

Letters to the Editor

State Laws on Emergency Holds: Updated Data Set

TO THE EDITOR: This issue of *Psychiatric Services* includes an article titled “State Laws on Emergency Holds for Mental Health Stabilization” (1), which provides data on emergency hold laws effective as of November 1, 2014.

Since the above article was published online earlier this year, we have updated the data set to reflect emergency hold laws effective as of February 1, 2016. The legal longitudinal data are freely available for use and review on the LawAtlas site (lawatlas.org/query?dataset=short-term-civil-commitment).

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- Hedman LC, Petrila J, Fisher WH, et al: State laws on emergency holds for mental health stabilization. *Psychiatric Services* 67: 529–535, 2016

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Is the NHS Mental Health Service Preparing Clients to Resume Employment?

TO THE EDITOR: In the U.K. population, mental disorders account for 47% of long-term sickness or absence from the workplace (1). The care program approach in the National Health Service (NHS) mental health service emphasizes a holistic approach that includes understanding the contribution of unemployment to mental illness (2). Supporting clients should involve advice about when to resume work if they are on leave, when to seek work if they are unemployed, and occupational impairments associated with a mental disorder. Support is particularly useful for clients taking psychiatric medication because of side effects relevant to workplace functioning. Daily error diaries from employees have shown that selective serotonin reuptake inhibitors can lower logical and semantic processing, recognition memory, and reaction times (3). Employees taking benzodiazepines can be accident prone (3), limiting employment that involves driving and machine operation. This study examined the extent to which the philosophy of supporting clients resuming employment is put into practice in the NHS mental health service.

This study examined cross-sectional survey data from 3,329 adult clients of the NHS mental health service. All expressed interest in employment support. Data were extracted from a Care Quality Commission survey. Between-subjects univariate

analyses of variance examined the association between medication status and receiving return-to-work support, controlling for recency and duration of contact with the NHS mental health service. Most clients (87%, N=2,831) were receiving psychiatric medication; therefore, each analysis was replicated in a subsample of 400 randomly selected clients (200 receiving and 200 not receiving medication).

Provision of return-to-work support was low (44% did not receive it, N=1,470), even though 40% of clients (N=1,263) had used the mental health service for one to five years, 14% (N=440) for six to ten years, and 29% (N=925) for more than ten years. Most (57%, N=1,863) had contact with the service in the past month.

Clients taking psychiatric medication were significantly more likely than those who were not to receive return-to-work support irrespective of service contact recency (F=11.49, df=1 and 3,174, p=.001, $\eta^2=.004$; replicated in the random sample, F=5.52, df=4 and 376, p=.019, $\eta^2=.014$) or duration (F=37.87, df=1 and 3,096, p<.001, $\eta^2=.012$; replicated in the random sample, F=10.05, df=1 and 361, p=.001, $\eta^2=.029$). Receipt of return-to-work support was significantly associated with contact recency (F=9.03, df=4 and 3,174, p<.001, $\eta^2=.011$; replicated in the random sample, F=5.08, df=4 and 376, p=.001, $\eta^2=.05$).

Many clients resuming employment (44%) did not receive return-to-work support from the NHS mental health service. Clients taking medication received significantly better support, which is important because medication can affect cognitive processing, memory, attention, and perception and cause drowsiness, agitation, confusion, and fatigue (3). Because employment support can benefit all clients, the NHS mental health service should improve provision across the board and provide staff with training in the care program approach. Occupational rehabilitation programs run by psychiatric teams are effective, even with severe disorders (4). Research should examine the provision of employment support for clients with depression because it is the most prevalent mental disorder in the working-age population (1,5) and causes the greatest work-related functional impairment.

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Admission Rates and Psychiatric Beds in Hong Kong, 1999–2014: A Population-Based Study

TO THE EDITOR: For the past 15 years, Hong Kong has been reducing the number of psychiatric beds and developing community mental health services. However, the effect on admission rates is unknown. This study examined trends in psychiatric admission rates in relation to the number of psychiatric beds.

The study was a retrospective analysis of data (1999 to 2014) from a population-based registry. Data on the total number of psychiatric admissions (involuntary, voluntary, and informal) and psychiatric beds were obtained from the Hospital Authority register through the Clinical Data Analysis and Reporting System (1). Involuntary and voluntary admissions refer to patients admitted under the Mental Health Ordinance. Informal admissions refer to patients admitted voluntarily but not under the ordinance; they may leave at any time that they request a discharge. Pearson correlation analysis was used to investigate associations between annual changes in the number of psychiatric beds and admission rates, with a time lag of zero, one, or two years.

Between 1999 and 2014, the overall admission rate increased by 32.0%, from 175.2 to 231.2 per 100,000 population per year, and the total number of psychiatric beds in Hong Kong decreased by 39.8%, from 93.1 to 56.0 per 100,000 population. During the same period, the involuntary admission rate increased by 5.4%, from 36.8 to 38.8 per 100,000 population per year. The voluntary admission rate increased by 68.4%, from 33.9 to 57.1 per 100,000 population per year. The informal admission rate increased by 29.3%, from 104.6 to 135.3 per 100,000 population per year. Overall, the number of admissions per psychiatric bed increased by 2.2-fold.

No significant association was found between changes in the number of psychiatric beds and admission rates when a time lag of zero, one, or two years was introduced.

The relatively small change in the involuntary admission rate may suggest the effect of community mental health services (2), which focus on patients who require monitoring and supervision in the community. However, the marked increase in voluntary and informal admissions suggests that a large number of patients cannot be managed by psychiatric outpatient services. Currently, primary care doctors receive little training and support to manage patients with mental illness. Therefore, psychiatric outpatient services are mostly supported by the Hospital Authority. In addition, high consultation fees of private psychiatrists and the need for long-term care have made public psychiatric services the only choice for most patients.

Chinese people with mental illness and their family members may delay seeking help because of stigma. When the condition worsens to the extent that family members cannot handle it, patients are admitted to a hospital because outpatient clinics are overcrowded and clinicians offer only brief consultations (3). Reductions in the number of psychiatric beds may have helped mobilize resources and manpower to community-based services; however, this may have led to a shortage of acute beds and problems of overcrowding. Simultaneous development of community-based services, including public education, training of primary care professionals, and expansion of outpatient psychiatric care, are all needed. In countries that have a hospital-based care system, provision of psychiatric beds must be carefully planned to avoid such complications.

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