The Transition from Psychiatric Hospitalization to Community Living: Local and Current Challenges

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ABSTRACT

While extensive efforts have been made in recent decades to enhance community mental health services around the world and in Israel, less attention has been given to the challenging transitional period from psychiatric hospitalization to community living. The current paper reviews the literature on discharge planning programs, which shows that using an interdisciplinary team and adapting a case management model to include overlapping relationships during the process of changing settings might lead to cost-effective outcomes. It is argued here that the current Israeli reform allows an opportunity to reconsider clients' needs and budget priorities, as doing so might lead to the development and implementation of appropriate discharge planning programs.

In Israel, public policy and legislation (1) reflect intensive and extensive efforts to promote recovery and community integration for persons with Serious Mental Illness (SMI), similar to the policy that exists in the United States (2). These efforts, which have focused on community mental health, resulted in a decline of psychiatric beds by approximately 50% between 2001 and 2011 (3) and the concurrent development, implementation and dissemination of various psychosocial interventions (4). However, despite the development of an impressive system to provide psychiatric rehabilitation services, and evidence of the effectiveness of the rehabilitation “basket of services” (4, 5), little attention has been given to the individual's transition from the hospital to the community.

The lack of a targeted intervention suited to the discharge phase indicates that specific challenges related to the transition from the hospital to the community are being overlooked. These challenges include the need to provide continuity of care, which would decrease rates of re-admission and promote community integration (6). The development and implementation of a discharge planning system that would create a bridge from hospital-living to community-living is crucial. Data have shown that while hospitalization durations have gone down in recent decades, rates of readmission have gone up (7, 8, see systematic review and full details in 9) and that persons with SMI do not feel sufficiently prepared for re-entry into the community upon discharge, and subsequently experience various unmet needs (10, 12). The current paper therefore views the new reform in mental health in Israel as an opportunity for creating a suitable discharge program. Accordingly, it reviews discharge programs that have been developed, implemented and studied in different countries, identifies their key elements, and suggests guidelines for adapting them to the local and current context of the reform.

THE ISRAELI CONTEXT: THE REFORM AS AN OPPORTUNITY FOR BUILDING BRIDGES

The reform that was recently instituted in the mental health system in Israel allows an opportunity for rethinking the needs of clients with SMI. The reform, launched in July 2015, transfers the responsibility for individuals' mental health care from the state to the health maintenance organizations. As a result, a single organization now bears responsibility for mental health care in both inpatient and community settings, leading to potentially greater cooperation between the various entities. Better coordination can also be expected with regard to the integration of physical and mental health care, as is often needed (13). In addition, the fact that the health maintenance organizations are now responsible for the provision of mental health care, both in hospitals and in community settings, might...
motivate them to minimize hospitalization days in order to lower costs. One key way to achieve this goal might be via appropriate discharge planning, which would likely reduce subsequent re-hospitalization. The Ministry of Health, which has taken on the role of regulation and planning (rather than being a service provider), could play a major role in the development of such discharge planning.

While it should be said that there is much debate with regard to the implications of the reform on quality and duration of treatment, stigma and additional issues, these matters are beyond the scope of the current paper. However, given that the reform has become part of the reality of mental health care in Israel, it is essential to look at this moment as an opportunity for the improvement of services. In the context of the hospital-to-community transition, ideas for improvement should be based on an exploration of the current discharge experience in Israel and also on an examination of discharge programs in other countries, which could potentially be adapted to the current and local emerging new conditions.

THE EXPERIENCE OF PSYCHIATRIC HOSPITALIZATION DISCHARGE IN ISRAEL

For many years concerns have been raised with regard to the discharge process in Israel. A project at Tirat Carmel Mental Health Center in Israel (11) that was described more than a decade ago, included a flexible intervention model of a transitional setting from hospital to community. The transitional setting was a hostel which provides temporary residence for persons who, upon release from the hospital, did not feel sufficiently prepared for direct re-entry into the community.

A recent survey in Israel addressed patient satisfaction among 835 persons who were discharged from psychiatric hospitals during the first half of 2015 (10). The survey showed that 63% of persons reported not being satisfied with the way the staff had prepared them for moving back into the community. The survey also showed that 66% reported that they knew what the next step in treatment was after discharge; 57% reported that their rehabilitation program was suited to their needs; 44% reported that the staff prepared them for discharge; and 39% reported that their social rights were explained to them. The results of this survey make it clear that the current situation is not satisfactory, and that there is a need for a formal systematic program to accompany people with SMI as they move back into the community from the hospital.

In addition, a recent qualitative study in Israel provided an analysis of interviews that were conducted with persons with schizophrenia with regard to their subjective experience of the transition from hospital to community (12). The analysis revealed that persons oscillated between feelings of vitality and strength, and feelings of despair and vulnerability. In addition, participants in this study reported that social, familial, employment and professional aspects were major factors that either enhanced or impeded their process of re-entering the community after hospitalization, dependent on the quality of provided support and involvement of significant others. Most importantly, the results highlighted the importance of supportive relationships and work as contributing to a successful transition (12). Not surprisingly, these factors are considered central to the various discharge programs reviewed below.

PSYCHIATRIC HOSPITALIZATION DISCHARGE: EXISTING PROGRAMS IN OTHER COUNTRIES THAT FOCUS ON PROVIDING CONTINUITY OF CARE

Beginning in the early 1980s, with the development and implementation of Assertive Community Treatment (ACT) model (14, 15) and additional psychiatric rehabilitation practices that occurred following deinstitutionalization (16), community integration became a major goal in mental health. In various places around the world, where the aim was to close psychiatric hospitals and replace them with community-based services, a focus on such services was evident (see Leff’s studies on the TAPS project in England, 17; and a sociological review on deinstitutionalization in England, Italy and additional countries, 18). ACT marked a major turning point in the treatment of people with SMI as it provided an effective means for the enhancement of community integration (19). ACT has also addressed the “revolving door” phenomenon, which refers to the phenomenon of people with SMI being frequently hospitalized, and having only brief periods of time during which they are not hospitalized (20).

As a practice, ACT is not a clinical intervention but rather a system for organizing different services in the community for persons with SMI (21), requiring numerous resources, mental health authorities and the active support of the administration (22).
Critical elements of ACT include the application of a multidisciplinary team approach, integration of services, low client-staff ratios, a focus on everyday problems, quick replies to client emergencies, assertive outreach, individualized and time unlimited services. While it is true that ACT practitioners are involved in hospital admissions and discharges, as a way of promoting continuity of care (21, 22), their particular focus is on ongoing community services and not on the specific challenges that typify the transition from hospital to community.

Moving back into the community from a stay in a psychiatric hospital marks a unique period that includes both risks and opportunities. Studies have shown that the transition back into the community puts people with SMI at high risk for homelessness, violence, suicide and psychiatric re-hospitalization (23-26). These risks are more evident among persons who are young, single, male, have had previous hospitalizations, have a psychotic illness, have a poor support network, have a challenging social environment, display poor compliance, do not adhere to their follow-up plan, and were discharged from hospitalization too early (20, 27). It is important to point out that a delay in or lack of follow-up treatment has been shown to be related to poor outcomes and subsequent re-hospitalizations (20, 28), pinpointing the need for continuity of care (6). Providing such ongoing care might not only reduce the risk of psychiatric re-hospitalization and additional poor outcomes, but might also provide new opportunities for people with SMI as they re-enter the community setting (6, 12).

In their study on discharge planning, Jensen et al. (29) reviewed the origin of the concept of continuity of care. It was first conceptualized by Bachrach (30) as a dimension of care for persons with SMI which was assessed by examination of chart data. Joyce et al. (31) later reviewed the literature on continuity of care which revealed that the majority of reviewed papers conceptualized it from the perspective of the mental health worker. As a result, they argued for the need to include the patients’ perceptions of continuity of care as well, and conducted a qualitative investigation based on both the literature on continuity of care (as reported primarily from the perspective of mental health workers) and on interviews with patients and family members. Their exploration resulted in the identification of themes that described the concept of continuity of care. These themes were service delivery, accessibility, relationship base and individualized care. Notably, the accounts of patients and family members corresponded to the descriptions of continuity of care in the literature (31).

First person accounts of care continuity correspond to a qualitative analysis of the literature (31), thus a complementary concept, namely “experienced continuity,” was introduced in order to express the need to include the clients’ perspective of the experience of continuity (32). With this in mind, most of the studies that assessed different programs of discharge planning examined continuity of care from both professionals’ and clients’ perspectives, as will now be detailed.

One comprehensive discharge planning program is the empirically tested clinical project in Canada, originally called the “Bridge on Discharge” and subsequently re-named as the “Transitional Relationship Model” (6, 33-36). This program was designed to assist individuals who had had prolonged psychiatric hospitalizations to successfully integrate back into the community, using a supportive constellation of interpersonal relationships (33-36). The program is therapeutic-relationship-oriented and uses a case management model that “transcends the traditional boundaries that separate hospital and community practice” (35). It emphasizes the need for an interdisciplinary team and overlapping relationships during the course of the move from one setting to the other, as well as the need to address peer and family relationships (35). Empirical evidence has shown that this program is cost-effective, as it saved 500,000$ (CAN) in one year, and improved participants’ quality of life (pilot study N=38). Additional studies in Scotland and Canada have replicated the cost-effectiveness of the program (e.g., 34, 36).

Another model aimed at bridging the transition from hospital to community is the Longitudinally Based Discharge Planning and Treatment Model (LDPTM) (37, 38). This model is also oriented toward clients’ needs, and it stresses a non-time limited and open-ended multidisciplinary and comprehensive program. As such, the program includes inpatient ward professionals, community mental health professionals and peers from the consumer group. The two key elements of the program are having peer support and overlapping services. In addition, a unique feature of this program is the feedback loop it provides, enabling clients to be readmitted to a crisis unit if necessary,
and then to proceed either back to the community or to the hospital. It is also based on case management models, as the hospital case manager assumes the role of discharge planner (37, 38). Unfortunately, although comprehensive and detailed information regarding this program is available, no studies have yet examined its effectiveness.

While the transitional relationship model and the LDPTM models stress a non-time limited discharge program, there is also evidence that a brief time-limited program is somewhat effective in creating a bridge from psychiatric hospitalization to the community setting. Dixon et al. (39) studied the effectiveness of a brief three-month critical time intervention (B-CTI) at discharge. In their study, they adapted the original nine-month critical time intervention to a three-month intervention. While the original nine-month program was found to be cost-effective and to reduce homelessness and negative symptoms (40, 41), the study on the brief version of the program at discharge showed that although this program did promote continuity of care (evident from both participant self-reports and from outpatient visits charts), there was a limited association between this continuity of care and overall patient outcomes (39).

Additional models also exist with a relatively less comprehensive description and less rigorous empirical support (e.g., Jensen et al. (29) used a single group evaluation strategy, and Price (42) used a qualitative oriented pilot study). Notably, the majority of the literature on this subject can be found in the fields of nursing and social work, although the need for a multidisciplinary team is emphasized. Nevertheless, upon an examination of the existing literature on discharge, and a review of the programs’ descriptions and empirical support, it is clear that a formal systematic discharge plan is needed in order to enhance community integration and reduce psychiatric hospitalization re-admissions.

While continuity of care is crucial, it requires policymakers’ support, funding and the cooperation of a variety of stakeholders. For example, the implementation of the transitional discharge model (previously called Bridge on Discharge) was followed by a discussion on the challenges in implementation and dissemination in both Canada and Scotland, summarized by Forchuk et al. (43). In Canada, the sustainability of the implementation and dissemination of the model was challenged as a result of its having only partial government support in Ontario, and funding that lasted for only three years. An additional challenge was the limited staff understanding and commitment to the model, especially with respect to the coordination of peer support, which is a central aspect of the model. This problem was made even more complex by the general upheaval surrounding the period of divestment and change of ownership of provisional hospitals, leading to a lack of leadership. In Scotland, the challenges involved small piloting data, limited funding, and problems in adopting peer support as part of the model. As peer support is a key aspect of the program, concerns were raised with regard to various issues, including maintaining boundaries in these relationships, providing support for peer volunteers, and funding peer volunteers’ activities and travel (43).

Deforge and Belcher (38), as well, discuss challenges to the implementation of discharge planning programs and make mention of governmental budget issues. They also stress that it is crucial for policymakers, staff and administrators to have a good understanding of the goals of the program. Interestingly, they call for a system reform that would provide resources to discharge planning programs. In addition, they mention clinical challenges that include high risk patients (e.g., those with a history of homelessness or violence) and the need to set priorities between staff members and clients, especially when there are co-morbid disorders (37, 38).

CONCLUSIONS

While extensive efforts have been made in recent decades to enhance community mental health services around the world and in Israel, less attention has been given to the challenging transitional period from psychiatric hospitalization to community living. Discharge planning programs that have been developed and implemented in different countries show that using an interdisciplinary team and adapting a case management model to include overlapping relationships during the process of changing settings might lead to cost-effective outcomes. It is argued here that the recent Israeli reform allows an opportunity to reconsider clients’ needs and budget priorities, as doing so would hopefully lead to the development and implementation of appropriate discharge planning programs. Specifically, there are key elements in the reviewed discharge programs which should be incorporated into the contemporary Israeli context. These elements are: 1) overlapping relationships during the course of moving from setting to setting. This would include the adaptation of a case manage-
ment model to the transitional phase, meaning that the same professional would manage a patient's case from beginning to end, i.e., from the time of his/her stay in the hospital all the way through his/her integration back into the community; 2) an interdisciplinary team that would address the patient's social, familial and employment issues. The work of the team would be coordinated by a case manager and their collaborative work would start during the patient’s hospitalization; 3) preparation of the family for patient’s return, and ongoing communication with the family; 4) tailoring the program according to the person's needs and choices, using a shared decision model; 5) addressing peer relationships, as they provide much-needed support and social opportunities.

As emphasized above, preparing the field for the implementation of a discharge program is essential in order to have both a sufficient budget and commitment to the model by different stakeholders. All stakeholders would need to receive information with regard to expected cost-effectiveness and the key elements of the program. Preparing the ground in this way would hopefully lead to a high degree of loyalty, motivation and commitment to the program. Studies examining the process of implementation and assessing the effectiveness of the programs would also be needed in order to track the challenges and possible solutions to these challenges, in the process of creating a bridge from hospital to community.

References


