Psychiatric Bulletin (1992), **16**, 357–358

Trainees' forum

The nature of out of hours admissions to a general psychiatric hospital

JUSTIN GARDNER, Registrar in Psychiatry, Barrow Hospital, Bristol BS19 3SG

The organisation of psychiatric emergency services varies widely in the UK. These can usefully be viewed as a spectrum. At one end are traditional services where the GP acts as the primary filter to admissions. At the other extreme are crisis intervention teams aimed at managing the patient in the community. Somewhere along this spectrum of service provision lie the emergency walk-in clinics. There have been few studies on how effective these different arrangements are.

A number of studies have looked at emergency walk-in clinics and have concluded that they provide a valuable, accessible service. However, they also report a high percentage of chronic alcohol problems and re-referrals (Lim, 1983; Blaney & West, 1987; Kehoe & Newton, 1990).

In view of recent changes within the NHS it seems relevant to evaluate the effectiveness of these different arrangements. This study looks at the working of a more traditional service and compares "routine" with "out of hours" admissions.

The study

Barrow Hospital is a hospital with 265 beds on the southern slopes of Bristol. It services a multi-ethnic population drawn from both rural and urban areas including nearby Weston-Super-Mare. Referrals come from a variety of sources including nearby casualty departments where they are first assessed by the casualty officer and then screened by the on-call psychiatrist.

Data were collected prospectively over three months (September–November, 1990). Source of referral, diagnosis, legal status and previous contact with the service were obtained from the interim hospital discharge letter. Out of hours referrals (5 pm–9 am, Monday–Friday and 5 pm Friday–9 am Monday) were identified by the duty doctor who made daily returns of their names. The data were compared using the χ^2 test.

Findings

Two hundred and eighty-seven admissions were studied; of these 64 (22%) were "out of hours".

(a) *Referral source*

GP referrals accounted for 25.1% of "routine" and 40.6% of "out of hours" admissions ($P<0.05$). CPN referrals comprised 11.2% of "routine" and 1.6% of "out of hours" admissions ($P<0.05$). Police referrals made up to 3.6% of "routine" and 18.8% of "out of hours" admissions ($P<0.001$).

Domiciliary and self referrals were responsible for 9% and 5% of the total number of admissions respectively. Referrals from other hospitals (including casualty departments and out-patients) made up 36% of the total. The remaining 5% came from miscellaneous sources, including social services, law courts and the prisons. There is no significant difference between "out of hours" and "routine" admissions from these sources.

(b) *Diagnosis*

Depression was the major diagnosis, making up 36.6% of the total. Schizophrenia and manic-depression made up 15.7% and 15.3% each. There was no significant difference between the "routine" and "out of hours" groups for these diagnoses.

Patients with dementia were only admitted during routine hours ($P<0.005$). Alcohol and drug related problems were responsible for 4.5% of "routine" and 18.8% of "out of hours" admissions ($P<0.001$).

A diagnosis of personality disorder was made in 3.6% of "routine" and 17.2% of "out of hours" admissions ($P<0.01$). Other diagnoses made up the remaining 7.3% of admissions.

(c) *Legal status*

Patients detained under the Mental Health Act made up 12.6% of "routine" and 17.2% of "out of hours" admissions (ns).

(d) *Previous contact with the service*

New cases accounted for 42.6% of "routine" and 53.1% of "out of hours" admissons (ns).

Comment

From these results it is clear that patients with alcohol/drug related problems and personality disorder are more likely to present and be admitted "out of hours". This pattern has already been recognised in studies of emergency clinics (Lim, 1983) and may in part reflect licencing hours (Mendelson, 1987). Police referrals are also more likely "out of hours". This might be partly explained by delays in securing the attendance of police surgeons and approved social workers, a problem highlighted by Dunn & Fahy (1987).

Blaney & West (1987) found that 94% of their sample were already known to the hospital which contrasts with 47% in this study. In fact, re-admissions were evenly distributed throughout the 24 hour period. Similarly, the patients detained under the Mental Health Act were as likely to be admitted during "routine hours" as "out of hours".

Conclusions

In this service, patients with alcohol/drug problems and personality disorder tend to be admitted as "out of hours" emergencies as do police referrals. They form a large proportion of the emergency work load. The reasons behind this need clarification in order to provide appropriate and accessible psychiatric services for these groups. Only a small proportion of such cases are admitted from emergency clinics. It is likely that this service admits unnecessarily in some cases instead of diverting into more appropriate channels. However, the relatively low rate of re-referral suggests that a traditional service may not foster the same degree of dependency as do the walk-in clinics. Nonetheless, mounting pressure on beds is likely to make the latter an increasingly attractive option as a more discriminating and accessible filter into available resources.

References

BLANEY, D. & WEST, A. (1987) Out of hours referrals to a General Psychiatric Hospital. *Health Bulletin (Scotland)*, **45**, 67–70.

LIM, M. H. (1983) A psychiatric emergency clinic: a study of attendances over six months. *British Journal of Psychiatry*, **143**, 460–466.

KEHOE, R. F. & NEWTON, R. (1990) Do patients need a psychiatric emergency clinic? *Psychiatric Bulletin* **14**, 470–472.

DUNN, J. & FAHY, T. (1987) Section 136 and the Police. *Bulletin of the Royal College of Psychiatrists*, **11**, 224–225.

MENDELSON, E. F. (1987) Alcohol-related psychiatric emergencies: Differences in characteristics between those arriving at a walk-in clinic during and outside office hours. *The International Journal of the Addictions*, **22**, 469–475.

Psychiatric Bulletin (1992), **16**, 358–360

Personal columns

Pseudo-science?

D. H. MARJOT, Regional Consultant in Drug and Alcohol Dependence, St Bernard's Hospital, Southall UB1 3EU

Our countrymen, including ourselves, share numerous prejudices.

We are sexist, racist, ageist, chauvinist (an unreasonable patriotism), and classist (by birth, wealth or education). We also share that fear, dislike and rejection of the mentally disordered, which I would like to call the prejudice of 'psychiatrism'. Not only those who suffer are stigmatised – but so are their carers.

The prejudice 'psychiatrism' is widespread in the field of healing in general and in the medical profession in particular. We hear, therefore, that psychiatry is a primitive, less well developed speciality than other branches of medicine. This view is based on a compelling lack of evidence. When you look at the scientific basis of psychiatry it is remarkable how much is known. In this respect it is second to none when compared to its sister specialities. Equally remarkable is how little of this knowledge seems to be transmitted to many medical students and doctors in training. For instance, textbooks of physiology present a view of the nervous system that is many years out of date. You can only comprehend those things that you know about and can intellectually and emotionally accept.