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Unnecessary hospitalisation in a psychiatric rehabilitation unit

Peter H Dick, Iain K Crombie, Tessa Durham, Callum McFee, Mary Primrose, Susan Mitchell

Dundee Psychiatric Rehabilitation Service, Royal Liff Hospital, Dundee DD2 5NF
Peter H Dick, consultant psychiatrist
Tessa Durham, occupational therapist
Callum McFee, charge nurse
Mary Primrose, social worker
Susan Mitchell, senior registrar

Department of Epidemiology and Public Health, University of Dundee, Ninewells Hospital and Medical School, Dundee DD1 9SY
Iain K Crombie, senior lecturer

Correspondence to: Dr Dick.

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Recent Scottish studies have claimed that 38% of "new chronic" inpatients and 32% of "old long stay" patients did not require inpatient care.^{1,2} We looked at a third group—admissions to a rehabilitation unit—to identify ways to reduce inpatient stay and to estimate the potential savings in inpatient time that could be achieved. The unit cares predominantly for patients with acute psychosis transferred from admission wards and patients with chronic psychosis admitted directly from the community.³

Patients, methods, and results

All admissions to the psychiatric rehabilitation unit from July 1984 to July 1986 were included in the study. When the multidisciplinary rehabilitation team thought that a patient was ready for discharge or required transfer they decided on required accommodation. Accommodation was categorised by level of staffing into (in ascending order) low staffed housing, high staffed housing, hostel (rehabilitation, long stay or residential home for the elderly), or hospital ward (acute or long stay). When the required accommodation was not available the patient was offered the option of early discharge with the best support we could arrange. The Morningside rehabilitation status schedule⁴ was completed when the patient was ready for discharge. Follow up was until discharge or for one year, whichever was earlier.

Of the 102 admissions to the unit, 63 were men, 71 were under 55, and 73 were suffering from schizophrenia or paranoid psychosis; their illnesses were long standing and severe. Mean ratings on the Morningside rehabilitation status schedule at discharge or transfer were dependency 6.1, inactivity 4.8, isolation 4.7, and current symptoms 4.6.

Discharge was delayed in 48 of the 102 admissions, with 50% of the total time in the unit being unnecessary. Mean duration of delay and total delay for each

category of required accommodation at discharge are shown in the table. Delays were greatest for rehabilitation hostel, residential home for the elderly, and high staffed housing. The commonest causes of delay were non-existence of the required resource (18 patients), lack of places in an existing resource (13), and underuse of an existing resource (12), with only five patients refusing an available resource.

Fifty one of the 63 patients requiring supported accommodation at discharge were not discharged to the required option. Most of these (35) went to an inadequate level of support. The remaining patients went to relatives rather than staffed housing (seven), to the rehabilitation hostel rather than long stay hostel (eight), or to high staffed housing (one).

Comment

In an earlier study we concluded that admissions to the rehabilitation ward were appropriate.³ The conclusion of the present study into duration of admissions is quite different—the audit identified considerable potential savings in the hospital stays of this group of patients. The patients in our study were predominantly community based and, unlike long stay patients, often had personal knowledge of the available options. Those who remained inappropriately hospitalised were there of their own informed choice.

In the government's view, "the successful implementation of community care depends crucially on the availability of, and ease of access to, adequate and appropriate services in the community."⁵ Our study highlighted major problems in both access and availability. Even after unnecessarily prolonged hospitalisation most of our patients were discharged to inappropriate accommodation.

The Dundee mental health unit, providing a comprehensive psychiatric service to its compact city catchment, is similar to many around the country and has relatively well developed community supported accommodation by Scottish standards (a rehabilitation hostel and staffed group homes). The extent to which it is possible to draw general conclusions from a single study is limited, but this study does suggest that rehabilitation units elsewhere should review their current practice to determine the extent of unnecessary hospitalisation and inadequately supported discharge. Unless priority is given to ensuring appropriately staffed accommodation on discharge it is unlikely that the cycle of recurrent inappropriately prolonged hospitalisation will be broken.

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Delay in discharge from psychiatric rehabilitation unit by type of accommodation required

Required accommodation at ready for discharge	No of patients		Time spent in unit (weeks)	Mean delay (weeks)	Length of unnecessary inpatient stay (weeks)
	Total	Discharge delayed			
Mainstream:					
Alone	1	1	52	4	4
Accompanied	4	0	49	0	0
Low staffed housing	0	0	0	0	0
High staffed housing	26	11	390	6	156
Rehabilitation hostel	29	15	464	8	232
Long stay hostel	10	7	166	10	100
Residential home for the elderly	8	7	281	28	224
Acute ward	12	2	153	1	12
Long stay ward	6	5	186	23	138
Total	96*	48	1741	9	866

*Assessments when patient was ready for discharge were not completed on six patients who stayed less than one month.