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SHORT REPORT

Patients prefer a continuity model of inpatient psychiatric consultant care: a patient survey in the Louth Mental Health Service

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Objectives. The objective of the paper was to survey patients' preference in relation to a continuity, or split, model of inpatient consultant care in the Louth Mental Health Service.

Methods. A written survey was administered to all patients attending the Louth Mental Health Service over a 2-week period. Participants were asked for their preferred model of care and clinical information was obtained from their clinical notes.

Results. In total, 149 patients completed the survey questionnaire and 103 respondents (69%) indicated a preference for a continuity model of inpatient consultant psychiatric care. There was a trend for those who reported a past experience of inpatient hospitalisation to indicate a preference for the continuity model (76% *v*. 61%, respectively, χ^2 3.67, $p = 0.056$).

Conclusions. Patients indicate a preference for a continuity model of inpatient psychiatric care and this is important to consider in service planning. More research is needed to evaluate if any model of consultant care is associated with better patient outcomes.

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Key words: Inpatient psychiatric care, models of care, patient preference.

Introduction

Although there has been a move towards community-based psychiatric care in Ireland, inpatient treatment is still frequently required. Hospitalisation is often the only safe way of managing risk and stabilising a person's mental state, however, it is relatively burdensome on mental health resources and can be an emotionally challenging experience for patients (O'Donoghue *et al*. 2010; Fenton *et al*. 2014). There is considerable international research interest in evaluating the most effective way of delivering inpatient psychiatric care, particularly in relation to different models of psychiatric consultant care (Giacco *et al*. 2015). The Louth Mental Health Service considered two different models of care when it recently moved its inpatient services to a new inpatient unit; in this context we undertook a survey of patient preferences and corresponded with the *Irish Journal of Psychological Medicine* (Roche *et al*. 2017).

Two different models of inpatient consultant psychiatric care have been described: (1) a continuity model in which the same consultant manages a patient's inpatient and outpatient care; and (2) a specialisation, or split, model of care in which different consultants manage outpatient and inpatient care. Continuity and split models of care have each been proposed to have advantages over the other, although at present there is a lack of strong evidence to suggest either model resulting in superior patient outcomes (Burns, 2010; Omer *et al*. 2015). In spite of this lack of evidence, there are several examples internationally of mental health services moving from one model of consultant psychiatric care to another. A Scottish study reported that patients' preference was for a continuity model (Begum *et al*. 2013), however, no equivalent study has been performed in an Irish setting.

The Louth Mental Health Service inpatient psychiatric unit recently moved to a different location and, during this process, consideration was given to changing from a continuity model to a split model of inpatient consultant psychiatric care. As part of a process of engaging with multiple stakeholders, a survey of patient preferences was undertaken. We sought to establish patients' preference in relation to model of consultant care and we aimed to evaluate for

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demographic or clinical characteristics associated with any preference identified. It was hypothesised that the majority of patients would indicate a preference for the continuity model.

Methods

A cross-sectional survey of patients' preference in relation to model of inpatient consultant care was undertaken. All patients attending the Louth Mental Health Service outpatient psychiatry department and the inpatient unit in St Brigid's Hospital were eligible to be included in the study. No age restrictions were applied. In keeping with exclusion criteria applied by Begum *et al*. those who lacked capacity, as determined by their treating team, or were too distressed to participate in the survey were excluded from the survey (Begum *et al*. 2013). Data were collected over a 2-week period in August 2016; all patients attending two outpatient clinics or admitted to the inpatient unit of St. Brigid's Hospital for the Louth Mental Health Service during this time period were considered for inclusion in the study.

A cover letter was provided to each potential participant, which explained the purpose of the survey and explained the difference between a continuity and split model of inpatient consultant psychiatric care. A written survey (Appendix A) requested participants to indicate their preferred model of care as well as basic demographic information and past experience of psychiatric hospitalisation. Information relating to patient diagnosis was ascertained by a review of their clinical notes, with the most recent diagnosis made by the patient's treating psychiatrist taken as the primary diagnosis. Data were entered onto an Excel worksheet and was analysed with IBM SPSS Statistics, Version 20 (IBM Corp., 2011). χ^2 test was used to compare binary variables and the Student's t test was used to compare continuous variables, with a p value of <0.05 taken to be statistically significant.

Ethical approval for this study was granted by the Health Service Executive North East Area Research Ethics Committee.

Results

A total 266 potential participants were screened for the study and the questionnaire was offered to 251 patients, of which 149 completed it (response rate 59%). A total of 15 patients were excluded because they were deemed to lack consent by their treating team ($n = 4$) or were too distressed to participate ($n = 11$). The characteristics of respondents are presented in Table 1.

In total, 103 respondents (69%) indicated a preference for a continuity model of inpatient consultant psychiatric care, nine (6%) indicated a preference for a split model of care and 37 (25%) had no preference. Those who reported to have any prior experience of psychiatric hospitalisation were somewhat more likely to describe a preference for the continuity model of care than those without (76% *v*. 61%, respectively, χ^2 3.67, $p = 0.056$), however, the result was not statistically significant. The preference for a continuity model of inpatient consultant care was not significantly associated with either age or gender: compared with those with a preference for split model/no preference: the mean age was 43.8 *v*. 42.8 years, respectively, $t = -0.44$, $p = 0.66$ and 66% were men *v*. 71% women, respectively, $\chi^2 = 0.39$, $p = 0.53$.

A content analysis of the reasons for preferred model of inpatient consultant care was performed, based on free-text replies. Of those who indicated a preference for a continuity model ($n = 103$), 55 provided a free-text reply and comments related to: the consultant's knowledge of their case ($n = 30$), therapeutic relationship with their consultant ($n = 29$), perceived tolerability of continuity *versus* split model of care ($n = 8$) and the principle of continuity ($n = 5$). Several participants' replies covered multiple themes, for example, 'it's important to have the same consultant as you get to know and trust the same person rather than having to explain yourself over and over'. Of those who indicated a preference for a split model of inpatient consultant care ($n = 9$), seven provided a free-text reply, six of which related to the perception that this model might result in more effective care, for example, '2 specialists, 2 opinions there for better results'. Of the 37 participants

Table 1. *Characteristics of survey participants*

Characteristics	*n* (%)
Gender (female)	93 (62%)
Primary diagnosis[a]	
Psychotic disorder	22 (15%)
Bipolar affective disorder	21 (14%)
Major depressive disorder	55 (37%)
Anxiety disorder	29 (19%)
Personality disorder	8 (5%)
Substance/alcohol use disorder	4 (3%)
Other	6 (4%)
Prior inpatient psychiatric hospitalisation	
Never	70 (47%)
Once	25 (17%)
Twice	17 (11%)
Three times	9 (6%)
More than three times	28 (19%)
Age (mean, S.D.)	43.5 (13.4)

[a] Information on primary diagnosis missing on four (3%) of respondents.

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who indicated no preference for model of inpatient care, eight gave a reason for their preference and six of these related to the perception that effectiveness of inpatient care would not be affected, for example, 'I don't mind as long as I get the right treatment'.

Discussion

In this survey we found that the majority of patients (67%) reported a preference for a continuity model of inpatient consultant care and a substantial proportion (25%) had no preference. These findings are broadly similar to those of Begum *et al*. who reported that 76% of a Scottish sample indicated a preference for the continuity model with 12% having no preference (Begum *et al*. 2013). We advance the literature by applying the survey to an Irish sample and by evaluating clinical and demographic factors associated with a preferred model of inpatient care. The trend for those who reported a previous experience of inpatient hospitalisation to report a preference for a continuity model perhaps strengthens further the case for this model.

Limitations to the study are acknowledged. Although the response rate to the survey was in the average range for patient questionnaires, the sample was drawn from a local population and results may not therefore be generalisable to other clinical populations. Information about prior hospitalisation may have been subject to recall bias and the proportion of participants who had prior experience of a split model of inpatient consultant care was not recorded. Response bias cannot be out ruled given that a continuity model was the model of consultant care delivered in the Louth service, and given the lack of strong evidence in favour of either model outlined in the cover letter for the questionnaire.

Giacco *et al*. (2015) summarise the proposed relative merits of each model of inpatient consultant care; for example, the split model may result in quicker clinical decision making, development of specialised expertise and positive risk management, whilst the continuity model may improve patient engagement, continuity of care and an enhanced therapeutic relationship. Continuity of care is an important principle of psychiatric care and applies not only to patient–staff relationships but also to transitions of care within services (Johnson *et al*. 1997). Continuity models of care may be associated with improved outcomes, based on the findings of a systematic review (Omer *et al*. 2015), however, significant methodological shortcomings have been identified in the existing literature.

In the absence of a strong outcomes-based evidence base, there are other factors to consider in relation to service planning. *A Vision for Change* remains the guiding document in relation to the development of mental health services in Ireland and it has continuity of care as a core guiding principle for care of those with mental illness (Report of the Expert Group on Mental Health Policy, 2006). Indeed patients' preference seems to be for a continuity model and it appears that aspects of patient satisfaction with consultant care is higher in those receiving care in continuity models than in a split model (Laugharne & Pant, 2012). Any service-level decision should include multiple stakeholders and be based on best available evidence or guiding principles. Decisions may also be affected by local factors such as resource availability and geographic spread of services, as well as postgraduate training practices. It can be hoped that, ultimately, such decisions will be informed by outcomes-based research in the area.

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Conflicts of Interest

None.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

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Questionnaire

1. What is your age in years? _____

2. What is your gender? Male ☐ Female ☐

3. How many times have been admitted for treatment to ANY adult psychiatric inpatient hospital?

Never ☐ Once ☐ Twice ☐ 3 times ☐ More than 3 times ☐

4. In the event that you required inpatient treatment, which would be your preferred model of consultant care?

- Same consultant for inpatient and outpatient care ☐
- One consultant for inpatient care and a different consultant for outpatient care ☐
- No preference ☐

Reason for preference (optional):

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