Influences on Fit Between Psychiatric Patients' Psychosocial Needs and Their Hospital Discharge Plan

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Objective: **The study examined factors that help determine a good or poor fit between the psychosocial support needs of hospitalized patients and the hospital's discharge plan.** ***Methods:*** **The Mount Sinai Discharge Planning Inventory was completed weekly for 494 consecutive admissions to the hospital's adult inpatient psychiatric units. The resources that patients brought with them into the hospitalization in the areas of housing, entitlements, daily activities, and psychiatric treatment were recorded as well as the resources that would constitute an optimal discharge plan. Good or poor fit was operationally defined by the match between the optimal, first-choice plan and the implemented discharge plan.** ***Results:*** **One-third of admissions were found to have an optimal fit on admission in all resource categories studied. For patients who entered the hospital with suboptimal resources, discharge planning was significantly more likely to establish clinically relevant psychiatric treatment options and to strengthen daily living activities than to change housing resources. Certain diagnoses and a history of drug abuse, criminality, violence, and treatment noncompliance were associated with poorer fits with first-choice disposition options.** ***Conclusions:*** **The Mount Sinai Discharge Planning Inventory provides a method to systematically evaluate discharge planning by tracking progress toward securing relevant posthospital care and support. (*Psychiatric Services* 48:518–523, 1997)**

Because of the continuing reduction in the number of intermediate and long-term care beds over the past four decades as the policies of deinstitutionalization have progressed nationwide, the locus of treatment of severely mentally ill persons has shifted to brief hospital stays and to community settings (1–3). In the 1990s the growing influence of managed mental health care is bringing about ever shorter stays in the hospital and even greater emphasis on community-based alternatives to hospital treatment (4). The confluence of these trends in the care of persons with severe mental illness underscores the increasingly important role of discharge planning in providing the linkages to community structures that are expected to prolong community tenure and enhance rehabilitation (5).

Relatively little, however, is actually known about the psychosocial factors that influence recovery from psychiatric illness, the time frames required to bring about stabilization in a hospital setting, and the level of community-based services that may minimize relapse and readmission. Assumptions underlying discharge planning are that stable support structures such as outpatient treatment, adequate housing, entitlement programs that include income supplements and adequate health insurance, and family or extended support networks contribute to maintaining discharged persons with mental illness in their communities. Despite the presumed importance of these psychosocial supports, a majority of patients in large urban settings are discharged into environments with fragile or limited community support structures. The relationships of these structures to hospital recidivism and to the quality of life experienced by persons with chronic mental illness has only occasionally been systematically examined (6–8).

An earlier study by Caton and associates (9) showed that the quality of discharge planning was predictive of rehospitalization within three months when the patient's prognosis was taken into account. As managed health care systems bring more pressure on hospital units to shorten length of stay, discharge planning will un-

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doubtedly be affected dramatically. Caton and Gralnick (10) reviewed the literature on length of psychiatric hospitalization and concluded that although diagnosis alone is not a good predictor of length of stay, other patient, environmental, and delivery systems factors together may have predictive ability. The complexity of the task of predicting length of hospital stay suggests that biomedical impairment is but one component of the recovery process. For example, for many patients in public-sector settings, social supports and helping networks are fragmented and are inadequate to facilitate reintegration into stable community tenure (11).

Access to environmental supports is felt to significantly influence recovery from psychiatric illness (12). Indeed, such factors as housing and placement considerations, level of social competence or functioning, severity of psychiatric condition, and adequacy of social supports have been reported to contribute to the length of inpatient stay (13–17). Furthermore, family involvement, psychoeducation, continuity of care, psychosocial rehabilitation, selection of appropriate medications, and patient cooperation and compliance have been identified as factors contributing to postdischarge recovery (18,19).

We hypothesized that the interactions of patient, environmental, and service delivery factors significantly affect patients' longer-term recovery from episodes of illness, including recidivism and quality of life, as well as their shorter-term inpatient treatment careers, including their length of stay and satisfaction with services. The outcome study reported here examined the factors that influenced the inpatient treatment team's ability to secure a "good-enough" fit between the patient's needs and an optimal discharge plan. Psychosocial support structures such as housing, entitlements (income supplements and medical insurance), structured daily activities, and ongoing psychiatric treatment after discharge from the hospital are seen as becoming increasingly important in the patient's longer-term outcome.

Through a close tracking of progress and any impediments to reaching an optimal or "first-choice" discharge plan, the clinical response to treatment can be isolated from the service needs and systems issues that significantly bear on the patient's ability to leave the hospital and enter a period of stability in community life. Analysis of the pathway toward accomplishing a good-enough fit between the patient's needs and the optimal discharge plan and of the impediments that interfere with attaining this fit may allow early identification of patients at risk for an extended hospital stay because of difficulties in clinical management, delayed or incomplete response to medical treatment, or the unwillingness of community providers to engage such patients. In this report, we explore the first issue—for which psychiatric patients and in which resource categories can an adequate fit be achieved between the proposed discharge plan, based on clinicians' perceptions of the patient's needs, and actual resources? The second issue—impediments to attaining an adequate discharge fit—will be discussed in a later report.

Methods

Assessment inventory

A previously pilot-tested instrument, the Mount Sinai Discharge Planning Inventory, was completed weekly for each patient by one senior supervising social worker, who reviewed the treatment and discharge plans regularly with all social workers on all treatment teams. Information on sociodemographic characteristics, diagnosis, and histories of high-risk behaviors such as substance abuse, violence, and noncompliance with treatment was obtained from patient interviews at admission and was used as a baseline for assessing subsequent developments during inpatient treatment.

The planning inventory systematically examines the component biopsychosocial pathways that constitute recovery during inpatient treatment. (A copy of the Mount Sinai Discharge Planning Inventory is available from the second author at the Department of Social Work, Mount Sinai Medical Center, 1 Gustave L. Levy Place, New York, New York 10029.) The resources that patients bring with them into hospitalization in the domains of housing and living arrangements, entitlements, daily activities, and psychiatric treatment are recorded at baseline. The first-choice, optimal resources in these categories are then chosen as components of the ideal discharge plan and the impediments to achieving each of these goals are coded in the respective resource category.

The resource category of housing resources includes living alone, living with family, and living in a supervised setting. Daily activity resources include activities provided within the residential setting, day programs, caretaking, educational programs, employment, or no structured activity. Psychiatric treatment resources include weekly outpatient treatment, day treatment, and treatment provided within the residential setting. A fourth resource category included in the planning inventory, entitlement resources, was dropped from the analysis when it was learned that more than 91 percent of the patients in the study sample entered the hospital with first-choice, optimal entitlements—that is, enough resources to pay for therapeutic needs and services on discharge—and thus the sample did not provide sufficient variability in outcome to include this resource.

Despite some overlap, the resource categories were assessed as discrete variables in this study. The items within each resource category represent a distillation of a number of possible discharge options and have been collapsed accordingly.

The planning inventory is used for weekly tracking of progress in securing a fit in those community supports needed to accomplish the discharge plan. The frequency of matches between baseline admission resources, the discharge resources eventually provided to the patient, and the extent to which optimal first-choice resources were actually implemented provides a snapshot of the accomplishments and failures of inpatient treatment with respect to each community support category. Good or poor fit is operationally defined by the match between the optimal first-choice discharge plan and the plan

Table 1

Percentage of patients with optimal and suboptimal fits of resources at admission and discharge

Resource	Admission		Discharge		p[1]
	Optimal	Suboptimal	Optimal	Suboptimal	
Housing (N=436)	73.6	26.4	76.2	23.8	.12
Daily activities (N=467)	50.0	50.0	61.2	38.8	<.001
Psychiatric services (N=413)	59.3	40.7	74.6	25.4	<.001

[1] McNemar test for changes in fit between admission and discharge

that is implemented. Optimal first-choice resources for individual patients were identified by a consensus among professional clinicians based on patients' needs.

A designation of "optimal fit" indicates that the patient's specific biopsychosocial needs have been matched with relevant resources; a designation of "suboptimal fit" indicates that this match has not occurred. For example, an optimal fit for the housing resource might vary from living with a family member to living in a supportive apartment program to living alone, depending on the patient's illness and functional status.

An optimal fit in housing for a patient with chronic paranoid schizophrenia might be perceived by the treatment team to be a supportive single-room-occupancy facility, a housing resource that permits ample opportunities for social distance while providing adequate shelter and safety. The same housing resource would be perceived as suboptimal for a young depressed patient with bipolar disorder, who requires a community residence that would encourage social interaction and participation in a structured treatment plan.

Similarly, for the daily activity resource, a patient with a psychotic diagnosis and a history of poor functioning might require a day treatment program, while a patient with the same diagnosis but with a history of good treatment compliance might need a vocational rehabilitation program. Patients who are severely compromised in their functioning but who are living in an environment that provides supervision and opportunities for various activities might require only maintenance psychopharmacological interventions. However, a patient struggling with interpersonal conflicts and the impact of the illness might require more frequent outpatient treatment services.

The concepts of optimal and suboptimal fit can be used in tracking change over the course of the patient's stay. For example, a patient with mental illness and chemical abuse diagnoses who needs to be living in a residence for dual diagnosis patients but who is homeless when admitted to the inpatient unit enters the treatment and housing arenas with a suboptimal fit. It then becomes the challenge to the inpatient team to provide the needed resources for an optimal fit on discharge—a match between the perceived needs of the patient and the actual discharge plan.

Sample

The study sample consisted of 494 consecutive admissions to the four adult inpatient psychiatric units of the Mount Sinai Medical Center between January and August 1993. The patients' ages ranged from 13 to 98 years, with a mean age of 49 years. Fifty-eight percent were female. Forty-five percent of the patient sample were non-Hispanic white, 26 percent were African American, and 25 percent were Hispanic.

Fifty-four percent of the patients had a primary diagnosis of an affective disorder, 28 percent had schizophrenia, 8 percent had an organic mental syndrome, and 6 percent had personality disorder. Twenty-four percent had a history of substance abuse and 23 percent a history of alcohol abuse in conjunction with the primary diagnosis.

Results

Of the 494 consecutive admissions to the inpatient adult psychiatry service, 185, or 34 percent, were found to have an optimal fit in all three of the resource categories—housing resources, daily activities, and psychiatric treatment. Table 1 shows percentages of patients with optimal and suboptimal resource fits at admission and discharge.

Housing resources at the time of admission were felt to be optimal for 321, or 74 percent, of the patients. Nineteen of the 321 patients, or 6 percent, with optimal housing resources on admission were not able to be discharged back to their favorable, optimal residential setting. Of 115 patients with suboptimal housing on admission, 30, or 26 percent, were able to be provided with a first-choice housing resource on discharge. Eighty-five patients, representing 74 percent of those who required strengthening of their housing resource, were unable to be provided with the optimal residential setting. A McNemar test for improvement in suboptimal fit status for housing resources from admission to discharge did not achieve significance.

In the resource category of daily activities, 233 patients, or 50 percent of consecutive admissions, had already attained an optimal fit with the first-choice resource option at the time of admission; that is, they were admitted with what was considered an optimal daily activity plan. Thirty of those 233 patients, or 13 percent, with a first-choice daily activities resource on admission were not able to be discharged back to their favorable daily activities. Of the 234 patients with suboptimal daily activities resources on admission, 83 patients, or 35 percent, were provided with the first choice of daily activities at discharge. A total of 151 patients, representing 65 percent of those who required strengthening of their daily activities resources, were unable to be provided with a significant change in daily activities. A McNemar test

for improvement in fit for daily activities resources from admission to discharge was significant ($p<.001$).

In the resource category of psychiatric treatment, 245, or 59 percent, of consecutive admissions were judged to have already obtained the first-choice resource option at the time of admission. Twenty, or 8 percent, of those patients did not maintain their favorable psychiatric treatment resource on discharge. Of the 168 patients with suboptimal psychiatric treatment resources on admission, 83, or 49 percent, were provided with the first-choice psychiatric treatment resource on discharge. Eighty-five patients, representing 51 percent of those who required improvement in their psychiatric treatment resources, were unable to be provided with any improvement from their inadequate fit at admission. A McNemar test for improvement in fit for psychiatric treatment resources from admission to discharge was significant ($p<.001$).

The quality of fit across resource categories attained statistical significance at discharge. Thus optimal or suboptimal fit in one resource category was significantly correlated with the same quality of fit in the other two resource categories ($r=.44$, $p<.01$, for the correlation between housing resources and daily activities; $r=.62$, $p<.01$, between psychiatric treatment resources and daily activities; $r=.45$, $p<.01$, between housing resources and psychiatric treatment resources).

The success of discharge planning across all resource categories was significantly influenced by patients' diagnoses. Although slightly more than half of the patients with either of the two most frequent diagnoses—affective disorder and schizophrenia—entered the hospital with an optimal fit in each of the three resource categories, the ability to secure a first-choice resource at discharge for those with suboptimal fits on admission was greater for patients with affective disorder (McNemar test, $p<.05$).

As Tables 2, 3, and 4 show, patients' histories of addictive and antisocial behaviors were associated with poor fits on all three resource categories. Twenty-four percent of the study sample, or 116 patients, reported a history of drug abuse, and 23 percent, or 113 patients, reported a history of alcohol abuse. These patients had significantly more poor fits with optimal resources at discharge for all three resource categories, compared with patients who did not report a history of drug or alcohol abuse.

A criminal history, reported by 30 patients, or 6 percent, and a history of violent behavior, reported by 83 patients, or 18 percent, were associated with poorer fits on admission with optimal housing needs ($p<.001$) and daily activities ($p<.01$). Similarly, a history of noncompliance with medications, reported by 225 patients, or 48 percent, was associated with suboptimal housing ($p<.05$) and daily activities ($p<.01$) on admission and with suboptimal housing ($p<.05$) and psychiatric treatment resources ($p<.01$) at discharge. Suicidality was not associated with poor fits for any of the three resource categories.

Readmission to the hospital within 90 days of discharge was predicted by a history of alcohol abuse (Goodman and Kruskal tau, $p<.01$) but not by any other demographic or clinical feature. There was a trend for greater readmission of patients with histories of noncompliance with treatment or medications (Goodman and Kruskal tau, $p=.06$). No relationship was found between readmission to the hospital and fits with any of the three resource categories measured.

Table 2

Clinical characteristics of patients with optimal and suboptimal fits between housing needs and resources at admission and discharge

Characteristic	Admission		Discharge		
	Optimal	Suboptimal	Optimal	Suboptimal	p[1]
Alcohol abuse					
Yes (N=102)[2]	58.1	41.9	66.4	33.6	.012
No (N=312)	78.8	21.2	79.1	20.9	ns
Drug abuse					
Yes (N=93)[3]	50.0	50.0	61.0	39.0	.012
No (N=323)	80.4	9.6	80.6	19.4	ns
Criminality					
Yes (N=24)[4]	41.7	58.3	53.8	46.2	ns
No (N=393)	75.4	24.6	77.8	22.3	ns
Violent behavior					
Yes (N=70)[5]	56.9	43.1	64.0	36.0	ns
No (N=345)	76.9	23.1	78.8	21.2	ns
Noncompliance with medication					
Yes (N=205)[6]	68.6	31.4	72.0	28.0	ns
No (N=213)	78.2	21.8	80.1	19.9	ns
Suicidal ideation					
Yes (N=176)	71.0	29.0	74.4	25.6	ns
No (N=240)	75.6	24.4	78.0	22.0	ns

[1] McNemar test for changes in fit from admission to discharge

[2] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=17.7$, df=1, $p<.001$) and at discharge ($\chi^2=7.1$, df=1, $p<.01$)

[3] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=35.6$, df=1, $p<.001$) and at discharge ($\chi^2=16.1$, df=1, $p<.001$)

[4] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=13.2$, df=1, $p<.001$) and at discharge ($\chi^2=7.7$, df=1, $p<.01$)

[5] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=12.4$, df=1, $p<.001$) and at discharge ($\chi^2=7.4$, df=1, $p<.01$)

[6] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=5.2$, df=1, $p<.05$) and at discharge ($\chi^2=4.0$, df=1, $p<.05$)

Discussion

Studying discharge planning provides an opportunity to elucidate the factors in recovery from psychiatric illness that are normally ill defined, poorly understood, or not readily measured. The Mount Sinai Discharge Planning Inventory identifies categories of social resources and the progress toward creating a fit between the patient's needs and the implemented discharge plan. When the

Table 3

Clinical characteristics of patients with optimal and suboptimal fits between needs and resources for daily activities at admission and discharge

Characteristic	Admission		Discharge		
	Optimal	Suboptimal	Optimal	Suboptimal	p[1]
Alcohol abuse					
Yes (N=113)[2]	32.7	67.3	54.9	45.1	.001
No (N=349)	55.3	44.7	65.4	34.6	.001
Drug abuse					
Yes (N=105)[3]	30.5	69.5	54.3	45.7	.001
No (N=359)	55.4	44.6	65.6	34.4	.001
Criminality					
Yes (N=26)[4]	23.1	76.9	51.7	48.3	ns
No (N=439)	51.5	48.5	64.1	35.9	.001
Violent behavior					
Yes (N=83)[5]	36.1	63.9	54.7	45.3	<.05
No (N=380)	52.9	47.1	64.9	35.1	<.001
Noncompliance with medication					
Yes (N=225)[6]	43.1	56.9	59.3	40.7	<.001
No (N=241)	56.0	44.0	66.7	33.3	.005
Suicidal ideation					
Yes (N=193)	48.7	51.3	62.3	37.7	<.01
No (N=271)	50.9	49.1	64.1	35.9	<.001

[1] McNemar test for changes in fit by clinical variables from admission to discharge

[2] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=17.4$, df=1, p<.001) and at discharge ($\chi^2=4.3$, df=1, p<.05)

[3] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=20.2$, df=1, p<.001) and at discharge ($\chi^2=4.8$, df=1, p<.05)

[4] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=7.9$, df=1, p<.01)

[5] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=7.6$, df=1, p<.01)

[6] Significantly greater proportion of patients with suboptimal fit at admission ($\chi^2=7.8$, df=1, p<.01)

Table 4

Clinical characteristics of patients with optimal and suboptimal fits between psychiatric treatment needs and resources at admission and discharge

Characteristic	Admission		Discharge		
	Optimal	Suboptimal	Optimal	Suboptimal	p[1]
Alcohol abuse					
Yes (N=87)[2]	53.3	46.7	59.8	40.2	.001
No (N=323)	60.8	39.2	78.3	21.7	<.001
Drug abuse					
Yes (N=71)[3]	56.9	43.1	57.7	42.3	.004
No (N=340)	60.0	40.0	78.2	21.8	<.001
Criminality					
Yes (N=13)	72.4	27.6	53.8	46.2	ns
No (N=398)	51.5	48.5	75.4	24.6	<.001
Violent behavior					
Yes (N=62)	53.5	46.5	69.4	30.6	<.001
No (N=348)	52.9	47.1	75.6	24.4	<.001
Noncompliance with medication					
Yes (N=190)[4]	57.3	42.7	68.4	31.6	<.001
No (N=222)	61.1	38.9	79.7	20.3	<.001
Suicidal ideation					
Yes (N=158)	61.8	38.2	75.3	24.7	<.001
No (N=253)	57.1	42.3	74.3	25.7	<.001

[1] McNemar test for changes in fit by clinical variables from admission to discharge

[2] Significantly greater proportion of patients with suboptimal fit at discharge ($\chi^2=12.4$, df=1, p<.001)

[3] Significantly greater proportion of patients with suboptimal fit at discharge ($\chi^2=13.1$, df=1, p<.001)

[4] Significantly greater proportion of patients with suboptimal fit at discharge ($\chi^2=6.9$, df=1, p<.01)

patients in our study sample entered the hospital, they differed markedly in the strength of community resources they needed to enhance their quality of life and prolong their tenure in the community.

Once the patient is admitted to the hospital, however, certain resource needs become easier to fill than others. For example, while 74 percent of the patients had optimal housing resources on admission, only 26 percent of the patients with suboptimal housing on admission received the housing dispositions they needed at discharge. In contrast, although the psychiatric treatment resources and structured daily activity resources of fewer patients were assessed as optimal on admission (59 percent and 50 percent, respectively), discharge planning was able to achieve greater success in securing these resources than it did with housing resources. In our setting, it was more feasible to establish clinically relevant treatment options and to strengthen daily living activities than to change housing resources while the patient remained on the inpatient service.

Certain clinical and behavioral characteristics of the population we serve make the discharge planning effort problematic and make suboptimal fits a likely outcome. For example, patients with affective disorders were significantly more likely to have optimal fits in each of the three resource categories on discharge than were patients with schizophrenia. Some resource categories proved to be more sensitive to patient characteristics than others. Optimal housing proved to be the most difficult resource to secure in the hospital, and it is not surprising that patients with histories of drug abuse, criminality, and violence had poorer fits with first-choice disposition options for this resource.

First-choice psychiatric treatment resources were easier to secure and were attained as frequently for patients with histories of violent behavior as they were for the remainder of the sample. However, because community treatment resources for drug abuse are relatively limited, patients with drug or alcohol abuse were less able to secure first-choice treatment

dispositions. In addition, patients with histories of noncompliance with medications were less able to be discharged into first-choice community treatment settings.

These findings are consistent with empirical evidence that the network of community resources directly affects the discharge planning effort. Like Caton and associates (9), we found that the most successful component of discharge planning was for psychiatric treatment and that suitable housing arrangements were available for less than a third of the patients who needed them. Caton's group studied discharge planning for patients with chronic schizophrenia at four inpatient facilities in New York City. The patient population in their study was more indigent than in ours, and a change in living arrangements was recommended for 39 percent of the patients, compared with 26 percent in our study, but attained for only 13 percent of those in need. In our sample, improved residential situations were arranged for 26 percent of those who needed them.

The Caton study did not find differences in the adequacy of discharge planning related to sociodemographic or clinical variables. However, the sample in that study was restricted to patients with chronic schizophrenia. The greater clinical diversity of the patients in our sample, which comprised 494 consecutive admissions, may explain our finding that clinical and behavioral history decidedly affects the results of discharge planning. Furthermore, the Caton study found that rehospitalization at three-month follow-up was influenced by the adequacy of the discharge planning. In our patient sample, the only significant predictor of rehospitalization was patients' history of alcohol abuse ($p<.01$); a trend for medication noncompliance was also found ($p=.06$).

Our findings are consistent with those of Fisher and colleagues (8), who found that enhancing resources for community-based care in a population of deinstitutionalized state hospital patients did not significantly prevent rehospitalizations. The Fisher study suggested that patients' attributes may have had a greater effect on problems of hospital recidivism than service system variables.

Conclusions

A core group of patients with major mental disorders appears to continue to require hospital admissions for stabilization despite the availability of social resources in their community. Nevertheless, the importance of discharge planning in assessing the needs of patients for social, rehabilitative, and specialized services remains essential to the goal of improving the quality of life of the vast majority of patients who have required hospital admission (12). The Mount Sinai Discharge Planning Inventory provides a method for systematically tracking progress toward securing relevant posthospital care and support. Clinicians can use the planning inventory to concretize discharge planning targets and evaluate discharge planning within the relatively limited time frame of hospitalization.

Future research examining the components of discharge planning in conjunction with measures of clinical response to psychiatric interventions should offer a meaningful biopsychosocial perspective on patient recovery and rehabilitation. The shift in focus toward community treatment of deinstitutionalized persons with chronic mental illness dictates that the social context of patients' lives be recognized and strengthened as a component of the treatment effort. Our study of how discharge plans fit with patients' needs and the relationship of that fit with patient and systems variables provides preliminary data that should enrich our understanding of the dimensions of successful community care. ♦

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