

Does discharge planning prevent readmission to inpatient psychiatric units?

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Clinical Question

Does discharge planning prevent readmission to inpatient psychiatric units?

Clinical Scenario

Staff of some inpatient psychiatric units spend many hours per week in meetings dedicated to discharge planning for clients in their service. These meetings can include many inpatient and community health professionals and so can come at a great cost to the service in funding this use of health professional's time. Is there high quality evidence which supports the resources spent in discharge planning?

Summary of Key Findings

- 7 articles were located that met the inclusion/exclusion criteria.
- All of these articles represent lower levels of evidence (literature reviews, descriptive studies etc).

Clinical Bottom Line

There is currently no high quality evidence to support the effectiveness of discharge planning for inpatient psychiatric units. Lower levels of evidence identify the following issues in relation to discharge planning for inpatient psychiatric units:

- Some articles proposed that discharge from psychiatric wards was often unplanned with little collaboration with the patient, their family and community services.
- Discharge planning can have a greater impact in the areas of strengthening daily activities post discharge and linking patients with post hospital community supports. Discharge planning is more challenging in the area of finding suitable living arrangements for patients and securing residential placements.
- Factors identified for successful discharge planning include: Involvement of consumers in a collaborative process, multidisciplinary input, education about diagnosis and symptom management and effective community support.
- Measurement tools used to measure aspects of discharge planning include: The Discharge Readiness Inventory, the Mount Sinai Discharge Planning Inventory and the Discharge Planning Schedule.

Limitation of CAT

This summary of evidence has been individually prepared and has not undergone a process of peer review.

Methodology

Search Strategy

Using the levels of evidence as defined by the NHMRC (2000), the search strategy aimed to locate the following study designs:

Level I Systematic Reviews and Meta-analyses;

Level II Randomised Controlled Trials;

Level III Controlled trials, cohort or case-control analytic studies;

Level IV Case series: Post – test only, Pre - test/Post – test;

Level V Expert opinion including literature/narrative reviews, consensus statements, descriptive studies and individual case studies.

A search was also conducted for clinical practice guidelines based on these levels of evidence.

Search Terms

Patient/Client: adult inpatients, clients, psychiatric unit, mental health unit, acute.

Intervention: discharge, discharge plan*, discharge process

Comparison: Nil

Outcome: Prevention of re-admission

Sites/Resources Searched

- National Health and Medical Research Council
- New Zealand Guidelines Group
- National Guidelines Clearinghouse
- UK Guidelines: National Electronic Library for Health, Clinical Guidelines Database
- Scottish Intercollegiate Guidelines Network (SIGN)
- Cochrane Library
- Database of Abstracts of Reviews of Effectiveness (DARE)
- Effective Health Care Bulletins
- Centre for Clinical Effectiveness (Monash University) – Evidence Reports
- HTA Health Technology Assessments
- Joanna Briggs Institute
- PubMed
- [Journals@Ovid](#) Full text
- Medline – Pre Medline
- CINAHL
- Embase
- Search of reference lists of articles obtained

Inclusion/Exclusion Criteria

Inclusion Criteria

- Studies including outcomes related to prevention of readmission eg. Stability in the community, stability of mental state, stabilisation of medication, return to usual daily functioning.
- Studies investigating the discharge planning process in acute psychiatric wards (assessment on admission, inpatient assessment, preparation of individualised discharge plan, provision of interventions, monitoring). Studies that included factors that impede discharge planning and factors that aid timely discharge were also included.
- Studies published in English

Exclusion Criteria

- Studies in which discharge planning was discussed as part of a multi faceted intervention (i.e. was not the main focus of the review).

Results

Results of Search

7 relevant studies were located and categorised as follows:

Table 1. Study designs of articles retrieved by search

Methodology of Studies Retrieved	Number Located	Source of Evidence
Clinical Practice Guidelines (Evidence Based)	0	N/A
Systematic Reviews or Meta – analyses	0	N/A
Randomised Controlled Trials	0	N/A
Controlled trials, cohort or case-control analytic studies	0	N/A
Case series: Post – test only, Pre - test/Post - test	0	N/A
Expert opinion including literature/narrative reviews, consensus statements, descriptive studies and individual case studies	4 2 1	PubMed Reference Lists CINAHL

Specific Results

Considering that searches revealed only lower levels of evidence to answer the research question, a brief summary of the articles retrieved follows in table 2. It is noteworthy also that most of the articles found are over 10 years old.

AUTHOR/TITLE	DESCRIPTION	RELIABILITY/ VALIDITY	RESULTS	COMMENTS
Moore, C. (1998). Discharge from an acute psychiatric ward.	This descriptive study aims to find out whether "discharge is planned to support improvement of symptoms and prevent future readmissions". However, little information is given about how the study was carried out. The Brief Psychiatric Rating Scale (BPRS) was administered weekly for 215 patients from 9 acute psychiatric wards.	Not discussed in this article. No reference for the BPRS given to check validity of this measure.	Major conclusions: Scores from the BPRS showed an improvement in patient symptom during admission. The authors report that discharge is often unplanned, community services are not involved and carers and families are not informed about discharge plans. Beds are often occupied by patients for social reasons.	The BPRS measures severity of patient's symptoms and is not related to any measurement of discharge planning. However the article makes many conclusions about the discharge planning process and there is limited discussion of how the measurements from the BPRS are linked to these conclusions.
Cohen, N., Gantt, A.B., Sainz, A. (1997). Influences on fit between psychiatric patient's psychosocial needs and their hospital discharge plan.	Purports to examine the factors that influence the inpatient teams ability to secure a "good enough" fit between the patient's needs and an optimal discharge plan. 494 consecutive admissions had the Mount Sinai Discharge Planning Inventory completed weekly during admission	McNemar test used to measure changes in fit between patients needs and optimal discharge plan from admission to discharge - figures are reported in the article.	Discharge planning was able to have greater impact in the areas of strengthening daily activities and establishing relevant treatment options. Assisting patients to find a more suitable living arrangement was an area that discharge planners had greater difficulty with. The authors advocate the Discharge Planning Inventory as a tool to track progress and evaluate discharge planning.	It is stated that the optimal first choice discharge plan was "identified by a consensus among professional clinician's based upon patient's needs" (p. 520). This implies that there was little input from patients in identifying their own needs for discharge. Similarly the Discharge Planning Inventory was completed by a Social worker with seemingly little input from patients. Reference given for inventory however, little information is given in the article about the format of the inventory and how the data was recorded.
Rock, B. (1987). Beyond discharge planning	Expert viewpoint about the essential elements in providing quality discharge planning services.	Not applicable	One department, discipline or division must be designated coordinator for discharge planning for the institution. Discharge planning must be a collaborative effort including all clinical departments. Discharge planning systems need to be supported by effective posthospital support programs.	This article is the opinion of one person and may present a limited analysis of the issues.
Altman, H. (1983). A collaborative approach to discharge planning for chronic mental	A brief article outlining a study which examined the use of collaborative discharge planning (CDP) meetings for patients with chronic mental illness. A	Not discussed.	Advocates discharge planning as a collaborative process between hospital staff, the patient the family and community agencies.	Little demographic information is given about the 2 compared groups or how patients were allocated to the groups. Sample is relatively small (29 patients).

patients.	higher percentage of patients who were involved in collaborative discharge planning became involved in aftercare services compared to those who were not involved on CDP.			
Batey, S.R. & Ledbetter, J.E. (1981). Consumer education in discharge planning for continuity of care.	An article describing the Resource Group Model. The consumer education model is used in a small group setting to provide information about medications, community resources and vocational rehabilitation services.	Not applicable as this is a description of an intervention rather than a formal study.	The authors propose that this model encourages involvement of consumers in discharge planning, facilitation of interpersonal skills, and integration of services.	This is an interesting outline of group work in an inpatient setting but is limited in the discussion and analysis of outcomes.
Kelly, A., Watson, D., Raboud, J & Bilsker, D. (1998). Factors in delays in discharge from acute-care psychiatry.	A survey of 327 patients from 12 psychiatry units. included the use of the Brief Psychiatric Rating Scale (BPRS) and the Discharge Readiness Inventory (DRI). There was follow up at 30 days to determine discharge outcome. This article describes the results of one aspect of this research.	Both the BPRS and the DRI were altered for use in this research, which may have affected the reliability and validity of the instruments. Reference sources are given for these instruments.	A proportion of patients who could (clinically) be ready for discharge are not discharged due to ongoing behaviour and medication stabilisation and lack of community resources (e.g. need for residential placement). Improved access to residential placement would reduce length of stay for some patients. Patients whose discharge was delayed were found to have higher levels of conceptual disorganisation, hallucinations, disorientation and more active symptoms. These patients could be targeted for early intervention and early discharge planning.	Appears to only give perception of discharge from the perspective of the staff members completing the survey. Clinical implications and limitations of the research are identified and discussed.
Buckwalter, K. C., (1982). Teaching patients self care: A critical aspect of discharge planning.	An article which describes the methods used by the authors in pre-discharge planning programs to assist patients "take charge of their illness and become partners in the treatment process" (p. 15) and reduce likelihood of readmission.	Not applicable as this article is written from the clinical experience of the authors.	The main components that should be included in discharge planning according to the authors are: Assisting patients to understand what their diagnosis means. Working with the patients family Giving the patient simple and accurate literature to read about their illness. Assigning homework that requires the patient and family to read instructional material between appointments. Assisting patients in looking at their stressors and exploring stress management techniques.	This article reflects the opinion of two clinicians from one discipline and so may be a limited representation of the issues related to discharge planning. This article is written from the perspective of the clinician and does not discuss at length the process of having the patient assess their own needs for discharge.

			<p>Assisting patients to recognise the meaning of their symptoms.</p> <p>Assisting patients to develop ways of explaining their hospitalisation when discharged.</p> <p>Encouragement to continue with recreational activity.</p> <p>Education about medication and encouragement of compliance.</p>	
<p>Caton, C., Goldstein, P, Serrano, O., Bender, R. (1984). The impact of discharge planning on chronic schizophrenic patients.</p>	<p>A study of the discharge planning processes for 114 patients with chronic schizophrenia at 4 inpatient psychiatric units. The discharge planning schedule was developed for this study and involved interviewing patients, staff and family. The Community care schedule was then administered to patients three months post discharge.</p>	<p>A study of the interrater reliability of the Discharge planning schedule and the Community Care Schedule was carried out (patients randomly assigned to 2/3 rater pairs). Co-efficient figures reported. As this was a study of the natural patterns of discharge planning patients were not randomly assigned to "good" and "poor" discharge planning. A series of analysis of variance tests were carried out to look at relationships between patient characteristics and planning adequacy. These are reported in a table format.</p>	<p>The adequacy of discharge planning bore no significant relationship to role functioning, daily activities, social isolation or employment at 3 months post discharge.</p> <p>Patients who had adequate discharge planning for vocational issues were not more likely to attend vocational rehabilitation or participate in the labour force.</p> <p>Patients who received adequate discharge planning for aftercare services were more likely to comply with aftercare treatment and were less likely to be rehospitalised.</p> <p>Discharge planning for living arrangements was based on what was available and the patient's financial resources rather than on what might have been most desirable for successful community living.</p>	<p>The validity of the schedules used is not addressed.</p> <p>No information is provided regarding dropouts from the study.</p> <p>Although some information was given about the contents of the Discharge Planning Schedule, little information was given about how the schedule was administered. It would be especially interesting to know how the sample who were reportedly the "high risk chronic" patients managed the demands of the interview (which would assumedly require concentration, reflection, planning etc).</p> <p>The discussion section provides useful information about factors that could be seen to promote 'good' and 'bad' discharge planning.</p>

References

1. National Health and Medical Research Council. (2000) How to use the evidence: assessment and application of scientific evidence. Handbook series on preparing clinical practice guidelines. Canberra: Commonwealth of Australia.

Articles tabled for this summary of evidence

Level IV Evidence

Level V Evidence

Altman, H. (1983). A collaborative approach to discharge planning for chronic mental patients. *Hospital and Community Psychiatry*, 34(7), 641-642.

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