BRIEF HOSPITALIZATION : RESULTS OF TWO-YEAR FOLLOW UP

Col DS GOEL^{*}, Lt Col D SALDANHA[†]

(Department of Psychiatry, Command Hospital Western Command, Chandimandir)

ABSTRACT

Brief hospitalization contributes to quicker and more effective recovery in psychiatric practice. It also leads to a progressive change in the pattern of mental morbidity. Two-year follow-up of patients treated with this technique indicates that recovery is sustained, and relapse/wastage rate is low. There is need for further research in this significant aspect of military medicine.

MJAFI 1996; 52 : 145-148

KEY WORDS : Follow-up studies; Hospitalization; Length of stay; Outcome assessment.

Introduction

The concept of brief hospitalization is now well established in psychiatric practice [1-10]. Its relevance to military psychiatry had been convincingly demonstrated in our earlier communications [11,12]. Employing management-by-objectives (MBO) techniques, quick diagnostic formulation and therapeutic planning, intensive treatment (including rapid neuroleptization) and rational disposal (avoiding sick-leave/low medical category in all except the more severely ill patients), average length of stay (ALS) at a Command Hospital psychiatric centre was brought down from 52.6 days to 15.5 days. The strategy resulted in a saving of over 20,000 soldier-days annually, with a four-fold rise in the percentage of those being returned to duty in medical category (med cat) 'AYE'. The issues involved have been keenly debated, and we have received a large number of reasoned comments from fellow professionals as well as health administrators. Often critical and always thought provoking, these have helped crystallize amorphous ideas. The larger consumer audience has been also addressed [13], and their reactions have been surprisingly positive. It therefore appears to be an idea whose time has come.

One basic issue had been, however, left unresolved: What of the day after, and the day after that? Brief hospitalization would lead to frequent relapses and repeated hospitalization. So argued

many who, like us, have been nurtured on the myth of a linear relationship between the length of hospitalization and the extent and stability of recovery. Nostalgia for those ancient shibboleths of military medicine, sick-leave and low medical category, is far more deeply ingrained than we had imagined. Statistically analyzed data appeared blunted in the face of an entrenched mythology.

In order to resolve this controversy, we now present the results of a two-year follow-up of psychiatric patients treated with brief hospitalization at a Command Hospital. As we had highlighted earlier [11], this technique involved two other vital components: avoiding sick-leave and low medical category in all except the more severely ill patients (eg., psychotics). This removed the element of secondary gain, and actually resulted in a change in the pattern of mental morbidity observed at that Centre; a statistically significant decline in the proportion of non-psychotics, coupled with rise in the number of psychotics ("core" psychiatric disorder) and those designed "NAD" [12].

Material and Methods

All patients (except those invalidated out of service) discharged from hospital were placed in a programme of active, 'mile-stone' follow-up at 6 months, 12 months, and 24 months intervals following discharge. This covered cases placed in conventional low medical categories as well as

^{*}Senior Adviser (Psychiatry) Military Hospital, Jodhpur 342010; [†]Classified Specialist (Psychiatry) Military Hospital, Kirkee.

those discharged to unit (DTU) in med cat 'AYE'. For purposes of this study the latter were regarded as being in med cat 'O' ("observation") [13]. Follow-up data were obtained from the individual's Commanding Officer on a structured proforma. About halfway through the study, we added a simple "self-assessment" check-list for completion by the individual himself. This yielded interesting information, but we have not included it in this study as data are not available for all subjects. These would be reported in a later communication. Except for those placed in conventional low medical categories, the decision to refer the individual for psychiatric re-evaluation was left to his Commanding Officer, in consultation with the authorized medical attendant. Thus only those subjects who relapsed, or who were otherwise symptomatic, were sent to hospital for psychiatric consultation. In case the individual had been posted out in the interim, the unit was asked to forward the follow-up protocol to his new unit, under intimation to us. The response was beyond all expectations.

Follow-up information in respect of patients discharged from hospital during the period 1 Oct 88 to 30 Sep 90 was compiled and analyzed with regard to outcome at the end of two years, i.e., based on the third and final milestone (24 months) input on the structured proforma. Since avoidance of low medical category constituted a major plank of the therapeutic strategy enunciated by us [11,12], data have been pooled medical category-

wise, rather than as per diagnoses. Diagnoses-wise analysis of follow-up data will be reported separately.

Results

Year-wise follow-up data is presented in Tables 1, 2 and 3. Data for the total period of the study is presented in Table 4. The majority of respondents were rated 'good' (6.3%) or 'satisfactory' (61.6%). A relatively insignificant number (1.6%) were reported 'unsatisfactory', or had to be invalidated out (1.4%). Discharge due to other reasons accounted for 4.6 per cent and 8 (1.0%) had deserted their units. No reply was received in 128 cases (16.1%). The percentage of non-responders showed a rise, from 6.9 per cent in the 1988 group to 30.5 per cent among those discharged during 1990 and followed-up till late 1992. No such trends are discernible in the case of other parameters.

Discussion

Analysis of results is handicapped by lack of comparable data from other sources. As far as we know, no similar study of such magnitude has been conducted in the Armed Forces. An empirical approach therefore becomes unavoidable. The most striking feature is a favourable outcome in a high proportion (67.9% - 'good+satisfactory') of cases, regardless of their medical category at the time of discharge from hospital. Even if the figures for discharge due to other causes (presuming these to be indirectly related to the psychiatric disorder)

TABLE 1
Outcome of patients discharged in 1988 (n = 316*)

Disposal outcome	Med Cat AYE n = 177		Med Cat BFF n = 79		Med Cat CEE n = 60		Total n = 316	
	No.	%	No.	%	No.	%	No.	%
Good	19	6.9	9	11.4	2	3.3	30	9.5
Satisfactory	124	70.1	41	51.9	35	58.3	200	63.3
Unsatisfactory	1	0.6	—	—	4	6.7	5	1.6
Invalidated out	2	1.1	3	3.8	1	1.7	6	1.9
Tfr to Pen Estab	9	5.1	12	15.2	7	11.7	28	8.9
Disch other reasons	8	4.5	7	8.9	5	8.3	20	6.3
Deserter	1	0.6	3	3.8	—	—	4	1.3
Deceased	—	—	—	—	1	1.7	1	0.3
No reply	13	7.3	4	5.1	5	8.3	22	6.9

*Excludes 14 cases invalidated out during initial hospitalization

TABLE 2
Outcome of patients discharged in 1989 (n = 247*)

Disposal outcome	Med Cat AYE n = 147		Med Cat BEE n = 40		Med Cat CEE n = 60		Total n = 247	
	No.	%	No.	%	No.	%	No.	%
Good	9	6.1	2	5.0	3	5.0	14	5.7
Satisfactory	102	69.4	21	52.5	38	63.3	161	65.2
Unsatisfactory	1	0.7	1	2.5	2	3.3	4	1.6
Invalidated out	1	0.7	2	5.0	2	3.3	5	2.0
Tfr to Pen Estab	6	4.1	2	5.0	2	3.3	10	4.0
Disch other reasons	7	4.8	2	5.0	2	3.3	11	4.5
Deserter	2	1.4	1	2.5	—	—	3	1.2
Deceased	1	0.7	1	2.5	1	1.7	3	1.2
No reply	18	12.2	7	17.5	10	16.7	35	14.2

*Excludes 12 cases invalidated out during initial hospitalization

TABLE 3
Outcome of patients discharged in 1990 (n = 233*)

Disposal outcome	Med Cat AYE n = 90		Med Cat BEE n = 39		Med Cat CEE n = 92		Total n = 233	
	No.	%	No.	%	No.	%	No.	%
Good	—	—	2	5.1	4	4.3	6	2.6
Satisfactory	59	65.6	23	59.0	47	51.1	129	55.4
Unsatisfactory	1	1.1	1	2.6	2	2.2	4	1.7
Invalidated out	—	—	—	—	—	—	—	—
Tfr to Pen Estab	—	—	3	7.7	1	1.1	4	1.7
Disch other reasons	4	4.4	2	5.1	—	—	6	2.6
Deserter	1	1.1	—	—	—	—	1	0.4
Deceased	—	—	—	—	—	—	—	—
No reply	25	27.8	8	20.5	38	41.3	71	30.5

*Excludes 12 cases invalidated out during initial hospitalization

TABLE 4
Consolidated outcome of patients discharged in 3 years 1988-90 (n = 796)

Disposal outcome	Med Cat AYE n = 414		Med Cat BEE n = 158		Med Cat CEE n = 212		Total n = 796	
	No.	%	No.	%	No.	%	No.	%
Good	28	6.8	13	8.2	9	4.2	50	6.3
Satisfactory	285	68.8	85	53.8	120	56.6	490	61.6
Unsatisfactory	3	0.7	2	1.3	8	3.8	13	1.6
Invalidated out	3	0.7	5	3.2	3	1.4	11	1.4
Tfr to Pen Estab	15	3.6	17	10.8	10	4.7	42	5.3
Disch other reasons	19	4.6	11	7.0	7	3.3	37	4.6
Deserter	4	1.0	4	2.5	—	—	8	1.0
Deceased	1	0.2	1	0.6	2	0.9	4	0.5
No reply	56	13.5	9	5.7	43	20.3	128	16.1

and desertion are clubbed with those for invalidment, the total wastage (5.6%) at the end of the year follow-up does not appear to be excessive. The same pattern is seen in data analyzed across various medical categories even though, strictly speaking, these are not comparable as those discharged in medical category 'AYE' had been less severely ill than those eventually placed in low med cat 'BEE/CEE'. Statistical levels of significance have not been worked out as analogous data from other studies are not available. Longitudinally the only important variation over the four-year period of this study was in the percentage of non-responders (up from 6.9 per cent for the 1988 group to 30.5 per cent for those discharged during 1990, with the pooled average being 16.1 per cent). It is difficult to explain this finding except on the premise that some of the later respondents may have been subject to more than one move in the interim. It is also a speculative possibility that some of these individuals had relapsed. No pragmatic means of verifying these hypothesis were available to the investigators.

Available evidence therefore suggests that brief hospitalization is not associated with a high relapse or wastage rate, and the overall outcome is gratifying, regardless of severity of illness or medical category at initial discharge from hospital. This accords with current psychiatric thinking [1-10]. The theoretical model underlying our endeavour is basically sound and widely accepted as a means for "maximizing patient care, providing better treatment, reducing personality damage (dependency, alienation from family/vocational environment), and more cost-effective utilization of scarce resources" [11]. Combined with avoidance of the routine use of sick-leave/low med cat this strategy curbs exploitative behaviour as well as elements of compensation neurosis.

The case for the defence rests for the present. We hope that others would take up the threads, and try to replicate our experiment. This would help dilute or eliminate any subjective artefacts which in our enthusiastic commitment to Brief Hospitalization we might have inadvertently introduced in this investigation.

REFERENCES

1. Burham AS. Short-term hospital treatment: A study. *Hospital Community Psychiatry* 1969; 20: 369-70.
2. Caffey EM, Gahlrecht CR, Klete CJ. Brief hospitalization and after-care in treatment of schizophrenia. *Arch Gen Psychiatry* 1971; 24: 81-6.
3. Weisman G, Feierstein A, Thomas G. Three-day hospitalization: A model for intensive intervention. *Arch Gen Psychiatry* 1969; 21: 620-9.
4. Herz MI, Endicott J, Spitzer RI. Brief Hospitalization of patients with families: initial results. *Am J Psychiatry* 1975; 132: 418-31.
5. Herz MI, Endicott J, Spitzer RI. Brief vs Standard Hospitalization: The families. *Am J Psychiatry* 1976; 133: 795-801.
6. Herz MI, Endicott J, Spitzer RI. Brief hospitalization - a two year follow-up. *Am J Psychiatry* 1977; 134: 502-7.
7. Herz MI, Endicott J, Gibbon M. Brief hospitalization - a two year follow-up. *Arch Gen Psychiatry* 1979; 36: 701-5.
8. Endicott J, Gohen J, Nee, Fleiss JL, Herz MI. Brief standard hospitalization: for whom? *Arch Gen Psychiatry* 1979; 36: 706-12.
9. Kennedy P, Hird F. Description and evaluation of a short stay admission ward. *Br J Psychiatry* 1980; 136: 205-16.
10. Dubin SE, Anath J, Bajwa-Goldsmith B. Three-day crisis resolutions unit. *Indian Journal of Psychiatry* 1990; 32: 30-4.
11. Goel DS, Saldanha D. Brief hospitalization - preliminary report on the Chandigarh experience. *Medical Journal Armed Forces India* 1992; 48: 27-34.
12. Goel DS, Saldanha D, Rathee SP. Changing pattern of mental morbidity: artefact of psychiatric policy? *Medical Journal Armed Forces India* 1991; 47: 275-9.
13. Goel DS. Caveat Vendor: The mythology of medical classification. *Combat Journal* 1992; 19: 60-6.