

Is there a real need for a short-stay unit in Al Ain, United Arab Emirates?

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This study explores the rationale and need for a short-stay psychiatric unit at Al Ain (United Arab Emirates) district hospital. The paper describes the demographic and diagnostic characteristics of patients with brief admissions over 40% - of all psychiatric admissions - most of whom have neurotic, stress-related and adjustment disorders. Only 12% of patients were severely disabled and in about half the patients, anxiolytic or no medications were prescribed. Significant reduction of distress was achieved by brief admission. In current circumstances, we believe that the short-stay unit might be the best available and least costly option.

The sparse data available indicate that less severely ill patients treated in short-stay units fare as well as or better than those managed on conventional in-patient wards (Herz *et al*, 1977; Martin *et al*, 1985; Gordon & Breakey, 1983; Schwartz & Vallance, 1987). Short-stay patients spend fewer days in hospital, which reduces financial cost and increases bed availability (Schwartz & Vallance, 1987). These benefits are not at the expense of increased rates of readmission (Hertz *et al*, 1977; Martin *et al*, 1985; Gordon & Breakey, 1983).

Background and rationale

From the inception of psychiatric services in Al Ain, in the early 1970s, services to mentally ill persons were delivered through an out-patient general hospital psychiatric unit and a joint medico-psychiatric in-patient unit. The arrival of the university department of psychiatry in 1990 was an impetus for the expansion of psychiatric services in Al Ain. Psychiatric services were extended into primary health care, new medical, paramedical and nursing staff were recruited and a new psychiatric unit with more bed capacity than the old one was established in July 1993. Plans for rehabilitative and community oriented psychiatry were put forward. All this opened the door for postgraduate training programmes in psychiatry and the newly established service was granted a provisional recogni-

tion as a postgraduate training centre by the Arab Board, the highest professional medical body in the Arab world. A computerised psychiatric register was established which records details of all in-patient episodes.

Unfortunately, some of our plans came to a halt as the building of the new unit began to crack and was attributed to land sliding. Portions with the most marked cracks were closed, leaving us with a small functional area. We have been promised by the health authorities that a new unit will be built in the near future but have to cope with what we have at the present time. This situation prompted us to look into the literature on how to cope with a smaller in-patient unit. Short-stay wards or units were reported to partially absorb pressure on traditional units and could be the final path patients could get to. We therefore intended to find the characteristics of patients admitted to our unit with less than one week of hospitalisation and whether they would justify the establishment of a short-stay unit.

The study

Records of patients with first ever admissions of less than one week duration to the unit from November 1993 to August 1995 were retrieved from the computerised psychiatric register. The computerised database includes details on demographics, diagnostic categories (ICD-10; World Health Organization, 1992), clinical aspects, treatment and degree of associated dysfunction or disabilities. Tabulation of patients by gender, nationality, employment status, disabilities, ICD-10 diagnosis, medications received, 'receipt of ECT' and combination of drugs were carried out. To test the efficacy of short hospitalisation, Wilcoxon matched tests were performed to test the significance of changes in dysfunction or disability on admission and on discharge.

Findings

One hundred and seventy patients were identified for the study. They constituted over 40% of all admissions. There were 85 male and 85 female patients. Their mean age was 30.12 with a range from 13–79 years. The mean length of stay was 2.9 days. The distribution of patients by disability was: 16% with minimum or no disability, 32% with mild disability, 40% with moderated disability and 12% with severe disability. The most common diagnoses were neurotic, stress-related, adjustment and dissociative disorders (44.7%), followed by mood disorders (18.4%). About 5% had a diagnosis of schizophrenia and related disorders. Organic mental disorders and substance use disorder each accounted for about 5% of patients. Two patients were given ECT. Over half of patients were prescribed no medications or anxiolytics alone, 24% and 23% of patients were prescribed antidepressants and neuroleptics respectively.

About 9% of patients were unemployed and the rest were employed, students or housewives. Nearly 79% were discharged to the out-patient clinic, 4% were transferred to medical or surgical facilities within the same hospital, 6.5% were finally discharged from psychiatric services, because there was no need for them to attend psychiatric services, and the rest were referred to psychiatric and non-psychiatric medical facilities outside Al Ain medical district. At the 5% level, significant reduction in dysfunction was achieved by brief admission. Table 1 summarises the details of all patients.

Comment

Our computerised register reveals that patients with brief admission constituted over 40% of patients admitted. The significant difference in disability at admission and discharge indicates the usefulness of brief admissions. Although the majority of patients were diagnosed as having neurotic, stress-related and somatoform disorders, 25% were assigned a diagnosis of mood or schizophrenic disorders. The broad spectrum of diagnostic status of patients with short admissions indicates that less severely and severely ill patients also benefit from short admissions. Our findings accord with those of Mok & Walter (1995) who reported the following diagnostic status of patients with short admissions: adjustment disorder in 46%, followed by substance abuse (30%), bipolar disorder (8%), dysthymia (7%), schizophrenia (6%), major depression (5%), and schizophreniform disorder (5%). If a short-stay unit existed, 40% of all patients requiring hospitalisation would have been admitted there rather than to a conventional in-patient psychiatric unit. A literature review indicates that short-

Table 1. Diagnoses and treatments of the sample

	n	%
Diagnostic categories		
Acute and transient psychotic disorders (F23)	6	3.5
Mental and behavioural disorders due to psychoactive substance use (F11–F19)	8	4.7
Reaction to severe stress and adjustment disorders (F43)	35	20.6
Mental and behavioural disorders due to alcohol use (F10)	1	1.8
Neurotic disorders (F40–F41)	10	5.9
Bipolar disorders (F31)	4	2.4
Dissociative disorders (F44)	30	17.6
Depressive episodes (F32)	19	11.2
Manic (hypomanic) episodes (F30)	3	1.8
Obsessive–compulsive disorder (F42)	1	0.6
Organic mental disorders (F00–F09)	7	4.1
Paranoid disorders (F22)	2	1.2
Persistent mood disorders (F34)	1	0.6
Personality disorders (F60–F69)	7	4.1
Recurrent depressive disorders (F33)	4	2.4
Schizophrenia (F20)	7	4.1
Somatoform disorders (F45)	2	1.2
Others	21	12.4
Disability on admission		
Minimum	27	15.9
Mild	55	32.4
Moderate	68	40
Severe	20	11.8
Electroconvulsive therapy		
No	168	98.8
Yes	2	1.2
Type of medication		
Anxiolytic alone or no medications	91	53.5
Antidepressants with and without anxiolytics	40	23.5
Neuroleptics with and without other drugs	39	22.9
Number of drugs received		
No drugs	60	35.3
One drug	60	35.3
Two drugs	38	22.3
> two drugs	3	1.8
Unknown	9	5.3
Total	170	100

stay units increase bed availability and reduce cost (Herz *et al.*, 1977; Martin *et al.*, 1985; Gordon & Breakey, 1983; Mok & Walter, 1995). Our findings support this observation. One interesting finding is that patients with brief admissions are less likely to receive polypharmacy and as a result are less likely to develop adverse side-effects.

Conclusion

The high proportion of patients with brief admission justifies the establishment of short-stay units. Such units could accommodate not only stress-related minor disorders but those with moderate and severe forms of illnesses. Brief admissions of patients with severe illnesses renders such patients more amenable to out-patient care. We believe that a short-stay unit reduces pressure on the remaining part of the in-patient unit. Staff of the existing unit can run the proposed unit and as a result the health authorities will be more willing to agree an immediate plan of action. The limitations of this study are the lack of information about the symptomatic and follow-up outcomes of such patients.

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