risk taking, whereas another is more risk-averse, causing discrepancies. Participants described experiencing "a lot of resistance" from community teams, ultimately arguing a need for more positive risk taking in the community to avoid long-stay or repeat admissions:

> When [patient name] left her placement and took herself to A&E, the community teams that went to see her should have taken that risk because she was on leave and sent her back to the accommodation, but they didn't. They readmitted her. So, then it falls back to being the ward's responsibility to take the risk.
>
> Ward Manager.

Disagreements with social workers, care coordinators and the Mental Health Independent Support Team (MhIST) were discussed, capturing inter-agency friction:

> We did a great piece of work with [patient name]. We reduced her incidents and restrictive interventions. We felt this patient needed specialist placement. MhIST completely disagreed and that argument has gone on for four-and-a-half months. As a result, the patient has deteriorated, risks have increased, and staff burnout is massive.
>
> Ward Manager.

Across themes, participant accounts point to a reinforcing dynamic in which risk-averse approaches to discharge contribute to prolonged admissions. In turn, longer stays were described as increasing patient dependency and contributing to staff frustration and moral distress.

3.3 | Theme 3: Emotional Labour and Burnout Among Staff

This theme captures the emotional demands of working in acute mental health settings. Staff discussed moral distress, exhaustion, and compassion fatigue resulting from systemic pressures and the challenges of delivering care within constrained environments. Emotional labour was not described as an isolated phenomenon, but as a response to structural and organisational constraints that limited staff capacity to deliver effective care.

3.3.1 | Moral Distress

Staff discussed the emotional impact of system blockages, breakdowns in therapeutic relationships, and lost ward identity:

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> You get someone better and then you have to watch them go unwell again. And they get angry at us, because they need an outlet for it, and we're their family, so it's us they take it out on. We want them to get better. We become frustrated that there are so many blocks to a discharge.
>
> Support Worker.

Staff were also frustrated at the lack of training around specific mental health disorders, with one support worker explaining that he does not understand what depressive or bipolar disorders are, nor how to manage patients with these diagnoses. He felt his lack of understanding "minimises the pain people go through, because we do not understand how their brain works." Staff felt that neurodiversity training is lacking and that acute wards are unsuitable for neurodiverse individuals, due to their lack of structure and routine, describing themselves as being "set up to fail" in this respect.

3.3.2 | Emotional Exhaustion and Compassion Fatigue

Participants highlighted how patient readmission may contribute to staff burnout, particularly when patients demonstrate *"antisocial behaviour"* such as verbal and physical abuse. Staff found it difficult to manage when certain patients were particularly demanding of their attention, resulting in other patients being neglected. Staff discussed experiencing a diminishing sense of compassion the longer a patient remained on the ward:

> You become overfamiliar. You become complacent with their care.
>
> Clinical Lead.

Staff described the frustration experienced by the team when it was agreed that all options had been exhausted regarding a patient's care:

> Team morale is directly linked to knowing there are people on this ward that have come to the end of their journey with us and should move on so we can help the next person. It's like reading the same book over and over again.
>
> Ward Manager.

3.4 | Theme 4: The Cycle of Institutionalisation and Dependency

This theme highlights how prolonged admissions and limited community provision foster patient dependency on ward staff. Participants reflected on how this cycle can erode autonomy and reinforce institutionalisation, particularly for those with personality disorder diagnoses. Participants described institutionalisation not as a patient-level issue alone, but as an outcome produced by prolonged admissions, delayed discharge, and risk-averse systems.

3.4.1 | Dependence and Loss of Autonomy

Participants reported concerns about the high level of dependency long-stay patients have on ward staff. They explained how these patients often have fractured familial relationships, resulting in increased reliance on the therapeutic relationships made on the ward:

> The sad thing is a lot of these people see the staff as their family or friends; because of the life they've had.
>
> Support Worker.

Although this behaviour was described as *"misguided,"* staff recognised how patients with an unhappy or unsafe living situation in the community would prefer to remain on a ward where they felt cared for:

> They want to come back to us because we're the only people being consistent in their lives. The only ones they think care for them. The only place they feel safe.
>
> Clinical Lead.

Participants felt that patients with a diagnosis of emotionally unstable personality disorder (EUPD) are the most dependent on staff, with some even jeopardising discharge plans to remain on the ward:

> When a placement is identified, she'll do things to mess it up. You can have periods where she's okay and not self-harming, but when somewhere is identified, it'll increase.
>
> Support Worker.

Staff reported that long-stay patients' symptoms tend to deteriorate the longer they remain an inpatient. They described patients becoming *"stuck,"* with *"no hope."* They reported that delays to discharge *"very much affect the patients,"* with instances of self-harm higher on acute wards than in the community, as patients rely on staff to provide physical and emotional support, as well as learning new self-harm methods from other patients.

3.4.2 | Pathways That Perpetuate the Cycle

Staff described an influx of long-stay patients with a primary diagnosis of EUPD in recent years and reported feeling that acute wards are not suitable for these individuals. They felt that a lack of specialist units and an unwillingness to engage in positive risk-taking in the community contribute to a vicious cycle of readmission:

> Long admissions, nowhere to go, increased self-harm, increased risk in hospital. Completely not appropriate. No care for them, no therapeutic benefit.
>
> Ward Manager.

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Staff explained that patients with EUPD not only become deskilled and often deteriorate during this process, but that they also tend to engage in problematic behaviour on the ward:

> It always sits heavy when that patient is negatively impacting other patients. It's not just about our care delivery. Their doing what they're doing takes us away from the other patients. Then we start getting quite bitter that the other patients are being left out because of them.
>
> Board Manager.

The frustration reported by most participants was not at the patients themselves, but at the response of community teams. Particularly, their risk aversion when discharging from hospital. The negative impact of long transitions and inconsistent plans were also discussed, highlighting that neither are beneficial for those with a personality disorder, as boundaries become blurred and the patient no longer feels safe:

> I know she's complex, but with her diagnosis, sometimes you have to ride that storm. I think a discharge date is a discharge date, and as long as the care package is in place and the house is suitable to meet her needs, it should be pushed ahead with regardless.
>
> Staff Nurse.

Across themes, these accounts suggest a self-reinforcing dynamic in which risk-averse decision-making delays discharge, prolongs admission, and contributes to both patient dependency and staff moral distress, which may in turn reinforce cautious practices.

4 | Discussion

4.1 | Summary of Findings

This study sought to explore staff perspectives on the factors contributing to long-stay admissions in acute mental health wards, as well as their experiences of working on an acute ward. Across six focus groups, participants highlighted how systemic constraints, bureaucratic delays, and the emotional impact of care interact to shape patient experiences and outcomes. Figure 1 illustrates a multi-level conceptual framework of care stagnation in acute mental health settings. Structural constraints (e.g., resource limitations and fragmented pathways) shape organisational processes (e.g., bureaucratic delays and risk-averse decision-making), which are enacted in frontline practice as moral distress and constrained care delivery. These dynamics contribute to prolonged admissions and patient dependency, while risk-averse decision-making delays discharge; in turn, extended stays generate staff moral distress, which may further reinforce cautious practices and sustain the cycle of delayed discharge.

The findings add to existing evidence that acute settings are often ill-equipped to manage prolonged admissions (Bowers et al. 2015; Health Services Safety Investigations Body 2025). Overall, participants were concerned about rising numbers of long-stay patients on acute wards; a pattern supported by local reports (McIntyre et al. 2025) and national statistics, as the number of patients with a stay exceeding 60 days increased by 22% between 2021 and 2023 (The King's Fund 2024). This trend, coupled with considerable variability in both length and quality of patient stays, suggests growing pressures and possible inefficiencies in discharge processes.

Staff described a shift in ward function, with acute settings increasingly serving as long-stay units. However, acute wards do not have the appropriate staffing, resources, or therapeutic input to provide recovery-focused care. They reported that staffing constraints, limited access to outdoor spaces, and inadequate community provision undermine the delivery of person-centred and recovery-focused care promoted by government initiatives. These findings support those of Gilburt (The King's Fund 2015), who argued that structural underfunding and service fragmentation erode the therapeutic capacity of acute wards. The perception that wards have lost their identity suggests a shift from short-term crisis stabilisation towards long-term containment. Based on staff accounts, the juxtaposition between expectation and reality of the role can result in cognitive dissonance, manifesting in frustration and burnout, due to feeling ill-equipped to manage long-term admissions. This is concerning, as people working in acute mental health settings are already more prone to burnout and poorer wellbeing than those working in other healthcare settings (Laker et al. 2018), which in turn impacts patient safety, absenteeism and turnover rates (Johnson et al. 2018). Research suggests that burnout can be exacerbated by working with individuals with complex mental health needs, as these patients may demonstrate problematic behaviours and refuse to engage with treatment (Sambrook et al. 2024).

NHS England (2024a) emphasises that acute wards are not appropriate environments for rehabilitation and that such needs should be met within the community; however, inadequate housing and community support mean that acute wards are increasingly absorbing roles intended for other services. This is reflected in the literature, with Commander and Rooprai (2008) reporting that 75% of patients considered ready for discharge had no housing available, with others delayed by forensic processes, funding decisions, or incomplete home adaptations. Staff in our study echoed these concerns, identifying insufficient housing and social care as major contributors to delayed discharges and repeated admissions. These systemic gaps are reinforced by international evidence showing that long-stay patients struggle with social integration, particularly regarding employment, housing and family relationships (Smith et al. 2020). Similarly, Duhig et al. (2017) found that recently readmitted patients experienced inconsistent support across the care pathway, including premature or overdue discharge, returns to unstable community environments, and reliance on inpatient wards as 'sanctuary.' This was evidenced in our study, where participants described a 'cycle of dependency' in which long-stay patients—particularly those with EUPD—become increasingly reliant on ward staff. This observation aligns with Goffman's (1961) theory of institutionalisation and more recent research on inpatient dependency (Hurst 2008). Staff accounts suggest that the relational

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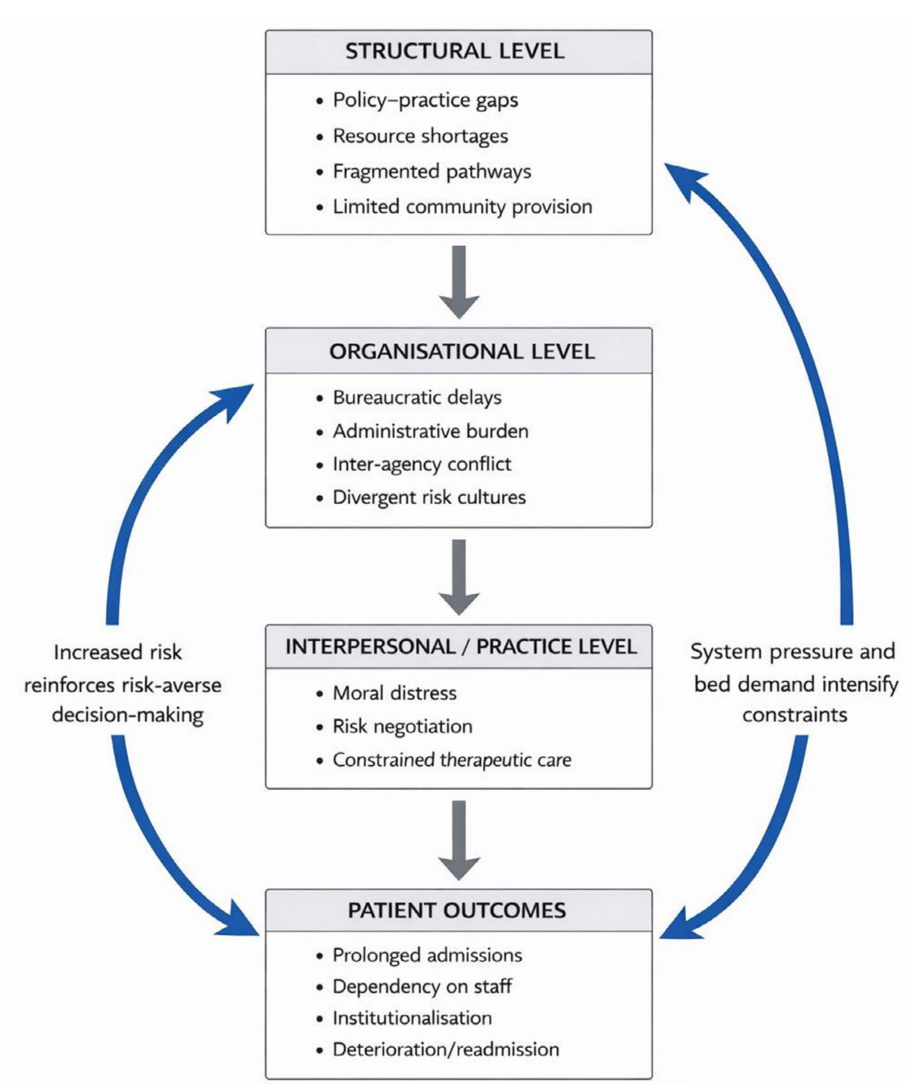

FIGURE 1 | A multi-level conceptual framework of care stagnation in acute mental health settings.

safety of the ward may offer a form of psychological containment that discourages patients from effectively transitioning to community living, particularly when community support is inconsistent or unavailable. Our findings can be explained by the mechanism of learned helplessness (Seligman 1972), in that patients learn to avoid difficulties faced in the community through readmission to hospital, where their needs appear more reliably met. The recent rapid review into data on mental health inpatient settings (Department of Health and Social Care 2024) similarly concludes that services are "swimming in data" while fragmented systems create significant administrative burden, pulling clinicians away from therapeutic work and effective discharge planning. These findings highlight the importance of developing robust step-down pathways and community-based therapeutic environments for people with complex needs. Interventions that promote autonomy, such as graded exposure to community settings and consistent multidisciplinary collaboration, may mitigate institutional dependency and reduce readmission rates.

Staff highlighted a recent rise in long-stay patients with EUPD, noting that elevated risk behaviours made working with this group particularly demanding. This is reflected in the literature, with nurses working with EUPD patients reporting emotional conflict and trauma when caring for this group (O'Brien and Flöte 1997). Negative attitudes towards EUPD are well-documented and reflect broader patterns of diagnostic stigma within mental health services, with greater exposure correlating with reduced empathy (McKenzie et al. 2022). Patient accounts demonstrate that staff stigma can harm self-concept, reducing the likelihood of recovery and reinforcing exclusion from appropriate care pathways, thus furthering the likelihood of readmission (Motala and Price 2024). The staff in our study also expressed frustration at the lack of training around specific mental health disorders, reporting that limited understanding of conditions reduced their confidence and ability to deliver effective care. This highlights the importance of continued comprehensive nursing training (Bifarin et al. 2024). Overall, staff felt the hospital environment is not conducive to the long-term needs of patients with EUPD, given the reinforcing nature of repeated admissions and the lack of consistent structure, reflecting wider structural gaps in specialist provision and community-based alternatives. While community-based care is often more appropriate for promoting autonomy, participants felt that staff in these

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settings have a lower threshold for risk, resulting in premature readmissions. This cycle reflects a discomfort with tolerating risk, which has been well-documented in the literature on EUPD management (Dale et al. 2017). Risk-averse practices can undermine therapeutic progress by reinforcing dependency and preventing the establishment of consistent boundaries, which are considered essential for the effective treatment of EUPD (Bateman and Fonagy 2010). Staff frustration with community risk aversion may indicate a need for shared risk frameworks and improved cross-agency communication, promoting more cohesive discharge planning and continuity of care. From a trauma-informed perspective, these behaviours may be understood as adaptive responses to past adversity, highlighting the importance of consistent, relational, and non-stigmatising care approaches.

Moving forward, a key priority is to investigate service-level determinants of length of stay, as few studies have examined ward type, use and turnover of locum consultants, ward transfers, outdated estates, understaffed units, and reduced skill mix across Trusts (Crossley and Sweeney 2020). Future research should also disentangle how socio-demographic and clinical characteristics shape length of stay, drawing on national-level data to clarify how these patient and service factors interact in the UK context.

4.2 | Strengths and Limitations

A strength of this study lies in its inclusion of different sites within one Trust, and a range of professional roles from students to consultants, allowing for a rich understanding of shared and divergent perspectives. However, this contextual specificity may limit transferability, as findings are shaped by local organisational structures, service provision, and commissioning arrangements. While the use of Braun and Clarke's (2024) reflexive thematic analysis ensured a rigorous and iterative approach to theme development, the findings are context-specific and intended to offer analytical rather than statistical generalisation. The reliance on self-reported data may have introduced social desirability bias, with participants more likely to emphasise systemic rather than individual factors. Finally, while focus groups increased accessibility, they may have constrained depth of disclosure due to group dynamics, including potential conformity (Bose et al. 2023), hierarchical influences, and participants' familiarity with colleagues within the same service.

5 | Conclusion and Recommendations

This study highlights critical pressures facing acute wards, including increasing lengths of stay, delayed discharges, repeat admissions, and system-level gaps in housing and community care. The findings illustrate how long-stay (and repeat) admissions are not solely a clinical issue, but are shaped by social isolation, systemic gaps, and a lack of appropriate follow-up care. To address these challenges, mental health services must invest in workforce development, inter-agency collaboration, and community capacity, ensuring that acute wards can once again fulfil their intended purpose: the short-term, recovery-oriented stabilisation of people in crisis.

Recommendations	
	Greater alignment between Trust-level policies, commissioning priorities, and NICE standards to reduce systemic inefficiencies and support timely discharge.
	Integrated care pathways that bridge the gap between acute and community mental health services.
	Enhanced staff wellbeing initiatives, reflective practice, and access to supervision to promote workforce resilience.
	Workforce shortages to be addressed to enhance the capacity for therapeutic engagement and continuity of care.
	Investment in community services capable of managing risk and complexity, including specialist provision for neurodiverse individuals, to promote recovery.
	Training initiatives focusing on personality disorders and autism to further improve staff confidence and compassion, reducing moral distress.
	Improved specialist interventions and support in the community to build alternative and long-term resources to cope outside of hospital.
	A reconfiguration of the acute care model to prevent further deterioration in patient outcomes and workforce wellbeing.
	Shared risk frameworks and improved cross-agency communication.

FIGURE 2 | Practice recommendations.

5.1 | Relevance to Clinical Practice

The findings demonstrate that gaps in community support, limited housing options, and complex discharge pathways hinder effective inpatient care and contribute to prolonged patient stays. Staff accounts highlighted the impact of workload pressures, emotional strain, and risk-averse decision-making on the quality and consistency of care. To address these issues, recommendations emerging from the data are as follows:

System level: improved inter-agency coordination, investment in community services capable of managing complexity, and integrated care pathways bridging acute and community settings.

Organisational level: targeted workforce support, reflective practice, supervision, and strategies to enhance staff wellbeing and resilience.

Clinical level: training on personality disorders and neurodiversity, shared risk frameworks, and guidance to support ward leadership in safe discharge planning and recovery-focused care.

Implementing these measures can improve patient flow, reduce staff burnout, and support acute wards in functioning as short-term, recovery-oriented environments while strengthening the capacity of mental health nursing teams to make informed risk decisions and provide consistent, compassionate care.

Further recommendations for service improvement directly from the data are presented in Figure 2.

Author Contributions

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors. All authors are in agreement with the manuscript.

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Disclosure

Oladayo Bifarin is a National Institute for Health and Care Research Leader; however, the views expressed in this article are those of the author(s) and not necessarily those of NIHR or the Department of Health and Social Care.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Appendix A

Focus group topic guide for staff

Evaluation of the Acute Transformation Project.

You are being invited to take part in this project, which is being conducted by Liverpool John Moores University and Cheshire and Wirral Partnership NHS Foundation Trust collaboratively. The project aims to undertake focus groups with staff who are familiar with the new models of care adapted within the transformation programmes, for example, through working with service users who have utilised these models of care. The project also aims to evaluate the pathways for individuals utilising the services and follow the history of these individuals. This will allow us to relate the changing mental health of individual people to the varying levels of care provided over time.

Before you decide, it is important for you to understand why the project is being carried out and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

Focus group questions:

Can you talk about the issues that have contributed to the length of stay being extended in this case?

Do you think skill mix/resources on the wards are important?

Do resources, including staff resources, play a part?

Are there any other roles that are needed to help with earlier discharge?

What do you think about the role of the ward 'days'/structure?

What is the relevance of community services?

How does the length of stay relate to the quality of care delivered?

How does length of stay affect Home Treatment Teams (HTT)/Community Mental Health Teams (CMHT)?

How do meetings, as they are currently set up, reduce length of stay?

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