Some Implications of
Time-Limited General
Hospital Psychiatric
Inpatient Treatment for
Outcome of Hospitalization

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ABSTRACT: Patients hospitalized in the same general hospital psychiatric unit and treated by the same staff during two consecutive periods of time are compared as to outcome. Average duration of stay during the first period, 31.7 days, was reduced to 18.5 days for the second period. The percentage of patients transferred to a state hospital rose from 17.5% to 29.1%, an increase of 66% in the rate of transfer. There was a concomitant decrease in the percentage of discharges to the community and a sharp increase in rate of requirement for aftercare by the staff of the unit, a disposition generally reserved for patients deemed still quite symptomatic at discharge.

In this article clinical outcomes will be described and compared for two groups of patients who began their psychiatric hospitalization for an episode of mental illness on the psychiatric service of the Harlem Hospital Center, a 900-bed municipal general hospital in New York City.

One group of patients was admitted and treated during the years 1966 and 1967. The second group, of roughly comparable size, was admitted and treated during 1968. For reasons to be described later the second group had a significantly shorter average duration of stay than the first group, 18.5 days as compared with 31.7 days. In all other respects the two groups were grossly comparable. The ward conditions, treatment methods, admission policies, staff-patient ratios, and, for the most part, the staff itself remained stable throughout the period during which both groups were hospitalized, namely, the years 1966-67 (for Group I) and 1968 (for Group II).

9K PSYCHIATRIC SERVICE

The psychiatric service, known locally as “9K,” provides 37 beds on one floor for 29 female and 8 male 24-hour care patients. Transitional day hospital care is available for a maximum of 13
patients at one time, bringing the total intensive care capacity to 50 patients. Direct admission to day hospital care is rare, not exceeding 10 admissions in any year of the period under discussion, and then usually associated with some 24-hour care.

Throughout the period covered by this study, the ward population of 50 patients was divided into either three or four groups, each consisting of both full-time and partial hospitalization patients in a ratio of about three to one. The staff of the unit consisted of two full-time and two half-time psychiatrists, two sessional psychiatric consultants, one or two psychiatric residents, one supervising social worker, two to three staff social workers, two recreational-occupational therapists, one psychologist, and thirty nurses of whom nine were registered nurses. The staffing pattern was designed to make available to every patient the individual attention of staff in each of the mental health disciplines, as indicated. The entire staff participated in daily ward rounds and a once weekly total ward therapeutic community meeting. Therapeutic community meetings for the individual patient groups met three times a week for 45 minutes followed by a staff discussion period. After discharge, those patients who required continued care by inpatient staff were followed as aftercare patients by the therapeutic team. Others discharged to the community were referred for outpatient clinic care or other agency follow-up as indicated. A schedule of staff and patient activities (see Figure 1) indicates the emphasis placed on the therapeutic community as a treatment modality.

During the period under review personnel changes were few. Most members of the staff had worked together on the service for 2 years prior to 1966. Admission policies were and are quite constant. Patients over 16 years of age requiring hospitalization for psychiatric illness are admitted from the outpatient psychiatric clinic, the emergency room, and the general wards of the hospital up to the census of 37 (29 females, 8 males). In almost all cases patients admitted are acutely ill and cannot be treated except as inpatients. Patients are admitted only on clinical indications. Those ineligible for admission are patients whose primary problem is narcotic or alcohol addiction when this is not associated with clearcut psychiatric symptomatology; patients who continue, after initial treatment and a period of observation in the emergency room, to be so assaultive that they cannot safely be contained in a coeducational unit that often houses adolescent and geriatric patients; patients whose physical condition requires round-the-clock medical or surgical care or which represents a severe health hazard to other patients; in example, sputum-positive tuberculous patients

GROUPS I AND II

Between January 1, 1966, and December 31, 1968, a total of 1,454 patients were admitted to 9K. Of these, 764 were ad-