A Combined Inpatient and Partial Hospital Program

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This paper describes a combined inpatient and partial hospital program, with a ten-bed short-term inpatient unit and a partial hospital program that can accommodate 24 patients. Inpatients and partial hospital patients are treated together by the same staff in a program located in the partial hospital. The authors highlight features of the program that address the five elements of continuity: place, personnel, program, patient-peers, and plan for treatment. The discussion focuses on the importance of continuity in sustaining a combined unit; potential benefits for patients, families, staff, and trainees; attractiveness to third-party payers; and impediments to fully realizing the potential of the unit. (*Psychiatric Services* 48:242–244, 1997)

Integration of inpatient and partial hospital care has been attempted in various ways (1–5). This paper describes a combined inpatient and partial hospitalization unit designed so that both groups of patients are treated by the same staff and attend a program located in a partial hospital setting. To our knowledge, ours is the first report of a treatment model in which place, personnel, program, plan for treatment, and patient-peers are continuous between the inpatient and partial hospital.

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We believe these "five Ps of continuity" are a crucial organizing framework to consider in designing cost-effective and efficient acute treatment programs that can reduce length of stay without compromising quality of care. Research demonstrates that patients treated in acute day hospital settings can have similar or better outcomes than inpatients on measures of psychopathology and social functioning and are more likely to be satisfied with their treatment experience (6,7).

The integrated treatment unit

The integrated treatment unit at the University of Rochester Strong Memorial Hospital was established in 1990 to decrease inpatient length of stay through earlier discharges to the partial hospital program and to divert some admissions from inpatient units to the partial hospital. It has two components: a ten-bed short-term inpatient unit and a partial hospital program that can accommodate 24 patients.

Table 1 describes demographic, diagnostic, and utilization characteristics of patients during a recent six-month period. Patients were included in the analyses when all required data were available in the record. Data for 159 of the 187 inpatients and 169 of the 233 partial hospital patients were included.

Inpatient length of stay averaged eight days; patients were screened at intake for factors predicting effective brief admissions (8,9). Patients for whom brief inpatient treatment was likely to be effective were preferentially admitted to the short-term inpatient unit. The screening did not absolutely rule out admission of patients for whom a long length of stay was likely, but these patients were triaged away from the unit when possible.

Most of the partial hospital patients (106 patients, or 66 percent) were former inpatients. The mean length of stay in the partial hospital program was 21 days. A small proportion of inpatients (nine patients, or 6 percent) required transfer to longer-term inpatient settings. Twenty-one of the partial hospital patients (12 percent) required inpatient admission during their course of treatment.

The partial hospital program, which is adjacent to the locked inpatient unit, includes group therapy rooms, professional offices, medical facilities, and reception and dining areas. The proximity of the two components provides continuity of place and makes it logistically possible to treat all patients in the same ambulatory-care-based program, using the same staff to provide treatment and manage both milieus. With such an arrangement, continuity of care can be extended to other levels.

Maintaining continuity of personnel has several benefits. First, it enriches staffing by allowing resources of the two components to be shared and thereby reducing redundancy and costs. The full-time staff includes five master's-level primary therapists from nursing and social work disciplines. They conduct intake evaluations, provide the bulk of individual and family therapies, and colead group therapies. Graduate-level trainees also function as primary therapists. Two full-time-equivalent psychiatrists collaborate with the primary therapists by focusing on diagnostic evaluation, medical management, and pharmacotherapy.

One inpatient staff nurse assigned each day to the partial hospital program provides a variety of conventional nursing services, including administering and monitoring medications. Internal medicine consultants evaluate all patients admitted to the inpatient service and those patients admitted to the partial hospital program who do not have immediate access to medical evaluation and consultation. A specialist in family therapies is employed for both consultation and primary interventions.

The higher density of professional staff makes it possible to manage patients with more severe symptoms in an ambulatory setting, producing an inpatient-like environment within the partial hospital program and easy access to nursing, psychiatric, and internal medicine services not generally found in most freestanding partial hospital programs. In addition, in this era of increased liability, teams are necessarily hesitant to discharge acutely ill inpatients to providers and treatment plans that they cannot control. Families are rightly skeptical about accepting earlier discharges unless continuity is assured. Using the combined model, it is easier to discharge patients with acute symptoms because the team that initiated treatment can follow through.

Finally, staff can maintain gratifying treatment relationships with patients, bringing many treatment episodes to greater resolution in the partial hospital program. Opportunities to observe the course of an illness and recovery and to complete a phase of brief psychotherapy are becoming increasingly rare in acute settings today and are important assets for staff retention and training.

Blending the patient populations provides continuity of patient-peers and the opportunity to realize other important psychological benefits. Inpatients see peers at various stages of recovery in the partial hospital program. When the momentum of treatment is not disrupted and continuity with the program and treatment plan are maintained regardless of the level of care required, patients are less likely to view inpatient admission and readmission from the partial hospital program as a sign of failure. The approach develops a culture of hopefulness for positive outcome that may be absent in short-term units without a combined ambulatory milieu to complete treatment.

This system of care leads to natural economic advantages. The enthusiasm and cooperation of our local insurers is an indication of the program's value in cost containment. Insurers reimburse for the partial hospital program as an inpatient treatment site and exchange one day of inpatient care for two to three days of partial hospital care.

Despite enthusiastic responses to care from insurers, patients, and families, we struggle with factors that lead to underutilization. Private practitioners, particularly psychiatrists, have been slow to accept partial hospital treatment for acute patients. Faced with conflicts of practice style and economics that favor inpatient treatment, they are also generally unfamiliar with their role in a hybrid setting that seems neither inpatient nor ambulatory. Many were initially uncomfortable about treating high-risk patients in an outpatient setting in an era of heightened concerns about liability. However, their discomfort has dissipated over time with education and with positive experiences with the system.

Severely impaired psychotic pa-

Table 1

Characteristics of patients consecutively admitted to a combined short-term inpatient unit and partial hospital program over a six-month period

Characteristic	Inpatient unit	Partial hospital
N admissions		
Total	187	233
With complete data[1]	159	169
Mean age (years)[2]	36.8±10.6	38.7±12.0
Gender (%)		
Male	51	44
Female	49	56
Admission status		
Voluntary	55	na
Involuntary	49	na
Discharge diagnosis (%)		
Nonpsychotic depression	30	44
Psychotic affective disorder	16	20
Nonaffective psychosis	16	7
Organic mood disorder	6	1
Adjustment disorder or other diagnosis	32	28
Comorbidity (%)		
Substance abuse or dependence	43	36
Personality disorder	39	39
Mean Global Assessment of Functioning score		
Admission	35.4±8.7	47.4±7.6
Discharge	49.8±10.3	53.2±11.4
Mean length of stay (days)[3]		
All patients	8.3±5.5	20.8±12.0
Voluntary patients	8.0±4.9	na
Involuntary patients	8.6±6.3	na
Patients with a psychotic diagnosis	9.1±6.4	17.9±12.0
Patients without a psychotic diagnosis	7.7±5.0	22.0±11.9
Final disposition (%)		
Partial hospital program	43	na
Other continuing treatment program	18	18
Substance abuse partial hospital program or clinic	5	6
Psychiatric clinic	11	33
Private psychiatric care	12	26
Inpatient transfer or admission	5	12
No aftercare	4	4

na, not applicable

[1] Only patients for whom data were complete were included in the analysis.

[2] Age ranges: inpatient unit, 19 to 78 years; partial hospital, 20 to 82 years

[3] If less than seven days elapsed between discharge and readmission, data were combined as a continuous admission.

tients who fail to respond in the early stages of treatment or who have no stable residence have typically failed attempts at short-term inpatient treatment and failed to successfully make the transition to the partial hospital level of care. Transfer to longer-term inpatient treatment has been the only alternative for some of these patients. Specific changes in public policy are necessary to improve access to housing and financial assistance before brief admissions and the partial hospital level of care will be feasible for patients who are homeless and destitute.

Conclusions

The next decade promises to challenge health care systems to respond to competing societal needs. Demands for access to acute treatment will require more rapid turnover of inpatient beds, which may be achieved by better use of a partial hospital level of care. We will be held to the same standards of quality and potential for liability while being required to contain if not reduce costs. Our patients and their advocates will continue to demand treatment that is less disruptive to the flow of their lives and less stigmatizing while insisting on both continuity and good outcome. Balancing these needs will become even more challenging as the country moves further along a course likely to lead to more managed and capitated systems of reimbursement.

We are hopeful that many elements of a combined program such as we have described may allow us to supply the demand for intensive resources without compromising quality or continuity of care, and while maintaining satisfying professional settings in which to work, teach, train, and conduct research. ♦

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Prevalence of Dissociative Disorders in an Acute Care Day Hospital Population

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To estimate the prevalence of dissociative disorders in a day hospital and examine their relation to traumatic experiences, trained clinicians evaluated 70 of 229 patients consecutively admitted to an acute care day hospital. They used the Mini-Structured Clinical Interview for DSM-III-R Dissociative Disorders and the Traumatic Experience Questionnaire. Six of the 70 patients (9 percent) received a definite diagnosis of a dissociative disorder. Five of the six patients reported a childhood history of sexual or physical abuse. The results show that dissociative disorders are not rare among general psychiatric patients in a day hospital setting and are associated with histories of childhood trauma. (*Psychiatric Services* 48:244–246, 1997)

A large percentage of psychiatric inpatients report histories of physical or sexual abuse (1). Dissociative symptoms and disorders are associated with a history of trauma (2,3).

The prevalence of dissociative identity disorder has been estimated to be between 3 and 10 percent in psychiatric populations (4), suggesting that the prevalence of severe dissociative disorders has been underestimated in the past. Data about other dissociative disorders are less clear. One recent study of a psychiatric inpatient population found the prevalence of dissociative disorder not otherwise specified to be 8 percent and the prevalence of psychogenic amnesia to be 1 percent (5).

The study reported here assessed the prevalence of dissociative disorders in a day hospital population. A second objective was to understand the relation between dissociative disorders and past traumatic experiences.

Methods

The Connecticut Mental Health Center day hospital serves adult indigent general psychiatric patients who need acute care but who are not imminently a danger to themselves or others. Patients requiring transition to the community from acute hospitalization are also served.

All patients admitted to the day hospital during a 16-month period from March 1992 to July 1993 were considered eligible for participation in the study unless they were grossly psychotic, their behavior was too disorganized, or their involvement might be detrimental to their treatment. Once informed consent was obtained, one of the first three authors administered and scored the Mini-Structured Clinical Interview for DSM-III-R Dissociative Disorders (Mini-SCID-D) (6) and the Traumatic Experience Questionnaire (7). Patients' active charts and charts from referring agencies were reviewed for demographic, historical, and diagnostic information.

The Mini-SCID-D was developed by Steinberg and associates (6) as a brief screening instrument with questions based on the full Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) (8). In one study interrater reliability was noted to be excellent (94 percent agreement, kappa=.88), and the instrument was found to have good-to-excellent sensitivity and specificity (6). When the Mini-SCID-D is used, a dissociative disorder is found to be absent, possible, probable, or definite. If a subject responds to questions unequivocally and in sufficient number in each symptom area to meet diagnostic criteria, a definite diagnosis is assigned. The instrument screens for psychogenic amnesia, psychogenic fugue, depersonalization disorder, dissociative disorder not otherwise specified, and multiple personality disorder.

The results of this study replicate earlier findings that a large percentage of psychiatric patients report a history of sexual or physical abuse during childhood.

The Traumatic Experience Questionnaire is an interviewer-administered inventory developed by Steinberg (7) that focuses on traumatic life experiences. Scoring can be done for nine subsections—verbal abuse, physical abuse, sexual abuse, incompetent parenting, death of parent, compromised parenting, chronic medical problems, other traumatic events, and abuse summary. Maximum scores are 3 points in each of the first five areas listed, 2 points in the next three, and 4 points for the abuse summary.

Descriptive statistics were used to characterize the sample. Information about age, gender, race, employment status, marital status, and Mini-SCID-D diagnoses was examined.

Results

A total of 100 of 229 patients consecutively admitted over the 16-month period were invited to participate. Eighty-seven (40 percent) consented. Reasons for not participating were scheduling difficulties (71 patients), premature discharge (33 patients), clinical incapacity to participate or refusal by the primary clinician to grant permission (12 patients who were grossly psychotic, developmentally disabled, or manic), transfer to an acute inpatient setting (11 patients), and poor English skills (two patients).

Of the 87 patients who consented to participate, 17 did not complete the interview. The final sample of 70 consisted of 31 males (44 percent) and 39 females (56 percent). The mean age of the sample was 35.7 years (range, 20 to 66 years). There were 50 Caucasians (71 percent), 14 African Americans (20 percent), four Hispanics (6 percent), one Asian (1 percent), and one Native American.

Sixty-two patients (89 percent) were unemployed, six (8 percent) were employed part time, one (1 percent) was on leave from work, and one was employed full time. Thirty-five patients (50 percent) had never married, 16 (23 percent) were divorced, ten (14 percent) had been married once, six (9 percent) had been married more than once, and one (1 percent) was widowed. For two patients (3 percent) information on marital status was not reported.

In the charts from the referring agencies, major depression was the

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most common diagnosis (for 19 patients, or 27 percent), followed by bipolar disorder (13 patients, or 19 percent), schizophrenia (ten patients, or 14 percent), schizoaffective disorder (eight patients, or 11 percent), and adjustment disorder (seven patients, or 10 percent). Other diagnoses (two patients, or 3 percent each) were psychotic disorder not otherwise specified, organic mood disorder, and multiple personality disorder, and (for one patient, or 1 percent each) panic disorder, dysthymia, delusional disorder not otherwise specified, organic personality disorder, personality disorder not otherwise specified, bulimia, and dissociative disorder not otherwise specified.

Dissociative disorders

According to the Mini-SCID-D, six of the 70 subjects (9 percent) definitely had a dissociative disorder. Five were diagnosed as having multiple personality disorder and one as having dissociative disorder not otherwise specified. The diagnoses for these five patients that were listed in the charts from the referring agencies were multiple personality disorder (two patients), dissociative disorder not otherwise specified (one patient), psychotic disorder not otherwise specified (two patients), and schizoaffective disorder, depressed type (one patient).

The two subjects with the referral diagnosis of psychotic disorder not otherwise specified met criteria for multiple personality disorder, and the subject with the referral diagnosis of schizoaffective disorder, depressed type, met criteria for dissociative disorder not otherwise specified. Fifty percent of the patients diagnosed by the Mini-SCID-D as having a dissociative disorder did not have that diagnosis when they were referred to the day hospital.

Traumatic experiences

Fifty-four of the patients (77 percent) reported a history of physical or sexual abuse. Physical abuse without sexual abuse was reported by 16 patients (23 percent), and sexual abuse without physical abuse was reported by six (9 percent). Twenty-one of the 39 women patients (54 percent) and 14 of the men (45 percent) reported a history of sexual abuse. Of the six subjects with definite Mini-SCID-D diagnoses, five (83 percent) reported definite memories of physical abuse, one (17 percent) suspected physical abuse, and four (66 percent) reported a history of sexual abuse.

Discussion

This study is one of the first to use a semistructured interview to determine the prevalence rate of dissociative disorders in an outpatient psychiatric population. The prevalence of dissociative disorders in the study group was found to be 9 percent, similar to that reported by Saxe and colleagues (5), who found a prevalence of 15 percent among psychiatric inpatients, and similar to those in other studies of psychiatric populations, which found prevalence rates of dissociative identity disorder between 3 and 10 percent (4). The association between traumatic antecedents and a diagnosis of a dissociative disorder was high; five of the six patients with a dissociative disorder (83 percent) reported definite recall of abuse, and one suspected abuse.

The results of this study replicate earlier findings that a large percentage of psychiatric patients report a history of sexual or physical abuse during childhood (1). Among the 70 patients in the study, the rate of sexual and physical abuse was 77 percent, with a similar proportion of men and women reporting a history of sexual abuse. Earlier studies have found that females were more likely to experience sexual abuse than males (9), suggesting that further research is needed in this area.

Conclusions

This study found a rate of dissociative disorders consistent with those in other studies of psychiatric populations (4,5). The results add to a growing body of literature documenting that dissociative disorders are not rare and that a large percentage of psychiatric patients in acute treatment settings report traumatic experiences. The prevalence of dissociative disorders found in this study is high enough to warrant the recommendation of routine evaluation for dissociative disorders of all patients in acute treatment settings. Unless adequate assessment of dissociative symptoms is made, patients' problems may be incorrectly attributed to another disorder, leading to ineffective treatment. ♦

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