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Inpatient Psychiatric Care in the United States: Former Patients' Perspectives on Opportunities for Quality Improvement

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Abstract

Patient-centered care is a salient value expressed by stakeholders, but a commitment to implementing patient-centered care environments lags in the context of inpatient psychiatry. The current study aimed to describe patients' suggestions for improving the quality of inpatient psychiatry. We fielded a national survey online in 2021, in which we asked participants to report their recommendations for care improvement through a free-response box. We used an inductive qualitative approach to synthesize responses into themes. Most responses described negative experiences, with suggested improvements implied as the inverse or absence of the respondent's negative experience. Among 510 participants, we identified 10 themes: personalized care, empathetic connection, communication, whole health approach, humane care, physical safety, respecting patients' rights and autonomy, structural environment, equitable treatment, and continuity of care and systems. To implement the value of patient-centered care, we suggest that those in positions of power prioritize improvement initiatives around these aspects of care that patients find most in need of improvement.

Keywords

hospitalization, patient-centered care, quality, safety, mental health policy

Key Points or Findings

1. Growing mental health needs in the United States have led to a call for increased investment in inpatient psychiatric beds, despite inadequate responsiveness to patient experiences in these settings.
2. Former patients of inpatient psychiatry reported 10 themes as areas in need of improvement in inpatient psychiatric facilities, including personalized care, empathetic connection, communication, whole health approach, humane care, physical safety, respecting patient's rights and autonomy, structural environment, equitable treatment, and continuity of care and systems.
3. The nature of inpatient psychiatric care, which some participants reported as nonresponsive at best and dehumanizing at worst, makes it essential to prioritize relationships and trust to ensure that treatment does not cause harm or discourage people from seeking support in the future.
4. Accountability mechanisms should prioritize measuring patient experience to understand and incentivize services, practices, and environments that meet patient-identified needs and address counter-therapeutic experiences.

Introduction

There has been limited empirical research to describe the quality of inpatient psychiatric care in the United States despite policy efforts to expand access to this service.[1,2] Empirical descriptions of care quality and the patient experience of inpatient psychiatry come primarily from countries outside of the United States.[3-5] However, journalistic investigations, lawsuits, and anecdotal testimony from the United States highlight the need for policymakers and payers to

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consider examining methods to better align inpatient psychiatric care with principles of patient-centeredness.[1,6-9]

In the current study, we elicited suggestions from former adult patients of inpatient psychiatry on ways to improve inpatient psychiatric care quality, filling a critical gap in the literature with relevant implications for evolving policies.

Methods

Sample and Procedure

An online survey was administered in 2021 from January to February to former adult patients of inpatient psychiatry. Details of the larger study are described elsewhere.[10] The survey was promoted via social media and shared via mental health-focused listservs. To qualify for inclusion, participants had to have had a psychiatric hospitalization in the United States between the years 2016 and 2021 and at ages 18+. At the end of the survey, participants responded to an open-ended question: "What are some things the hospital/psychiatric facility could have done to improve your experience?" Participants could enter a lottery for a $20 gift card. This study was approved by the Institutional Review Board at the University of Pennsylvania (#844878); all participants assented to participate.

Analysis

Responses to the open-ended question were coded following an inductive approach, where themes emerged from the data through an iterative process of coding and constant comparison.[11] Three members of the research team engaged in a multistep process of developing codes, establishing themes, and coding for themes, supported by constant comparison and discussion. Inter-rater reliability (IRR) was assessed and used to inform refinement of the codebook.

Results

Out of the 814 responses to the survey, 510 (62.65%) participants responded to the free-response question asking for suggestions to improve inpatient psychiatry. Table 1 reports sample characteristics, with seven participants (1.37%) missing information on the demographic variables. There were 10 final themes with excellent IRR (see the Appendix for reliability scores, frequency statistics, and definitions). We describe each of the 10 themes below and provide sample quotes in Table 2.

Empathic Connection

Participants detailed a lack of empathy, respect, and kindness, including harmful statements and gross insensitivity from staff during their stay. Sentiments like "emotionally distant," "seen as lost cause," "making fun of me," and descriptions of staff expressing disdain, comprised this theme.

Table 1. Sample Characteristics (N = 503).

	n	%
Age		
18–24	183	36.38
25–34	198	39.36
35–44	77	15.31
>44	45	8.95
Gender		
Female	256	50.89
Male	204	40.56
Nonbinary, third-gender, or other	43	8.55
Race/ethnicity		
Non-Hispanic White	335	66.60
Non-Hispanic Native	21	4.17
Non-Hispanic Hawaiian/Pacific Islander	12	2.39
Non-Hispanic Black	16	3.18
Non-Hispanic Asian	16	3.18
Non-Hispanic "other"	5	0.99
Non-Hispanic multiple races	21	4.93
Hispanic/Latinx	77	15.31
Education		
High school degree or less	85	16.90
Some college/associates degree/trade school	221	43.94
Four-Year college degree	141	28.03
Advanced degree (master's, M.D., J.D., PhD	56	11.13
Income		
<$25,000	189	37.57
$25,000–$49,999	154	30.62
$50,000–$99,999	110	21.87
>$99,999	50	9.94
Had insurance	459	91.25
Number of psychiatric hospitalizations		
1 (first hospitalization)	173	34.39
2	105	20.87
3	77	15.31
4–6	84	16.70
7–9	29	5.76
>9	35	6.96
Involuntary/did not want to be hospitalized	233	46.32
Hospitalized during the COVID era	111	22.07

Notes: Seven observations were missing information on demographic characteristics.

Communication

Participants expressed a lack of communication across several dimensions, such as a lack of a "clear timeline for discharge" and being held "for several days with no answers to my questions about what I should expect or how long I would be there." Participants suggested that providers clearly communicate processes and rules, explain side effects and dangers of treatment, and discuss discharge plans. Patients' confusion often resulted from a lack of answers to concerns and a lack of coordination among the inpatient staff and with outpatient providers.

Humane Care

Participants reported being treated like prisoners, animals, and objects during their hospitalization. Participants reported

Table 2. Quotes Associated with Each Theme.

	Quote 1	Quote 2	Quote 3
Empathic connection	"I once asked for the water pitcher to be refilled in the common area (the water fountains were shut off) and the woman had a nasty tone and loud voice as she said 'yes, I know you want water, you have to wait, I have other things to do.' When I reported this to another worker on the floor, she went back to the same woman and asked her to get water. The woman exploded…."	"The floor staff was often verbally and physically (in stance and demeanor) unkind, uncaring, and obviously exasperated with patients (not necessarily nurses)."	"They don't care about people at that facility."
Communication	"They could have told me I was being admitted voluntarily instead of lying and telling me it was involuntarily."	"I was started on lithium and while it has been helpful, it also caused thyroid problems that I was not made aware of as a possibility before starting the treatment. I wish I had been more informed of the risks of the medication or able to consider other options."	"I got no orientation, no change of clothes (they made me walk through the rain wearing socks) and no explanation of meal schedules, group sessions or who to talk to ask for help. I was literally dropped off and forgotten."
Humane care	"Treated me like an intelligent human being with real thoughts and feelings instead of a dog to be sedated and trained."	"It was horrible and made me feel less than human. I will never ask for help in that way again, even at the very depths of desperation."	"If I'd simply been allowed to express and talk through suicidal feelings versus being put into safe rooms and stripped of clothing and my glasses and put into safety clothes it would have been far more helpful."
Respecting patients' rights and autonomy	"They could have not lied and said I wasn't allowed access to my medical records when I asked."	"Well, when you're voluntarily admitted to the facility and then are unable to leave or even request to leave without implication that you will be forced to stay longer and treated like a crazy person with no way to escape. Definitely won't be returning."	"I reported another patient for sexually harassing me. Multiple other women in the unit did as well. Instead of asking if I was ok, removing the guy, or anything helpful, they instead told me I was no longer getting discharged, moved me to another unit to sleep for my 'safety.'"
Equitable treatment	"[They should offer] more understanding of transgender identities and lives."	"[They should] understand that physically disabled folks can't check their medical issues and accommodation needs at the door because 'this isn't a medical unit.' Taking a person's wheelchair away, denying access to medications and supplements that someone was already taking for their medical problems, and refusing to make any disability accommodations as a blanket policy is always abusive, and these institutions are required to follow the ADA."	"I had a fine experience but was saddened by how poorly less educated/not white/less 'easy' patients were treated. I was hospitalized for a suicide attempt and as a college educated white woman felt like I was taken mostly seriously, but they did not take patients with more severe mental illness seriously or people with substance use and that made me really sad."
Personalized and effective care	"I am a lot further in my recovery than a lot of people in that unit, and I already knew everything that they were sharing in group. I needed personalized and individual help, and I didn't receive that. I left feeling not helped at all."	"Through my entire time there, not once was I ever offered a single piece of help from anyone in regard to my self-harm and how to help me get better."	"They care about following rules and procedure, and they will use rules and procedure to block patients from participating in their own recovery in any way."

(continued)

Table 2. (continued)

	Quote 1	Quote 2	Quote 3
Whole health/ person approach	"Being able to do art more. I use art to help me cope and a lot of places only have colored pencils that you can uses supervised maybe or a safety pen."	"A wider array of recreational activities to help patients pass the time and also keep them happy…."	"Provided access to the outdoors (the unit was not equipped with outdoor facilities)."
Physical safety	"What made me feel even more unsafe, though, was that there was one specific doctor who threatened to sedate anyone who even raised their voice at him. People were being sedated left and right, even at times that I felt were inappropriate."	"There was also a nurse who made me feel particularly unsafe. He made so many inappropriate comments about women in our ward and was the first to volunteer every time this one patient (who happened to work in adult entertainment) needed someone to watch her shave. He made moves at almost all the women in our ward…."	"The environment was incredibly stressful and scary and I was flashed, sexually harassed, and are surrounded by other patients with varying degrees of mental illness and drug withdrawal."
Structural environment	"I was in a concrete room with no windows other than the one in the door, which had the shades drawn. There was nothing in the room besides my bed."	"[They should provide] more comfortable furniture/surroundings because it felt very institutional."	"Facility was very run-down, burnt-out lights in hallways etc It would have been nice to be in a fully working hospital."
Continuity of care and efficiency of systems	"I did not plan on any treatment because I was not from the area nor was I seeking treatment. However, the discharge process left me literally without anything and on the street, so ensuring I could've made it to my hotel would have improved my experience."	"I really feel that inpatient services would serve their clientele well by assessing what clients would benefit from a partial hospitalization program or outpatient intensive program after discharge."	"Understand that 'danger' doesn't begin and end with suicidality, situations involving interpersonal violence (domestic violence, human trafficking, etc) exist, and discharging a trafficking victim to a random hotel or the 'care' of a person who is known to be affiliated with their trafficker should never happen."

serious restrictions on autonomy, a sterile and unwelcoming physical environment, and a rigid routine. These dehumanizing experiences left some participants traumatized, impacting health outcomes and future help-seeking.

Respecting Patients' Rights and Autonomy

Participants reported providers using indiscriminate court orders, not sharing information about legal processes, threatening patients with longer stays, and lying to patients about their rights and legal status. In addition to issues like privacy and coercive services, participants also experienced violations of basic rights, such as being free from violence and having access to proper grievance channels. Participants suggested that providers "ensure that staff are not abusive … toward patients," there be "no more strip searches and chemical restraints," to "unblock channels for reporting and complaining," to "allow people to report unfair treatment/being misunderstood by doctors," and to "allow … access to an advocate." Several participants reported experiencing sexual assault during their stay and that their reports were not taken seriously. Participants also described being "denied the most basic hygienic care." Multiple respondents described a lack of access to items like soap, menstrual hygiene products, and the ability to shower.

Equitable Treatment

Participants reported experiencing discrimination based on gender and disability. Multiple respondents noted that privilege skewed their experience, whether it be along dimensions of race, socioeconomic status, or clinical needs.

Personalized and Effective Care

We grouped *personalized* care and *effective* care because achieving *effective* care often requires some degree of personalization. Participants overwhelmingly reported that they often received services without consideration of their specific crisis or point in recovery. Participants described staff's attempts at therapy as lacking meaningful engagement or lacking relevance to their conditions and needs. In addition, participants reported that staff's rigid adherence to organizational policies, rules, and bureaucratic norms often conflicted with personalized and effective care. Further,

participants reported that staff and clinicians did not take their history and insights seriously, sometimes resulting in misdiagnosis and inappropriate medications, as well as compromising patients' trust in providers.

Whole Health/Person Approach

Overwhelmingly, participants expressed that they lacked access to a variety of health-promoting behaviors, such as "outdoor activities," "healthy food," and "spiritual guidance." Further, participants alluded to the ways diverse therapeutic activities, like art and music, could improve the effectiveness of their hospitalization. Participants also described how efforts to mitigate risk often compromised their access to these other health-promoting activities.

Physical Safety

Participants described a need for increased staff competency in managing conflict and crisis. Participants also described violence or threats of violence coming from staff. Multiple participants noted that individuals experiencing psychosis were treated more aggressively by staff—sometimes with violence—than those who experienced mood-related challenges. Participants sometimes experienced staff's attempts at risk mitigation as threatening and disruptive to their health. Participants also reported experiencing general dismissal and neglect of their physical healthcare needs, as well as access to lethal means.

Structural Environment

Multiple participants reported concerns about cleanliness, including rat infestations and lack of comfort, such as lack of access to blankets, comfortable beds, and depressing aesthetics. Some participants also reported that they "were all trapped indoors, packed like sardines in a small ward with many people." Providers were not always equipped to support patients in mitigating the discomfort of the structural environment.

Continuity of Care and Efficiency of Systems

Participants reported difficulties finding outpatient providers, with sometimes limited support from inpatient staff. Discharge planners did not always build patients' confidence and comfort with discharge timing or provide connections to appropriate services following discharge. Participants described a range of additional post-discharge care transition needs, especially for those hospitalized away from their hometown, experiencing violence in their home, experiencing homelessness, or needing substance use treatment. Before hospitalization, participants reported a lack of options for higher levels of support outside of inpatient hospitalization. One participant noted, "There are no good options for a homeless kid mentally breaking apart on the side of the road. I called a suicide hotline to try and get resources, and they sent someone to tell me that there was literally nothing they could do." Additionally, many participants reported experiencing long wait times and confusing experiences in emergency departments.

Discussion

Former patients of inpatient psychiatry identified several areas where quality improvement efforts might target. Although we asked an opened-ended question about how inpatient psychiatric facilities might improve quality, participants primarily provided descriptions of their experiences to communicate what they wished *did not* happen. Participants described past experiences of being consistently ignored, treated as objects, or even mocked by staff. Participants also reported a lack of communication about what to expect during their hospitalization, their treatment plan, and the potential side effects of medications. Participants experienced coercion, threats, and violence, including some instances of sexual assault and harassment.

In contrast to other forms of health care, evidence-based mental health care treatment is anchored around relationships and trust.[5] As such, the quality of interaction between staff and patients significantly shapes the balance of benefits to harms that patients experience in these settings.[12] However, strong interpersonal relationships and safety are challenged in these settings, given their restrictive nature, carceral design, and skepticism of patients' perspectives and autonomy, which can affect long-term outcomes.[13,14]

Limitations

Results should not be interpreted as representing the average experience of patients. Participants were necessarily anchored to consider those aspects of care that were "less than ideal," as they were prompted to provide suggestions for improvement. Additionally, participants were recruited through social media, leading to a sample that skewed younger and not representative of all patients; however, the large sample was balanced on gender and captured the full range of demographic categories, with most respondents being lower income. Given the unusually large sample for a qualitative study, we likely identified the most salient themes, even if their distribution might vary.

Conclusions

Accountability mechanisms should prioritize the measurement and reporting of patient-centered care in the inpatient psychiatry context to understand how quality varies across organizations (eg, the role of ownership, organizational mission, geography) and patients (eg, race and ethnicity, condition, gender) and to identify solutions to address the root causes underpinning counter-therapeutic care experiences

(eg, aligning financial incentives and accreditation standards).

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethical Approval

This study was approved by the University of Pennsylvania's Institutional Review Board [#844878].

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Informed Consent

All participants in this study provided assent to participate in the study by clicking a button at the end of the first page of the internet survey, which provided information about the study and IRB contact information.

Statement of Human and Animal Rights

All procedures were conducted in accordance with the University of Pennsylvania's Institutional Review Board guidelines.

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Supplemental Material

Supplemental material for this article is available online.

References

1. Shields MC, Stewart MT, Delaney KR. Patient safety in inpatient psychiatry: a remaining frontier for health policy. *Health Aff.* 2018;37(11):1853-1861.
2. Hollander MA, Patton A, Shields MC. Changes in institution for mental diseases (IMD) ownership status and insurance acceptance over time. *Health Aff Sch*. 2024;2(1):qxad089.
3. Aguilera-Serrano C, Guzman-Parra J, Garcia-Sanchez JA, Moreno-Küstner B, Mayoral-Cleries F. Variables associated with the subjective experience of coercive measures in psychiatric inpatients: a systematic review. *Can J Psychiatry*. 2018;63(2):129-144.
4. Staniszewska S, Mockford C, Chadburn G, et al. Experiences of in-patient mental health services: systematic review. *Br J Psychiatry*. 2019;214(6):329-338. doi:10.1192/bjp.2019.22
5. Gilburt H, Rose D, Slade M. The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Serv Res.* 2008;8(1):92.
6. Shields MC, Reneau H, Albert SM, Siegel L, Trinh N-H. Harms to consumers of inpatient psychiatric facilities in the United States: an analysis of news articles. *Issues Ment Health Nurs*. 2018;39(9):757-763.
7. Jones N, Gius BK, Shields M, Collings S, Rosen C, Munson M. Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Soc Psychiatry Psychiatr Epidemiol.* 2021;56(1):2017-2027.
8. Shields MC, Beidas RS. The need to prioritize patient-centered care in inpatient psychiatry as a matter of social justice. *JAMA Health Forum*. 2022;3(2):e214461. doi:10.1001/jamahealthforum.2021.4461
9. Shields MC, Hollander MA. Complaints, restraint, and seclusion in Massachusetts inpatient psychiatric facilities, 2008–2018. *J. Patient Exp*. 2023;10(1):1-10.
10. Shields MC, Hollander MAG, Busch A, Kantawala Z, Rosenthal MB. Patient-centered inpatient psychiatry is associated with outcomes, ownership, and national quality measures. *Health Aff Sch*. 2023;1(1):qxad017. doi:10.1093/haschl/qxad017
11. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;3(2):77-101.
12. Wieman DA, Camacho-Gonsalves T, Huckshorn KA, Leff S. Multisite study of an evidence-based practice to reduce seclusion and restraint in psychiatric inpatient facilities. *Psychiatr Serv.* 2014;65(3):345-351.
13. O'Dwyer C, Tarzia L, Fernbacher S, Hegarty K. Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units. *BMC Health Serv Res.* 2019;19(1):1-9.
14. Smith CP. First, do no harm: institutional betrayal and trust in health care organizations. *J Multidiscip Healthc.* 2017;10(1):133-144.