as the expectation of training their own and various other professional groups. This may result in the training of junior doctors not receiving the priority it requires. Junior doctors with busy clinical jobs often do not attend all teaching sessions and it requires a highly motivated supervisor who can liaise with other senior medical staff to increase attendance. It is also often easier for a senior member of the medical staff to emphasise the importance of this training to other senior medical colleagues. Trainees themselves are also likely to attach more importance to training offered by a senior member of their own profession and are likely to view such training as being more relevant to their own needs. Moreover, there are many paramedical professionals who claim behavioural and cognitive expertise but who, in practice, are familiar with only a small range of patients. Catchment area psychiatrists, however, see many wide-ranging difficult and chronic patients and the application of behavioural and cognitive techniques to these groups requires a different repertoire of skills than a more limited clientele.

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Trainees' forum

Patients repeatedly admitted to psychiatric wards

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Many admissions to general adult psychiatric beds occur as emergencies, either due to social crisis or relapse of psychiatric illness. Other admissions are planned to arrest or reverse deterioration in mental state. Length of stay varies from days to months depending on reason for admission and adequacy of support in the community. Rapid readmission or failed discharge, defined as readmission within three months, has been linked with multiple previous admissions and personality factors (Jones, 1991).

All units have a few "revolving door" patients who are frequently readmitted although their illnesses and social circumstances do not appear to differ markedly from others who can live successfully in the community for longer periods. We defined such patients as those admitted six or more times within 12 months.

The aim of this study was to identify factors which would differentiate those patients admitted frequently from those remaining in the community for longer periods.

The study

A retrospective review of admissions over 12 months was carried out on two acute psychiatric wards in a district general hospital (DGH), a 10 bed high dependency ward and a 25 bed medium dependency ward. Patients are transferred between these wards as necessary, allowing disturbed behaviour to be controlled with the minimum of sedation. The DGH serves a catchment population of approximately 360,000, with 90 adult medium dependency beds and 20 adult high dependency beds. The catchment area is mixed rural and urban with a level of unemployment higher than the national average.

Case-note review was undertaken on the "revolving door" patients. As these patients had a history of frequent discharge against medical advice (DAMA), a further review of all recorded DAMA on the wards over the same period was carried out, with case-note review of all patients involved.

Findings

A total of 440 patients were admitted 573 times. Sixty-two (30 male, 32 female), 14% of the sample, were re-admitted within three months. Three of these, all male, were readmitted over six times during the 12 months of study, and classified as "revolving door" patients.

Case 1: male, b. 1966. Diagnosis: schizophrenia, drug abuse. Eight admissions in study period, length of admissions 4–48 days, time between admissions 6–83 days. Usually hallucinated, sometimes threatening or violent behaviour on admission, settled quickly on the ward. Hallucinations resistant to neuroleptics. DAMA on three occasions. Poor compliance with after-care programmes and medication post-discharge.

Case 2: male, b. 1947. Diagnosis: bipolar affective disorder, alcohol abuse. Eight admissions in study period, length of admissions 1–24 days, time between admissions 10–96 days. Usually hypomanic relapses. DAMA on five occasions, detained formally (Section 2) once. Established on depot but poor compliance with after-care programme.

Case 3: male, b. 1970. Diagnosis: affective disorder, alcohol and drug abuse. Seven admissions in study period, length of admissions 1–37 days, time between admissions 1–68 days. DAMA on four occasions. Very short admissions precluded proper investigations or implementation of treatment programme. Most admissions precipitated by suicidal threats. Used alcohol and drugs on the ward. Poor compliance with after-care programmes.

The majority of the readmissions in these three cases (18/23) were self or GP referrals to a junior doctor. None were assessed by the consultant or senior registrar prior to admission. In five of the 13 recorded DAMA incidents, the patient left the ward without assessment by a medical officer.

The 32 patients who were recorded as DAMA over this period often showed a pattern of behaviour with repeated episodes during their psychiatric history of leaving hospital against advice. Some would then be compliant with follow-up in the community, others would refuse contact until the next crisis, still others have as yet had no further contact. There was no link with age or sex, the mean age of each group being 37 years (unique episodes) or 38 years (pattern of behaviour).

Comment

The main factors associated with the "revolving door" patients were non-compliance with treatment and frequency of DAMA. Assessment before DAMA considers whether or not the patient is detainable. DAMA usually occurs "our of hours", so assessment is likely to be carried out by the junior doctor on call. It is not the policy on many units to discuss such patients with a more senior doctor unless an element of risk is obvious and formal detention is being considered. These patients quickly become known to medical and nursing staff on the unit. Once a patient becomes a "revolving door" patient, this may influence attitudes of staff towards him, both on the ward (making the chances of him discharging himself against medical advice stronger) and in the community (increasing the chances of early readmission). The criteria for detention are strict but, if this results in allowing a patient to discharge against medical advice, before he is able to survive any length of time in the community, this is detrimental to the patient's health. While a treatment order can keep the patient in hospital for longer periods, it cannot be used in the community for any length of time. The non-compliance shown by these patients could probably only be controlled by a community treatment order were one to exist.

The three "revolving door" patients had had a time of illness prior to this unstable period with admissions at a more "usual" rate. Indeed, two of the patients have since had relatively lengthy periods in the community and appear to have reverted to their previous pattern of illness. It was not possible to identify any social cause for the change, nor did the illness appear more severe when comparing signs and symptoms on admission. Compliance with treatment during this unstable period would be more likely to produce and maintain remission while social and psychological rehabilitation could also be carried out.

Crisis intervention teams can prevent some admissions by giving short term intensive support in the community to the patients or their carers. In the three cases described above, support in the community was not accepted.

Alcohol and/or drug abuse was present in the three cases, and this was also a factor found in patients in whom DAMA was a pattern of behaviour. However, these are not uncommon findings in psychiatric patients. Another indication of likelihood to DAMA was if the patient had done so on a previous admission.

Conclusion

There is a small group of psychiatric patients for whom current services are not providing successful care. Discussion of all potential DAMA incidents with the appropriate consultant, as is recommended in the Code of Practice before Section 5(2) is implemented, may enable a treatment programme to be established in hospital. Compliance in the community is more likely to occur if the programme has been established prior to discharge. It is important that these people who need help in times of crisis but will not accept it otherwise are not forgotten in future service developments.

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