



editorial

Psychiatric Bulletin (2002), 26, 241–242

SHONA A. WALKER AND JOHN M. EAGLES

Discharging psychiatric patients from hospital

In the period following discharge from hospital, psychiatric patients are at high risk of readmission. Within the first 6 months, readmission occurs for between 20 and 40% of patients (Caton *et al*, 1985; Boydell *et al*, 1991). In selected groups of patients the figure is higher; over 50% of patients were readmitted within 6 months of a course of electroconvulsive therapy (Robertson & Eagles, 1997). The peak period of risk for readmission is within the first month (Naji *et al*, 1999). For long-stay psychiatric patients a similar pattern obtains, with likelihood of readmission exhibiting a decaying curve over time, albeit with a lower initial rate of returning to in-patient care (Rothbard *et al*, 1999).

Suicide data tend to mirror those for readmission. Rates of suicide are high in the year after discharge, notably within the first 28 days (Goldacre *et al*, 1993; Geddes & Juszcak, 1995; Geddes *et al*, 1997; Sohlman & Lehtinen, 1999). Noting an increase in rates of post-discharge suicide among women from 1968 to 1992, Geddes and Juszcak (1995) made a link with decreasing numbers of in-patient beds. The National Confidential Inquiry into Suicide and Homicide (Scottish Executive, 2001) found a peak of post-discharge suicides within the first 2 weeks, when 8% of all suicides by community psychiatric patients occurred. Eighty per cent of this group died before their first follow-up contact. These findings gave rise to the authors' recommendations that all patients should be followed up within 1 week of discharge (within 48 hours for patients 'who have been at high risk'), and that discharge should be preceded routinely by a joint case review between in-patient and community teams, with this review including an assessment of risk.

Inter-professional communication

As reflected in the second confidential inquiry recommendation above, it is often held that poor communication, notably between healthcare professionals, is responsible for problems that arise around the time of discharge. Certainly, with respect to the communication that hospital specialists have with general practitioners (GPs), this criticism is probably well founded.

If GPs are to implement continuity and changes in care following admission then they require information,

accurately and promptly, following a patient's discharge. Orrel and Greenberg (1986) found that only 26% of GPs had received a brief communication about an in-patient stay within 2 weeks of discharge. While it is straightforward to tailor information to suit GPs' preferences by altering the format of the hand-written discharge letter (Walker *et al*, 1998), this information still has to reach the GP. Once fears about confidentiality have been allayed, it is to be hoped that electronic transmission will usually be used. Meanwhile, we rely on patient transmission by hand. Although this can be augmented by posting a copy of the hand-written discharge summary (Curran *et al*, 1992), patients are, perhaps surprisingly, usually quite reliable in relaying this letter to their GP (Colledge *et al*, 1992; Naji *et al*, 1999). GPs are keener to be telephoned about their patients at the time of discharge than hospital specialists might think (Sagar, 1990; Walker & Eagles, 1994).

Poor information transfer at discharge does appear to increase the likelihood of readmission (Olfson & Walkup, 1997) and one study found that, after discharge, an alarming 90% of elderly patients were receiving different medication regimes at home from those they had been prescribed in hospital (Cochrane *et al*, 1992). Are efforts to improve communication helpful in a patient's post-discharge care? McInnes *et al* (1999) found that pre-discharge visits to the frail elderly improved GP-hospital collaboration, were associated with increased patient satisfaction and gave rise to greater use of community resources. It is perhaps doubtful that this would transfer cost-effectively to psychiatric settings. A randomised trial in Aberdeen (Naji *et al*, 1999) of standard discharge procedure *v.* a package of enhanced communication (GPs were telephoned; patients' appointments were arranged with GPs before discharge; discharge letters were posted as well as hand-delivered) indicated marginal benefit only. There was a trend towards lower rates of readmission and patients had more consultations about psychiatric issues with their GPs after discharge.

Clinical care at discharge

Various clinical interventions have sought to ameliorate patients' vulnerability in the post-discharge period. As



editorial

with efforts to enhance inter-professional communications, there is little evidence that these have been successful.

The UK 700 trial recruited patients with psychosis, either at the time of discharge from hospital, or when living in the community but having been admitted during the preceding 2 years. The patients were randomly assigned to standard or intensive case management, the latter being similar in format to the Care Programme Approach. Intensive case management had no impact on suicidality (Walsh *et al*, 2001), nor on either clinical status or social functioning (Burns *et al*, 1999). There was no impact on likelihood of readmission (Burns *et al*, 1999). However, a similar study in London (Tyrer *et al*, 1995) found that closely monitored community-based patients spent significantly longer in hospital. Tyrer *et al* (1995) did find that loss to follow-up was less common in the closely monitored group.

Few studies have focused more specifically on the post-discharge period. Sullivan and Bonovitz (1981) found that subsequent out-patient attendance was improved by offering the first appointment within 3 days of discharge. A nurse discharge coordinator had no positive effect on readmission rates, on post-discharge well-being or on patient satisfaction ratings (Walker *et al*, 2000). As in Roy's (2001) recent review, there have been no intervention studies of representative cohorts of discharged patients to determine whether suicidality can be influenced. Psychological autopsy studies, with all their inherent flaws, can perhaps yield pointers towards clinical practices that may reduce suicidality. King *et al* (2001) found that discontinuity of contact was associated with post-discharge suicides in Wessex. However, rates of 'key personnel on leave or leaving' were said to be 1% in the control group and 5% in the suiciding patients. Given that the average consultant psychiatrist is on leave for some 15% of the time, this strongly suggests incomplete and selective recording.

Comments and conclusions

Currently, we know that psychiatric patients are vulnerable in the post-discharge period, but we have no good evidence to direct our efforts to improve the situation. Attempts to enhance inter-professional communication have the advantage of being very cheap (Naji *et al*, 1999), which probably makes them worth pursuing despite the tenuous evidence of effectiveness. The same cannot be said for clinical packages of care in the post-discharge period, such as the pre-discharge meetings and rapid follow-up espoused by the National Confidential Inquiry (Scottish Executive, 2001). As others have pointed out (Marshall, 1996; Geddes, 1999), it is probably premature to introduce such policies without an adequate evidence base. It seems much more logical to conduct good research studies to determine whether patients' vulnerability in the post-discharge period can indeed be ameliorated and to design appropriate policies thereafter.

References

- BOYDELL, K. M., MALCOLMSON, S. A. & SIKERBOL, K. (1991) Early rehospitalization. *Canadian Journal of Psychiatry*, **36**, 743–745.
- BURNS, T., CREED, F., FAHY, T., *et al* (1999) Intensive versus standard case management for severe psychotic illness: a randomised trial. *Lancet*, **353**, 2185–2189.
- CATON, C. L. M., KOH, S. P., FLEISS, J. L., *et al* (1985) Rehospitalization in chronic schizophrenia. *Journal of Nervous and Mental Disease*, **173**, 139–148.
- COCHRANE, R. A., MANDAL, A. R., LEDGER-SCOTT, M., *et al* (1992) Changes in drug treatment after discharge from hospital in geriatric patients. *BMJ*, **305**, 694–696.
- COLLEDGE, N. R., SMITH, R. G. & LEWIS, S. J. (1992) The delivery of interim discharge summaries to general practitioners by the elderly. *Health Bulletin*, **50**, 219–222.
- CURRAN, P., GILMORE, D. M. & BERINGER, T. R. O. (1992) Communication of discharge information for elderly patients in hospital. *Ulster Medical Journal*, **61**, 56–58.
- GEDDES, J. (1999) Suicide and homicide by people with mental illness. *BMJ*, **318**, 1225–1226.
- & JUSZCZAK, E. (1995) Period trends in rate of suicide in first 28 days after discharge from psychiatric hospital in Scotland 1968–92. *BMJ*, **311**, 357–360.
- , —, O'BRIEN, F., *et al* (1997) Suicide in the 12 months after discharge from psychiatric inpatient care, Scotland 1968–92. *Journal of Epidemiology & Community Health*, **51**, 430–434.
- GOLDACRE, M., SEAGROATT, V. & HAWTON, K. (1993) Suicide after discharge from psychiatric inpatient care. *Lancet*, **342**, 283–286.
- KING, E. A., BALDWIN, D. S., SINCLAIR, J. M. A., *et al* (2001) The Wessex Recent In-Patient Suicide Study, 1: Case–control study of 234 recently discharged psychiatric patient suicides. *British Journal of Psychiatry*, **178**, 531–536.
- McINNES, E., MIRA, M., ATKIN, N., *et al* (1999) Can GP input into discharge planning result in better outcomes for the frail aged: results from a randomized controlled trial. *Family Practice*, **16**, 289–293.
- MARSHALL, M. (1996) Case management: a dubious practice: undervalued and ineffective, but now government policy. *BMJ*, **312**, 523–524.
- NAJI, S. A., HOWIE, F. L., CAMERON, I. M., *et al* (1999) Discharging psychiatric in-patients back to primary care: a pragmatic randomized controlled trial of a novel discharge protocol. *Primary Care Psychiatry*, **5**, 109–115.
- OLFSON, M. & WALKUP, J. (1997) Discharge planning in psychiatric units in general hospitals. *New Directions for Mental Health Services*, **73**, 75–85.
- ORREL, M. S. & GREENBERG, M. (1986) What makes psychiatric summaries useful to General Practitioners? *Psychiatric Bulletin*, **10**, 107–109.
- ROBERTSON, C. & EAGLES, J. M. (1997) Review of ECT prescription and outcome in depression. *Psychiatric Bulletin*, **21**, 498–500.
- ROTHBARD, A. B., KUNO, E., SCHINNAR, A. P., *et al* (1999) Service utilization and cost of community care for discharged state hospital patients: A 3-year follow-up study. *American Journal of Psychiatry*, **156**, 920–927.
- ROY, A. (2001) Psychiatric treatment in suicide prevention. In: *Suicide Prevention* (ed. D. Lester), pp 103–127. Hove: Brunner-Routledge.
- SAGAR, G. (1990) The telephone – an under-used instrument? *British Journal of General Practice*, **40**, 349–350.
- SCOTTISH EXECUTIVE (2001) *Safety First. Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. Edinburgh: Scottish Executive.
- SOHLMAN, B. & LEHTINEN, V. (1999) Mortality among discharged psychiatric patients in Finland. *Acta Psychiatrica Scandinavica*, **99**, 102–109.
- SULLIVAN, K. & BONOVIK, J. S. (1981) Using pre-discharge appointments to improve continuity of care for high-risk patients. *Hospital & Community Psychiatry*, **32**, 638–639.
- TYRER, P., MORGAN, J., VAN HORN, E., *et al* (1995) A randomised controlled study of close monitoring of vulnerable psychiatric patients. *Lancet*, **345**, 756–759.
- WALKER, S. A. & EAGLES, J. M. (1994) Review of the early discharge summary in the Grampian area. *Psychiatric Bulletin*, **18**, 140–141.
- , BOEHLHOFF, G. A. E. & EAGLES, J. M. (1998) Early discharge summaries. *Psychiatric Bulletin*, **22**, 148–149.
- , NAJI, S. A., HOWIE, F. L., *et al* (2000) The effectiveness of psychiatric discharge coordinators. *Primary Care Psychiatry*, **6**, 149–153.
- WALSH, E., HARVEY, K., WHITE, I., *et al* (2001) Suicidal behaviour in psychosis: prevalence and predictors from a randomised controlled trial of case management: report from the UK 700 trial. *British Journal of Psychiatry*, **178**, 255–260.

*Shona A. Walker Senior Registrar, John M. Eagles Consultant Psychiatrist, Royal Cornhill Hospital, Cornhill Road, Aberdeen AB25 2ZH