Identifying Gaps in Care Upon Discharge from Inpatient Psychiatry Settings to the Community

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Abstract
This literature review examines gaps in care within healthcare systems that negatively impact service users as they transition from inpatient psychiatric settings to community settings. Topics such as historical contexts, readmission rates, intrapersonal factors, and institutional limitations are taken into account to explain the complex relationship between community and inpatient psychiatric services and how they influence current gaps in care. Interventions to address these limitations are explored, which is aimed at examining different models of care and their subsequent impact on gaps in care. In these interventions, concepts such as continuity of care and therapeutic relationships are then proposed as vital factors when addressing gaps in care. Finally, this literature review suggests areas for future research to improve upon gaps in care.

Introduction

Between 2012 and 2020, 18.1% to 20.1% of adult-aged Canadians reported struggling with mental health concerns, and almost half of these people said that their needs were either completely unmet or only partially met (Cutumisu et al., 2022; Statistics Canada, 2021). These statistics present readers with two poignant pieces of information: One, that mental health concerns are a prevalent issue in Canadian society and two, that the way the healthcare system is addressing mental health concerns is not meeting the needs of Canadians to a sufficient level. Traditionally, Canadian health care services have primarily viewed health and its attainment through the lens of the "biomedical model of health," which defines wellness as the absence of disease and focuses treatment modalities on physical elements of health, mainly ignoring the societal influences that impact an individual (Matsuoka, 2023, p. 25). Inevitably, this model of health has influenced Canada's approach to mental health treatment, being especially prominent in inpatient psychiatric hospital settings where treatment focuses on the nullification of symptoms and other observable factors (Matsuoka, 2023). This approach has drawn heavy criticism from mental health advocates who state that healthcare providers cannot view mental health through a reductionist lens and that effective mental health care must encapsulate the entirety of a person and the environment in which they exist. Failure to conceptualize a person from a holistic stance and look beyond the immediate issues will inevitably limit the ability of a service to provide adequate care, as unaddressed issues which could have been dealt with earlier could manifest into more grave problems.

Inpatient psychiatry gets scrutinized over the phenomena of discharging patients after deeming them to be “well enough” to manage in the community on account of their symptoms being minimized, only to see these same patients be readmitted back to the hospital within a short timeframe. Readmission rates of mental health patients have been a hotly debated topic

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among many mental health advocates, with many experts looking for new ways to address it. As such, this narrative literature examines the gaps in care for individuals upon discharge from inpatient psychiatric units and their subsequent return to life in the community.

Purpose

By reviewing the available literature, I present an overarching narrative on the influences behind the gaps, their essential elements, and how our current healthcare system can provide better holistic care for those returning to community living after being discharged from an inpatient setting.

Search Strategy

I conducted research as a literature review, compiling peer-reviewed articles related to gaps in mental health care published during the past five years. I included only three articles in this review published before 2018 due to their historical importance in the available literature. Of these articles, one was an original article written by Peplau (1997), and two were supporting articles referenced to better understand the current mental health care landscape of Norway (Myklebust et al., 2011; Omer et al., 2015). I gathered all referenced articles from the following databases: the MacEwan University Library website, CINAHL, and PubMed. I used MacEwan's Library Resources to refine search terms to find relevant articles better. Key search terms included deinstitutionalization, community mental health, psychiatric discharge, psychiatric readmission/recidivism, recovery-oriented care, continuity of care, theory of interpersonal relations, and antipsychotic medications. Articles were further refined by reading their abstracts to see their relevance to the gap in care between discharge from inpatient psychiatric settings and community living. Articles were excluded if they did not contain adequate sample sizes, were more than six years old (except for the three aforementioned articles), or did not examine relationships between inpatient psychiatry and discharge to the community. In total, I reviewed and included 21 articles in the literature review.

Historical Contexts

It is essential to recognize the influence that institutionalization has had on Canada's approach to mental healthcare in order to understand the current gaps in care between inpatient psychiatry and discharge to the community. Historically, Canada delivered mental healthcare within the context of institutionalization, where those deemed "mentally ill," "insane," or even to be a "lunatic" were placed into asylums and involuntarily subjugated to the psychiatric treatments of the time, all while being segregated from mainstream society in the name of societal betterment. According to Milaney et al. (2022), the legacy of institutionalization continues to reinforce a vilifying narrative around how mental illness is viewed, in that mental illness is a deviation from societal norms of behaviour and that this deviation must be controlled and modified in order maintain societal stability.

Institutionalization and asylums were the norm in Canada until the end of the Second World War, when society began to pay increased attention to the poor treatment that patients faced in psychiatric institutions (Milaney et al., 2022). This perceptual shift ushered in the deinstitutionalization movement, evolving how mental healthcare should be conceptualized and

delivered. Deinstitutionalization promoted shifting mental healthcare away from traditional, asylum-based systems and advocated for care in home-based and community-based settings with the belief that this would not only improve the overall health of individuals with mental health concerns but also help progress human rights as a whole and decrease negative stereotypes around mental illness (Milaney et al., 2022). While this approach did champion a more humane and respectful approach to how society views mental health treatment, there were also harmful outcomes that various advocacy groups have heavily criticized.

One of the most significant critiques of deinstitutionalization and how it unfolded in Canada is that psychiatric institutions and inpatient beds were closed at a faster rate than community-based mental health services were being funded and created by the Canadian government, decreasing the overall amount of mental health resources available for those who need them (Milaney et al., 2022). The authors further remarked that this shift in service modality happened too rapidly to allow those released from institutions to acclimate to community life, even if there were appropriate community-based services. Further, critics claim that the government's portrayal of deinstitutionalization as an evolution in humanitarian care was a guise and that overall funding for mental health was decreased as an intentional and insidious result (Milaney et al., 2022). This criticism parallels the neoliberal influences that permeated Canada in the 1980s, which promoted the reduction of government spending on social programs to reduce deficits (Baum & Freeman, 2022; Milaney et al., 2022). Overall, this mindfulness of deinstitutionalization's impact on the current landscape of mental healthcare services can help an observer conceptualize the substantiality of the existing gaps in care our system faces and how we can address them.

Modern Conceptualizations of Gaps in Care

Deinstitutionalization has transformed the conceptualization of inpatient mental healthcare in the modern world. The course of inpatient care has shifted from providing chronic care over a singular, long-term stay in an asylum to providing acute care over multiple stays in short-stay general psychiatric hospital beds (Baeza et al., 2018). This change in inpatient care conduct has given rise to the concept of "revolving door patients" and has become a highly criticized topic when evaluating the efficacy of mental health services (Baeza et al., 2018; Lassemo et al., 2021, p. 2). At its root, the concept of a “revolving door patient" describes the process of an individual using healthcare services in a repetitive, nonproductive manner. In the context of this literature review, it refers to mental health service users who get admitted to a psychiatric hospital for treatment, get discharged back into the community, and ultimately get readmitted back to the hospital within a short period.

One of the biggest concerns that arise from normalizing the concept of “revolving door patients" is that it inadvertently places the onus of achieving wellness solely on the shoulders of the patients themselves. Doing so diverts accountability away from otherwise ineffective and outdated aspects of our mental healthcare systems, overlooking systemic gaps in care that can have their roots traced back to the deinstitutionalization movement (Tyler et al., 2019). Focusing on the service user and not the system in which the user exists has also influenced how most research on the quality of care in inpatient settings is framed, with readmission rates serving as

a negative indicator of a system's overall effectiveness (Baeza et al., 2018; Lanvin et al., 2022; Lassemo et al., 2021). However, by studying key factors that lead to admissions to an inpatient setting, recognizing shared hardships that people face in the community, and examining trialled treatments upon discharge, we can appropriately adapt our current mental healthcare system to provide more holistic care and ensure patient wellness is protected not only upon discharge from an inpatient psychiatric setting but also throughout the larger context of their lives.

Framing Readmission Rates

While the previous section of this literature review may have been critical of focusing on readmission rates, it is nonetheless essential to gauge this statistic to gain a sense of the gravity of the situation. This section of the literature review aims to examine common influences behind readmission rates and present them in a unified manner to help construct action plans to address gaps in care and help reduce readmission rates.

When considering readmission rates, it is important to consider that individuals with comorbid, concurrent, and complex diagnoses are more likely to be readmitted within 28 days of discharge than individuals with a single diagnosis (Hope et al., 2021). While this may seem straightforward, it nevertheless highlights the complex reality of readmission rates in the field of mental health, as mental illness is a multifaceted issue that influences and interacts with other aspects of a patient's life and does not exist in a vacuum. Baeza et al. (2018) performed a prospective and observational study in a Brazilian general hospital psychiatry facility to identify predictors of readmission by the one-year mark after patient discharge. The authors determined that the overall readmission rate within their research population was 29.17% (Baeza et al., 2018). They also came away with two key findings: that with each previous admission, a patient has increased their likelihood of being readmitted and that the presence of depressive and psychotic symptoms at discharge increases the probability of readmission (Baeza et al., 2018). For those admitted to inpatient psychiatry with depression, each previous admission a patient had increased their likelihood of being readmitted by 35%. Additionally, patients being discharged while still presenting active depressive symptoms increased readmission likelihood by 140% (Baeza et al., 2018). For those admitted due to manic symptoms, Baeza et al. (2018) found that with each previous admission, a patient had increased their odds of readmission within one year post-discharge by 79%, while each prior admission for schizophrenia and other related illnesses increased a person's likelihood of readmission by 126%. In a broad Canadian context, the Canadian Institute for Health Information (2023) found the percentage of readmissions within 30 days of discharge from a psychiatric inpatient setting was 13.8%. This statistic is comparable to the rate that Lam et al. (2020) report, where readmission rates within 30 days of discharge are 12.8%, with over half of those occurring within the first 14 days of discharge.

Lassemo et al. (2021) further researched readmission rates by examining Norway's inpatient mental healthcare services. Gathering data for all of Norway's inpatient health services between 2012 and 2014, Lassemo et al. (2021) found the 30-day readmission rates to be 15.1% and the 365-day readmission rates to be 47.7%. The authors further found deviations between readmission rates between patients admitted on their first admissions, either voluntarily or

involuntarily, and found the 30-day readmission rates to be 10% and 15%, respectively (Lassemo et al., 2021).

Service Users' Experiences with Gaps in Care

When addressing gaps in care and how to remedy them, it is essential to account for the lived experience of those our system serves. By recognizing the service users' experience and validating it, we as a healthcare system can better identify the difficulties that individuals face and better focus our system to help address these concerns. While mental health concerns impact Canadians indiscriminately, there are recorded patterns of mental health support utilization that highlight which demographics of Canadians are seeking out professional mental health support services. Simultaneously, this also shows us, as mental health service providers, the populations that are underrepresented and underserved by the professional services in our system. One tool that illuminates service use patterns is the Canadian Community Health Survey-Mental Health (CCHS-MH). This cross-sectional, computer-assisted interviewing survey collected data on mental health status, mental healthcare service utilization, and health determinants for Canadians. Cutumisu et al. (2022) conducted research to identify patterns of service use as indicated by the CCHS-MH, discovering that the following populations were less likely to access professional mental health supports than their counterparts: rural Canadians compared to urbanites, Canadians older than 40 years old compared to 39 and under, males when compared to females, immigrants when compared to people born in Canada, and those without any post-secondary education when compared to people with even some post-secondary education. By approaching gaps in care with this information, we can better observe service use patterns with specific populations in mind and have the data needed to improve service provision for underserved demographics. For example, one of the largest and most politicized populations that suffer from gaps in care are those living with substance use disorders as well as mental illness.

Substance use has a complex relationship with mental health as it both influences the prognosis of a mental illness and can also be the result of a mental illness (i.e., individuals self-medicating). MacNeil and Fuller-Thomson (2023) conducted research examining the relationship between mental illness and substance use in a Canadian context. In their research, MacNeil and Fuller-Thompson (2023) found that around half of Canadians with a substance use disorder have a concurrent mental illness and that individuals with concurrent disorders tend to have worse social and health consequences and poorer treatment outcomes when compared to Canadians with just a single disorder. On top of this, MacNeil and Fuller-Thomson (2023) found that individuals without a history of drug dependence were five times more likely to report satisfactory mental health than those with a documented history of drug dependence.

This information only becomes graver when you consider that one in three Canadians meets the criteria for a mental illness or substance use disorder at some point in their lifetime and that the way our healthcare system promotes treatment for concurrent disorders is considered outdated and inefficient by many modern healthcare professionals, as it fails to meet the diverse needs of Canada's population (Palis et al., 2018). Prevention and treatment efforts for substance use disorder primarily focus on the individual level interventions such as

interpersonal psychotherapy, counselling, and cognitive behavioural therapy. These efforts above are mainly informed by the biomedical model of health and often fall short of incorporating more significant social and community factors when delivering services (Palis et al., 2018).

An example of a complication that arises in trying to provide care for individuals with concurrent disorders is how a large number of housing services often require abstinence from substances as a prerequisite for housing (Milaney et al., 2022). This prerequisite complicates the recovery process for those with even a remote history of substance use, as the factors of homelessness, substance use, and mental illness are all complexly interconnected, and failing to acknowledge and accept any one of those three factors in treatment planning prevents the process of holistic recovery. For service users living with concurrent disorders, especially in the context of homelessness, this limitation around accessing new and necessary services can create a repeating cycle of service use, leaving them with a sense of hopelessness and feeling stuck in their current state. This ineffectiveness is partly due to how the treatments our healthcare system offers to individuals with complex and comorbid needs have stipulations surrounding them that do not align with the complex lived experience of the service user (Milaney et al., 2022).

Our current health service system is also criticized for failing to provide holistic and impactful care because it does not prioritize the power that fostering a sense of belonging has on a person's wellness while also not placing enough emphasis on creating opportunities for community involvement, both of which are factors that have been deemed critical in promoting recovery from not only substance use, but also in promoting overall mental health (Baum & Freeman, 2022; MacNeil & Fuller Thomson, 2023; Milaney et al., 2022; Palis et al., 2018).

While substance use and mental illness are multifaceted, complex issues that cannot be easily remedied, modernizing the treatments and philosophies that our system uses to address them can set service users up for varying degrees of success in both short-term and long-term attainment of health. Realistically, however, the degree to which a service can provide holistic care depends on the system that gives it, and any attempt to alter service delivery must be mindful of the system that offers it and the limitations and institutional barriers it faces. By better understanding the challenges that beset our healthcare system, we can uncover where it requires assistance to address gaps in care and discover strengths that can serve as inspiration.

COVID-19's Impact on Gaps in Care

When discussing gaps in care and any institutional barriers that limit the efficacy of community mental health services, it is vital to account for COVID-19 and how it has impacted the relationship between the service user and the services they use. Kassam et al. (2023) conducted online surveys with 144 members of Ontario's Assertive Community Treatment (ACT) teams and Flexible ACT teams to gain insights into their unique roles as the primary point of contact for vulnerable service users living in the community with severe mental illnesses to see how COVID-19 affected this population. Of those surveyed, 26.4% of the respondents reported that their clients did not attend scheduled in-person appointments out of fear of contracting

COVID-19 in a healthcare setting, and 18.6% of respondents reported that their clients were having increased difficulties meeting their basic needs due to how COVID-19 affected the accessibility of services delivered by our healthcare system in the forms of lockdowns, general restrictions, and even suspended services (Kassam et al., 2023).

One such strategy to address the needs of community service users in the face of COVID-19 restrictions was a shift towards online mental health services and virtual appointments. While this offered a new way to provide services without the need for physical proximity, the overall quality of care that service users received deteriorated, as such a rapid shift in treatment modality did not give service users enough time to adjust to its delivery appropriately (Berardini et al., 2021). These statistics highlight a novel disruption to the continuity of care that mental health service users were receiving and demonstrate that COVID-19 has created new gaps in care that need to be accounted for when addressing gaps in care holistically. Kassam et al. (2023) also remarked on how many of the respondents reported that their patients experienced significant levels of social isolation and general loneliness due to COVID-19 lockdowns and restrictions, contributing to the problem of social isolation and its detriment on one's health. This beckons to previous research examining the correlations between mental health and socialization, finding that mental health deteriorates when an individual, especially one with mental illness, is isolated from society (Kassam et al., 2023; MacNeil & Fuller-Thomson, 2023; Milaney et al., 2022). Further, this issue of social isolation due to COVID-19 draws parallels to the previous criticisms levied against institutionalization by Milaney et al. (2022), highlighting how social isolation has been a longstanding issue for those receiving mental healthcare.

The decrease in accessibility to services also resulted in some respondents reporting that their clients resorted to accessing more acute services to meet their needs. 29.9% of respondents said their clients had increased emergency department (ED) visits from their baseline to access mental health resources (Kassam et al., 2023). Some respondents reported that their patients had difficulties navigating the newly implemented online services and that these ED visits were a way for service users to interface with the healthcare system in a straightforward and face-to-face manner that circumvented the complexities they faced online (Kassam et al., 2023) Tragically, a number of these ED visits were also the result of substance abuse that resulted in hospitalization (i.e. overdosing on opiates or experiencing substance-induced psychosis), as 31.1% of respondents reported having patients who disclosed an upsurge in substance use from pre-pandemic levels (Kassam et al., 2023). Lastly, 6.3% said their patients were experiencing increased contact with police and justice services for various reasons. Kassam et al. (2023) found that one such reason for this included how Community Treatment Orders (CTOs) were getting interrupted by the paring down of outreach services in the community and some workers resulted to using legal arms to reach out to clients to maintain the conditions of a service users CTO.

In summation, the impact that COVID-19 has had on community mental health services has been extensive, as it has widened pre-existing gaps in care while simultaneously creating new ones that will be felt for years to come. COVID-19 has also created a nouveau hierarchy of prioritized services in our healthcare system, and seeing as how Canada's system is structured

around the biomedical model of health, community mental health services have been largely viewed as a non-priority in the face of a viral pandemic. This hierarchy has diminished the available amount of mental health resources for not only regular community mental health service users, but the entire Canadian population as a whole. While the availability of mental health services in the community has decreased, the overall demand for services has not, resulting in more acute services being used to meet needs that could have otherwise been met with less acute community services (Kassam et al., 2023).

Further, the reported increase in service users visiting EDs in the face of scaled-back community services could be misconstrued as a simple case of "revolving door patients" when taken out of context, leaving the more significant elements of institutional problems out of consideration. Such a portrayal of this statistic without considering the more considerable institutional limitations that COVID-19 has wrought upon our healthcare system could be harmful, as newly formed barriers to receiving care may be unaccounted for when formulating plans to address gaps in care. As such, it is essential to account for institutional barriers when addressing gaps in care, as these factors can prevent even the most effective services from being used by the service users who need them.

Addressing Institutional Barriers Contributing to Gaps in Care

Limited research exists in regard to identifying institutional barriers that contribute to gaps in care during the transition of mental health service users from specialized care (inpatient psychiatric settings) to primary care settings (community mental health services). Most of the available research on transitions between care settings is focused on transitions to more acute settings and specialized care, leaving the process of returning to the community after hospitalization largely unstudied. This scarcity has led to Kim et al. (2023) conducting a scoping review on potential barriers and facilitators in transitioning mental health service users from specialty to primary care settings to improve the efficacy of mental health resource use overall. The most common findings that Kim et al. (2023) found in their scoping review were that effective transitions from inpatient to community settings require strongly clarified roles for healthcare providers, efficient shared clinical information systems, confidence in care competency, and adequate organizational support.

One of the most significant issues that Kim et al. (2023) identified was a need for more role clarity between inpatient and community care providers, and the services that should be provided throughout the discharge process. Inevitably, this lack of clarity leads to gaps in care during the transition process, as one provider may incorrectly assume that care providers in other settings will address a patient's concerns and needs throughout the discharge process. To address the ambiguity created during the discharge process, Kim et al. (2023) propose creating formal agreements between care providers in inpatient and community settings that would clarify which care provider is accountable for specific tasks before transferring patients from inpatient services to community services. In an Albertan context, this could be something as simple as a template on ConnectCare that a patient’s assigned care providers complete as part of their discharge planning, where basic needs and patient goals are clarified, and care providers can document measures taken to meet them.

The need for role clarity also lends itself to the second finding by Kim et al. (2023), which states that clinical information needs to be shared effectively and timely to facilitate smooth transitions. Poor communication during care transitions for mental health patients, from acute inpatient services to their community care providers, results in poor coordination in continuing care and disruptive patient lives (Bucy & Cross, 2023). This reality is especially true for patients with complex needs and behavioural health conditions, as hospitals often delay relaying information about troublesome behaviours that may prevent a community care provider from accepting the patient (Bucy & Cross, 2023). Incomplete information sharing between care settings creates problems upon discharge, as receiving care providers must be fully aware of a service user's case. Without complete information, the receiving care provider is unprepared and ill-equipped to meet the service users' unique needs. A universal clinical information-sharing system would help address this by better preparing community care providers to receive patients with complex needs and ensure they are as well-prepared and connected to appropriate services before discharge from an inpatient setting. ConnectCare could help remedy this problem because care providers can use it to access vital patient records and history electronically. However, because some primary healthcare providers are not subsidiaries of Alberta Health Services (AHS), they cannot access a patient's ConnectCare records as quickly as an agency under AHS could. In this case, community care providers must establish clear and open communication with other care providers to ensure that vital clinical information is shared appropriately.

Additionally, the perceived competence of care providers and service users in managing their conditions and meeting their needs is vital to addressing gaps in care upon discharge. Unfortunately, there are limited opportunities for primary care providers to obtain continued education about specialized mental healthcare (Kim et al., 2023). Often, individuals may come into contact with primary care providers, such as their family doctors, seeking mental health assistance that does not require hospitalization. This situation may lead to primary care providers feeling inadequate in their ability to competently address patient concerns due to their limited knowledge and training. One recommended solution to this issue proposed by Kim et al. (2023) would be to embed mental health experts into primary care networks to deliver mental health services to this population. However, the reality of our current healthcare system and our limited resources make implementing this solution costly and not immediately feasible. As such, Kim et al. (2023) suggest clarifying roles among primary and specialized care providers to define which conditions should be managed by primary care providers and which require specialized care. This clarification can help primary care providers develop their capacities and confidence to successfully manage a patient's mental health concerns within their professional scope (Kim et al., 2023). Developed role clarification also means that specialized care providers should be aware of the limitations of primary care providers and the types of services they can be expected to provide in an effort to not pre-emptively discharge patients from specialized care before their community care providers can responsibly manage them.

Building on this, a patient's perceived ability to self-manage their conditions is critical in ensuring successful transfers from specialized settings to the community. Kim et al. (2023) state that promoting a patient's ability to self-manage their concerns as a goal early on in their contact

with specialized/inpatient care can help frame their subsequent discharge into the community as an empowering process that moves them towards recovery as opposed to being a process that removes them from the immediate mental health supports of a hospital. All in all, care providers and service users alike need to feel empowered with their perceived abilities and decision-making in treating mental health concerns, as a lack of steadfastness can have a cascading effect on poor health outcomes.

Lastly, any efforts to address gaps in care require strong organizational and leadership support. Kim et al. (2023) state that the endorsement, support, and subsequent rewarding of desirable efforts by those in leadership positions helps influence the viewpoints and priorities of those providing care, subsequently changing care provider behaviours and practices. Without the meaningful support of those in leadership positions and other positions of influence, attempts to address gaps in care that arise during discharge from inpatient settings to the community may fail to gain the traction needed to be adopted by the healthcare system. While it is vital and empowering to recognize the importance of individual efforts embodied by frontline workers, the influence provided by leadership ensures these efforts result in change and do not go in vain.

Common Interventions to Address Gaps in Care

Various healthcare services have trialled different interventions to help mental health service users obtain optimal health outcomes upon their discharge from inpatient psychiatric settings. Tyler et al. (2019) completed a narrative synthesis of 45 peer-reviewed articles to compare and contrast interventions used to support safe discharges from acute health inpatient settings to community services and how these interventions can reduce potential future readmission rates. Three of the more commonly used intervention styles that the authors investigated were critical time interventions (CTI) tailored to assist homeless service users during the ‘critical time’ following discharge from hospital to get connected to appropriate housing services, educational interventions (EI) that focused on the delivery of training or educations to service users and/or their families, and the Transitional Discharge Model (TDM) that has inpatient nurses work with service users post-discharge while therapeutic relationships are being established with community workers. Tyler et al. (2019) found that each intervention they examined had unique strengths that offered viable solutions to different problems during the discharge process, some of which will be discussed in the following paragraphs. With each intervention and its potential to improve readmission rates highlighted, Tyler et al. (2019) posit that a synthesis of each intervention is needed to address the problems associated with discharge on a case-to-case scenario, as each mental health service user has unique needs and that no one-size-fits-all solution exists in the field of mental health. In addition to Tyler et al.’s narrative synthesis (2019), the concepts of consultation-liaison psychiatrists as care providers solely responsible for admission assessments, inpatient treatment plan creation, and post-discharge follow-up are explored.

Critical Time Intervention

Critical time intervention (CTI) was the most frequently tested intervention in Tyler et al.'s (2019) narrative synthesis and is focused on reducing homelessness in the "critical time" following

hospital discharge (p. 894). Tyler et al. (2019) found that CTI significantly reduced readmission rates in mental health service users with histories of homelessness in comparison to control groups that did not receive CTI. This finding suggests that CTI and ensuring service users have stable housing is a critical factor in addressing gaps in care, which echoes the previous research by Milaney et al. (2022), stating that housing is an essential part of ensuring wellness in individuals living with mental illness.

Educational Services

Educational interventions (EIs) are centred around the delivery of training and education to service users and their families with the intent to increase overall knowledge about mental illnesses and how to manage them. Tyler et al. (2019) found that EIs resulted in significant increases in knowledge about psychological conditions when tested during post-education sessions and that 66% of the articles examining EIs found measurable improvements in symptom reduction and treatment adherence in service users post-discharge when compared to control groups that did not receive EIs. EIs are unique compared to their compatriots because they focus on knowledge acquisition and improving behavioural outcomes instead of meeting basic/physiological needs such as housing, funding, and other tangible factors. Due to this, EIs offer different outcomes and measurements in addressing readmission rates than the other interventions. Regardless, Tyler et al. (2019) have found evidence to suggest that EIs improve some service-level outcomes related to discharge, including readmission rates.

Transitional Discharge Model

Tyler et al. (2019) examined the Transitional Discharge Model (TDM), and it sets itself apart from other interventions because it intentionally aims to increase the continuity of care from hospital to community. Within the context of Tyler et al.'s (2019) review, TDM was characterized by how inpatient nurses work with service users until they establish a therapeutic relationship with their community workers and ensure that peer support in the community is in place before being discharged. Three studies in this review examined TDM in which the first one found a significant reduction in readmission rates, the second reported an unexpected finding of early discharges (on average 116 days earlier), and the last one was an action-oriented research study that highlighted the need to address inter-professional team working to improve staff uptake of this intervention (Tyler et al., 2019). TDM is further expanded upon by Lam et al. (2020) in a Canadian context, where the authors' prior research on TDM found increased discharge rates, decreased readmission rates, reduced lengths of stay, and improved overall quality of life for service users.

Lam et al. (2020) frame the 30-day readmission rate for individuals with mental illnesses in Canada at 12.8%, with over half of those occurring within the first 14 days of discharge. The authors claim that discharged individuals should be given stronger connections to community-based mental health support systems during this vulnerable period, as the transition from inpatient settings to community living is characterized by a marked drop in readily available professional services (Lam et al., 2020). To measure TDM's impact in a Canadian context, the authors conducted a retrospective, secular trend analysis to compare the use of psychiatric health services across nine participating hospitals in Ontario that adopted TDM into their psychiatric inpatient practices between June 2013 and February 2014. The authors measured overall service use at these nine hospitals between June 2010 and February 2017 to allow for

ample time during pre- and post-implementation to encapsulate macro-level trends. Lam et al. (2020) found that these nine hospitals demonstrated a decrease in readmission rates and a significant decrease in the median length of stay for patients admitted to acute care units.

While these results are promising, it is essential to note that each participating hospital implemented TDM independently without a standardized template, meaning the participating hospitals had no shared best practice/evidence-informed practice in implementing TDM. Also, there was an inability to collect data on readmissions to other hospitals outside of the nine participating hospitals, meaning that the overall data on readmission rates and lengths of stay may need to be more accurate. Lam et al.'s (2020) findings were less grand than the previous research they referenced before conducting their own. Still, their findings suggest that emphasizing continuity of care during discharge is beneficial in addressing and minimizing the existing gaps in care.

Consultation-Liaison Psychiatrists

Another trialled intervention for improving gaps in care upon discharge from inpatient settings to community living is the use of consultation-liaison psychiatrists (CLPs). CLPs serve a distinct role in inpatient psychiatry, as they are responsible for conducting the initial patient assessment upon their admission and creating a treatment proposal that will be the foundation of the treatment plan that the attending psychiatrist and patient will create collaboratively. The CLP may see the patient multiple times during their admission to adjust the treatment plan as all parties see fit. Providers also may work with the patient post-discharge to provide services and treatments during the critical time that follows a discharge. Lanvin et al. (2022) conducted a retrospective cohort study to examine readmission rates of inpatients who worked with CLPs in Paris, France, from January 2008 to December 2016 and found that the risk of being readmitted within 30 days of discharge increased if patients were not consulted by a CLP within 72 hours of their admission. Lanvin et al. (2022) found that among patients with an admission longer than 21 days, those consulted within the first 72 hours of their admission had a 30-day readmission rate of 8.6% and that those consulted after 72 hours had a 30-day readmission rate of 15.8%. These results infer that early intervention in mental health concerns and the collaboration between patients and healthcare providers in treatment planning can create better health outcomes for service users upon discharge.

These interventions provide examples of how we, as a healthcare system, can better adapt to address the gaps in care during the discharge process. Of note, TDM and CLPs offer an insight into a critical concept behind promoting the best outcomes for all stakeholders involved, that being continuity of care. TDM does this by promoting the formation of strong therapeutic relationships with community care providers before discharging a patient from an inpatient setting, along with curating peer supports that can follow a patient throughout their time post-discharge. Meanwhile, CLPs act as a consistent presence throughout an individual's treatment in an inpatient setting, with the ability to follow them into the community after discharge. Further, CTIs show that addressing socioeconomic issues such as housing has measurable benefits in addressing gaps in care, and EIs are effective in addressing gaps in care given their nature to educate and increase a service user's autonomy and competency.

Areas for Future Research

One area of research that would greatly benefit the literature is how our healthcare system can improve inter-setting communication between inpatient settings and community providers. Primary care providers would need to be accounted for in this, as they are a common primary contact point for many individuals living with mental health issues. While the literature reviewed identified communication amongst care providers as an area that needed improvement to address gaps in care better, research needs to be done on tools or interventions that healthcare providers can implement to remedy this. Another topic of research that would be useful would be to gain insight into the knowledge of inpatient nurses on the issues of community mental health in regards to what services are available, what care and wellness look like, how goals are made and prioritized, and what are the common problems service users face in the community. In my work in inpatient nursing, many nurses who have not worked in the community had little ability to conceptualize care beyond the context of inpatient psychiatry, limiting their ability to think of mental healthcare in a bigger picture. Gaining a snapshot of current inpatient care providers' perceptions about community mental health could better provide a template on how we can educate inpatient nurses to adjust their practice better to prepare service users for discharges to the community.

Conclusion

This literature review discusses key contributing factors to gaps in care between inpatient and community psychiatric care and how healthcare providers can address them. Many gaps in care can be traced back to the deinstitutionalization movement and the unintended consequences it had on mental healthcare, shifting the priority of psychiatric service provision from inpatient settings to the community. Some of the most common factors creating gaps in care include institutional level barriers that limit a service's ability to be holistic, ineffective communication between service providers, COVID-19’s impact on service availability, and insufficient mental health knowledge held by healthcare providers. Some of the most common interventions discussed to address these gaps in care focus on educational efforts to improve mental health knowledge and dispelling misinformation and the creation of roles focused on providing holistic care for patients while they navigate transitional periods from one care setting to the next. Reading about the importance of continuity of care and therapeutic relationships in providing meaningful patient care assured me that my strengths in, and devotion to, being a source of kindness for patients experiencing hardships has benefits that research cannot measure objectively like it does readmission rates.

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