CASE IN POINT

OVER 100 UNNECESSARY PSYCHIATRIC ADMISSIONS

Roy R. Reeves, DO, PhD, Ray Kimble, MD, and Randy S. Burke, PhD

Besides driving up health care costs, patterns of unnecessary hospitalization hurt patients by delaying appropriate intervention. This case illustrates what can go wrong when providers fail to recognize and address the problems underlying such behavior.

Given the high costs associated with inpatient care, as well as the availability of appropriate and effective outpatient interventions for many conditions, health care systems have been working for decades to reduce unnecessary admissions. In the 1990s, for instance, the VHA underwent major changes to shift from inpatient- to outpatient-based models of care and, since then, has intensified its focus on preventive approaches.

Among these efforts have been investigations into risk factors for frequent or early readmission. In patients with medical conditions, research has revealed a number of factors that influence readmission, including relapse or complication of the original condition, development of a new condition, problems with medications, failure to seek medical attention promptly, a higher number of previous admissions, nonadherence to therapy, social problems or inadequate social support, and difficulty coping with the condition.[1–3] An even larger body of psychiatric research shows that the following additional factors affect the frequency of admission among patients with mental illness: aggressive behavior; financial stressors and lower socioeconomic status; advanced age; single marital status; female gender; malingering; shorter length of hospital stay; lack of education; negative attitudes toward medication; lack of case management; poor satisfaction with life; and comorbid conditions, such as substance use disorders, sexual impulse control problems, and medical problems.[4–8]

Here, we present the case of a patient who, after more than 150 hospitalizations over the course of 27 years, ultimately proved to have no medical or psychiatric disorder other than alcohol dependence and malingering. In addition, we discuss factors affecting his numerous readmissions and alternative approaches that might have resulted in earlier recognition and appropriate treatment of his condition—and, therefore, better overall care.

INITIAL EXAM

A 66-year-old, white, male patient was admitted to a VA medical center (VAMC) in September 2000 for alcohol intoxication. His medical records indicated numerous hospitalizations over the preceding years. Although the most frequently cited diagnoses were alcohol abuse and alcohol

Dr. Reeves is the associate chief of mental health, **Dr. Kimble** is a staff psychiatrist, and **Dr. Burke** is a staff psychologist, all at the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS. In addition, Dr. Reeves is a professor of psychiatry and neurology, Dr. Kimble is an assistant professor of psychiatry, and Dr. Burke is a clinical assistant professor of psychiatry, all at the University of Mississippi School of Medicine, Jackson.

dependence, his records included a variety of other diagnoses, including depression, schizophrenia, delusional disorder, personality disorder, and malingering. At the current admission, he was homeless and was beginning to show signs of cognitive impairment that were attributed to his long-term alcohol use.

Magnetic resonance imaging of the brain revealed early cortical atrophy and ventricular enlargement. Electroencephalography showed mild diffuse slowing of background rhythms. His medical history included a previous diagnosis of hypertension, for which he had been prescribed antihypertensive therapy. At the current admission, however, his blood pressure was normal. Laboratory studies were significant only for mild macrocytic anemia, which probably was secondary to alcohol consumption. A thorough psychiatric and psychological assessment revealed mild cognitive impairment but no evidence of any other active mental disorder. The patient demonstrated antisocial and dependent personality traits.

PATIENT HISTORY

Due to the recurrent nature of his presentation, a detailed assessment and review of the patient's medical records was performed. To the surprise of the reviewers, the patient was found to have had 153 prior hospital admissions: 139 to the same VAMC, 11 to a local state hospital, and three to another local hospital.

Between 1974 and 2000, the patient averaged 5.7 admissions per year. He was cared for at various times by over 12 different psychiatrists, several primary care physicians, and numerous social workers. Of the 139 admissions to the VAMC, 41 (30%) involved documentation of an intoxicated state and 80 (58%) ended with him leaving the hospital against medical advice. Over the 27 years, he had visited the emergency department 145 times but had kept only seven regularly scheduled follow-up appointments—which worked out to an average of 0.26 appointments per year, or about one every four years. Chart reviews suggested that more than 100 of his admissions occurred as a result of fabrication of symptoms and apparently were unnecessary.

Family history revealed that the patient's father had been an alcoholic and that several relatives in his paternal line had used alcohol as well. His own relationship with alcohol had begun in childhood, during which time he was extremely shy and had difficulty interacting with other children. After being introduced to alcohol by his father at the age of five, he soon concluded that alcohol "took away all my shyness," and by his late teens, he was drinking on most weekends. He reported only brief experimentation with other drugs.

He dropped out of high school and joined the Marines at age 17. At age 24, he married but, according to his own description, never developed close emotional ties to his wife or their two daughters. In 1974, around the time his frequent hospitalizations began, he and his wife separated and his drinking increased significantly. Four years later, he was legally divorced. He reported having no contact with his ex-wife or daughters since 1990.

Initially, his admissions had been related primarily to alcohol use. With time, however, his physicians apparently became reluctant to continue admitting him, performing detoxification, and discharging him (often against medical advice), only to have him return within a relatively short period of time to begin the cycle again. The patient then began reporting a variety of symptoms to gain admission, including suicidal ideations, hallucinations, and delusions.

During the current admission, he admitted to previous fabrication of symptoms, describing a pattern in which he would obtain admission when he wanted to go into the hospital and then report his symptoms resolved and demand discharge when he wanted to leave. He related a fear of developing delirium tremens and explained that, at times, his reason for obtaining admission had been to avoid withdrawal symptoms through detoxification, all the while intending to resume alcohol consumption at a later time.

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TREATMENT COURSE

Due to his developing cognitive decline and increasingly poor judgment, the patient was recommended for placement in a supervised living arrangement. He firmly refused, however, insisting that he could care for himself properly. After much debate with the patient and consultation with the hospital ethics committee, his physician formulated a treatment plan that was agreeable to him: He would be discharged to an apartment, but if he proved unable to care for himself, long-term supervised treatment would be sought—by court order, if necessary.

Within a few weeks of discharge, the patient returned, homeless, penniless, intoxicated, and requesting readmission. During this hospitalization, his physician petitioned the court for commitment to long-term care on the basis that he had demonstrated clearly his inability to care for himself. The patient became intensely angry and loudly berated the staff for requesting commitment. He seemed surprised and concerned when it became apparent to him that the staff would not withdraw the petition. His court hearing resulted in his commitment to an inpatient geropsychiatric unit.

After one month in this unit, he was transferred to an outpatient program, which required him to live in a residential setting approved by his mental health care provider, attend his scheduled outpatient appointments, take medications as directed, and abstain from alcohol. His failure to adhere to these stipulations would result in a return to the inpatient unit.

During the subsequent year, the patient's behavior changed remarkably. He began to participate actively in his structured outpatient program, which provided some degree of social support. He attended all of his scheduled appointments and had no emergency department visits or hospitalizations. For the first time in years, he appeared to take his physicians' recommendations seriously. The change from his past behavior was striking.

UNDERSTANDING THE CONDITION

The patient's behavioral patterns—including his chronic, excessive alcohol use (despite its consequences) and his intentional production of false or exaggerated psychological symptoms, motivated by external incentives—were consistent with the diagnoses of alcohol dependence and malingering, as described in the text revision of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition.[9] At times, he also may have demonstrated elements of factitious disorder, since some of his feigned symptoms may have been to assume the sick role to get nursing care and attention. Usually, however, he appeared to have had an external motivation, and he was able to "stop" his symptoms when they were no longer useful to him.

Financial stressors, intermittent homelessness, single marital status, and lack of social support undoubtedly contributed to his recurrent admissions. The most significant factors, however, were his chronic alcohol consumption and fabrication of symptoms. It's likely that his primary problem was alcohol dependence and that the malingering actually was intended to enable him to continue with his drinking patterns.

The patient's malingering contributed to the difficulty of treating his alcohol dependence. Establishing that a patient's symptoms are the result of overt fabrication can be difficult. The Minnesota Multiphasic Personality Inventory-2 or other psychological tests may be helpful.[10,11] Because this patient's malingering appeared to be so closely related to his alcohol use, confronting and treating the alcohol dependence earlier might have resolved both problems.

MANAGING THE CASE

Clearly, this patient should have been confronted about both his alcohol dependence and malingering many years ago, with recommendation of appropriate treatment interventions. Because the relationship with his providers was somewhat adversarial, they would have to have approached him carefully. With sensitive efforts, however, his providers might have been able to overcome his denial mechanisms, educate him about future difficulties his continued drinking would bring him, and help him recognize his need for treatment. For example, once his diagnoses were established, a multidisciplinary team of providers might have presented him with their findings, suggesting that his illness did not require the numerous admissions he desired and recommending a more suitable approach to treatment, such as a structured outpatient program that would address his psychosocial needs.

If he were willing to accept treatment, a number of modalities could have been considered.[12–14] Group treatment enables patients to see their own problems mirrored in others and to learn better coping skills. By focusing on day-to-day issues, counseling helps patients stay highly motivated to sustain abstinence, enhance levels of functioning, and learn to build a lifestyle

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that excludes alcohol. The importance of self-help groups such as Alcoholics Anonymous should not be underestimated. And if the patient has close family members, they should be included in the treatment process and encouraged to attend a support group as well. Finally, disulfiram treatment may be a helpful adjunct for some patients.

If the patient were unwilling to accept alcohol treatment when offered, involuntary treatment could have been considered sooner. For many years, this patient met criteria for legal intervention in the form of commitment to a residential program. Undertaken early on, such an intervention could have altered the subsequent course of his illness radically.

Consistent case management and continuity of care also might have helped prevent the excessive admissions. If the same providers had seen the patient regularly, they might have gained a better understanding of his situation, behavioral patterns, and needs. Intensive case management using frequent follow-up visits or participation in a day treatment program could have been tried as an alternative to many of his admissions. In fact, this approach might have provided the patient with the emotional support and psychological insight required to diminish his need for frequent hospitalizations. Case management also might have promoted a sense of alliance between the patient and his providers.

It's not easy to draw general conclusions from this case. Other factors beyond our interventions may have contributed to the patient's improvement. For example, it's possible that his changes in behavior were related to his advancing age and progressing cognitive decline. Implementing treatment that involved confining him to a housing program would have been more difficult if he were younger. Nevertheless, his problems should have been addressed in some manner much earlier in the course of treatment. Failure to confront the patient's alcohol dependence and associated behaviors in a timely manner led to a downward spiral that ended only when he began having difficulty caring for himself. A much different course could have resulted with appropriate early intervention. ●

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