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A discharge planning model for the high risk psychiatric inpatient

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A DISCHARGE PLANNING MODEL FOR THE HIGH RISK PSYCHIATRIC INPATIENT

by

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Abstract

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Psychiatric discharge planning is a function in search of a focus. Although it is a complex clinical task requiring a high degree of skill and knowledge, it has not yet been described systematically or linked to theory. Further, inpatient social workers have conducted little research regarding psychosocial characteristics of patients served, discharge interventive methods used, and their differential effectiveness. This thesis is intended as an initial attempt to articulate and evaluate a discharge planning program specifically designed for one subset of the psychiatric population within a suburban private voluntary teaching hospital - those patients who pose the greatest number of difficulties and dilemmas in discharge planning for social work, the institution, and the community.

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Chapter 1

Introduction to the High Risk Psychiatric Discharge Planning Program

1.1 The Current Context of Psychiatric Discharge Planning

The nature of psychiatric inpatient care has changed radically over the past thirty years in response to multiple influences including developments in psychopharmacology, the deinstitutionalization movement and federal mandates that patients be treated in the least restrictive environment commensurate with their condition.[1] Prior to 1960, the trend in both state and private psychiatric systems was to maintain a high census and to provide long-term care to persons who had no history of prior hospitalization. The reverse situation is in effect today. In New York State, for example, the inpatient psychiatric population (average daily census) dropped from 93,000 in 1955 to 24,000 in 1980, and 75 percent of all patients are now hospitalized for less than 90 days.[2] Further, eighty-five percent of all persons admitted to psychiatric facilities have a record of prior treatment for mental illness, and sixty-seven percent have had a history of previous hospitalization.[3]

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[1]Edward Beis, *Mental Health and the Law*, (Rockville, Maryland: Aspen Systems Corporation, 1984), pp. 193-198.

[2]John Flaherty, *Literature Review and Background Paper for Discharge Planning Program Development* (Albany, New York: New York State Office of Mental Health, Division of Policy Planning and Program Development, 1980), p. 1.

[3]Ibid., p. 1.

As the figures indicate, psychiatric inpatient care is no longer custodial and rarely functions as an alternative to community life. Rather, the objective is to reduce symptoms rapidly and to prepare patients to resume independent living as quickly as possible. Since inpatient care is now only one aspect of a complex treatment system, psychiatric hospitals have become increasingly dependent upon surrounding resources.

Given the fact that shortened hospital stays, repeated brief admissions, and primary emphasis upon outpatient aftercare have become the norm for most psychiatric patients, there has been heightened focus upon discharge planning practices. By linking and integrating the hospital with community services, social work discharge planning becomes crucial to both systems: to patient and family in arranging an orderly transition; and to the inpatient facility by mediating among the varied interests of patient, hospital, third party payors, and continuing care providers.

Medical hospitals have traditionally operated under strict bed utilization and length of stay criteria. A number have therefore established discharge planning models which promote early identification of high risk patients, prompt social work intervention, referral and follow-up.[4]

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[4]Leatrice Kolber, "Discharge Planning: A Process for Continuity of Care," *Discharge Planning Update* 3 (Winter 1983), pp. 26-33; Richard Edwards, "Professionals in 'Alliance' Achieve More Effective Discharge Planning," *Hospitals* 52 (June 1, 1978), pp. 71- 72; Louise Cunningham, "Early Assessment for Discharge Planning," *Quality Review Bulletin* (Special Edition - Spring 1982), pp. 66-71; Opal Bristow, Carol Stickney and Shirley Thompson, *Discharge Planning for Continuity of Care* (New York: National League for Nursing, 1976); Faith Jackson Crittendon, *Discharge Planning for Health Care Facilities* (Bowie, Maryland: Robert J. Brady Co., 1983).

Psychiatric settings, however, have fallen behind in developing such comprehensive programs because lengths of stay for each category of illness have not been firmly established and funding has been relatively open-ended. However, with federal initiatives (prospective reimbursement) and recent New York State policy shifts (e.g. implementation of the PRI/SCREEN system for admission into residential health care facilities, limitations on payment for alternate care days) which are directed toward reduction of health care spending, mental institutions too are coming under increased pressure to lower costs.[5] Within such a political environment, psychiatric social work has an opportunity to enhance its capability in an area of skill vital to both the profession and to the institutional setting.

Psychiatric social workers have long been aware that a subgroup of the inpatient population presents formidable impediments to discharge from the hospital and consumes an extraordinary proportion of social work time. Often these patients remain hospitalized longer than clinically necessary and are refused by numerous community agencies. The majority of this high risk population meet Goldman, Gattozzia, and Taube's criteria for severe and persistent mental illness (SPMI) in that they have a major psychiatric disorder, of long duration, accompanied by substantial disability.[6] Although such patients are consuming an increasing pro-

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[5]Howard Goldman, Guest Editor, "Special Section on Prospective Payment," *Hospital and Community Psychiatry* 35 (May, 1984), pp. 447-464.

[6]Howard Goldman, Antoinette Gattozzia, and Carl Taube, "Defining and Counting the Chronically Mentally Ill," *Hospital and Community Psychiatry* 32 (January 1981), p. 22.

portion of inpatient hospital days,[7] community resources have become increasingly restrictive and unavailable due to state and national policies. Therefore a pressing need exists to specify and test effective discharge planning methodologies (especially for those patients presenting the greatest risk) if the gains of hospitalization are to be supported, and if acute inpatient units are to fulfill their mission to provide short-term rather than custodial care.

Caroff notes that one of the distinguishing features of social work practice is our concern with "the social context within which individual or family problems occur and are altered."[8] Despite the fact that maintenance and/or enhancement of social functioning are major social work goals, there are as yet no adequate theories which explain how the provision of concrete services may be used to affect the individual's (or family's) inner life.

As a concrete service, discharge planning can be a powerful therapeutic intervention, providing the client with an ongoing environment in which healthy psychological functioning can be learned, supported, and nurtured. However, this function has not yet been systematically described, related to theory, or evaluated in a manner which would link this important task to the larger body of social work knowledge. Until this is accomplished, discharge planning practices will remain idiosyncratic and therefore difficult to conceptualize, to teach, and to assess. The

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[7]New York State Office of Mental Health, *1988 Update and Progress Report for the Five Year Comprehensive Plan for Mental Health Services 1985-1990,* (Albany, N. Y.: N. Y. State Office of Mental Health, October 1, 1987), p. 44.

[8]Phyllis Caroff, "Clinical Social Work: Present Role and Future Challenge," Social Work in Health Care 13 (Spring 1988), p. 23.

purpose of the thesis is to address this imperative by developing, implementing, evaluating, and linking to theory a focused, clearly articulated discharge planning program for high risk psychiatric inpatients. It is intended as one step in the larger task of specifying the manner in which concrete services can act as a powerful therapeutic intervention with potential for critical impact upon clients' lives.

1.2 Overview of the High Risk Psychiatric Discharge Planning Program

The discharge planning program for high risk psychiatric inpatients was conceptualized as having several key content areas. The first was a high risk indicator list used to identify (at admission) those patients most likely to present very complex discharge planning needs. Social work staff assigned to work with this group of highly vulnerable patients were then offered assistance in: a) conducting a clearly articulated, focused aftercare assessment; b) formulating a discharge planning hypothesis; c) providing conditions conducive to a healthy decision-making process; and d) establishing linkages among all elements of the aftercare network. Staff were also offered senior level consultation and advocacy, and detailed resource and referral information throughout the course of their involvement with these patients.

In order to assess the effectiveness of this program, a study was conducted which consisted of a prospective group of 26 high risk patients with whom the above interventions were used, and a second retrospective group of 26 high risk patients for whom usual institutional discharge planning practices were followed. The two groups were compared along critical dimensions to determine whether the

provision of concrete services within a systematic, clearly conceptualized framework (in contrast to unspecified practice) would yield indications of greater positive therapeutic outcome.

1.3 Summary of Thesis Content

Chapter 2 of this thesis describes aftercare of the mentally ill as a social problem and outlines its scope, history and the nature of organized attempts to deal with its manifestations. In Chapters 3 and 5, theoretical formulations and practice-derived propositions, relevant to the program's design, are identified. From these, key hypotheses are derived and concepts to be tested through the project are operationalized. Major policy issues related to the care and treatment of the severely mentally ill within this society are analyzed in Chapter 4. In Chapter 6, the program's design (including goals, scope, feasibility, practice principles tested, and evaluative strategies) is reviewed.

In Chapters 7 and 8, the rationale for implementing the program is given, and the organizational context for the project is examined (in both its temporal and structural aspects). The necessary sponsorship, approvals, support and funding required for the program are also reviewed with attention given to those organizational issues which may produce impediments to the establishment and operation of the model elsewhere. Chapter 9 presents the process of implementation, including assignment of tasks and the chronology of events. Quantitative and qualitative findings are discussed in Chapters 10, 11, and 12. The program's relation to legal issues is discussed in Chapter 13, and unanticipated outcomes are reviewed in Chapter 14. The final Chapters, 15 and 16, concern recommendations for the

future evolution of the high risk program, evaluate the program's effectiveness in meeting stated goals, and assess its strengths and limitations as a method for improving discharge planning services to high risk psychiatric inpatients.

Chapter 2

Rationale for the High Risk Psychiatric Discharge Planning Program

2.1 Introduction

The development of a comprehensive discharge planning program for high risk psychiatric inpatients entails the allocation and expenditure of scarce resources. In order to justify the commitment of assets for this purpose rather than for other pressing social needs, a persuasive case must be made in favor of altering the current situation. In addition, a group in charge of resources must want to invest in the improvement, a means must exist to bring about the desired change, and the intended recipients must be willing to participate.[1] To establish the existence of an unmet need, a thorough preliminary evaluation must be undertaken since "not all conditions we ourselves find deplorable are necessarily so to those most affected by them."[2] It is also important to locate the area of concern in time and place — to describe current circumstances, their rate of change, and to predict a realistic future state.

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[1]Harold Lewis, *The Intellectual Base of Social Work Practice* (New York: Haworth Press, 1982), p. 177.

[2]Ibid., p. 178.

2.2 Contextual Data

New York State has a current population of approximately 17.6 million individuals residing in 62 counties.[3] During 1986, there were 132,457 annual enrollments (census at beginning of reporting period plus annual admissions) to all inpatient psychiatric faciliites in the state. These admissions involved 9,571,642 patient days of service and an average length of stay of 72.3 days.[4] For these psychiatric inpatient stays, New York State spent $1,738,905,009 in 1986 or $98 per capita for psychiatric hospital care — the highest rate in the nation.[5]

The major program strategies being pursued by the Office of Mental Health (OMH) for 1989–1990 are summarized in the following statement:

> "Currently a person with a serious mental illness often confronts a fragmented service system which is difficult to negotiate, a system which may frequently exclude those most in need. It is the task of OMH to develop a unified and coordinated system designed to meet the needs of the most seriously ill."[6]

The Office of Mental Health defines the SPMI population (seriously and persistently mentally ill) as:

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[3]New York State Office of Mental Health, *1988 Update and Progress Report for the Five Year Comprehensive Plan for Mental Health Services, 1985 - 1990,* p. 8.

[4]New York State Office of Mental Health, *Statewide Comprehensive Plan for Mental Health Services 1989 - 1991,* (Albany, New York: N. Y. State Office of Mental Health, 1988), p. 16.

[5]Ibid., p. 18.

[6]Ibid., p. 5.

> "... persons, ages 18 and older, who have a current DSM- III-R mental illness diagnosis and experience substantial and prolonged impairments in social functioning due to the severity of their clinical condition. These adults currently experience substantial dysfunction in a number of areas of role performance or are dependent on substantial treatment and support services in order to control or maintain functional capacity. Furthermore, they have had the mental illness for an extended duration on either a continuous or episodic basis."[7]

The OMH estimates that approximately 185,000 persons, or 1.3% of New York State's adult population have a serious and persistent mental illness.[8] Children and adolescents with serious emotional illnesses are estimated at 43,000 or 1% of the entire population; and the number of adults with both serious mental illness and chemical dependencies are estimated as between 23,500 and 31,000.[9]

In response to criticisms that OMH has provided insufficient resources and support for people with serious mental illnesses, the agency states that its current goal is to "functionally establish the idea that the purpose of the public mental health system is to provide emergency access, treatment and rehabilitation within a comprehensive, coordinated system to those persons of all ages who are experiencing serious mental illness."[10] Fulfillment of this commitment to SPMI patients

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[7]Ibid., p. 20.

[8]Ibid., p. 20.

[9]Ibid., p. 21.

[10]Ibid., p. 4.

is to be guided by the principle that the vast majority of persons with serious and long-term mental illness "can live meaningful and productive lives in community settings when given flexible support."[11]

In its five-year plan, the Office of Mental Health notes that it will develop a comprehensive array of community-based treatment, rehabilitative, residential and acute inpatient services in order to decrease over-reliance on long-term (state hospital) inpatient care.[12] The State's position is that short-term acute hospitalization is best provided in acute units of general hospitals which are close to the individual's home community. This is because (unlike the state hospitals) general hospitals are assumed to have intensive staffing and the medical services needed to treat acute episodes of mental illness.[13]

The setting for the high risk discharge planning program (New York Hospital - Westchester Division) is licensed as an acute care unit of a general medical hospital (an Article 28 facility), even though it is free-standing and most similar to the intermediate length of stay private psychiatric hospitals (Article 31). There are 115 licensed Article 28 inpatient acute units in New York State with 4,967 beds, and only 14 licensed Article 31 facilities with 1,395 beds.[14] In contrast, the

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[11]Ibid., p. 4.

[12]New York State Office of Mental Health, *1988 Update and Progress Report for the Five Year Comprehensive Plan for Mental Health Services 1985 - 1990*, p. 3.

[13]New York State Office of Mental Health, *Statewide Comprehensive Plan for Mental Health Services 1989 - 1991*, p. 6.

[14]New York State Office of Mental Health, *1988 Update and Progress Report for the Five Year Comprehensive Plan for Mental Health Services 1985 - 1990*, p. 18.

state-operated inpatient programs have about 25,000 admissions annually with a census of 20,000 patients (there are 22 adult inpatient state psychiatric centers).[15]

In addition to New York State's mission to reduce the use of state psychiatric faciliites for treatment of the SPMI population, the Office of Mental Health is developing ways to amend the hospital reimbursement structure so that incentives are provided for acute care hospitals to reduce length of stay and to treat the most severely ill.[16] New York State's psychiatric hospital system costs over $1.2 billion per year to operate and receives $400 million in third-party payments. Three-quarters of this revenue is from Medicaid and Medicare.[17] The purpose of the proposed Alternate Reimbursement Methodologies Project for New York State is to limit the rate of increase in health care expenditures in psychiatry to the rate projected for the national prospective payment system.

For a large (322-bed) acute-care hospital such as New York Hospital–Westchester Division, these developments ensure that the inpatient population will be more seriously ill, more dysfunctional and chronic, and that funds will be available for only short-term stays. While the Office of Mental Health recognizes that "too many services are now delivered through the inpatient sector because inadequate alternatives exist in the community,"[18] the establishment of additional community resources has been exceedingly slow.

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[15]Ibid., p. 9.

[16]Ibid., pp. 62-68.

[17]Ibid., p. 62.

[18]Ibid., p. 63.

In past years, voluntary psychiatric hospitals have been able to act as asylums to patients for whom there were no appropriate aftercare resources by providing long-term stays during which extensive rehabilitative efforts could be made, and numerous aftercare arrangements explored. With the mandate to lower cost and reduce usage of inpatient units, this vital safety net for the fragile SPMI population is now being dismantled.[19]

2.3 The Current State of Psychiatric Discharge Planning for High Risk Patients

Since the inception of social work as a recognized field of professional practice, discharge planning has been an expected function. In fact, the main impetus for social work's entry into hospital settings in 1903 was patient need for aftercare assistance.[20] However, as the profession became strongly influenced by psychoanalytic theory in the 1920's and sought to establish practitioners as psychotherapists, "social, cultural and environmental factors were considered secondary to repressed fears and unresolved frustrations."[21] The essential and nuclear role of social work in attending to the comprehensive biopsychosocial needs of clients was underemphasized in the struggle for status and recognition of an emerging profession. However, beginning in the mid-1970's, discharge planning again became

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[19]Winifred Christ and Sharon Hayden, "Discharge Planning Strategies for Acutely Homeless Inpatients," *Social Work in Health Care* 14 (Winter 1989), forthcoming.

[20]Martin Nacman, "Social Work in Health Settings: A Historical Review," *Social Work in Health Care* 2 (Summer 1977), p. 409.

[21]Ibid., p. 412.

a focus of concern in psychiatric (as well as medical) settings due to a variety of patient-related, institutional, and societal factors which are summarized below.

2.3.1 Patient/Family Related Factors

1. Advances in psychopharmacology have meant that persons with serious and recurrent psychiatric illnesses can be discharged earlier from inpatient settings, and that they can be treated in alternative environments. Their functioning, however, is often at a dependent, non-autonomous level requiring numerous supports.[22]

2. There is a severe shortage of community aftercare resources for chronic mental patients, especially in the area of housing.[23] Further, many psychiatric patients lack the financial resources necessary to secure adequate living quarters and other basic needs.

3. Changes in family structure have meant that fewer chronic patients can simply be discharged to the care of kin. Due to economic demands and the isolation of the nuclear family, relatives are often either unable or unwilling

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[22]Phyllis Solomon, Barry Gordon, and Joseph Davis, "Assessing the Service Needs of the Discharged Psychiatric Patient," *Social Work in Health Care* 10 (Fall 1984), pp. 61-62; Edward Cochrane, "Editorial Comments," *Discharge Planning Update* 1 (Fall, 1980), p. 1.

[23]Stuart Kirk and Mark Therrien, "Community Mental Health Myths and the Fate of Former Hospitalized Patients," *Psychiatry* 38 (August 1975), pp. 209-217; New York State Office of Mental Health, *Statewide Comprehensive Plan for Mental Health Services 1989 - 1991*, p. 2.

to care for the semi-dependent psychiatric patient.[24]

4. Discharge planning is mandated by law as the psychiatric patient's right — every patient can expect that he will be informed about his continuing care requirements following discharge and referred to whatever services are necessary to improve or maintain the status of his health.[25]

5. The chronically mentally ill are among the most unwanted clients of social agencies.[26] This lack of attractiveness to facilities stems primarily from the degree of pathology and need for extensive services. SPMI applicants are often "screened out" or discouraged from receiving needed care.

6. The high risk psychiatric patient usually requires multiple services post-discharge. New York State's Office of Mental Health has noted that "a significant issue in the area of acute care is a relative absence of an adequate and coordinated outpatient system of care."[27] Having conflicting requirements and contradictory mandates, aftercare agencies "present a tangled web for

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[24]Cochrane, "Editorial Comments," p. 1.

[25]U. S., President, "Medicare and Medicaid Conditions of Participation for Hospitals," *Federal Register* 51, no. 116, 17 June 1986, 22043; McKinney's Consolidated Laws of New York (Annotated), Book 34A *Mental Hygiene Law*, Article 29.15, "Discharge and Conditional Release of Patients to the Community" (Minnesota: West Publishing Co., 1988), pp. 290–296.

[26]Kirk and Therrien, "Community Mental Health Myths and the Fate of Former Hospitalized Patients," p. 216; Stuart Kirk and James Greenley, "Denying or Delivering Services?" *Social Work* 19 (July 1974), pp. 439-447.

[27]New York State Office of Mental Health, *Statewide Comprehensive Plan for Mental Health Services 1989 - 1991*, p. 62.

for even the well-informed."[28] The complexity of negotiating a separate bureaucratic structure for each need (e.g. the housing, health, mental health, financial benefit, vocational rehabilitation systems) in turn causes chronic patients to fail to receive care or to experience disruptive discontinuities.[29]

2.3.2 Institutional Factors

1. Hospital financial survival is now clearly linked to effective discharge planning.[30] Therefore, competition for jurisdiction over this function has developed, and other groups (nursing, therapeutic activities) have claimed discharge planning as part of their domain. Loss of this professional task would threaten an important aspect of social work's legitimacy, its traditional field of expertise, and claim to resources within hospitals.

2. Discharge planning is a professional activity "without benefit of an evolved theory or methodology. There is no formal education and/or training available for discharge planners."[31] As many models as institutions exist, and

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[28]New York State Service Planning Committee, *Committee Report to the Commissioner of Mental Health on the Need for Discharge Planning Procedures and Follow-Up Services for Patients Released from Facilities Licensed or Operated by the Office of Mental Health,* (Albany, N. Y.: New York State Office of Mental Health, 1982), p. i.

[29]Robert Surber, et al., "Medical and Psychiatric Needs of the Homeless – a Preliminary Response," *Social Work* 33 (March–April 1988), p. 119.

[30]Committee on Discharge Planning of the Society for Hospital Social Work Directors, *Reference Article on Discharge Planning,* (Chicago: American Hospital Association, 1980), p. 4.

[31]Anita Glassberg and Sheila Fallik, *Hospital Discharge Planning: A Function in Search of a Focus,* (New York: Greater N. Y. Hospital Association, April 1982),

there are few formal studies to guide the social work practitioner in selecting effective interventions.

3. Delays in patient discharges from psychiatric hospitals have raised issues about stewardship of scarce resources and have placed pressure upon social workers to enhance expertise in this function.[32]

2.3.3 Societal Factors

1. Retrenchment in federal funding (e.g., cutbacks in the Health and Human Services budget and in Title XX) has reduced available community services for the discharged psychiatric patient.[33]

2. The introduction of the Medicare prospective payment system across the nation has produced pressures from all third-party payors upon hospitals to reduce lengths of stay.[34] In New York State, an alternate reimbursement methodology to curtail psychiatric inpatient costs is scheduled to go into effect in 1989.[35]

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p. 2.

[32]Winifred Christ, "Factors Delaying Discharge of Psychiatric Patients," Health and Social Work 9 (Summer 1984), p. 178.

[33]Sherry Arnstein, ed., "Reagan Proposes FY 1984 Budget with Few Surprises for Health," *Washington Report* 9 (February 1, 1983), p. 4.

[34]Helen Rehr, "Discharge Planning: An Ongoing Function of Quality Care," *Quality Review Bulletin* 12 (February 1986), p. 47.

[35]Alternate Reimbursement Methodologies Project Task Force, *Reimbursement of Psychiatric Inpatient Stays: Proposed Regulatory Revisions, Part 86 of Title 10 NYCRR, Section 86* (Albany: New York State Office of Mental Health, August 3,

3. Supreme Court decisions mandating that patients be treated in the least restrictive environment commensurate with their needs has lent further impetus to early releases from psychiatric hospitals.[36]

4. The availability of Medicaid, Medicare, SSI and SSDI which offer partial federal reimbursement for certain types of community care, has prompted the overuse of facilities unsuited to the needs of the mentally-ill (e.g. nursing homes).[37]

5. The reduction in state hospital beds has led to the unavailability of this resource for those mentally ill persons who realistically need long-term, custodial care.[38]

6. New York State's new method for reimbursing residential health care facilities and the Nursing Home Reform Law, implemented on 1/1/89, have served to further exclude psychiatric patients from admission to SNF's and HRF's,

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1988), pp. 1-15.

[36]Edward Beis, *Mental Health and the Law*, (Rockville, Maryland: Aspen Systems Corporation, 1984), pp. 193-198.

[37]Leona Bachrach, *Deinstitutionalization: An Analytic Review and Sociological Perspective* (Rockville, Maryland: U.S. Department of Health, Education and Welfare, 1976), p. 13.

[38]David Ames, "The Limits of General Hospital Care: A Continuing Role for State Hospitals," *Hospital and Community Psychiatry* 24 (February, 1983), pp. 145-149; John Talbott, "The Need for Asylum, Not Asylums," *Hospital and Community Psychiatry*, 35 (March 1984), p. 209.

and to reduce monies for their care.[39]

7. On 11/1/86, all New York State Article 28 acute-care Hospitals were informed by the Department of Health that only 1– 2 alternate level of care days would be automatically reimbursed. A complicated appeals process is now necessary in order to obtain payment beyond one day for psychiatric patients delayed in their discharge to community settings.[40]

2.4 Persons, Programs and Organizations Concerned with Psychiatric Discharge Planning

As Lewis points out, "The practice of social work is never static. It is constantly responding to economic and political pressures and to changes in the knowledge base on which it operates."[41] While this dynamic ensures that the profession will remain relevant to a society which is in flux, it also requires the ongoing investment of professional effort in specifying and in quantifying what is known in an emerging field such as discharge planning.

Because discharge planning has been undervalued by social work, it has been

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[39]Cynthia Rudder, "Case–Mix Reimbursement and Resource Utilization Groups (RUGS) – What Consumers Should Know," (New York: Nursing Home Community Coalition of N. Y. State, November 1985), unpublished manuscript; Hospital Association of New York State, "OMH and OMRDD Announce Implementation of Plans for Nursing Home Reform Law," *HANYS News* 20 (December 23, 1988), p. 2.

[40]N. Y. State Department of Health, *Hospital Memorandum, Series 86-97, Hospital Procedures for Completing and Using the Long Term Care Patient Review Forms and Criteria for Level of Care,* (Albany, New York: New York State Department of Health, October 2, 1986), p. 11.)

[41]Lewis, *The Intellectual Base of Social Work Practice,* p. 41.

viewed as an irksome duty requiring no special skills or knowledge—to be delegated to others wherever possible. In many hospitals, members of other disciplines have been allowed to assume responsibility for this task since social workers have failed to evaluate and establish that their own profession is best suited by training and skill to carry out discharge planning functions.

Recently, a number of practitioners and organizations have decried this situation and have urged social work to vigorously embrace discharge planning as a vital aspect of practice. [42] For example, Fields states, "To view discharge planning as low status, is to miss its significance. How we plan for those who need care reflects our societal as well as our social work value system."[43] Coulton asserts that the tasks involved in discharge planning require a high level of professional sophistication which warrants the development of a valid conceptual framework by social work.[44]

In 1980, the Committee on Discharge Planning of the Society for Hospital Social Work Directors wrote that the social work profession is uniquely able to offer the biopsychosocial assessment, skilled counselling, linkage, advocacy, and knowledge of community resources required by this function. The skills necessary to view patients in relation to their entire social system, their needs, values and

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[42]Grace Fields, "The Anatomy of Discharge Planning," *Social Work in Health Care* 4 (Fall 1978), pp. 5-6; Edward Cochrane, "Discharge Planning, the Central Role of Social Work," *NASW News* 26 (February, 1981), pp. 14-15; Cochrane, "Editorial Comments," pp. 1-3.

[43]Fields, "The Anatomy of Discharge Planning," p. 6.

[44]Claudia Coulton, "Social Workers in Discharge Planning," *Social Work* 25 (January 1980), pp. 81-82.

aspirations and to match these with the opportunities of the environment, are basic social work competencies.[45]

A 1982 report by the Greater New York Hospital Association noted that although there is an intense current focus upon discharge planning, "very little research or formal education has been done to provide a basis for the development of professional discharge planning systems."[46] After conducting an extensive search, the Association found that "the literature does not formulate or support any particular teaching definitions, methodologies or techniques." Their survey of New York City hospitals "revealed a definite need for assistance in developing, educating and implementing today's discharge planning programs."[47]

Lurie, Pinsky and Tuzman surveyed course content in two metropolitan New York schools of social work and found that while the necessary information is available, no formal organization or curriculum specifically focused on discharge planning exist.[48] They conclude that a more focused introduction of this subject should be offered in graduate school and in fieldwork to integrate practice and theory, and to reduce worker ambivalence towards this role.

In response to these identified conceptual imperatives, a major purpose of this

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[45]Committee on Discharge Planning of the Society for Hospital Social Work Directors, *Reference Article on Discharge Planning*, p. 5.

[46]Glassberg and Fallik, *Hospital Discharge Planning: A Function in Search of a Focus*, p. 2.

[47]Ibid., p. 3.

[48]Abraham Lurie, Sidney Pinsky and Leonard Tuzman, "Training Social Workers for Discharge Planning," *Health and Social Work* 6 (Fall 1981), pp. 16-18.

project has been to formulate and test a clearly delineated discharge planning methodology specifically adapted to the needs of a high risk psychiatric inpatient population. The model is informed by the existing social work knowledge base from which have been derived practice principles and hypotheses.

2.5 Psychiatric Discharge Planning — An Historical Perspective

Lewis points out that "evaluations of conditions are as much a function of an anticipated future as of a current state. When we locate a condition in time and place, it may be far more important to mark the direction of its development and the rate at which it is changing than merely to describe the condition itself."[49] Therefore it is important to consider psychiatric discharge planning in terms of its history, how it is perceived by those who are most affected, and what pragmatic changes may be possible.

The historical roots of social work in health care are attributed to Dr. Richard C. Cabot who employed the first hospital social worker in 1905 to understand social adjustment as it related to response to medical treatment.[50] The entry of social work into the mental health field can be traced to 1904 when Dr. Adolph Meyer, Director of the New York State Psychiatric Institute asked his wife (a social worker) to visit patients both in hospital and in their homes to obtain case histories. The first training program for psychiatric social workers opened at

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[49]Lewis, *The Intellectual Base of Social Work Practice*, p. 178.

[50]Beulah R. Compton, "Traditional Fields of Practice," in *Handbook of Clinical Social Work*, eds., Aaron Rosenblatt and Diana Waldfogel (San Francisco: Jossey-Bass, 1983), p. 1003.

Smith College in 1918.[51] During the decades of the 1940's and 1950's, psychiatric social workers gradually became recognized members of the inpatient mental health team. Hospital social work services were further supported by the conditions of participation set forth under Medicare and Medicaid, and by the Joint Commission on Accreditation of Health Care Organizations.[52]

The concept of discharge planning as a required service for the hospitalized mentally ill did not exist prior to the 1960's when the civil rights movement compelled both the court system and society to define rights for this population. Prior to this, courts had been reluctant to hear cases brought by institutionalized patients "because their care and treatment were considered matters beyond the scope of judicial competence."[53] However, as abuses in state mental facilities were brought to public attention, the courts began taking a more active role in defining patients' rights. A landmark case which shifted the focus of inpatient care from custodial services to provision of active care was that of *Wyatt v. Stickney* which held that the involuntarily institutionalized "have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition."[54] The court ruled that each

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[51]Ibid., p. 1008.

[52]U. S., President, "Medicare and Medicaid Conditions of Participation for Hospitals," 22043; and Joint Commission on Accreditation of Health Care Organizations, *Accreditation Manual for Hospitals, AMH/88* (Chicago: JCAH, 1987), pp. 261-268.

[53]Robert Schwitzgebel and R. Kirkland Schwitzgebel, *The Law and Psychological Practice* (New York: John Wiley and Sons, 1980), p. 44

[54]Ibid., p. 45.

patient must have an individualized treatment plan developed by qualified mental health professionals which specified (among other issues) criteria for release to less restrictive conditions, and criteria for discharge.

In 1976, the New York State legislature amended the Mental Hygiene Law (Section 29.15) by enacting new provisions for the discharge and release of patients from state-operated psychiatric facilities. In amendments of 1980, requirements for written service plans for the discharge and release of psychiatric inpatients were extended to all facilities licensed by the Office of Mental Health.[55]

The second major court doctrine with implications for discharge planning was that of the right to refuse treatment. While the right to treatment doctrine seeks to make adequate treatment available to patients, the patient is not required to exercise his right to treatment. Although the relevant law is in a period of development and flux, the basic concept is that treatment should not be imposed upon a dissenting patient (except in an emergency) without judicial determination of mental status and ability to consent.[56] The right to refuse treatment in effect shifts the locus of responsibility for decisions regarding psychiatric care from medical practitioners to the courts.

In addition to the civil rights movement, the development of psychotropic medications allowed many severely mentally ill persons to function at a level that permitted consideration of discharge from a psychiatric hospital to community level

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[55]James A. Prevost, Commissioner, *Information Memorandum: Discharge and Release of Psychiatric Patients to the Community* (Albany, New York: New York State Office of Mental Health, March 11, 1981), p. 1.

[56]Schwitzgebel and Schwitzgebel, *The Law and Psychological Practice*, p. 53.

care. At the same time as these developments were occurring, changes in funding mechanisms provided economic incentives for shifting state hospital patients to community care. Medicaid and Medicare legislation passed in 1965 permitted expanded numbers of elderly and indigent mentally ill to receive outpatient (as well as inpatient) psychiatric care. In 1972, PL 92-603 established Supplemental Security Income which funded living expenses and reimbursed community residences. Because Medicaid, Medicare and SSI are funded through federal (or federal/state) contributions, incentives were present for shifting patients from state hospitals to facilities such as nursing homes, adults homes, or halfway houses where costs would be shared.[57]

All of these factors — the civil rights movement, developments in psychopharmacology, and new federal funding mechanisms — contributed to deinstitutionalization and community placement. Deinstitutionalization is a term used to summarize the readjustment and redefinition of all components of the mental health delivery system. Sullivan and Brody note that one of its major goals was to develop a multimodel, pluralistic system of community care which would afford people psychiatric care in the least restrictive setting while also providing protective and supportive environments when necessary.[58] In 1955, there were 558,922 long-term residents of the 275 state and county mental hospitals which existed in the United

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[57]Carl A. Taube et al., "The Chronic Mental Hospital Patient," *Hospital and Community Psychiatry* 34 (July 1983), pp. 611-615.

[58]Anne O'Sullivan and Michael Brody, "Discharge Planning for the Mentally Disabled" *Quality Review Bulletin* (February 1986), p. 57.

States.[59] In contrast, by 1980, there were only 137,810 long-stay residents in the same number of facilities. However, while there were 126,498 discharges from state hospitals in 1955, by 1980, this number had jumped to 395,165. In sum, although fewer patients received long-term custodial care in state and county hospitals, the number of short-term inpatient care episodes increased impressively. This trend was also duplicated in private psychiatric hospitals where lengths of stay were reduced from 1-2 years to 1-2 months. In New York State in 1980, for example, there were 110,000 total inpatient psychiatric admissions. Seventy-seven percent of these patients were admitted to the non-state-operated sector, and 75 percent of the 110,000 were released within 90 days.[60] Thus the pattern of shortened but repeated psychiatric stays which began in the 1950's has continued despite the lack of capacity in the municipal and voluntary systems to care for the number of persons involved. As a result, "A revolving door policy has developed to cope with this overload; only the sickest, most violent or disruptive patients can be admitted in this triage situation."[61]

Discharge planning was first mandated by the federal government in 1972 (PL 92-603) for hospitals, skilled nursing facilities, and home health agencies wishing

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[59]Howard Goldman, Neil Adams and Carl Taube, "Deinstitutionalization: The Data Demythologized," *Hospital and Community Psychiatry* 34 (February 1983), pp. 129-34.

[60]New York State Service Planning Committee, *Committee Report to the Commissioner of Mental Health on the Need for Discharge Planning Procedures and Follow-Up Services for Patients Released form Facilities Licensed or Operated by the Office of Mental Health*, p. 3.

[61]Ibid., p. i.

to participate in the Medicare and Medicaid programs.[62] These amendments to Title XVIII of the Social Security Act mandated that hospitals establish internal utilization review committees which (among other functions) were to operate discharge planning programs to ensure that each patient had a planned program of continuing care to meet post-discharge needs. Assessment of patients' aftercare requirements had to be completed within seven days after admission, and updated on a regular basis. These regulations required the appointment of a discharge coordinator, and the provision of a summary of information about post-discharge needs to those responsible for aftercare. In addition, utilization review committees were to determine whether admission and continuing stay criteria were met by each patient. Inappropriate admissions were to be denied, and patients remaining in hospital beyond the acute phase were to be placed on alternate level of care status (which is not reimbursed by the federal government).

The amendments of 1972 were intended to uphold a broad humanitarian tradition which preserved maximal human freedom while offering protection for the disabled. At the same time, they reflected concern with cost containment and with maintaining social control over potentially disruptive elements. The dilemmas posed by endorsing these conflicting values concurrently are apparent in present New York State discharge planning regulations which attempt to ensure supportive services for those released from psychiatric institutions, without incurring prohibitive cost, while simultaneously protecting the community from deviants.

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[62]American Hospital Association, "Introduction to Legislation and Regulations Governing Discharge Planning," *Discharge Planning Update* 1 (Fall 1980), p. 11-12.

Translated into practice, patients are discharged to the least restrictive environment without the wherewithal to succeed; discharge planning and community services are mandated without accompanying funding; and patients are granted rights they cannot exercise because they lack basic necessities.

For the above reasons, serious questions can be raised about the extent to which the full intent of the 1972 amendments to the Social Security Act can actually be carried out by providers. Previously, it was possible for patients to remain in hospital if adequate aftercare could not be arranged. Although this led to some abuses (such as lack of vigorous effort to discharge patients rapidly), it also offered a safety net for those who had insufficient supports in the community. The federal government's failure to fund alternate level of care days while discharge plans are awaited gives hospitals financial disincentives for retaining patients until essential aftercare services are in place. Doubtless, more aftercare plans are recorded in inpatient charts, but there is much evidence that patients are not actually receiving the quantity and quality of care recommended.[63]

2.6 Psychiatric Discharge Planning as Viewed by Patients and Their Families

How psychiatric patients and their families experience the consequences of discharge planning is not well-documented. A number of studies[64] suggest that most

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[63]New York State Commission on Quality of Care for the Mentally Disabled, *Discharge Practices of Inpatient Psychiatric Facilities*, (Albany, New York: N. Y. State Commission on Quality of Care for the Mentally Disabled, August, 1988), p. 5.

[64]Frank Summers, "Characteristics of New Patient Admissions to Aftercare," *Hospital and Community Psychiatry* 30 (March 1979), pp. 199-202; Leona

communities are ill-equipped to provide the extensive services (ranging from supportive living arrangements to recreational opportunities) which many former psychiatric patients require in order to survive outside a total institution. Kirk and Therrien state, "former patients are not welcomed back into communities with open arms; instead they are often confronted by formal and informal attempts to exclude them."[65] Agencies often do not know how to manage patients who use psychiatric services on a revolving-door basis. Therefore, such persons "are treated perfunctorily ... by a staff that is too discouraged to do more than go through the motions."[66]

In a recent New York State Commission on Quaality of Care survey of discharges from psychiatric hospitals in New York State, considerable patient resistance to and dissatisfaction with outpatient services was discovered. In fact, over half of the 60 patients studied refused at least one service referral, and an additional 23% quickly dropped out of services after an initial acceptance.[67] One of

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Bachrach, "Planning Mental Health Services for Chronic Patients," *Hospital and Community Psychiatry* 30 (June 1979), pp. 387-92; Thomas Craig and Eugene Laska, "Deinstitutionalization and the Survival of the State Hospital," *Hospital and Community Psychiatry* 34 (July 1983), pp. 616-622; David Ames, "The Limits of General Hospital Care: A Continuing Role for State Hospitals," pp. 145-149; Leona Bachrach, "Young Adult Chronic Patients: An Analytic Review of the Literature," *Hospital and Community Psychiatry* 33 (March 1982), pp. 189-97; Stuart Kirk and Mark Therrien, "Community Mental Health Myths and the Fate of Former Hospitalized Patients," p. 213.

[65]Ibid., p. 213.

[66]Bachrach, "Young Adult Chronic Patients: An Analytical Review of the Literature," p. 192.

[67]New York State Commission on Quality of Care for the Mentally Disabled, *Discharge Practices of Inpatient Psychiatric Facilities*, p. 21.

the primary reasons for this was that recipients of services and families reported "that the current array of outpatient services is not responsive to patients' needs and wants."[68] The Commission also found that no one was assigned primary responsibility to follow-up with patients to ensure that they connected with services, there were minimal efforts on the part of providers to reach out, and there was no funding for assisting patients with the transition to the community.

Practitioners have long suspected that the quality of life for certain groups of discharged psychiatric patients may actually be at a level below that in most state mental hospitals. While quality of life measures have been applied repeatedly to the elderly, to minorities and to financially disadvantaged groups, the mentally ill population has only begun to be tested. Several studies have measured objective factors which suggest that some groups of former psychiatric patients experience an inadequate standard of living (e.g., poverty-level income, poor health, high unemployment, lack of daily activities, isolation, etc.).[69] Only one study could be located (of severely and persistently mentally ill Community Support System clients) which attempted to measure subjective indicators, or patient satisfaction with various life areas.[70] The authors found that these chronic patients (who

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[68]Ibid., p. 24.

[69]Richard Tessler, et al., "The Chronically Mentally Ill in Community Support Systems," *Hospital and Community Psychiatry* 33 (March 1982), pp. 208-211; Summers, "Characteristics of New Patient Admissions to Aftercare," pp. 199-202; George Spivack, et al., "The Long-Term Patient in the Community: Life Style Patterns and Treatment Implications," *Hospital and Community Psychiatry* 33 (April 1982), pp. 291- 295.

[70]Frank Baker and James Intagliata, *CSS Evaluation: Final Report* (Albany, New York: New York State Office of Mental Health, 1981).

were clients in the Community Support System program) experienced considerable dissatisfaction with their economic situation, health, leisure time activities, family relations, clothing and available services. The degree of distress reported by these individuals was not compared to that of similar persons residing in a state hospital, for example, so that relative dissatisfaction in a possible alternative environment cannot be assessed.

A further area which has only recently received attention is the degree of burden experienced by families or significant others in caring for discharged psychiatric patients. Studies have reported that between 25% and 66% of discharged psychiatric patients return to their families.[71] In New York State during 1980-81, 80% of all state hospital psychiatric patients with stays less then 3 months were discharged home.[72] Since the nuclear family is clearly a major resource for the psychiatric patient, ways to provide assistance in the onerous task of assuming responsibility for a relative with a chronic illness must be part of every aftercare plan. However, in actuality, families receive few services in providing the primary community support for discharged patients. For example, the previously cited study by the New York State Commission on Quality of Care for the Mentally Disabled found that

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[71]Howard Goldman, "Mental Illness and Family Burden: A Public Health Perspective," *Hospital and Community Psychiatry* 33 (July 1982), pp. 557-560; H. Richard Lamb, *Treating the Long-Term Mentally Ill,* (San Francisco: Jossey-Bass, 1982); Kenneth Minkoff, "A Map of the Chronic Mental Patient," in *The Chronic Mental Patient,* ed. John Talbott (Washington, D.C.: American Psychiatric Association, 1978), pp. 11-37.

[72]Agnes B. Hatfield, "Families as Caregivers: A Historical Perspective," in *Families of the Mentally Ill,* eds. Agnes B. Hatfield and Harriet P. Lefley (New York: Guilford Press, 1987), p. 8.

although 58% of the patients studied were discharged to live at home, only 3% of their families actually received support services.[73]

In one article, professionals were surveyed about whether patients' families would be psychologically and/or socially burdened by their relatives' return after an inpatient stay.[74] The degree of distress actually experienced by families was then measured six months post-discharge, and it was found that no discipline could accurately predict amount of hardship in advance. Agnes Hatfield poignantly writes, "It is a matter of considerable consternation and concern that over a period of nearly 3 decades of deinstitutionalization, mental health professionals were so oblivious to what it might mean for families to replace the ward staff without the training and resources ordinarily available in the hospital."[75]

Anderson and Meisel offer a framework for assessing the family's reaction to the stress of schizophrenic illness which includes the family's current experience of the patient's behavior and its meaning to them; the role of the patient in the family; past reactions to crisis; other current life stresses; the extent of family isolation from other social systems; and the family's transactional style.[76] The

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[73]New York State Commission on Quality of Care for the Mentally Disabled, *Discharge Practices of Inpatient Psychiatric Facilities*, p. 13.

[74]George Williams, Fu-tong Hsu and Tsung-yi Lin, "Prediction of the Burden of Released Mental Patients," *Community Mental Health Journal* 9 (September 1973), pp. 303-315.

[75]Hatfield and Lefley, "Families as Caregivers: A Historical Perspective," p. 8.

[76]Carol Anderson and Susan Meisel, "An Assessment of Family Reaction to the Stress of a Psychiatric Illness," *Hospital and Community Psychiatry* 27 (December 1976), pp. 868-871.

authors note that through evaluating the family's tolerance of stress, its capacity to be supportive and to enable the ill member to live outside the hospital might be predicted in advance of discharge.

Pilisuk and Parks point out, "To understand the impact of caregiving on families it is important to examine both objective burden (physical tasks and financial responsibilities) and subjective stress to assess the different meanings of events to the individuals experiencing them."[77] Caregivers need physical, financial, informational and psychological services not only to care for the disabled member, but also to care for themselves. However the single consistent feature of government policy towards family caregivers has been cost containment which in effect punishes them financially for illness, disability or for the decision to provide needed care in the home.[78]

Thompson and Doll point out that community tenure is not an adequate measure of successful discharge – it is also necessary to look at degree of subjective and objective burden experienced by family caretakers who may find rehospitalization more unpalatable than keeping the family member at home. These authors note that when families cope with kin who have chronic disabilities, there is an accumulation of stress which tests and threatens the stability of the support system over time. "Thus, although patients remain in the community, they are often in home environments marked by relatives' feelings of despair, resentment and at

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[77]Marc Pilisuk and Susan Hillier Parks, "Caregiving: Where Families Need Help," *Social Work* 33 (September – October 1988), p. 436.

[78]Ibid., p. 438.

times isolation."[79]

2.7 The Scope of Issues to Be Addressed in Psychiatric Discharge Planning

Obviously societal policies affecting the mentally ill, such as deinstitutionalization, have not been based upon careful assessment of the impact of the intervention upon the involved populations in order to determine whether the anticipated future state will actually improve current conditions. Lewis points out that "failure to consider the history of the condition, prior efforts to deal with it, and the context in which it is currently evolving, can result in myopic or utopian visions of what is desirable or promote logical blind spots – with a resultant failure to consider reasonable goals."[80]

These broader philosophical and ethical issues regarding how the mentally ill shall be treated in society, what services shall be provided, under what auspices and funding structure, are the overarching structure in which the problem to be addressed by the proposed program is embedded. By concentrating upon the development of a discharge planning model for high risk psychiatric inpatients, the program deals with only one quite limited aspect of the multi-faceted concerns raised by policies directed towards those with emotional disorders. Thus this proposal does not attempt to change federal or state policies. Crucial needs of discharged mental patients such as housing, day treatment, the coordination of

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[79]Edward Thompson, Jr., and William Doll, "The Burden of Families Coping with the Mentally Ill: An Invisible Crisis," *Family Relations* 31 (July 1982), pp. 386-387.

[80]Lewis, *The Intellectual Base of Social Work Practice*, p. 182.

benefits, etc. are not addressed in the program although these are certainly pressing and deserving of scarce resources. The author's viewpoint is strongly affected by the institutional setting through which the program must be implemented, and by knowledge based upon much experience of what is indeed possible within these constraints. To be supported, new initiatives must meet a combination of the profession's and the facility's goals. Although the hospital where the study was conducted does not see its mandate as the creation of additional community resources, it has strong concerns about its financial viability in view of shortened stays. Therefore efforts which reduce risk, facilitate transitions, and at the same time produce patient/family satisfaction do invoke interest and receptivity.

While the discharged patient's condition in the community is of great concern, the lack of tested, systematized models for aftercare planning, based upon practice principles is also alarming. If we cannot be assured that social workers are carrying out a crucial task (discharge planning) with the highest level of professionalism, we also cannot be certain that some of the negative outcome of that function, for the patient and family, are not iatrogenic. In a modest way, the high risk discharge planning program seeks to help separate those effects of discharge planning which are due to societal conditions from those which may be caused by a lack of knowledge (which is remediable) in the field. If we as practitioners can demonstrate that deplorable conditions exist despite the provision of social work services based upon the highest level of professional practice, we are then in a much stronger, better informed position to advocate change.

2.8 Existing Discharge Planning Models

Models for implementing a well-functioning discharge planning system are available in certain medical settings, and some aspects of these are applicable to a psychiatric hospital. For example, numerous general hospitals have developed medical high risk lists to be used by social workers to identify patients likely to require intensive efforts in order to effect discharge.[81] Some departments have established discharge data systems which allow them to know what resources are most in demand for what types of patients, and to identify service patterns for particular workers.[82] At least one other psychiatric social service department has established a Resource Office whose librarian obtains and disseminates information to workers for use in aftercare planning (McLean Hospital, Belmont, Mass.). Finally, a number of discharge planning handbooks for medical hospitals have been written.[83]

Some of the elements of the high risk program have been adapted from literature about the management of chronic patients. Wasylensky and others have

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[81]Barbara Berkman, Helen Rehr, and Gary Rosenberg, "A Social Work Department Develops and Tests a Screening Mechanism to Identify High Social Risk Situations," *Social Work in Health Care* 5 (Summer 1980), pp. 373-385; Claudia Coulton, *Social Work Quality Assurance Programs: A Comparative Analysis* (Washington, D.C.: NASW, 1979), pp. 52-53.

[82]Donald Wasylenki, et al., "Psychiatric Aftercare: Identified Needs Versus Referral Patterns," *American Journal of Psychiatry* 138 (September 1981), pp. 1228-1231; Ruth Lindenberg and Claudia Coulton, "Planning for Posthospital Care: A Follow-Up Study," *Health and Social Work* 5 (May 1980), pp. 45-50.

[83]Faith Jackson Crittendon, *Discharge Planning for Health Care Facilities*; Opal Bristow, Carol Stickney and Shirley Thompson, *Discharge Planning for Continuity of Care*; Patricia Volland, ed., *Discharge Planning: An Interdisciplinary Approach to Continuity of Care*, (Maryland: National Health Publishing, 1988).

identified five elements of a successful aftercare program for chronic patients.[84] These include systematic aftercare assessments, weekly collaborative meetings between hospital and community staff, the provision of transitional staff, immediate response to referrals by receiving agencies, and strong ties among involved community providers.

Bachrach suggests several principles to promote continuity of care for chronic patients: there must be temporal continuity, individual tailoring of the aftercare plan, comprehensiveness, flexibility, accessibility and availability, communication and linkage among all involved, and the development of positive, trusting relationships.[85]

Cutler, Terwilliger and Faulkner note that patient networks should be assessed as part of the initial patient evaluation so that planning-linking conferences can be held to overcome obstacles to the continuous flow of services. They also suggest that there be a principal support person for the patient post-discharge who will constantly monitor the patient's system and intervene if gaps occur. These authors underline the importance of training commuity helpers to respond to the multiple needs of chronic clients.[86]

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[84]Donald Wasylenki, Elizabeth Plummer, and Sebastian Littmann, "An Aftercare Program for Problem Patients," *Hospital and Community Psychiatry* 32 (July 1981), pp. 493-496.

[85]Leona Bachrach, "Continuity of Care for Chronic Mental Patients: A Conceptual Analysis," *American Journal of Psychiatry* 138 (November 1981), pp. 1449-1456.

[86]David Cutler, Wesley Terwilliger and Larry Faulkner, "Integrating an Aftercare Plan for the Chronic Patient," in *Effective Aftercare for the 1980's*, ed. David Cutler (San Francisco: Jossey-Bass, 1983), pp. 95-104.

While such articles provide helpful principles to guide aftercare practices, they do not suggest how to operationalize these concepts within the context of an inpatient psychiatric setting.

Other issues which inform the program and have been addressed in recent literature concern the timing of aftercare interventions, the type of planning process most conducive to community tenure, and the nature of community services which promote adequate functioning outside an institution.[87]

In the last decade, studies about discharge planning for psychiatric patients have focused upon assumed concrete indicators of outcome "success" - a reduction in recidivism and relapse rates, or the patient's appearing at aftercare appointments. In reviewing this material, it is evident that not only are more sophisticated, better delineated and controlled studies of outcome essential, but there is also a need to investigate and describe the actual process of psychiatric dis-

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[87]Sherman Eisenthal, et al., "Adherence and the Negotiated Approach to Patienthood," *Archives of General Psychiatry* 36 (April 1979), pp. 393-398; Edward McCranie and Terrence Mizell, "Aftercare for Psychiatric Patients: Does It Prevent Rehospitalization?" *Hospital and Community Psychiatry* 29 (September 1978), pp. 584-587; Edwin Zolik and Edna Lantz, "Hospital Return Rates and Prerelease Referrals," *Archives of General Psychiatry* 18 (June 1960), pp. 712-717; Peter Zeldow and Harvey Taub, "Evaluating Psychiatric Discharge and Aftercare in a VA Medical Center," *Hospital and Community Psychiatry* 32 (January 1981), pp. 57-58; Sondra Stickney, Richard Hall and Gail Gardner, "The Effect of Referral Procedures on Aftercare Compliance," *Hospital and Community Psychiatry* 31 (August 1980), pp. 567-569; George Wolkon, Carolyn Peterson and Alexander Rogawski, "A Program for Continuing Care: Implementation and Outcome," *Hospital and Community Psychiatry* 29 (April 1978), pp. 254-256; Carolyn Peterson, George Wolkon and Bonnita Wirth, "A Comparative Study of Referral Success in First Appointments Made by Patients and by Staff," *Hospital and Community Psychiatry* 32 (November 1981), pp. 800-801; Richard Tessler and John Mason, "Continuity of Care in the Delivery of Mental Health Services," *American Journal of Psychiatry* 136 (October 1979), pp. 1297-1301.

charge planning. As yet, we do not know what constitutes a "good" discharge plan, for what type of patient, and there are no measures of quality. Little is known about which psychiatric patients pose a high risk for aftercare planning difficulties, although unquantified experience suggests that a number of factors appear repeatedly. Thus the area is currently represented by a small, fairly rudimentary literature which does not do justice to what is understood by social work practitioners.

While some useful knowledge has been accrued about what constitutes a facilitative discharge planning process, it has not been integrated, applied systematically or tested with outcome measures. At present then, psychiatric social work discharge efforts do not follow consistent standards, cannot be quantified and lack a unifying theory and set of principles to guide practice. This state of affairs hinders both the development of discharge planning research and teaching programs which could test and transmit knowledge to practitioners.

Chapter 3

Theoretical Framework for the High Risk Program

3.1 Individual and Family Casework Versus Environmental Interventions

For decades, the field of social work has wrestled with the dilemma of integrating knowledge about individuals, families, groups and associated interventions, with information about the social environment and strategies for producing social change. The discharge planning program for high risk psychiatric patients raises these same issues — how to avoid the historically based inclination of social work staff to separate clinical practice from the skilled management of situational problems. Staff have traditionally viewed discharge planning as "the provision of concrete services," and have divorced it conceptually from what they considered more sophisticated "clinical treatment" functions. This perception is a disservice to the profession if our unifying mission is to help people, by whatever method assessment suggests would be most effective. Harold Weissman summarizes the issue well, "Such a mission [helping people] allows no room for swearing allegiance to a particular helping method or theory until it can be scientifically proven to be better than any other, in any situation. It might be said that clinical social work has neither eternal clients nor techniques, only an eternal interest, helping people."[1]

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[1]Harold Weissman, "Knowledge Base of Clinical Social Work," in *Handbook of Clinical Social Work,* eds. Aaron Rosenblatt and Diana Waldfogel (San Francisco:

In discussing social work's effort to define its distinctive content, Eda G. Goldstein states, "the historical tendency to separate knowledge of individuals and strategies of people-helping from knowledge of the social environment and approaches to society-changing has fragmented rather than unified theories of social work."[2] She further states that social work's tendency to polarize people-helping and society-changing has served to prevent consolidation of a distinct scientific base for the profession.

3.2 Ego Psychology

From the inception of social work in the United States at the turn of the century, two major schools of thought were evident — one which concentrated upon the individual as the primary focus of interventive strategies, and one which embraced social conditions as its primary concern. This schism between understanding the individual and understanding his social situation was bridged to some extent in the 1930's and 1940's by the development of ego psychology which moved social work away from its reliance upon the study of internal processes. Ego psychology "provided a theoretical rationale for delineating the client's functioning in the here and now, assessing the nature of the client's adaptive as well as maladaptive ego functioning, identifying the situational factors that might be part of the problem but could become part of the solution, creating more selective developmental his-

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Jossey-Bass, 1983), p. 1.

[2]Eda G. Goldstein, "Issues in Developing Systematic Research and Theory," in *Handbook of Clinical Social Work,* eds. Aaron Rosenblatt and Diana Waldfogel (San Francisco: Jossey-Bass, 1983), p. 5.

tories of past events as they pertained to current functioning, and determining the internal and external resources that might be mobilized on behalf of the client to produce the desired changes."[3]

Concepts from ego psychology which have been drawn upon in the formulation of the high risk program include: adaptation, mastery, coping strategies, cognitive processes, biopsychosocial factors, person-environment transactions, and the impact of life stresses and social change. The aftercare environment (and that of the psychiatric institution) are seen as important factors contributing to both sustaining and enhancing ego functions. The program takes into account not only the patient's typical coping style, areas of both conflict free and deficient functioning, but also ways in which the external environment may be impeding healthy adaptation, mastery, and change.

Ego psychological concepts provide "the rationale for interventive approaches that [are] directed at improving or sustaining adaptive ego functioning by means of work with both the individual and the environment."[4] Interventions derived from ego psychology focus upon: 1) freeing and enhancing innate ego capacities; 2) providing experiences in the worker/client relationship and in real life which can correct for past failures and can reinforce new behavior; and 3) creating or making available environmental supports which permit more effective use of adaptive ego functions. All of these concepts are incorporated into the operation of the high

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[3]Ibid., pp. 12-13.

[4]Eda G. Goldstein, *Ego Psychology and Social Work Practice* (New York: Free Press, 1984), p. 30.

risk discharge planning program which seeks to develop, enhance and support autonomous ego functions.

3.3 The Ecological Model

A further promising approach which endeavors to unify individual psychodynamics with social treatment has been the ecological or life model. Carel Germain notes, "In an ecological view, practice is directed toward improving the transactions between people and environments in order to enhance adaptive capacities and improve environments for all who function within them." There is a dual concern for "the adaptive potential of people and the 'nutritive' qualities of their environments."[5]

Ecologically oriented interventions attempt to release, develop and strengthen the individual's innate capacity for growth and adaptation while enhancing supportive elements in the milieu.[6] Professional actions may be directed toward the individual, the environment, or the interaction of the two. Germain states that person-oriented actions might include procedures to increase self-esteem or coping skills, to provide information, reduce psychic discomfort, etc. Those directed towards the environment can be restructuring situations for better fit, or providing opportunities for mastery, decision-making, or action.[7] These notions have been particularly helpful in informing those aspects of the discharge planning program

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[5]Carel B. Germain, *Social Work Practice: People and Environments* (New York: Columbia University Press, 1979), p. 8.

[6]Ibid., p. 17.

[7]Ibid., p. 18.

which attempt to strengthen ego functions and to improve the match between person and situation.

Ideas from the ecological model have been useful in the area of problem definition. In the medical-disease paradigm, problems are defined as being within the person and attention to the environment is therefore narrow and concrete. A social systems perspective directs analysis toward maladaptive aspects of the client's situation. However, if an ecological perspective is used, not only are the person and his environment assessed and acted upon, but also the interface or transaction between the two. Thus difficulties may also be located within reciprocal interactions between the person and his situation so that interventions which affect both simultaneously are required. This premise undergirds the high risk discharge planning program in which attention is paid to all three areas — the patient, his environment, and the unique interplay between the two. However, concepts within the ecological model are abstract and incompletely articulated. Goldstein states, "social workers have not yet made concepts relating to interface phenomena come alive in ways that do justice to the complexity of an individual's transactions with the environment."[8]

The key problem is how to conduct evaluative studies which simultaneoutly concern both descriptive personality and social theories and theories about how interventions lead to change in both the person and his situation since different research strategies are required for each.

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[8]Eda G. Goldstein, "The Knowledge Base of Clinical Social Work," *Social Work* 25 (1980), p. 174.

3.4 Crisis Intervention

Crisis intervention theory has been drawn upon because it offers valuable insights about the nature of disruptive events, individual reactions, and preventive measures to avert long-term negative effects.

A crisis is defined as "an imbalance between the perceived difficulty and significance of a threatening situation and the coping resources available to an individual."[9] The significant elements distinguishing à crisis are the notions of degree of perceived threat, difficulty, and event significance versus the individual's adaptive capacity. For example, the point of discharge from a psychiatric institution can be more traumatic than the admission itself because the patient is asked to sever ties to a caring familiar staff, to resume relations with a changed social network, and to adjust to a different daily structure at a point when his capacity to integrate new demands is likely quite fragile. While the transition from the hospital is not a highly critical event for all patients, it tends to be so for the high-risk patient who has often had multiple admissions and multiple aftercare failures. Crisis theory is valuable in understanding the stages of crisis, the range of individual responses, and methods for management or prevention. The stages of crisis include intense feelings of anxiety, followed by use of habitual coping strategies. If these strategies are insufficient to restore equilibrium, tension increases and the individual may become disorganized or chaotic in his attempts to cope. In the following stage,

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[9]Lawrence H. Cohen and Dean W. Nelson, "Crisis Intervention: An Overview of Theory and Technique," in *Crisis Intervention,* (2nd ed.), eds. Lawrence Cohen, William Claiborn, and Gerald Specter (New York: Human Sciences Press, 1983), p. 14.

emergency or novel problem-solving may occur, but if these fail, the person may become overwhelmed and paralyzed.

Caplan (who first enunciated principles of crisis analysis and management) emphasizes that critical situations may produce either growth and mastery or impairment and regression.[10] He notes that in psychiatric patients, significant negative changes in personality development can occur during a short period of crisis in which a novel situation is not managed effectively with existing coping and defense mechanisms.[11] Because the brief period of crisis may rapidly accelerate negative processes, it is vital that interventions occur which can increase the possibility of a healthy outcome.

Assessment of persons in crisis involves understanding the hazardous event (and why it is thus defined by the individual experiencing it), the client's coping repertoire and previous attempts at mastery, his environmental supports and the stage of crisis he is currently experiencing.[12] The worker should seek to evaluate the client's intellectual functioning, interpersonal assets, emotional resources, level of hope, motivation to help himself, and extent to which he might have contributed to the situation becoming more threatening.[13] Cohen and Nelson suggest that interventions be very focused, present-oriented, and that discussion center upon

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[10]Gerald Caplan, *Principles of Preventive Psychiatry* (New York: Basic Books, 1964), p. 36.

[11]Ibid., p. 35.

[12]Cohen and Nelson, "Crisis Intervention: An Overview of Theory and Technique," p. 16.

[13]Ibid., p. 16.

threatening event and the client's attempts (past and present) to cope with it. It is essential that the therapist play a very active role, communicate a sense of caring, optimism and help, and offer empathetic understanding. The work must have a collegial nature, with both therapist and client generating effective responses. Additional aspects of crisis intervention include sessions with the family, advocacy with community resources, and follow-up evaluation.

Crisis theory also suggests that the urgent situation always has novel aspects which can permit growth, and that major future problems may be prevented if the crisis is handled constructively. Successful crisis management combines three types of interventions by the therapist: cognitive strategies such as providing information; affective strategies such as offering emotional support; and instrumental strategies such as teaching new skills.[14] While crisis theory is usually applied to normal individuals experiencing an unexpected traumatic event, many of its key propositions are applicable to psychiatric discharges. High risk psychiatric patients tend to experience frequent crises, expecially at points of transition, and may not have had focused help with how they might respond in ways that limit damage and lead to possible resolution rather than continuation of the crisis state. The program therefore provides cognitive approaches (an analysis of past plans and outcome, the discharge planning hypothesis and assessment), affective processes (exploration and working through of subjective responses), and instrumental techniques (preparation of the patient for the demands and expectations of the next

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[14]Rita Cohen, "Crisis Intervention for Medical Problems," in *Crisis Intervention* (2nd ed.), eds. Lawrence Cohen, William Claiborn and Gerald Specter (New York: Human Sciences Press, 1983), pp. 131-133.

environment).

3.5 A Cognitive-Behavioral Perspective

A related area of theory is the cognitive-behavioral approach to problemmatic social experiences which specifies learnable components of the coping process.[15] Several of these ideas have been useful in the formulation of the high risk program. For example, this perspective suggests that patients be helped to develop awareness of early warning cues (both internal and external) of developing problem events. Expectations for influencing a better outcome must be positive, and patients must be helped to define the problem clearly, delineating all personal and external influences. Creative thinking is used to generate a range of solutions which are analyzed in terms of costs and benefits. The patient is helped to learn to take credit for progress, to anticipate and prepare for difficult situations, and to maintain change. Part of the strategy includes having patients try out new behaviors through modeling, role-playing, and rehearsing. Many psychiatric patients have difficulty conceptualizing change because they do not define issues clearly, or allow themselves to explore options fully. Therefore trying out the anticipated situation in advance of discharge can be very beneficial.

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[15]Sharon Berlin, "Cognitive-Behavioral Approaches," in *Handbook of Clinical Social Work,* eds. Aaron Rosenblatt and Diana Waldfogel (San Francisco: Jossey-Bass, 1983), p. 1099.

3.6 Decision-Making Theory

Coulton points out that negative consequences ensue when individuals and families do not participate in decisions about their own health care.[16] Because the emotionally ill may be considered "mentally impaired," professionals are apt to overlook the importance of full collaborative involvement, and plan "for" rather than "with" the patient.

Vigilant decision-making is believed to be related to health because of the greater degree of control and predictability experienced by persons who take an active role in aftercare planning. Patients can become "emotionally innoculated" to future setbacks and doubts if they are permitted to appraise alternatives and their consequences in advance, and have opportunities to deal with any associated fear, depression, anxiety or regret.[17]

Coulton suggests that patients be given information about resources, perceive that they have some options, have adequate time, are helped to be hopeful about outcomes and to have some influence upon their significant others, share common family goals for aftercare, and receive social support.[18] In addition to substantive information about sources of care, the social worker may need to help the patient and his family clarify values and feelings regarding illness, responsibility, dependence, etc.

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[16]Claudia Coulton, et al., "Discharge Planning and Decision Making," Health and Social Work 7 (July 1982), pp. 253-254.

[17]Ibid., p. 154.

[18]Ibid., p. 259.

A healthy decision-making process is posited to reduce subsequent regret, anger, guilt and helplessness which can negatively affect both the patient's health and the success of the aftercare plan.

3.7 Systems Theory

A systems approach to treatment first emerged in the 1960's in the field of biology. A system has been defined as a set of elements standing in interaction.[19] Any system is composed of elements that are organized by the consistent nature of the relationship between the elements; there are subsystems to carry out particular processes, patterns, boundaries and hierarchies. Systems vary in their degree of openness or closedness, and a combination of homeostatic and adaptive mechanisms operate at the same time.[20]

Nichols and Everett suggest three perspectives which must be kept in mind simultaneously in dealing with any system: the historical — viewing the system's functioning and difficulties in relation to what has happened in the past to parts and to the whole; the interactional — perceiving recurrent interactions and structures that exist within the system; and existential — apprehending the emotional life of the system and its members as well as the therapist's own emotional experience and reactions when working with the system. The therapist must be both adequately responsive and sufficiently differentiated from the system to be

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[19]William Nichols and Craig Everett, *Systemic Family Therapy: An Integrative Approach* (New York: Guilford Press, 1986), p. 69.

[20]Ibid., pp. 68-75.

empathetic, while meeting therapeutic needs.[21]

Systems theory is applicable to (and helpful in understanding) not only the patient and his family, but also the psychiatric hospital in which the program is embedded, and the community agencies and supports with which the patient interacts.

3.8 Network Theory

Theories which address the interface between the patient/family and the environment have been difficult to locate because it is an area which has not been clearly conceptualized. The field of family network therapy appears to have gone farthest in the development of concepts related to interacting systems. Family therapy theorists define a network as a set of social relationships for which there is no common boundary. Each person is in touch with a number of people, some of whom are directly in contact with each other and some who are not.[22] The size and quality of social networks has been found to be significantly different in the severely mentally ill. Whereas normal persons have from 20-30 persons in their social networks, psychotic persons have only 4-5, and these are usually family members or individuals who are in instrumental (non-reciprocal) positions.[23]

While we cannot know for certain whether influencing these variables will im-

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[21]Ibid., pp. 82-85.

[22]Fritz Simon, Helm Stierlin and Lyman Wynne, *The Language of Family Therapy: A Systemic Vocabulary and Sourcebook* (New York: Family Process Press, 1985), pp. 244-245.

[23]E. Mansell Pattison, et al., "A Psychosocial Kinship Model for Family Therapy," *American Journal of Psychotherapy* 132 (December 1975), p. 1249.

prove the chronic patient's functioning, the literature suggests a number of strategies such as enlarging the network to include new clusters of non-kin; counseling families to reduce critical or negative interaction with the patient; establishing long-term relationships with providers and other contacts; and developing meaningful functions for patients to perform for others within their networks.[24]

Network therapy is a form of therapeutic intervention used with larger social systems such as those involved in aftercare planning.[25] Relatives, friends, neighbors, involved professionals and any persons relevant to the family are involved in a therapeutic process. Through this means, the context or ecosystem of the family is made visible. Goals of intervention include questioning of rigid patterns and behavioral sequences, establishing new bonds and changing the structures of perception and consciousness as well as the organization of the entire social network.

Equilibrium of interacting systems is a further concept useful in the discharge planning process. It is defined as the maintenance of a stable condition within a system; the system must compensate for changes generated from within or by outside disturbances.[26] Feedback is one method for achieving system adjustment by inserting the results of past performance. Any system (like a family or community agency) must have multiple, linked and overlapping feedback structures to

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[24]David Cutler and Ellie Tatum, "Networks and the Chronic Patient," in *Effective Aftercare for the 1980's,* ed. David Cutler (San Francisco: Jossey-Bass, 1983), p. 18.

[25]Simon, Stierlin, and Wynne, *The Language of Family Therapy: A Systemic Vocabulary and Sourcebook,* pp. 241-245.

[26]Ibid., pp. 116-117.

maintain equilibrium. It is hypothesized that the ability of the system to balance change and stability determines the maturity and life conditions of its members.[27] The High Risk Discharge Planning Program incorporates these ideas through interventions designed to identify, enlarge, and link patient/family networks.

3.9 Summary

The discharge planning program for high risk psychiatric patients draws upon a number of theoretical sources. A major focus has been to locate those theories which are relevant to the three primary areas of concern: for the patient — theories concerning transitions, decision-making, and crisis; for the environment — concepts regarding networks; and for the interface of the two — methods of analyzing interacting systems. The program evolved out of an externally imposed reality — the need for patients to move from the inpatient care system to the community at a pace that is usually not of their own choosing. It therefore has greatest affinity with those theories which address coping and mastery of stressful events. Because the program draws broadly upon the current knowledge base of social work practice, it can be seen as a series of clinical interventions (with the patient/family and the environment — and with the interaction between the two) which require the same degree of skill as those strategies directed solely towards psychodynamic or interpersonal issues.

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[27]Ibid., pp. 155-159.

Chapter 4

Policy Issues Associated with the High Risk Program

The comprehensive discharge planning program for high risk psychiatric inpatients is embedded in national and New York State policies related to conditions for the release of mentally ill persons from inpatient psychiatric units. The major regulations governing practice in this area will be analyzed using David Gil's schema.[1] This framework has been selected because it takes an institutional rather than residual view of social policy — i.e. it assumes that social welfare services have comprehensive long-term societal aims. Gil states that social policies "shape the overall quality of life in a society, the living conditions of its members, and their human relations to one another and to society as a whole."[2] This broad viewpoint is conducive to considering social policy as a powerful tool for dealing with problems which are both evolving and enduring.

4.1 Regulations Governing Psychiatric Discharge Planning

Summarized below are the major requirements for discharge planning in psychiatry in New York State:

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[1]David Gil, *Unraveling Social Policy*, (Cambridge, England: Schenkman Publishing Company, 1981.)

[2]Ibid., p. 13.

- There shall be a discharge planning coordinator who has been delegated the responsibility for the execution of the organized discharge planning program.[3]

- Written screening criteria for high risk must be used with all admissions.[4]

- An anticipated discharge plan must be begun by the third day of hospitalization and recorded in the chart by the fifth day after admission.[5]

- Each patient shall be interviewed, provided an opportunity to actively participate in the development of an aftercare plan, and advised of whatever services might be available to him.[6]

- Each patient potentially in need of post-hospital care must be assessed by those health professionals whose services are appropriate to the needs of the patient to determine his post-hospital care needs.[7]

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[3]New York State *Public Health Law,* Chapter V, Title 10, Section 405.9, (f)(2), "Admission/Discharge" Amend. 6/9/88.

[4]Ibid., (f)(2)(ii); New York State Department of Health, *Hospital Memorandum Series 86-64, Hospital Discharge Planning,* (Albany, N. Y.: New York State Department of Health, 7/3/86), p. 2.

[5]New York State Department of Health, *Hospital Memorandum Series 77-86, Criteria and Standards for Admission of Persons Over the Age of 16 Years to Psychiatric Units of General Hospitals,* (Albany, N. Y.: New York State Department of Health, 9/30/77), p. 2.

[6]McKinney's Consolidated Laws of New York (Annotated), Book 34A, *Mental Hygiene Law, Article 29.15, Discharge and Conditional Release of Patients to the Community,* (St. Paul, Minn.: West Publishing Co., 1988), p. 292.

[7]New York State *Public Health Law,* "Admission/Discharge," Amend. 6/9/88, (f)(3)(v).

- An individualized, comprehensive discharge plan, consistent with medical discharge orders and identified patient needs is to be developed by the patient, his family/representative, and the health professionals whose services are medically necessary.[8]

- A written service plan shall be prepared which includes: 1) a statement of the patient's need (if any) for supervision, medication, aftercare services and assistance finding employment; 2) specific recommendation of the type of residence in which the patient is to live, and services available to the patient in the residence.[9]

- The patient, family, or representative shall participate in decisions regarding selection of post-hospital care. Planning cannot be limited to placement in residential health care facilities, but must also include consideration of non-inpatient services such as day, respite and home care.[10]

- Discharge planners are required to give the patient and family or representative, orally and in writing, information concerning the range of services in the patient's community which have the capability of assisting the patient and patient's family or representative in implementing the patient's discharge

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[8]New York State *Public Health Law*, "Admission/Discharge," Amend. 6/9/88, (f)(3)(vi).

[9]McKinney's Consolidated Laws of New York, Book 34A, p. 292.

[10]New York State *Public Health Law*, "Admission/Discharge," Amend. 6/9/88, (f)(3)(viii).

plan.[11]

- There must be documented reasonable attempts to contact the patient's family or representative to participate in discharge planning (telephone, mail, telegram).[12]

- The plan for discharge shall be updated weekly, including the history of the patient's response, modifications to treatment and expected duration of continuing hospital care.[13]

- The discharge plan should insure that there is adequate continuity and exchange of information with the receiving facility, clinic, or office and access to the hospital treating staff during the interim before treatment is assumed by the succeeding provider.[14]

- Post-discharge, the discharge planner shall verify that the patient is receiving the services in the written plan and shall recommend and take steps to assure the provision of any additional required services.[15]

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[11]New York State Department of Health *Hospital Memorandum Series 86-64, Hospital Discharge Planning,* Albany, N. Y: N. Y. State Department of Health, 7/3/86), p. 2.

[12]New York State *Public Health Law*, "Admission/Discharge," Amend. 6/9/88, (f)(6)(ii).

[13]New York State Department of Health, *Hospital Memorandum Series 77-86, Criteria and Standards for Admission of Persons Over the Age of 16 Years to Psychiatric Units of General Hospitals, p. 2.*

[14]Ibid., p. 3.

[15]McKinney's Consolidated Laws of New York, Book 34A, p. 293.

(The summary of pertinent regulations above does not include those pertaining to alternate level of care days which are to be used for Medicaid patients whose discharge is delayed because of factors beyond the control of the hospital.)

4.2 Analysis of Mental Health Discharge Planning Policy Using Gil's Framework

4.2.1 The Domain of Concern

The issues addressed by discharge planning regulations in New York are summarized by the New York State Commission on Quality of Care for the Mentally Disabled:

> "Responding to widespread complaints about overcrowding in these [psychiatric] facilities, as well as allegations of their overly restrictive admission practices, this request [for the Commission to examine discharge practices] also reflected public concern that persons discharged from inpatient psychiatric facilities were not afforded adequate services or assistance to facilitate their transition to community living. In particular, many families of persons with mental illness and many former inpatients had complained publicly and to their legislators that the basic aftercare services often were not arranged for patients upon discharge, and that critical follow-up assistance was not available when the patient encountered problems in the community".[16]

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[16]N. Y. State Commission on Quality of Care for the Mentally Disabled, *Discharge Practices of Inpatient Psychiatric Facilities,* (Albany, N. Y.: New York State Commission on Quality of Care for the Mentally Disabled, August, 1988), p.i.

Although the above was written in 1987, it reflects the sentiments of legislators and consumer groups in 1976 who were instrumental in drafting the original New York State Mental Hygiene Laws (29.15) which were intended to ensure that psychiatric patients were discharged with a written service plan, that they could participate in the development of the plan, and that the hospital would conduct followup to ensure that services were received. In effect, these policies expanded patient rights beyond treatment within the hospital and mandated that hospitals were responsible for arranging aftercare. One of the hypotheses underlying the legislation was that patients were not receiving follow-up care because hospitals simply ended their responsibility as individuals left their premises. What was neglected by the law was specification of the reciprocal responsibility of community agencies to accept discharged psychiatric patients in timely fashion, to offer relevant, meaningful services, and to pursue those who did not keep initial visits.

As Gil implies, social policies are not merely potential solutions to social problems, but also contribute to the underlying causes of the next, emerging generation of social problems.[17] Regulations pertaining to discharge planning were not attached to any additional funding, so that the services mandated had to be provided within existing resources. These initial attempts to exert control over discharge planning did not take into account interconnected systems and dealt myopically with the identified culprit — large hospitals, particularly those operated by the state. Hospitals of course had no control over (or even preferred access to) community services. Referrals made did not equal referrals accepted; and aftercare

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[17]Gil, *Unraveling Social Policy*, p. 18.

needs identified did not translate into services actually existing.

A recent re-evaluation of the problem, its causes and solutions is again well-stated by the Commission on Quality of Care for the Mentally Disabled,

> "the study showed that outpatient services to address the needs of the individuals studied were usually not offered and that, in many cases, needed services were not available. Relatedly, the review found significant patient resistance and dissatisfaction with available services. Many patients, as well as their families, viewed existing services as not addressing their most critical needs, especially in vocational and educational areas ... As a result of these problems, many of the individuals studied had very troubled and sometimes tragic life experiences in the six months following their discharge."[18]

While existing discharge planning regulations propose that aftercare mental health resources be distributed more equitably to released inpatients, no funding or other incentives are attached. This was doubtless because the problem was defined as hospitals' failure to take post-discharge responsibility rather than as a larger issue including lack of community resources, services which did not fit the population, and unwilling providers.

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[18]New York State Commission on Quality of Care for the Mentally Disabled, *Discharge Practices of Inpatient Psychiatric Facilities*, p. i.

4.2.2 Policy Objectives

Policy objectives of the discharge planning regulations were to set standards for the functioning of all psychiatric hospitals, thereby reducing regional differences in level and quality of service, and assuring that the mentally ill were not deprived of their right to continuing care. A further agenda was the reduction of the expensive "revolving door" syndrome in which discharged patients rapidly cycled back to the institution because of failure at community tenure. The earliest discharge planning regulations were an attempt to correct the excesses of deinstitutionalization in which state hospital staff were under considerable pressure to reduce inpatient beds and state expenses, and released patients with little or no provision for their ongoing needs.

Underlying the discharge planning regulations remains the assumption that the mentally ill population (seen as a homogeneous group) can be best served within the community from whence they came. The notion that patients have the right to be treated in the least restrictive environment commensurate with their condition is upheld by the regulations which suggest that hospitals must aid the mentally ill to participate as fully as possible in normal community life. However, no differentiation is made amongst those who are acutely ill for a brief period and reconstitute to a high level of functioning versus those who are severely and permanently impaired by their illness.

The regulations expand the prerogatives established under the Mental Health Systems Act which included the right to participate in treatment planning, explanation of the objectives of treatment, freedom from restraint or seclusion, confi-

dentiality of records, the right to refuse treatment, etc.[19], by addressing the right to participate in and receive an appropriate aftercare plan.

The discharge planning regulations cited previously contain a number of explicit and implicit values about the mentally ill, their care, and the role of state government in assuring this. However, their emphasis was upon solutions which addressed hospitals as the sole causative agents and upon short-term goals rather than long-range planning.

4.2.3 Implications of Policy for Key Processes of Society

Gil identifies three basic mechanisms which may be modified by a given policy: 1) resource development - the type, quality and quantity of all material and symbolic goods and services generated; 2) the allocation of individuals and groups to specific statuses within the total array of societal tasks and functions; and 3) the distribution to individuals and groups of specific rights to material and symbolic, life-sustaining and life-enhancing resources, goods and services.[20] Gil also points out that social policies which involve no modification of these key mechanisms cannot be expected to bring about significant changes in the quality and circumstances of living and in the nature of human relations in society.

1. Resource Development

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[19]Martha Gottron ed., *A Review of Government and Politics,* vol 5: *Congress and the Nation* (Washington DC: Congressional Quarterly, Inc., 1980), p. 648.

[20]Gil, *Unraveling Social Policy,* pp. 33–35.

Discharge planning regulations are accompanied by no funding and therefore require that hospitals offer an additional service (which does not further inpatient goals) without adding staff or increasing cost. Thus they provided little incentive for engaging in the extensive efforts required to ensure community tenure by the SPMI population. New York State's Office of Mental Health states that it now plans to add approximately 9500 certified residence placements to the State's roster by 1996,[21] and to divert monies from state outpatient programs for an intensive case management system.[22] However, no increase in community services initially accompanied discharge planning regulations, many of which have been extant for 20 years.

The regulations did ensure that at minimum, a written service plan was placed in the chart for each patient. They did not certify that the services existed, were appropriate, could be accessed by the patient, or were even listed in writing for the patient. Funds were minimally reallocated internally within each hospital so that somewhat more staff time was spent in discharge planning rather than in other inpatient services.

2. Status Allocation

The discharge planning laws gave psychiatric patients protected statuses at the point of transition from the institution to the community — they were

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[21]New York State Commission on Quality of Care for the Mentally Disabled, *Discharge Practices of Inpatient Psychiatric Facilities,* Appendix p. 2.

[22]New York State Office of Mental Health, *Statewide Comprehensive Plan for Mental Health Services 1989 - 1991,* p. 7.

no longer to be in a gray area which was no one's responsibility, but were now clearly under the purview of the hospital until they were connected to outside services. Yet the Office of Mental Health itself states, "The lack of discharge and placement options is primarily due to inadequate and poorly distributed outpatient and aftercare services, along with inadequate housing and limited options."[23]

3. Rights Distribution

In terms of distributing rights to resources, the regulations have done nothing to ensure preferential access of the formerly hospitalized to community services and facilities. Funding to most community mental health services does not distinguish between persons who are severely and persistently mentally ill versus those who suffer from problems in daily living — the same rate is paid regardless.

Thus we can conclude that since there was no substantive reallocation of resources, the legislation regarding discharge planning produced no great change in the situation of the released mentally ill.

4.2.4 The Effects of the Policy upon Society

New York State discharge planning policies do reflect a shift from relying upon idiosyncratic practices within psychiatric institutions to governmental standard setting and oversight of this function. The priority given to the institutionalized

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[23]Ibid., p. 2.

mentally ill reflects their increased visibility in society since deinstitutionalization and the influence of various interest groups (such as the Alliance for the Mentally Ill). The laws underscore an attempt to enhance the status of the mentally ill by according them increased power and voice in decision-making regarding their aftercare.

Further, the regulations change the relationship of the state government to psychiatric hospitals — whereas previously the Office of Mental Health had been concerned with admission and treatment practices, it now focused upon the transition from institution to the community.

While the regulations were a step forward, they did nothing to decrease community resistance to the mentally disabled; they did not increase resources, ensure public safety, give asylum to the socially disruptive, support those who could not function independently, or give care and respite to burdened families.

4.2.5 Alternative Policies to Achieve Similar Objectives

The Intensive Case Management System of New York State (ICM) is an outstanding example of a program which serves the most severely mentally ill, provides long-term follow across settings and levels, and has fewer barriers than most programs to clients receiving services which are relevant and timely.[24] However, the program is limited in the numbers it can serve, and can only provide continuity in follow-up if the former patient remains in one catchment area. None-the-less, the ICM serves as a model which has fewer than usual bureaucratic and regulatory

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[24]Ibid., p. 41-42.

constraints, and which genuinely delivers needed service to those most in need.

One of the major issues which was not addressed in discharge planning regulations is the inherent discontinuity among systems designed to treat different levels or stages of illness rather than the person who is ill. Despite what is known about continuity or caregivers, discharge planning will always be a high risk area for the patient if it means severing bonds to people he has come to trust.

Ideally, patients would be able to remain with one system, and even with one mental health team which would provide long-term follow regardless of whether the patient required inpatient, halfway house, supportive apartment, or independent living. If this were the case, discharge planning would become a misnomer and would have to be re–named "planning for continuity of care." For those functioning at a fairly high level, severing the ties to a hospital can be appropriate and an affirmation of health. However for persons who have had no stability, the disruptions inherent in our system lead to a nomadic and rootless existence. Those who need the availability of hospital level care in an ongoing way should be permitted to have services closely affiliated with an institution so that transitions are made within a familiar and trusted environment.

In a context in which the needs of the high risk population (generally the severely and persistently mentally ill) are differentiated from those for whom it is a recoverable episode, discharge planning regulations could make sense and could ensure that careful linkages are provided. Without individualizing the needs of the varying groups of mentally ill, and operationalizing them through focused services, the regulations have little real meaning and offer little real help.

Chapter 5

The Relation of the Program to Social Work's Intellectual Tools

Social work's mission is to enable individuals and groups to acquire more of the civilizing aspects of life — that is to have universal human needs met more fully (i.e. security, justice, health, knowledge, self-realization, and aesthetic satisfaction).[1] The proposed discharge planning program for high risk patients conforms to this definition in addressing issues related to self-realization, mental health and knowledge. Since every social system produces those who are disadvantaged, who are outside the defined jurisdiction of major institutions, social work has taken on such persons as a major interest. In the case of discharge planning, while hospital staff are allocated for all aspects of the inpatient treatment of the mentally ill, virtually no formal structure exists for aiding inpatients to contend with the crisis of transition after hospital ties are severed. A program to ensure that this passage between hospital and community domains is negotiated more successfully by those at highest risk for experiencing discontinuity and relapse would therefore be in the larger tradition of social work's primary concern.

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[1]Interview with Harold Lewis, Hunter College School of Social Work, New York, New York, 20 September 1982.

5.1 Knowledge

Unfortunately, there is no consensus about the criteria to use in selecting what knowledge may be relevant to the proposed program, or how best to formulate what is known for use by the social worker in discharge planning functions.[2] Since the knowledge pertinent to any of the tasks of social workers (including those required by this program) is extraordinarily broad, "one concludes that this profession embraces the entire human condition."[3] The approach used here was to start with the problem, what needed to be changed, as the initial stimulus in the quest for relevant theories and information.[4] While knowledge and theories have been drawn from a variety of sources to inform the high risk program, it is extremely difficult to translate from this level of information into "how to do." Theories specifically related to the high risk discharge planning are summarized in Chapter 3.

Because ours is an action-oriented profession, replete with uncertain situations which require judgment, rules and principles can provide the necessary guidance for the worker in how to proceed. Since they are derived in a hierarchical manner from theories and knowledge, one can say that the core body of knowledge that will prepare the worker for professional discharge planning practice is the sum of the associated rules and principles. Rules and principles, therefore, provide the intermediary which connects and permits translation of knowledge into practice.

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[2]Lewis, *The Intellectual Base of Social Work Practice,* p. 106.

[3]Ibid., p. 114.

[4]Ibid., p. 116

The principles and rules that define the practice of discharge planning will be enumerated in Section 5.4 of this chapter, and the relevant bodies of knowledge that inform them will be indicated in Section 5.3 below.

5.2 Values

Values are enduring beliefs about what is to be preferred in behavior. In contrast to knowledge, values enable judgments and choices to be made on the basis of what is viewed as worthwhile. Like knowledge, values are at a level of abstraction which does not permit their direct translation into the workings of the proposed program. However, since values are embedded in the commendations incorporated in principles and in the commands codified in rules, the implementation of certain value premises can be assured through careful attention to the formulation of rules. It is vital that principles be derived from clearly stated values, and rules from a consistent set of principles to ensure that workers be able to carry out tasks in a manner which supports their moral justification.

While a number of theories have been drawn upon to inform discharge planning practice, an attempt has been made to delineate consistent and clear values and ethical imperatives which give legitimacy to the program. The underlying values, intended to be carried out through the high risk discharge planning program, are noted below.

Discharge Rights:

1. Freedom of choice for individual and family

2. Complete information and explanation concerning needs and alternatives

3. Receipt of treatment in the least restrictive environment commensurate with personal condition

4. Access to needed services

5. Freedom to pursue chosen goals (which do not violate others' rights)

6. Privacy and confidentiality for patient and family

7. Discharge to an environment in which quality of life is valued and supported

Lewis notes that "Without criteria by which the presence or absence of these values can be recognized in specific instances, however, there is little possibility of establishing their presence in the structure of the products that result from practice decisions."[5] To resolve this dilemma, the program is based upon well-defined principles which can offer the worker guidance in uncertain situations involving values. (See Section 5.4 for discussion of principles and rules.) The results of worker decisions can then be examined to determine whether the purposes of the program have actually been upheld.

5.3 Theories and Propositions

Practice principles combine both propositional statements derived from theory and commendations derived from ethical imperatives and values. Theory therefore provides the "means," the conceptual framework which suggests how goals might be reached, while values direct choices among possible objectives. Theories "permit inferences to be drawn, order revealed, meanings surmised and an explanatory

[5]Ibid., p. 129.

guide for action planned."[6] While the theories informing this program contain biases, they do not impose conditions upon the use to which they are put and do not ensure the attainment of ethical ends. To achieve this goal, they must be translated into principles and rules. The theories selected for reference (see also Chapter 3) are functional — they appear to explain observed phenomena related to discharge planning logically and adequately, and suggest functional alternatives.

5.3.1 Propositions Relevant to the High Risk Program

- If high risk psychiatric patients can be identified at admission, then specialized and focused interventions can be applied differentially.

  Theory informing this proposition is contained in material concerning social work assessment — the primary characteristic of the individualizing process is being able to differentiate people from each other so that interventions are selected appropriately.[7]

- If social work staff are offered senior level consultation, assistance and advocacy with their most perplexing discharge planning problems, they will learn specialized techniques for the high risk psychiatric patient through observation, role-modelling, and discussion. A further anticipated consequence is lessening of burden experienced by staff.

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[6]Ibid., p. 61.

[7]Carol H. Meyer, *Social Work Practice*, 2nd edition (New York: Free Press, 1976), pp. 169-187.

This proposition derives from theories about how social workers learn — as adults who have considerable skill, experience and autonomy.[8]

- If social workers are given specific guidelines for conducting discharge planning with high risk patients (which are based on both theory and practice experience), including a clearly articulated protocol, principles and rules, the quality, feasibility and effectiveness of aftercare plans will be increased.

  This proposition is derived from theories concerning how social workers think and act in professional practice and the intellectual tools which are essential to the helping relationship.[9]

- If all biopsychosocial factors contributing to each high risk admission are identified and integrated into a discharge planning hypothesis, which informs both inpatient treatment and discharge planning, then the likelihood that the patient can adapt to the community environment is increased. Use of the discharge planning hypothesis for guidance should also prevent rapid readmissions.

  This proposition is related to the mandate that calls for social workers to "rigorously analyze and study their own practice activities with research methods," in order for theory to guide practice, and to permit verification

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[8]Suanna J. Wilson, *Field Instruction: Techniques for Supervisors,* (New York: Free Press, 1981), pp. 89-94.

[9]Lewis, *The Intellectual Base of Social Work Practice.*

of change results.[10]

- If prior to discharge, linkages and communication are established among all persons who will be involved in the aftercare plan, roles, tasks, connections, misconceptions, and contingencies can be identified and dealt with before the patient leaves the hospital. This intervention is intended to prevent disintegration of the plan post-discharge.

  The above proposition is related to published social work research which indicates that when a collaborative approach is used, adherence among chronic patients is substantially increased and readmission decreased.[11]

5.4 Practice Principles and Policies

Practice principles, composed of propositions and commendations, are derived from both theories and ethical imperatives. Principles structure programs and justify a practice, while rules (containing directives and commands) structure a practice[12]. Rules are intended to instruct the worker in how to engage in a task and "make no explicit claim to knowledge or belief"[13]. Principles, in contrast, formulate predictive statements having theoretical relevance which can be tested

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[10]Wayne D. Duehn, "The Process of Social Work Practice and Research," in *Social Work Research and Evaluation*, ed. Richard M. Grinnell (Illinois: F. E. Peacock, 1981), p. 12.

[11]Helen Altman, "A Collaborative Approach to Discharge Planning for Chronic Mental Patients," *Hospital and Community Psychiatry* 34 (July 1983), pp. 641-642.

[12]Lewis, *The Intellectual Base of Social Work Practice*, p. 43.

[13]Ibid., p. 49.

and focus awareness upon the practice situation[14]. Unlike rules, principles offer elements to be considered in performing a role and allow the worker choice in their application.

In formulating principles for the high risk discharge planning program, it is important to note that the sum of their propositions should constitute the core of essential knowledge, while the sum of their commendations should embody all necessary values. If these criteria are met, the resulting service will be both effective and principled.

Rules were articulated for the project keeping in mind that they are most helpful when unambiguous, least demanding of worker judgment, and quickly associated with the situation to which they apply[15].

The principle that governed the selection of substantive content for the proposed program can be stated as follows:

Principle 1

Social work discharge planning services shall be provided to all inpatients. Such services are to meet the highest standards of practice in terms of timeliness, comprehensiveness, and feasiblity. The planning process is to incorporate an assessment of the patient's needs, capacities, future living conditions and the interventions required to prepare him for leaving the hospital.

Rules:

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[14]Ibid., p. 56.

[15]Ibid., p. 49

- A discharge assessment, considering all areas of aftercare need, must be completed within the first week post-admission for all patients. This is to be documented in the Discharge Needs Assessment Form (see Appendix E) and in the Multidisciplinary Treatment Plan section of the medical record.
- Weekly progress notes are to reflect ongoing social work efforts to explore and make referral to resources which are appropriate to meet identified aftercare needs.
- Social work staff are to review discharge needs and tentative plans for patients identified as at high risk with the Discharge Planning Coordinator by the end of the first week post-admission.

Principle 2

Discharge planning shall ensure that patients have access to those services which will enable them to regain, maintain and even improve the level of functioning achieved in the hospital.

Rules:

- The discharge needs assessment must include not only the provision of further therapy, but must also address how the entire spectrum of patient and family aftercare needs are to be met, e.g. rehabilitation, social, transportation, etc. (see Appendices E and O).
- The discharge plan must address both immediate needs and those services required to achieve ongoing goals.

Principle 3

To the maximum extent possible, patients and families should be aided to engage in a healthy decision-making process concerning discharge options. Conditions to be provided are: adequate time, alternatives, freedom of choice and social support.

Rules:

- **Patients and their families must be given complete information about all of the relevant resources which have potential for meeting their aftercare needs. This process is to begin at the time of the initial meeting with the social worker.**
- **The social worker will assist patient and family to consider the pros and cons of each option in light of their own values, goals, assets and liabilities. Where differences exist among family, patient and staff, the worker will promote open negotiation and consideration of all relevant factors.**
- **Concrete steps which must be taken in order to implement the discharge plan must be discussed with patient and family, with responsibility for each action clearly delineated.**
- **The worker will aid team members to support the patient in considering aftercare alternatives.**

Principle 4

Patients and families should have an opportunity to become familiar with the

aftercare environment and providers in order to reduce anxiety, to anticipate problems, and to forge linkages.

Rules:

- Those patients who have open hall privileges are to be aided in arranging visits to discharge facilities while still hospitalized. Where appropriate, families are also to be encouraged to make such visits.
- For those patients who are unable to leave the unit before discharge, the social worker is to arrange a meeting of patient, family, the treatment team and as many aftercare staff as possible to discuss the actual operation of the plan (see Appendix N). Where this is not feasible, linkages may be made via telephone calls to all aftercare providers to clarify roles and the operation of the plan. The results are shared with patient and family.
- A contingency plan must be formulated so that patient and family know what to do should problems with arrangements arise post-discharge.
- A written aftercare plan must be given to the patient and his family at least 24 hours before discharge (see Appendix Q).

Principle 5

Follow-up of the discharge plan should be offered to all patients in order to ascertain that arrangements are in place and to provide any further assistance which may be needed in resolving problems.

Rules:

- The social worker will call the patient and/or his family and the responsible mental health professional within two weeks post discharge to determine whether all aspects of the plan are in place. This is to be documented in Part II of the Social Service Closing Summary (see Appendix G).
- If aspects of the plan are not working, the social worker will provide further assistance to patient and family in terms of advocacy, linkage, or referral to additional resources.

Principle 6

Social workers should be given regular feedback about the nature of their discharge planning practice in order to improve awareness and to make possible efforts at improvement.

Rules:

- On an annual basis, social workers will be provided with a report abstracting the aftercare referral information for all discharged patients contained in the Social Work Closing Summary (see Appendix G).
- Complaints or problems regarding discharge planning which are brought to administrators by families, patients, or community representatives will be shared with involved social workers in order to resolve issues and to enhance learning.

Principle 7

Social workers should receive training in the task of discharge planning in order that they be equipped with state of the art tools for undertaking this function.

Rules:

- Orientation sessions to discharge planning, to financial benefits programs and other crucial resources, and to the Resource Library will be offered to all new staff and students during their first months of employment or fieldwork placement.
- Advanced seminars will be offered periodically to update workers on new developments in the field.
- All new staff will be invited to join the Discharge Planning Committee in order to become familiar with resources.
- Bulletins will be sent as needed to all staff concerning new resources or changes in community facilities or benefits.

Principle 8

Patients and families should not be referred to resources which are unscreened and unfamiliar to members of the social service department.

Rules:

- The Associate Director of Social Work will hold meetings with agency representatives and interested staff to resolve issues which have emerged in the reciprocal use of facilities and to establish or refine procedures for making referrals.

- As part of her job description, the Resource Consultant will evaluate new or changing facilities and will report these back to the Discharge Committee and to staff at large.
- Lists of New York State licensed facilities (for residence and treatment) will be available to all social work staff to use in making referrals.

Principle 9

Serious complaints about discharge planning practices at the hospital will be centrally reviewed by the Discharge Planning Coordinator so that repetitive and systemic issues can be identified and resolved. A report will be prepared for the hospital's Quality Assurance Committee bi-yearly.

Rules:

- After discussion with the social work supervisor and coordinator, non-routine or serious discharge planning issues raised by community representatives or by patients/families are to be brought to the attention of the Discharge Planning Coordinator for review.
- The Discharge Planning Coordinator will ensure that follow-up is provided and that institutional action is taken where indicated so that such problems are resolved satisfactorily wherever possible.

Principle 10

As the person who links hospital, patient and community, the discharge planner is in a special position to recognize gaps or impediments in services,

both within the hospital and the community, which may jeopardize aftercare arrangements.

Rules:

- Social workers are to act as advocates for the patient (and family) with both internal and external systems. A primary responsibility is to see that obstructions are not allowed to arise to the patient's further care. To this end, the social worker will channel information from all parties and act to reduce obstacles to the implementation of the most appropriate discharge plan.

- Where problems with services are identified which cannot be resolved at the worker's level, (or that of the supervisor), these should be brought to the attention of the Discharge Planning Coordinator.

5.5 Manual Content for the Program

A manual to be used as a reference guide by all staff and students was prepared by the author and the Resource Consultant during the project's operation. It is intended as a working document subject to frequent revision as change and experience dictates. (For further discussion of the Discharge Planning Manual, see Section 7.5.3.) A table of contents for the Discharge Planning Manual is located in Appendix C.

5.6 Definition of Key Variables

The five propositions described in Section 5.4 contain at least six key variables included in the project design. Both narrative and operational definitions for each of these are offered below.

- High Risk Psychiatric Patients — through two previous studies undertaken by the author in 1983 and 1985, factors which delayed discharge from the inpatient setting were identified and combined into a check-off list to be used at admission and discharge (see Appendix A). A study completed by the author in 1987 revealed that the check list could identify those patients likely to require exceptional social work discharge planing efforts with over 57% accuracy. Social work staff complete a high risk rating at discharge as well so that actual experience can be compared to the initial predicted rating.

- Senior Level Consultation, Assistance and Advocacy in Discharge Planning with High Risk Patients — each social worker assigned to a high risk patient in the prospective study was offered help in conducting a focused assessment described in detail in Chapter 6.

- Specific Guidelines, Protocol, Principles and Rules — Specfic Guidelines refers to identification of the high risk patient at admission, use of the interventions listed in Chapter 6, the formulation of a discharge planning hypothesis, and the use of a collaborative model with the patient's aftercare network.

A set of principles and derived rules to guide social work practice are described in Section 5.4.

- Discharge Planning Hypothesis — Using the grid outlined in Appendix D, social workers were helped to identify those factors which were required, contributed to, or allowed the current admission to take place. This list then served as a guide to suggest what modifications and corrective action needed to be taken to prevent the operation of the same factors post-discharge.

- Collaborative Discharge Planning — Social workers were encouraged to have the patient, his family and aftercare providers in contact with and aware of each other's roles before the date of discharge. All aspects of the plan were to be reviewed with lines of communication clarified in advance of the patient's leaving the hospital.

- Quality of Plans — A discharge plan of high quality was defined as a design for the patient's and family's aftercare needs which is timely, comprehensive, and feasible. For purposes of this study, "timely" was equated with the completion of an assessment of discharge needs within the first week after admission. This task was documented through the Discharge Needs Assessment Form (see Appendix E) and in the multidisciplinary treatment plan section of the medical record. Social worker follow-through in making arrangements required by the plan was recorded in the medical record under the weekly Social Service Progress and Discharge Planning Note. A quality review assessment for discharge planning of all charts in the study was made using

the Quality Assurance Form (see Appendix F). An additional descriptive and anecdotal indicator of social work effort was derived through interviews with the worker assigned to each high risk case regarding the actual course of discharge planning.

5.7 Previous Efforts to Manipulate or Control Key Variables

Several searches of the literature have not located any published research studies of social work discharge planning in psychiatric settings. There are, however, numerous reports of research in related areas which suggest some of the issues regarding key variables which must be taken into account in the design of this program.

5.7.1 Outcome Measures of Discharge Planning

What is to be considered evidence of successful discharge planning is problemmatic since there is no direct measure of the process, and since results are influenced by many intervening and interactive variables. The simplest studies, for example, concern whether discharged patients keep their first aftercare therapy appointment. However, discharge planning consists of many more areas than psychotherapy referrals, and appearance at one appointment may have little relation to long-term follow through. Favorable outcome of the planning process might be considered as any of the following: reduction in unnecessary inpatient days; approval of payment for all inpatient days by third party payors; length of tenure in the community; adherence to part or all of the discharge plan; patient and family satisfaction with

the plan; quality of life for the patient post-hospital; patient course longitudinally compared to other similar individuals.

While the current study does not answer the larger question about what are to be accepted as ultimate outcome measures of discharge planning, its evaluative design allowed for some verification of the degree to which the program was operating as intended. For example, it was possible to determine whether the high risk screening mechanism actually identified those patients who later posed substantial discharge planning problems. It was also feasible to assess how comprehensive, timely and practical plans formulated by staff for this population actually were and to provide this feedback to them. While extensive follow-up of patients is not achievable within the hospital structure, calls during the two week post-discharge period were made to patients and professionals to determine the extent to which plans were actually being followed. A comparative design was used so that customary discharge planning practice could be compared with the new program. This has offered some information about whether the model warrants continued application, at least within the host setting.

5.7.2 Population

Most follow-up studies of psychiatric patients reviewed lacked generalizeability because investigations were conducted with non-random samples of patients with widely differing diagnoses and demographic variables which were not specified. Since hospitalized psychiatric patients are a non-unitary group, interventions which are helpful for some subsets may not be so for others. The current study was

conducted within acute, intermediate, and extended inpatient psychiatric units which treat the gamut of psychiatric diagnoses and age groups. While it was not possible to randomly select cases for assignment to an experimental or control unit, important dimensions of the retrospective and prospective study populations (such as age, sex, number of previous hospitalizations, diagnosis, race, financial base, etc.) were recorded. It was therefore possible to analyze data according to results for persons with particular characteristics and to observe whether the discharge planning interventions described here were differentially effective. Since care was taken to gather demographic data, differences between the comparison groups could be described.

5.7.3 Staff

Social workers who were involved in the study differed in the skill, interest and years' of experience which they brought to the task of discharge planning. While it was not possible to have total equivalence among staff involved in the two comparative studies, the facility's standards for hiring staff and for accepting social work students have remained constant.

Other outcome studies of psychiatric patients have identified participating staff only in terms of their discipline, implying that all practitioners with similar training function in a like manner. While the 1985 and 1987 studies contained the same number of social work students and staff workers, important intangibles such as style, motivation and enthusiasm could not be examined since only the 1987 workers were interviewed by the program coordinator. Because of this, the role that

individual worker attributes play in the success of discharge planning practices can only be surmised from the anecdotal experiences of the Discharge Planning Coordinator.

5.7.4 Instruments

Since no related or similar studies could be found of psychiatric discharge planning with high risk patients, it will not be possible to use instruments tested in other settings. This raises questions about reliability and validity which cannot be laid to rest in one application of the program. All questionnaires and forms used in the study were pre-tested to improve clarity; however extensive testing of instruments was not possible due to time and resource constraints so that results can be considered only formative and subject to further research.

5.8 The Setting for the High Risk Discharge Planning Program

The psychiatric hospital in which the study was conducted must be considered an important variable since it is constantly in flux, thereby introducing unexpected changes into the program. Shifts which occurred (and could not be controlled) were such factors as staff turnover and changes in regulations and in the nature of oversight by reviewing agencies and third party payors. While such disruptions could not be eliminated from the study, the two comparison groups of high risk patients were drawn from the same institution and were separated by a period of one year. This relatively short time frame did protect the study against far-reaching changes (such as replacement of medical leadership, introduction of an

alternate reimbursement methdology, etc.).

New York Hospital – Westchester Division is a 322-bed private, voluntary teaching hospital which is licensed as an acute care unit of a general medical facility. Because the hospital is affiliated with Cornell University, provides residency training, has a strong reputation, and many well-known clinicians, it draws patients from Westchester County, the metropolitan region, and the larger United States. Referrals are often made of patients who have not responded to treatment elsewhere since the hospital has a variety of specialized programs.

Although the hospital is licensed as an acute inpatient unit of a larger medical center, its natural peer group had historically been those those private teaching hospitals which offered longer-term, more intensive treatment to privately insured or private pay patients (such as The Menninger Foundation, Sheppard and Enoch Pratt Hospital, The Institute for Living, etc.) Until 1975, this was the population admitted to NYH-WD; since that time, however, Medicaid and Medicare have been accepted and the proportion of such publically-funded patients has risen to over one-half of all admissions. Thus the hospital is in transition and is experiencing to an increasing extent the issues pertinent to other large metropolitan medical institutions. At this time, the hospital is most similar to such facilities as Hillside Hospital of the Long Island Jewish Medical Center, or St. Vincent's Hospital's psychiatric division. Additional relevant data about the hospital in which the study was conducted is presented in Chapter 7.

Chapter 6

The Program Design

6.1 Description of the Program

In order to study the implementation and effects of the comprehensive discharge planning model for high risk psychiatric inpatients, two non-equivalent comparison groups were used.

In 1985, all consecutive admissions to two intermediate stay inpatient general psychiatric units (3N and 8N) were rated by assigned social work staff using the High Risk Indicator List (see Appendix A).[1] Out of 60 new admissions to these two units, 26 patients were identified as high risk in the initial rating. It required 8 months to accumulate 26 newly admitted high risk patients since these units were primarily filled through in-house transfers. All patients in the 1985 study were discharged by December, 1986.

Beginning in September, 1987, the High Risk Indicator List was put into effect hospital-wide to rate all incoming admissions. Invitations were issued to each social worker assigned a high risk case to participate in the 1987 study from October, 1987 through January, 1988 until a sample of 26 patients was obtained. During the 1987-88 four month study period, there were 447 total admissions, and 138 (or 31%) were rated as high risk. All patients in the 1987 study were discharged by

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[1]The High Risk Indicator List was developed by the author using factors known to delay discharge which had been identified in an earlier study (Winifred Christ, "Factors Delaying Discharge of Psychiatric Patients," pp. 178-187).

September, 1988.

6.2 Interventions with the 1985 High Risk Study Group

The 1985 non-equivalent comparison group consisted of the first 26 patients (from a total of 60 admissions to halls 3 North and 8 North) who were identified through high risk indicator list ratings (see Appendix A) as likely to require exceptional aftercare planning efforts. Each of these study patients was provided with the following discharge planning interventions.

- The social workers assigned to patients in this study group followed usual and customary discharge planning practices which included:

    1. Documentation in the chart of an initial discharge plan by the 7th day post admission (this is a brief, non-uniform narrative note).
    2. Discussion of discharge plans with family and patient as the social worker deemed appropriate.
    3. Use of the Resource Library at the social worker's discretion.
    4. Documentation in the chart of discharge planning efforts in weekly Social Work Progress and Discharge Planning Notes.
    5. Completion of the Social Service Closing Summary documenting the actual discharge plan (see Appendix G).
    6. Follow-up calls to the patient, family or responsible professional at 2 weeks post discharge (documented in Part II of the Social Service Closing Summary).

- Upon the patient's discharge, the social worker completed a second high risk indicator list which rated the actual degree of difficulty experienced with discharge planning.

- The project coordinator conducted retrospective chart reviews, gathering demographic and psychosocial data, and assessing quality and comprehensiveness of discharge planning efforts using the documents in Appendices D, E, F, and L.

6.3 Interventions with the 1987 High Risk Study Group

The second comparison group (drawn from admissions during the period October, 1987 - January, 1988) consisted of the first 26 patients rated as high risk whose assigned social workers agreed to participate in the study. (A total of 138 patients were rated as high risk during the study period, so that the sample agreeing to participate in the program was 19% of this.) The initial high risk rating occurred within 72 hours following the patient's admission.

For these 26 high risk patients, the comprehensive discharge planning program described below was implemented in addition to the "usual and customary social work practices" noted in Section 6.2.[2]

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[2]The program did not involve patient contact by the Discharge Planning Coordinator; rather consultation and assistance were provided to assigned social work staff.

6.3.1 Content of the High Risk Discharge Planning Program

The discharge planning program for high risk psychiatric inpatients incorporated the following major elements:

- **Focused Assessment**

  The worker assigned to each the high risk case included in the study was assisted by the Discharge Planning Coordinator in formulating a focused discharge planning assessment directed towards the special needs of the high risk patient. It encompassed the following areas:

  1. Critical review of past discharge planning efforts and aftercare arrangements (see Appendix L).
  2. Identification of actual and potential financial resources and review of eligibility for benefits (see Appendix B).
  3. Evaluation of the patient's actual and potential support network (see Appendix K).
  4. Assessment of the degree of structure, and level of stimulation and demand, most appropriate for the patient in his/her aftercare living, treatment, work, and social environments (see Appendix R).

  The above elements were then combined to suggest the specific array of aftercare resources the patient would require in the areas of: housing, treatment, rehabilitation, transportation, supportive services, financial benefit programs, education, and social-recreational referrals (see Appendices E and

O). Interim and contingency plans, and services for family members were also considered.

- **Discharge Planning Hypothesis Formulation**

  For each case, a discharge planning hypothesis which specified biopsychosocial factors contributing to the admission, was defined (see Appendix D). The hypothesis was then used to formulate objectives important to the transition from the hospital, and to inform both the treatment and discharge plans.

- **Provision of Conditions for a Healthy Decision-Making Process**

  Patients and families were given an opportunity to canvas as broad a range of post-hospital alternatives as possible and to evaluate objectives to be fulfilled, values implied, the cost, and positive and negative consequences of each option. This process was facilitated by beginning early in the stay, by providing as much time as possible, and by offering freedom of choice, hope, and support from staff in decision-making.

- **Establishment of Linkages**

  An effort was made to establish linkages among all members of the patient's support network in advance of discharge to ensure ongoing collaboration among all involved and to enhance the likelihood of adherence to the plan (see Appendix N).

- **Consultation and Advocacy**

Consultation and ongoing assistance with high risk cases were provided by the Discharge Planning Coordinator. Wherever necessary, advocacy with larger systems was offered since high risk patients are frequently denied access to needed community resources, or are adversely affected by restrictive social and agency policies.

- **Resource and Referral Information**

  Staff participating in the study were given assistance by the Discharge Planning Coordinator in locating specific information about relevant resources for each study patient. This data was obtained through the files of the Resource Library,[3] through the Discharge Planning Manual[4] or through telephone research. Social Work Resource Library staff were also asked to give priority to the study population in providing information regarding aftercare facilities and services.

At discharge, each patient was given the Discharge Plan Information Form (see Appendix Q) which gave the names, addresses, and phone numbers of all aftercare providers and dates of first appointments.

Follow-up calls to the patient/family or responsible professional were made 2 weeks post-discharge in order to assess adherence to the plan and to provide

[3]In 1982, as part of the groundwork for the project, a Resource Library was established under the supervision of the author at New York Hospital - Westchester Division. Staffed by a part-time librarian and social worker, its major functions are to maintain a comprehensive collection of discharge planning resource materials and to provide information and consultation to staff.

[4]For a description of the Discharge Planning Manual, prepared by the Discharge Planning Coordinator and the Resource Consultant, see Chapter 7.

assistance with any emerging difficulties. These were documented in the Social Work Services Closing Summary (see Appendix G).

As required by the hospital, social workers participating in the study also completed the hospital-required Multidisciplinary Treatment Plan which describes the initial discharge plan, and weekly progress notes which document ongoing discharge planning efforts.

Upon the patient's discharge, the assigned worker completed the final high risk indicator list which rated actual risk factors experienced during the discharge planning process (see Appendix A).

Retrospective chart reviews of social work activity for the 26 1987 study cases were conducted in order to assess quality, timeliness, comprehensiveness and outcome of discharge planning (see Appendix F).

6.3.2 Social Work Staff Participating in the 1987 Study

All hospital social work staff and students were informed about the nature of the 1987 comparison study including its design and goals. Suggestions and criticisms were invited during the planning phase. Individual training sessions in which program elements were explained in detail were offered to social workers participating in the study. The author also met frequently with staff carrying high risk patients to discuss and assist with discharge planning efforts.

6.4 Goals and Purposes of the Program

The goal of the program was to develop a technology for timely, high-quality discharge planning for high risk psychiatric inpatients. It was intended that this

prototype produce a service which could be replicated, principles and rules which could be followed and taught, and outcome measures which might suggest that the program was more effective for this population than usual social work discharge planning practices.

Embedded within the overarching goal of the program was a set of objectives which the individual interventions were designed to achieve. Primary objectives were as follows:

1. Reduction of inpatient days which were not clinically necessary but were accumulated by high risk patients awaiting implementation of a discharge plan.

2. Modification or elimination of the factors which had contributed to the patient's admission.

3. Achievement of a high degree of adherence to the discharge plan by the at-risk patient and his family.

4. Enhancement of worker competence in and satisfaction with the task of high risk discharge planning.

5. Articulation of a set of principles and rules to guide psychiatric discharge planning.

6. Attainment of higher quality, more timely and feasible aftercare plans with high risk patients.

7. Creation of a data base about discharge planning with high-risk psychiatric

patients to aid in identifying areas for further study and to provide a feedback loop for staff.

8. Development of a reliable high risk indicator list to permit early identification of psychiatric patients likely to experience unusual difficulty in discharge planning.

9. Preparation of a psychiatric discharge planning manual to provide practical information regarding this function. The manual's purpose is to ensure that all workers have access to the same basic information and tools which can permit them to engage knowledgeably in this function.

6.5 Impact Model

The program was conceptualized as having five major components that were directly related to the achievement of specified objectives.

1. High risk patients were accurately identified at admission so that intensive social work services could be deployed differentially. It was expected that by knowing very early in the hospitalization which patients would require exceptional effort, the worker would be better able to triage and plan use of his/her time.

2. A series of specially designed interventions was implemented for high risk patients in the 1987 study to augment the assigned social worker's own resources and to ensure that prompt attention was given to this population's aftercare needs. It was expected that these intensive services would reduce

discharge delays, decrease the social worker's burden and increase her satisfaction with a potentially frustrating task.

3. A uniform initial discharge needs assessment and discharge planning hypothesis were formulated for all high risk patients participating in the 1987 study. Their combined purpose was to focus, inform and guide social work intervention. Use of these tools was intended to ensure that all areas of aftercare requirements were taken into account, and that treatment goals and discharge planning objectives were integrated so that planning and follow-through would be more realistic and timely.

   It was anticipated that plans made after the completion of the assessment and formulation of the hypothesis would be more comprehensive, of higher quality, and developed earlier in the hospital stay than those made according to usual procedures followed throughout the 1985 study. In addition, these procedures were intended to provide a better match between patient and discharge environment so that adherence and tenure would be enhanced.

4. A collaborative model was used in that all key persons involved in the patient's aftercare environment were to be informed about each other's roles and the operation of the plan prior to discharge. The purpose of this intervention was to identify gaps, misunderstandings, and to establish lines of communication.

5. Explicit procedures, principles, and rules for discharge planning were reviewed with workers assigned to patients in the prospective study. Since

these were derived from theory, knowledge, values, and ethics, they provided powerful intellectual tools for guiding staff in their work as discharge planners. It was believed that having such guidelines would lead to increased clarity in practice as indicated through higher quality plans, greater worker competence and satisfaction, and a greater degree of patient adherence.

Chapter 7

The Program's Location in Time and Place — Critical Elements in the Internal Environment

7.1 Description of the Setting for the Program

The program was implemented in New York Hospital - Westchester Division, a 322 bed, non-profit, voluntary facility serving patients of all socioeconomic statuses in need of psychiatric care. The institution has been affiliated with the Cornell University Medical College as a teaching center for psychiatric residents and medical students since 1965.[1]

New York Hospital was granted a charter to operate by King George III in 1771.[2] From the first, wards were set aside for the treatment of the mentally ill, and in 1808, a building was constructed specifically for those with emotional disorders. In 1821, New York Hospital established the Bloomingdale Asylum, one of the first separate facilities in the United States dedicated solely to the care of the mentally ill. It was located on the present site of Columbia University in New York City. Physicians provided humane or moral treatment for patients in a rural environment which, at the time, represented a radical departure from accepted psychiatric care. In 1894, the Bloomingdale Asylum was moved to White Plains (25 miles north

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[1]Public Information Department, N. Y. Hospital - Westchester Division, *New York Hospital - Cornell Medical Center, Westchester Division* (White Plains, N. Y.: Public Information Department of N. Y. Hospital, Westchester Division, January, 1982), p. 2.

[2]Ibid., p. 23.

of New York City) because of the wish to preserve a rural environment, and in 1936, the name was changed to the Westchester Division of New York Hospital. The affiliation with Cornell University Medical College established in 1965 led to improved medical care, the development of comprehensive education and training programs, and basic research in the behavioral sciences.

In addition to its 322 bed inpatient program, the Westchester Division has developed outpatient and day hospital services for children, adolescents and adults, and a newly opened halfway house.

Inpatients are treated on fourteen units which accommodate from 14 - 25 patients in semi-private or private rooms. While the units are autonomous, each has access to all staff and facilities. Each unit is led by a senior psychiatrist who is in charge of overall management and patient care. The treatment staff for each unit includes senior psychiatrists, psychiatry residents, psychologists, social workers, therapeutic activity coordinators, nurses, and mental health workers.

The fourteen inpatient psychiatric units at the Westchester Division are allocated among four major divisions, and each of these is led by a Division Chief (a senior psychiatrist). The Division of Acute Treatment Services includes five inpatient units for the short-term treatment of acutely disturbed patients or patients with complex multiple illnesses such as combined neurological, medical and psychiatric disorders. This division also includes the Alcohol Treatment Service, the Eating Disorders Institute, and a unit for the treatment of affective disorders. Lengths of stay (LOS) are held to a minimum within this division with the average being 44.8 days. The Division of Extended Treatment Services includes four

inpatient units structured to provide specialized individual treatment programs for patients suffering a variety of severe psychiatric disabilities such as refractory characterological or borderline disorders, and chronic psychotic states. The average length of stay ranges from a few months to over a year (the mean in 1988 was 385 days). The Division of Geriatric Services provides diagnostic evaluation and treatment services for the older psychiatrically ill patient. It provides integrated psychiatric, psychological, medical and neurological services in a therapeutic supportive environment. Its mean LOS in 1988 was 169 days. The inpatient services of the Division of Child and Adolescent Services include 2 inpatient units for younger children and adolescents. Each of these programs provides a broad range of psychiatric services for children and their families, and in 1988, the mean LOS for this division was 152 days.

The hospital admits and discharges approximately 1400 inpatients per year and had an overall average length of stay of 98 days in 1988.

7.2 Institutional Factors Related to Discharge Planning

In the past, discharge planning at New York Hospital - Westchester Division could proceed at a relatively leisurely, unpressured pace because there was ample time to explore and implement aftercare arrangements, and because the majority of patients had sufficient private funds to ensure ready access to community resources. However, over the past decade, there have been significant changes in the population, the financial mix, and in constraints imposed by third party payors (see Table 7.1).

	Jan-Jun 1988	1975
Medicare	13.9%	10%
Medicaid	47.6%	17%
Blue Cross	10.0%	03%
Other Insurance	28.5%	70%
Total	100.0%	100%

Table 7.1: Inpatient Financial Mix — Per Cent of Total Days

Whereas in 1975, private insurance patients comprised 70% of inpatient days (and Medicaid patients only 17%), in 1988, privately insured patients accounted for only 28.5% of days while Medicaid days had grown to 47.6% of all days. This shift in financial mix has had a profound impact upon upon the hospital in terms of budget deficits and concerns regarding fiscal viability. The primary reason for focus upon changes in patient mix stems from the fact that Medicaid pays only $335 per day (1988 rate) whereas the privately insured patient will receive 80% of the full rate ($560 per day) from his insuror and will be asked to pay the remainder himself. In addition, Medicaid patients tend to be those who are more severely ill and disabled, who have fewer supports, and who are likely to require use of alternate level of care days while awaiting a community placement.[3]

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[3]On 11/1/86, New York State's Department of Health announced that it would automatically pay for only one non-acute day for Medicaid patients. For the hospital to be reimbursed beyond this single day (for discharge-delayed patients), a complex appeals process must be used. Approvals are based upon there having been timely and comprehensive discharge planning, and upon the presence of factors beyond the institution's control which delayed the patient's departure. In 1987, New York Hospital accumulated 3,492 alternate level of care (ALC) days for Medicaid patients awaiting community placements. These non-acute days are reimbursed at only $147 each, rather than the full rate of $355, and thus reduce hospital revenue. The state's ALC policy ensures that the hospital will support programs which enhance discharge planning - a function now directly and demonstrably tied to reimbursement.

	Mean LOS Under 1 Year	Mean LOS Over 1 Year
1975	73 days	1,327 days
1986	56 days	653 days
1987	52 days	320 days

Table 7.2: Lengths of Stay over a 12-Year Period

The hospital is also experiencing a much higher turn-over rate of patients. In 1975, there were 844 discharges whereas in 1987, this had increased to 1,435. This 70% increase in the number of patients served reflects a major reduction in length of stay and an increased demand for timely, effective discharge planning services. Lengths of stay over a 12-year period are shown in Table 7.2.

While the federal government is working to revise its prospective payment system to incorporate psychiatric care, New York State has been developing an alternative methodology for reimbursing all payors except Medicare. The State's concern is that a federally sponsored psychiatric payment system would under-reimburse services to the most severely ill, thereby shifting these patients into the state hospital system (where federal cost-sharing is not possible). To ensure that acute units of general hospitals increase their commitment to the seriously mentally ill while limiting the rate of increase in mental health expenditures, the New York State Office of Mental Health has devised the Alternate Reimbursement Methodology Project. The ARMS reimbursement system is intended to cover all acute inpatient psychiatric units and all payors.[4] In effect, this system will impose serious financial disincentives for any inpatient stays which extend beyond

[4]New York State Office of Mental Health, *Reimbursement of Psychiatric Inpatient Stays: Proposed Regulatory Revisions, Part 86 of Title 10 NYCRR, Section 86-1.57* (Albany: Office of Mental Health, 8/3/88), pp. 1-15.

approximately 30 days, and will offer financial incentives for hospitals to admit those with chronic, major psychoses.

For all the above reasons, the setting chosen for the proposed program is strongly concerned about future financial solvency and its ability to compete with non-acute private psychiatric hospitals which are exempt from the ARMS proposal and ALC regulations. Given this framework, social work innovations which can produce cost saving by aiding patients to leave promptly when an acute level of care is no longer needed are viewed in a favorable light.

One of the propositions underlying the program is that discharge planning needs to be articulated as a professional task for which there are explicit methods, derived from theory, that can be tested and proven efficient and effective. As long as the process remains idiosyncratic and informal, it cannot be taught to others and its effects cannot be demonstrated to hospital administration. (There is also the danger that it will be viewed as a non-professional activity which can be managed by persons with no clinical training.) If social work can aid the hospital to meet the challenge of reducing non-acute days for high risk patients by developing a well-functioning system for discharge planning, its value to the institution (and its security) can be enhanced.

Patti notes that internal resistance to change is encountered when the change agent is low in the agency hierarchy, when there is strong investment in the status quo, and when the decision-maker's commitment to the organization as an instrument of service is weak.[5] While the author had little power vis-a-vis medi-

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[5]Rino Patti, "Organizational Resistance and Change: the View from Below,"

cal leadership, she could exert a fair degree of influence within the Social Service Department, and had the backing of her own Director. While the Hospital would not fund any new programs which were not self-supporting, administration was more amenable to a proposal for improving existing services and to reducing financial risk at minimal cost. Although staff did have investment in the status quo, the intent of the program was not to expose poor performance or to alter practice radically, but to organize and systematize high quality discharge planning — initially for the high risk patient. Given the fact that outside funding pressures will have negative impact upon social service unless strategies are developed now, convincing hospital administrators to permit testing of the proposed model was less difficult than it might have been several years ago.

Rosner states that there must be organizational slack in order for an agency to afford the cost of innovation and to absorb possible failures.[6] Since the author had been working towards the project for some time, the necessary additional staff lines had been implemented prior to the study phase (a half-time Resource Consultant and a 10 hour per week Resource Librarian). The remainder of the program involved improving service currently mandated, by using existing resources in a different fashion. If the program had proven to be no more valuable than current practice, retrenchment would have been quite easy, producing little risk for the institution. The proposal therefore appeared to meet the criteria for success outlined

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Social Service Review 48 (September 1974), pp. 376-378.

[6]Martin Rosner, "Economic Determinants of Organizational Innovation," *Administrative Science Quarterly* 12 (March 1968), p. 615.

by Brager.[7] It had apparent advantages over current practice; it was tested on a limited basis; it required modest use of scarce resources; it was not very radical; it did have a widespread effect upon other organizational actors; and it could be perceived as consistent with the values and interests of those whose approval had to be sought.

A major investment of time had to be made by the author in order to oversee and manage the program. Fortunately, part of her job description as Associate Director of Social Work was to advance the interests of the department by identifying problems and implementing innovative solutions. Also, as a faculty member, she was permitted to engage in program evaluation approved by the Social Work Director and the hospital's Research Committee. Partly as a result of the high risk program, the author has been appointed the hospital's Discharge Planning Coordinator, and her job description has changed substantially to encompass associated functions.

Shifts in the focus of the social work department associated with the program (and with changes in the outside environment) are in consonance with social work's historical commitment to respond to the practical needs of people in real situations.[8] By defining clinical social work as concerned with the person-in-situation, one allows for specific foci at specific points in time. Weissman notes:

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[7]George Brager, "Helping vs. Influencing: Some Political Elements in Organizational Change," in *Social Administration: the Management of the Social Services,* Simon Slavin ed. (New York: Haworth, 1978), pp. 560-561.

[8]Harold H. Weissman, "The Knowledge Base of Clinical Social Work," in *Handbook of Clinical Social Work,* eds. Aaron Rosenblatt and Diana Waldfogel, (San Francisco: Jossey-Bass, 1983), P. 3.

"Any other definition would severely limit the ability of social workers to meet people's needs as they emerge over time."[9]

7.3 The Client Group

For high risk patients, the transition from the hospital is often more traumatic than the actual inpatient stay. Social work has traditionally recognized and provided for the service needs of such socially vulnerable persons and those upon whom they depend. Patients and their families within this setting are not an organized group and have no forum in which to express mutually perceived concerns. The individual's condition during hospitalization, and the family's absorption with inpatient treatment mitigate against patients being advocates for themselves in obtaining the highest quality discharge planning services. For these reasons, it behoves our profession to make available interventions that reflect the "state of the art" in the field of social work.

Patient and family opinions about the discharge planning process were not directly explored in the study because its scope was limited, and because another department (the Community Services Division) had been assigned responsibility for patient-family satisfaction surveys. While this is not ideal, it may be possible to undertake better delineated evaluations of this function by patients and families in the future. Besides anecdotal descriptions of high risk family and patient responses to discharge planning interventions, two indicators of client reactions to the program were included in the study: 1) the degree of adherence to aftercare ar-

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[9]Ibid., p. 3.

rangements two weeks post-discharge and 2) the numbers of complaints regarding aftercare planning received for the study group (see Chapter 10 for discussion).

7.4 Organizational Impediments to the Program

The 14 inpatient units upon which the program was implemented function fairly independently under individual medical leadership, with their own social work supervisors and staff. (There is a social work to patient ratio of 1:12.) Most units house 23-25 patients, are organized according to divisions (geriatric, extended treatment, acute treatment and child and adolescent), and function on an interdisciplinary team model. Fortunately, the proposed study was non-intrusive, impacted minimally upon the functioning of other disciplines and was almost totally under the aegis of the Social Work Department's mandated area of functioning. Coordination of the program, however, was made problemmatic by the physical isolation and programmatic autonomy of both units and workers. This arrangement therefore required much administrative time from the author who streamlined monitoring as much as possible by testing forms and procedures in advance. Trial runs were used to minimize work for staff who were likely to oppose any new, time-consuming responsibilities.

7.5 The Creation of Essential Supports for the Program

In addition to institutional readiness to embrace innovations in discharge planning, it is essential that there be support services, staff and structures in place which make possible a high degree of responsiveness to social workers conducting discharge planning. In order to carry out this function well, staff require prompt

assistance with aftercare issues and dilemmas and ready access to the information required to craft an individualized plan for each patient.

A constellation of coordinated back-up services was developed and used to undergird this program which consisted of: a Discharge Planning Coordinator (the author); a Resource Library staffed by a Resource Consultant and Resource Librarian; a Discharge Planning Manual and Indexed Forms File; and Discharge Planning and Community Liaison Committee (see Figure 7.1).

7.5.1 Discharge Planning Coordinator

It is vital that the high risk program (and Resource Library staff) be supervised and administered by a hospital social work discharge planning coordinator who has visibility, access to key individuals, and influence within the system. The author's appointment to this position grew out of a long-term commitment to issues in discharge planning which caused her to be seen as the logical candidate for Hospital Discharge Planning Coordinator.[10]

7.5.2 Resource Library

The project coordinator planned and now supervises a Social Work Resource Library.[11] Staffed by a part-time Resource Consultant (MSW - 17.5 hours/week) and a Resource Librarian (MLS - 10 hours/week), the office contains a comprehensive collection of information regarding resources and provides searches and

[10]See Appendix H for job description of the Discharge Planning Coordinator.

[11]See Appendices I and J for job descriptions of the Resource Consultant and Resoursce Librarian.

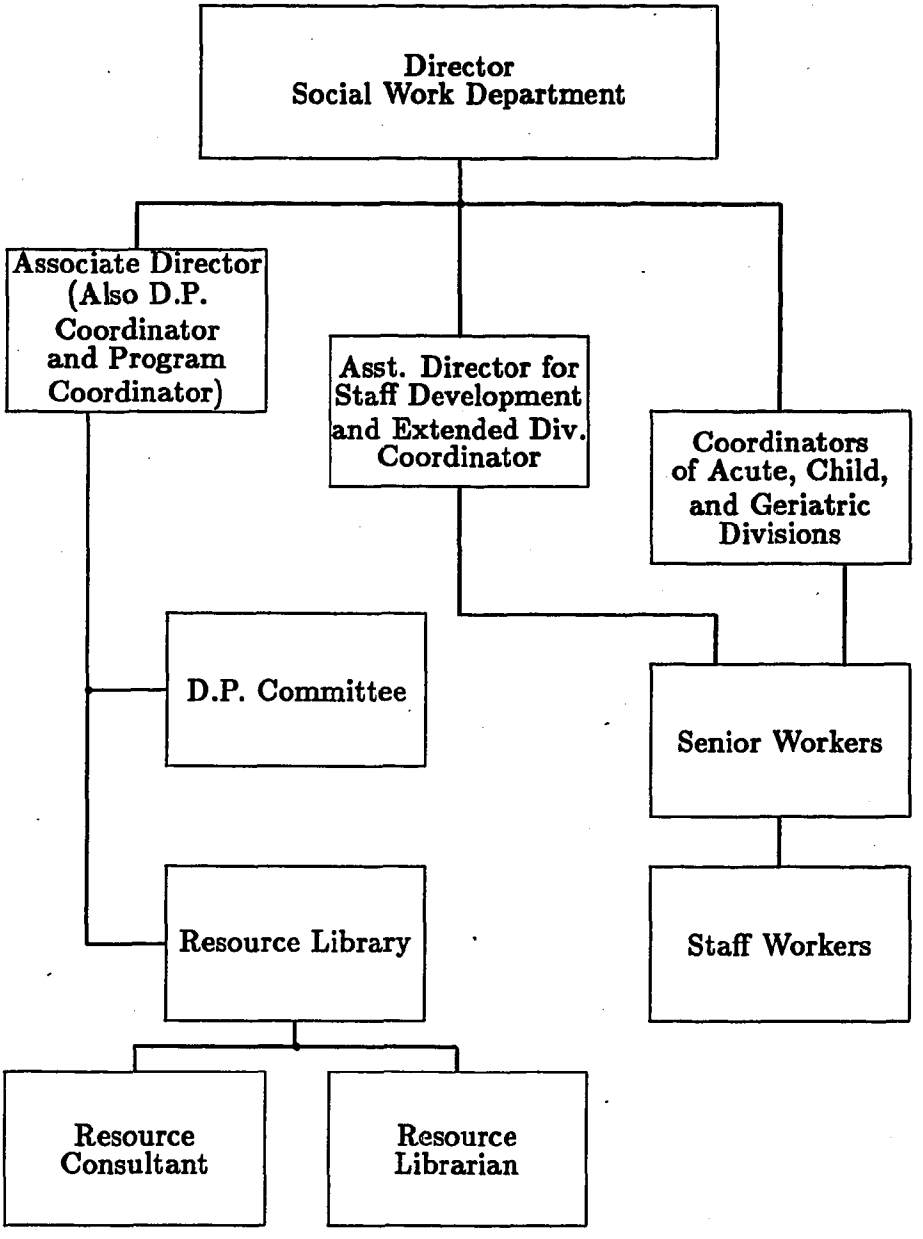

Figure 7.1: Location of Program Elements in the Social Work Department

consultations to members of all disciplines regarding discharge plans.[12]

It must be emphasized that without an organized central system for cataloging information about resources, benefits, and application forms, each social worker would be placed in the position of having to maintain extensive personal files. A centralized resource library ensures that materials are up to date, available, and comprehensive (as well as readily located by each worker). Staff lines for the Resource Library had to be pieced together from portions of full-time social work lines over a several year period - there was no independent funding available. However, the Resource Library has reduced the need for hiring additional social workers by helping those already on staff to use their time more efficiently.

The Resource Library has been very successful in aiding social workers to cope with a more rapid turn-over rate and with patients who require a wide range of facilities, in disparate geographic locations. The Resource Consultant and the project coordinator have also offered numerous inservice seminars to staff and community representatives on such topics as how to obtain SSI/SSDI benefits, how to write

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[12]The Resource Library was begun with minimal funds and staff time. A retired librarian was hired first to begin to collect, evaluate and organize resource materials using a library system. Seven months later, a retired social worker with special expertise in concrete services and financial benefits was hired part-time to assist the Discharge Planning Coordinator in providing aftercare consultation to social work staff. Each step required demonstrating to administration that the Resource Library could enable current staff to do more and to become more efficient and skilled in offering high quality, timely discharge planning services. Eeking out lines for the Resource Library has required much advocacy and negotiation on the part of the Social Work Director to overcome administrative resistance to investing in a new program. Most difficult to negotiate was space for the Library - this required asking for the personal intervention of the Medical Director. To obtain approval for the expansion of services, it has been crucial to publicize services and cost-savings produced by Resource Library staff to hospital administration, and this function has been ably carried out by the Social Work Director.

effective referral summaries, reviews of the major financial benefits programs, how to meet alternate level of care criteria, and effective charting for discharge planning. On-going staff development is crucial in building and maintaining discharge planning skills within the social work department.

7.5.3 Discharge Planning Manual

To guide social work staff in the range of tasks and procedures involved with psychiatric discharge planning, the author (and Resource Consultant) prepared a Discharge Planning Manual (see Appendix C for Table of Contents). Contained within the manual are guidelines for conducting discharge planning, descriptions of the Resource Library and its staff functions, regulations governing discharge planning, instructions for internal chart documentation, guidelines for all major types of referrals, instructions for forms, descriptions of all financial benefits, and copies of the most frequently used forms.

The forms contained in the manual are also cross-referenced in an Index of Forms which was then used to set up a Forms File. Since the Forms File is organized in the same way as the Discharge Planning Manual, social work staff and students can easily locate needed forms on a self-serve basis. Prior to the implementation of this system, workers often could not locate forms because they might be filed according to number, title, or distributing agency.

The Discharge Planning Manual and Forms File have served to improve worker efficiency and to ensure that the time of Resource Library staff is not used for repetitive and basic questions which staff can answer for themselves by consulting

the manual.

7.5.4 Discharge Planning and Community Liaison Committee

The author also serves as the chairperson of an interdisciplinary Social Work Discharge Planning and Community Liaison Committee which meets monthly and is open to all social work and hospital clinical staff. The committee has three primary mandates: to hone social work discharge planning skills; to disseminate resource information; and to establish connections with community agencies. The committee is involved in planning inservice training programs directed towards areas which require strengthening (topics might include how to obtain financial benefits for patients, strategies for achieving residential health care facility placement, methods for coping with new regulations and procedures). The committee keeps itself and the department informed about new and existing resources and establishes valuable personal relationships and referral procedures by inviting staff of agencies to present their programs at monthly meetings. (Minutes are widely distributed.) In addition to these functions, committee meetings with providers can be used to identify and plan joint action regarding systemic issues affecting psychiatric patients.

7.5.5 The Role of Social Work Leadership

A further critical ingredient for a successful program for high risk patients is the commitment and backing of the Social Work Director. Fortunately, at New York Hospital–Westchester Division, this individual has been highly supportive of initiatives in discharge planning and has provided strong advocacy for staffing and

office space with hospital administration. She has also been instrumental in raising consciousness about the critical role of discharge planning, and in placing discharge planning issues upon institutional agendas.

Chapter 8

Costs Associated with the Program

8.1 Staff Requirements and Costs

Since September, 1987 when the High Risk Indicator List was implemented for all new admissions to New York Hospital - Westchester Division, approximately 30% of all admissions have been rated as presenting more than average discharge planning difficulties.

Offering assistance to staff with the high risk patients alone requires approximately 10 hours per week on the part of the Discharge Planning Coordinator. (Additional hours are used to assist with lower risk cases.) The Resource Consultant spends an additional 2 hours per week with this population, and the Resource Librarian invests 1.75 hours per week in researching resources for high risk patients.[1] Use of social work secretarial time for high risk patients has been minimal and is related primarily to typing and updating the Discharge Planning Manual (1 - 2 hours per week after an initial investment in establishing the manual).

Although the direct cost per week of the program ($397.41) may appear high, it must be measured against potential losses. For example, while the above Resource Staff cost $79.48 per day, one lost full-pay patient day is worth $560 (1988 rate) to the hospital. Even if a patient is on alternate level of care status and the hospital

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[1]The remainder of the Resource Consultant's and Resource Librarian's time is spent in assisting workers with lower risk cases, in maintaining the collection, educating staff, attending meetings, etc.

Staff Member	Hourly Cost	Weekly Cost
Secretary	$13.26	$26.52
(@ 2 hours/week) Resouce Librarian	$11.72	$20.51
(@ 4 hours/week) Resource Consultant	$20.42	$81.68
(@ 10 hours/week) D P Coordinator	$26.87	$268.70
(@ 10 hours/week) Total		$397.41

Table 8.1: Costs of Resource Staff Time for Services to High Risk Patients.

is being reimbursed at the lowest rate of $147/day, Resource Staff daily cost is still less. Throughout 1987 and 1988, the Discharge Planning Consultant worked with staff to ensure that the hospital received payment for as many alternate level of care (ALC) days as possible. (This is a complicated process which involves following many regulations and preparing an involved letter of appeal.) During the 24 month period, 3033 days were approved for a total revenue to the hospital of $665,414 while losses were only $7,502. (During 1987, New York City medical and psychiatric hospitals had 37% of their ALC days denied.)[2] Such cost-saving figures can help demonstrate to hospital administration that highly skilled Resource Staff are worth the investment.

It should be noted that no new lines were added to implement the high risk program; rather portions of existing lines were used to create the Resource Librarian and Resource Consultant positions, and the program coordinator simply shifted her functions. The Resource Library is housed in an existing office and utilizes a small other-than-personnel budget to obtain reference materials.

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[2]Harry Feder, Senior Vice President, Island Peer Review Organization, "Report on ALC Approvals and Denials by the Island Peer Review Organization" (New York City: Discharge Planning Association of New York City, 12/14/88), unpublished speech.

The most significant change in job description occurred for the Discharge Planning Coordinator (the author) who is also the Associate Director for the Social Work Department. Whereas prior to the project, the percent of her time spent in discharge planning functions was approximately 5%, it has now jumped to 60 - 70%. The fact that this change has become permanent reflects not only the success of the program, but a shift in the focus and allocation of resources within the Social Work Department.

Social work staff participating in the 1987 study usually spent no more than 3 - 4 hours per case during the course of the patient's stay working with the Discharge Planning Coordinator and other Resource Library staff. (Of course, they spent much additional time in actual discharge planning activities on behalf of patients and families.) All forms necessary for program evaluation were completed by the Discharge Planning Coordinator on her own time.

A volunteer was used briefly for 2 hours per week over a three month period in which she organized a "Forms File" containing copies of the most frequently used referral and application forms. It has been difficult to obtain volunteer help to supplement Resource Library and secretarial time since most appropriate tasks did not involve any patient contact, and were quite repetitive.

In sum, the 1987 comparative study was implemented within existing staffing patterns since it was not possible to increase lines or social work time. Additional tasks for staff were kept to a minimum in order to permit the project to reduce burden and to enhance efficiency.

8.2 Internal Political Issues and Costs

The program had minimal negative impact upon other departments because 1) social work had already been recognized as the discipline administratively responsible for discharge planning and 2) points of interface had been explored in advance with the Admissions, Utilization Review, Finance, and Medical Records Departments and their support obtained.

Few territorial issues have emerged during the project because the program has been viewed as providing assistance to other departments which share concerns regarding the high risk population. The Utilization Review Department has seen the project coordinator (and social work) as an ally in raising key institutional issues and in seeking policy and program change. The Finance Office no longer views social work as adversarial but believes that our department is also working to reduce financial risk; Medical Records has been willing to give priority to outgoing material for high risk patients since it recognizes that these cases can generate adverse consequences for the institution. The Admissions Department has benefitted from having feedback from the Discharge Planning Coordinator regarding the outcome of work with patients. On occasion, Admissions has been helped to avoid decisions which might have created financial risk and brought criticism later on. These four key departments have become allies who vouch for the usefulness of the services provided by the Resource Library and Discharge Planning Coordinator. Politically, their support has helped social work to shift staff time to the Resource Library and to move to more spacious quarters.

The major source of resistance anticipated to the program was within the social

work department itself. (For full discussion of the specific issues, see Chapter 9). However, any department considering implementing such a program should carefully consider the following:

- Issues concerning autonomy and authority between the project coordinator and the unit senior social workers may be raised. This area requires much personal diplomacy, groundwork behind the scenes, and active seeking of ideas and input from supervisory staff.

- The setting of new policies and standards for discharge planning requires the support of the department director and of the social work administrative group. To suggest improving an existing area of practice may be perceived as threatening to those invested in the status quo.

- Secretarial staff may believe they will be overburdened with extra work generated by the program. By placing a used typewriter in the Resource Library, its staff have been able to write most of their own brief memos to social workers. Further, systems have been set up so the Resource Librarian takes responsibility for ordering books, pamphlets and forms. The actual call upon secretarial support services has only been 1-2 hours per week.

- The project has an opportunity cost in that its staff may be prevented from using time for some other professional activity which is highly valued. For example, the program may usurp resources which could be used for other research, professional papers and the like. This cost must be balanced against allowing discharge planning with high risk patients to skew social work func-

tions and to place undue pressure upon staff workers. In the end, there may be few tasks as vital to social work and the institution as improving discharge planning services.

Potential positive results of implementing a high risk program within a social work department include the possibility that outcome measures demonstrate that a coherent discharge planning technology for high risk patients can make a difference in ways important to the institution. If it can be shown that financial risk to the hospital can be reduced, that patient/family satisfaction is increased, and that residency training needs are met (patients are helped to leave as soon as inpatient care is no longer warranted), then social work discharge planning relates directly to high priority hospital goals. By strengthening its position in this fashion, social work can better ensure that its own objectives and standards will not be attenuated by having to adopt expedient measures in order to survive.

Chapter 9

The Process of Implementing the Program

9.1 The Preparation and Involvement of Social Work Staff

When the author moved into her present position as Associate Director of Social Work Services in 1980, discharge planning at New York Hospital - Westchester Division was a devalued task described as "scut work". Ambitious social workers were interested in becoming hospital psychotherapists for inpatients, using psychodynamically-informed interventions. With strong advocacy by social work administration, attitudes changed, and recognition has been given to this function. At present, demonstrated skill and interest in discharge planning is a prerequisite for being hired by the Department, and the task is viewed as one requiring the unique preparation, knowledge, and abilities of professional social workers.

Through two previous research studies, the author had much contact with staff about discharge planning functions. Workers were quite willing to share their experience and frustrations, and in general, were cooperative with preliminary studies (such as that to establish a high risk indicator list). However there was a qualitative difference between staff's perception of the initial formulation and testing of instruments, and the actual implementation of the high risk discharge planning program. Although staff had input into the design and operation of the program and were aware of the likely advantages it would have for their practice, there was none-the-less a surprising degree of resistance to participating in the

program.

The 1985 study involved several social workers on two intermediate term inpatient units. They had volunteered to assist in the formulation of a high risk indicator list, and had only to complete the high risk rating at each patient's admission and discharge. Since these units had low turn-over rates, the minimal additional paperwork was not experienced as burdensome, and there was keen interest in how the rating scale was progressing. While the 1985 sample was being accumulated, there was no attempt made to intervene in social worker's usual discharge planning practices so that territorial issues were not raised.

In contrast, for the comparison group formed in 1987, workers were asked to collaborate with the program coordinator in approaching high risk patients according to the interventions noted in Chapter 6. Because this meant exposing, exploring and even changing practice, a range of reactions was elicited.

9.2 Chronology of Events in Program Implementation

In June, 1987, copies of the program proposal were distributed to the Director of Social Work and to the department's executive group (the social work coordinators of the five major divisions within the hospital). Informal response was very positive and encouraging (e.g. "it looks fabulous").

Permission was received from the Chairman of the Westchester Division Research Committee for implementation of the High Risk Discharge Planning Program on August 11, 1987.

On August 6, 1987, the proposed program was presented to the Social Work Department's administrative group. The study's purpose was described as spec-

ifying and testing a discharge planning methodology for patients at high risk for presenting difficulties in aftercare planning. It was noted that the project coordinator would not see any patients or families or interfere with the treatment process. Social work staff would be invited to participate on a voluntary basis. It was emphasized that the project coordinator would complete all paperwork for the study, and that participating staff would only be required to meet with the coordinator several times during the course of the patient's stay to consult regarding discharge planning. While responses were generally positive, the following issues were raised:

- Staff were feeling deskilled and morale was low because they could not do the kind of clinical work that was previously possible when stays were longer. The workers believed the study just emphasized the shift from clinical work to discharge planning as a priority.

- Who would determine what amount of discharge planning was sufficient - the worker or the project coordinator?

- If there were a disagreement about discharge planning between the worker and the project coordinator, who would make the decision? (A disagreement could also occur between the worker's supervisor and the project coordinator. Since the project coordinator's position was higher, would her opinion prevail, thus undermining the authority of the supervisor?)

- How would the study address unmotivated, resistant patients, or those who insisted upon a particular plan?

The issues concerning turf were addressed by the project coordinator stating

that for purposes of the project, she would not act as Associate Director, but rather in an advisory, consultative capacity, and that staff did not need to feel compelled to accept her advice. The administrative social work group believed that that workers might none-the-less feel intimidated due to the rank of the project director.

Concerns about morale and the staff's view that discharge planning was not a valued clinical function have been wrestled with throughout the life of the project and beyond. The project coordinator's expressed opinion has been that discharge planning requires the highest level of clinical skill combined with innovation, creativity, and persistence. Some of the newly hired workers have shared with the project coordinator (in private) that they have come to really enjoy discharge planning - they gain much satisfaction from overcoming often insuperable odds on behalf of patients. However, for more experienced workers who have been accustomed to conducting long-term family interventions, the reduction of these opportunities and the shift to a short-term model emphasizing discharge planning has been felt as a severe loss. For them, the project only served to underscore their fears about and dissatisfaction with an over-arching change occurring in the way the institution operates and in the functions of social work. Partially due to these changes in practice, the social work department (which has a staff of 50) experienced 13 resignations in 1987 and 14 in 1988 as compared with 7 in 1986.

The High Risk Discharge Planning Program (for 1987) was presented to the social work department at a staff meeting in September, 1987. The purpose, design, outcome, and possible benefits to staff were discussed as well as what participation would entail. Thoughtful questions were asked, but no real objections or negative

feelings were brought forward. However, the project coordinator was then asked to meet with acute division social work staff since they had expressed concerns to their supervising social worker. The minutes of that meeting state: "The staff presented the issues of job satisfaction, lowered morale, substantial increased activity of concrete services with concomitant decrease of clinical assessment and practice. Many expressed the difficulties in coping with a chronic patient population ... who have unavailable families with few financial or social resources (including transportation to Westchester), many of whom have language difficulties. Some of the families have expressed anger due to the lack of available social work time for them as a result of the increased advocacy and telephone work. Basically, the shift towards a preponderance of concrete services seems to be related to the case mix, decreased length of stay, admissions and reimbursement issues."[1] Staff also asserted that they believed at least "75%" of their cases were high risk and that they were asked to do too much in a limited time with limited resources. The project coordinator was invited back to the next meeting of acute division social work staff.

Following the above meeting, several workers who helped to set staff meeting agendas met with the social work director on 9/25/88 and shared that workers felt they might be coerced into doing the project coordinator a favor in assisting with her thesis. They acknowledged that she was helpful and facilitative with discharge planning, but did not like the idea of a quid pro quo. The director of social work

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[1]Ruth Corn, "Minutes of the ATSD Social Work Staff Meeting," (White Plains, New York: New York Hospital - Westchester Division Social Work Department, 9/21/87)

confronted them by asking what was so terrible about doing a colleague a favor, and noted that this is the way most relationships operate.

At a second staff meeting on 9/28/88, the project coordinator was not present. At that time, staff spoke much more openly and freely regarding their concerns about participating in the research. Some of the issues noted were:

- Are explicit or implicit standards regarding discharge planning being imposed? There are tensions between perceived departmental standards and social work time available to meet them.

- To whom will the staff be responsible — to their senior worker, to their social work division coordinator, or to the project coordinator?

- What is considered a "good enough" job in discharge planning? How exhaustive do efforts have to be and who will determine this?

- When the project coordinator makes a recommendation, is it really a directive?

- Doesn't the program concern a lack of trust in the worker's judgment? When the team and worker feel the patient is unmotivated and resistant to planning, who has the authority to review (and possibly overturn) this determination?

- When are workers required to consult with the project coordinator? It seems like double work since they are already consulting with their own supervisors.

- When there are conflicts as a result of the project, who will resolve them?

Since the project coordinator was not present, the social work director had to deal with these concerns, which she did by acknowledging that the study had really brought to the fore issues which had been troubling workers for some time.

At the end of September, the acute division social work coordinator wrote a note to the project coordinator stating that there were too many written communications (resulting from the program) requiring her workers' attention. At the same time, one acute division worker wrote the project coordinator saying that she wanted no more notes - she felt she had to respond and it added to her work. She stated that she would contact the author if she felt the need.

Following these initial expressions of concern and resistance by staff, the project coordinator had many additional meetings with social work staff, with social work division coordinators, with division social workers, etc. in which the above issues were discussed at length. The primary results were that a) people felt they had begun to air some of their discontents over the changing practice environment and b) they were willing to take a "wait and see" attitude about how the study might impact upon them.

To the project director, the implementation of a modest and small-scale study felt like the opening of Pandora's box. An unanticipated consequence was the degree of turmoil and discontent which it tapped that had been developing amongst staff for a long period. A healthy effect of the intense discussion was that eventually staff became willing to engage in problem-solving around issues created by shorter stays and treatment of a much more dysfunctional population.

It should be noted that it required a little over three months to obtain the

study sample of 26 high risk cases. During the four month study period (October, 1987 - January, 1988) a total of 138 patients were rated at admission as high risk, but social workers for only 19% of these agreed to be involved. However, during the same period, the project coordinator received over 70 requests monthly for assistance with discharge planning issues and questions — a pattern which has continued to the present. Staff noted that they very much wanted assistance, but were leary about being involved in the actual study since they thought it would require more of their time.

Incentives for involvement in the research had been considered in advance. Weissman suggests that a feedback loop be built into the program so that staff are given information of value throughout the stages of the study.[2] While this was done, it rewarded persons already positively disposed to be involved and did not affect those who refused.

Reluctance to participate in research is a well-known phenomenon for which there are no ready answers.[3] Staff involved with the 1987 study actually did experience relief of burden and felt much less isolated with exceedingly difficult

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[2]Harold Weissman, "Clients, Staff and Researchers," *Administration in Social Work* 1 (Spring 1977), p. 47.

[3]Research technique literature tends to skim over the issue of how to elicit staff cooperation. For example, Epstein and Tripodi state, "Provided that the administrator is effective in fostering staff cooperation, research concepts and techniques can be usefully employed for securing information relevant to many aspects of program monitoring." From Irwin Epstein and Tony Tripodi, *Research Techniques for Program Planning, Monitoring and Evaluation* (New York: Columbia University Press, 1977), p. 57.; or Reyes Ramos who states: "Time and patience are required, as well as the sensitivity to know whether or not rapport has been gained." From Reyes Ramos, "Participant Observation," in *Social Work Research and Evaluation,* ed. Richard M. Grinnell, (Illinois: F. E. Peacock, 1981), p. 151.

cases, as had been promised. (For example in November, 1987, one worker wrote, "Welcome back! It had never occurred to me that I couldn't live without you - but there it is!!") The project coordinator had anticipated some resistance, but not the degree which actually materialized. The strong feelings elicited seemed to be related to the timeliness of the project — it tapped underlying negative perceptions related to major shifts beginning to occur in the organization's philosophy, method of operation, and clientele for which discharge planning served as "the tip of the iceberg".[4]

Unfortunately, social workers are not regularly exposed to research about practice and programs in which they are involved. They are much more comfortable with research concerning patient characteristics and responses than with evaluation of program design and effectiveness. This means that when a study relating to social work interventions is undertaken, it is perceived as highly threatening and as having far-reaching implications.[5] It is only over a long period of time, with repeated evaluative studies, that workers may come to see research as potentially

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[4]Two well-known researchers advise, "Getting people to change long-established procedures is a delicate, difficult, and time-consuming matter. You should try to anticipate the reactions that your report is likely to produce." From Robert Sommer and Barbara B. Sommer, *A Practical Guide to Behavioral Research: Tools and Techniques* (New York: Oxford University Press, 1980), p. 19.

[5]This perception is not unfounded since Epstein and Tripodi note, "Program monitoring generates information affecting the following administrative decisions: whether to reallocate staff to different programs...; whether to increase or decrease staff efforts in relation to particular program functions...; whether to ask for an increase in the operational budget...; whether to modify program objectives...; whether more skilled staff are needed...; whether existing staff activities in a particular program can be reduced or restructured;" from Epstein and Tripodi, *Research Techniques for Program Planning, Monitoring and Evaluation*, p. 56.

helpful in their practice.[6]

[6]Schinke states, "Social work research and evaluation are best approached as integral components of social work practice, and professional social workers engage in research during every phase of the problem-solving practice." from Steven Paul Schinke, "Ethics," in *Social Work Research and Evaluation,* ed. Richard M. Grinnell (Illinois: F. E. Peacock, 1981), p. 58.

Chapter 10
Findings

10.1 Introduction

The high risk discharge planning study was undertaken to answer two types of questions. The first (Category 1) asks whether the goals and objectives of the comprehensive discharge planning program (as stated in Chapter 6) are being met. The second set of questions (Category 2) concerns possible modifications of the program design to increase its effectiveness and value to the institution. Such findings, obtained during the course of the study, have implications for both future research and application of the methods described herein.

The study seeks to answer one major question under Category 1 — is the comprehensive discharge planning program more effective for high risk patients than unstandardized practice? Primary measures which were used and evaluated concerned: comprehensiveness, timeliness, and quality of discharge plans, patient adherence to the plan, the number of alternate level of care days, and complaints regarding discharge planning.

Category 2 contains ancillary issues which evolved or became apparent during the course of the study. Examples are:

- Factors in addition to those noted on the High Risk Indicator List which cause patients to be difficult to discharge.

- Those mitigating circumstances which seemed to reduce the effects of identi-

fied high risk factors for patient and family, thereby producing less difficulty in discharge planning than would have been anticipated.

- Social workers' evaluation of the relative value of using elements of the comprehensive discharge planning program beyond the study period, i.e. those elements which were actually incorporated on a permanent basis into the setting.

- Issues regarding the interface of discharge planning functions with other departments and with hospital policy which were raised by the study.

- Deficiencies in the larger mental health delivery system which became apparent during the course of the study (e.g. no vocational rehabilitative programs, no housing for those not suitable for existing facilities, deficiencies in the benefits system, lack of outpatient electroconvulsive therapy, difficulties with the court system).

- The extent to which staff find the discharge planning manual and information from the computerized discharge data base helpful in practice, other supports for staff suggested during the operation of the program.

- Further aides needed for staff such as a file of referral application forms, a guide to financial benefits for children and adolescents, a system for moving urgent outgoing material through the hospital, an omnibus discharge planning consent firm, changes in the Social Service Closing Summary, a discharge planning activities worksheet.

Age	15-19	20-24	25-29	30-39	40-49
% of Pts	30.7%	19%	30.7%	15.4%	4%
	(8)	(5)	(8)	(4)	1

Table 10.1: Age Distribution in 1985 Sample

- Other problemmatic areas of discharge planning practice not addressed by this program such as: the need for discharge planning to be part of the Admission Department's rounds; how to integrate brief family interventions with discharge planning; etc.

- The feasibility of expanding the program for high risk patients to include all psychiatric inpatients.

Information concerning the issues in Category II was derived primarily from personal observations, from interaction with staff, and from reactions of the host setting. It is the story of the evolution of the program over time within a particular place rather than an analysis of specific research results.

10.2 Data Derived from the Program

10.2.1 Age and Race Distribution

The 26 patients in the 1985 study consisted of 10 females and 16 males, ages 15 to 45. Age was distributed as noted in Table 10.1. Patients in the 1985 study were all under 45 because the two units involved were primarily for treatment of psychiatric disorders within a young adult population.

Twenty-three of the patients in the 1985 study were described as White; there were 2 Hispanics and 1 Black.

The 26 patients in the 1987 study consisted of 13 females and 13 males, ages

Age	15-19	20-24	25-29	30-39	40-49	50-59	60-85
% of Pts	15%	12%	12%	12%	16%	16%	20%
	(4)	(3)	(3)	(3)	(4)	(4)	(5)

Table 10.2: Age Distribution in 1987 Sample

	Never Married	Divorced	Separated	Married	Widowed
% of Pts 1985	81% (21)	15% (4)	4% (1)	0% (0)	0% (0)
% of Pts 1987	54% (14)	12% (3)	15% (4)	4% (1)	15% (4)

Table 10.3: Marital Status

19 - 89. Age was distributed as noted in Table 10.2. The age range was much broader in the 1987 sample because patients could be drawn from all units (child through geriatric) whereas in the 1985 sample, patients came only from two general psychiatric units for younger adults.

For the 1987 sample, 18 patients were listed as White, 6 Hispanic, 1 Oriental, 1 Asiatic Indian and no Blacks.

10.2.2 Marital Status

It is interesting to note that the 1987 sample consisted of a much higher proportion of persons who were or had been married (e.g. 46%) whereas in the 1985 sample only 19% of the patients had ever been married. This in part reflects the greater age range present in the 1987 sample. However, in both groups, the number of persons actually married at the time of the hospital admission was not higher than 1, probably because those who have an intact marriage (and therefore a support network) are unlikely to be in the high risk discharge planning group.

% Pts	West. Co.	NYC	Other NYS	Out of State
1985 Study Sample	12% (3)	38% (10)	42% (11)	8% (2)
1987 Study Sample	35% (9)	46% (12)	15% (4)	4% (1)
Entire Hospital	43%	33%	16%	8%

Table 10.4: Patient's Home Address at Admission

10.2.3 Geographic Location at Admission

Geographic locations of the study patients at admission are noted in Table 10.4. Significant differences exist between the two study populations and that of the hospital at large in terms of geographic code. Whereas 43% of the overall hospital population came from Westchester County, only 12% of the 1985 study group and 35% of the 1987 study group resided there. This skewing is probably because the risk of discharge planning difficulties increases with geographic distance. Social workers find it much easier to deal with resources within the county than with agencies in other areas where services, personnel, and procedures are not as well known or as readily influenced.

10.2.4 Legal Status at Admission and Discharge

A large proportion of the 1985 sample had been involuntarily admitted to the hospital, and in addition, a high number signed out of the hospital against medical advice or eloped (see Table 10.5). It is interesting to note that the 1985 group contained virtually the same proportion of involuntary admissions as the hospital as a whole (25%) while 42% of the 1987 group were admitted on two-physician certificates. However, while 31% of the 1985 sample left the hospital against medical

% Pts	Involuntary Admission	AMA Discharge	Elopements
1985	27% (7)	31% (8)	0% (0)
1987	42% (11)	4% (1)	0% (0)
Entire Hospital (1987 data)	25%	10%	1%

Table 10.5: Legal Status at Admission and Discharge

LOS (days)	≤13	30-99	100-199	200-299	300-399
% of Pts 1985	15.4% (4)	23% (6)	34.6% (9)	11.5% (3)	15.4% (4)
% of Pts 1987	7.7% (2)	61.5% (16)	19% (5)	7.7% (2)	3.8% (1)

Table 10.6: Length of Stay Distribution

advice, only one patient in the 1987 sample was discharged AMA. This is an interesting finding which may be associated with social workers' intensive interventions with and engagement of the 1987 study population.

10.2.5 Lengths of Stay

Length of stay for the 1985 population ranged from 3 days to 392 days and for the 1987 sample, the range was 9 days to 314 days. (Distribution of length of stay is noted in Table 10.6.) For the 1985 study group, 73% of the patients had stays under 199 days. For the 1987 group, this figure was 88% reflecting reductions in length of stay for the entire hospital. In 1985, the hospital's mean LOS was 82.4 days, whereas in 1987, this had decreased to 75.2 days.

# Pts.	SSI	SSDI	Soc. Sec. Retirement	CSE RTF	PA	Priv.	Unspec.
1985	15% (4)	8% (2)	0% (0)	8% (2)	4% (1)	15% (4)	50% (13)
1987	46% (12)	15% (4)	15% (4)	0% (0)	4% (1)	19% (5)	0% (0)
Entire Hospital	8%	5%	4%	2%	12%	47%	22%

Table 10.7: Money for Living Expenses at Discharge

10.2.6 Patient Funding Sources

For the 1985 patients, 20 (77%) had Medicaid as the primary payor for the hospital stay. The 6 remaining patients were funded through private insurance. For the 1987 patients, 16 (61.5%) had Medicaid, 7 (27%) had Medicare and 3 (11.5%) were funded through private insurors.

At the point of discharge, the primary source of money for aftercare living expenses for the two samples is noted in Table 10.7. A major increase in the number of patients receiving Supplementary Security Insurance occurred from 1985 to 1987, reflecting social workers' greater attention to obtaining this benefit for inpatients who qualified. Also remarkable was the large number (50%) of patients for whom aftercare monies were unspecified in the chart by the social worker in 1985. In 1987, there were no cases in which funding for aftercare living and treatment expenses were not documented. It should be noted that both study groups contained only one third the number of patients supported via private funds as were present in all hospital discharges.

Diagnostic Grouping	% of Patients 1985	% of Patients 1987
Disorders of Infancy, Childhood and Adolescence	11.5% (3)	3.8% (1)
Substance Use Disorder (Alcohol)	3.8% (1)	7.6% (2)
Substance Use Disorder (Other)	3.8% (1)	15.4% (4)
Schizophrenic Disorders	34.6% (9)	26.9% (7)
Paranoid Disorders	7.6% (2)	3.8% (1)
Other Psychoses	15.4% (4)	30.8% (8)
Affective Disorders	23.0% (6)	11.5% (3)
Total	99.7% (26)	99.8% (26)

Table 10.8: Diagnostic Groupings

10.2.7 Diagnostic Groupings

Patients were grouped according to the primary diagnosis for admission (see Table 10.8). If the paranoid disorders, other psychoses and schizophrenic disorders are combined, we find that 57.6% of the 1985 patients and 61.5% of the 1987 patients fell into this larger group of major psychotic disorders. Interesting diagnostic differences between the groups include the greater number of primary substance abuse disorders and the lower number of affective disorders in the 1987 sample. These differences reflect not only the increase in persons admitted for treatment of drug abuse, but also the fact that the 1985 patients were drawn from only two intermediate units whereas the 1987 group encompassed the entire hospital.

Eleven (42%) of the 1985 study patients had Axis III medical disorders and 6 (23%) had secondary alcohol/substance abuse problems in addition to the primary psychiatric diagnosis listed above. For the 1987 patients, 19 (73%) had serious Axis III medical conditions and 15 (58%) had secondary alcohol/substance abuse

disorders in addition to the primary psychiatric diagnosis listed in 10.8. The increase in medical and substance abuse problems from the 1985 sample to that for 1987 is quite striking and reflects staff's general impression that the population served by the hospital is now more dysfunctional and multiply disabled.

10.3 Assignment of Units and Social Workers

For the 1985 study, all 26 patients were from the two intermediate length of stay, general psychiatric, young adult units. Five patients were assigned to graduate social work students and the remaining 21 were seen by MSW staff workers. For the 1987 study, 12 patients were from geriatric units, 12 from acute units, and 2 from intermediate length of stay units. Of the 26 1987 patients, 5 were assigned to graduate social work students; the remainder were seen by MSW staff workers.

10.4 Distribution of High Risk Factors

In order for patients to be rated as high risk for discharge planning, they had to have 5 or more factors checked on the High Risk Indicator List for Discharge Planning (see Appendix A). During the period September 1987 – February, 1988, high risk forms were completed at admission and at discharge for all admissions to New York Hospital - Westchester Division, and a total of 642 patients were admitted and rated. It was found that 213 or 33% of the entire hospital's population was rated as high risk for presenting serious discharge planning difficulties.

A comparison of the items checked for the 1985 and 1987 study groups, as well as for the entire hospital's high risk population is given in Table 10.9. It should be kept in mind that some of the factors which did not present with high frequency

(such as a dual diagnosis of psychiatric disorder plus mental retardation), were found to be predictive of severe discharge planning problems in virtually 100% of the cases where they were present.

10.5 Discharge-Delayed Patients

The only measure of patients who remain in hospital longer than is clinically necessary is the placement of such persons on "alternate level of care" (ALC) status. This status signifies that the patient no longer meets acute care criteria, according to weekly chart reviews by Utilization Review staff. However, these figures tend to be inaccurate because UR staff are frequently intimidated by inpatient clinical staff into backing off from suggesting placement on ALC. (It should be noted that ALC status brings many negative consequences, including a lowered level of payment, so that staff tend to avoid its use even though failure to do so may result in retrospective denial of all non-acute days.)

In 1985, the total number of ALC days for the entire hospital was 3,199 while in 1987, this number was 3,492. The numbers of patients in the study groups who were placed on ALC and the non-acute inpatient days accumulated is shown in Table 10.10.

10.6 Resources Needed and Arranged

For both the 1985 and 1987 study groups, a form was completed by the project coordinator (see Appendix E) listing all resources believed to be needed for the patient based upon psychosocial information available in the chart. During the 1987 study, these were reviewed with the social worker assigned. A simple tabulation

% 1985 Pts.	% 1987 Pts	Entire Hospital	Description of High Risk Factor
65% (17)	46% (12)	49%(104)	Arrangement of residence different from that at admission was required
42% (11)	46% (12)	29% (61)	Financial benefits had to be applied for
77% (20)	81% (21)	69%(147)	Pt. had serious difficulty in impulse control at time of admission
27% (7)	100%(26)	90%(191)	Pt. had serious and prolonged performance in work, school or activities of living
35% (9)	12% (3)	23% (50)	Pt. had left this or other facilities AMA
65% (17)	54% (14)	53%(112)	Pt. had numerous and/or lengthy inpatient stays
27% (7)	50% (13)	28% (60)	Pt. had a non-voluntary status during this stay
27% (7)	31% (8)	17% (36)	Pt. had a serious medical condition or physical disability
23% (6)	35% (9)	35% (74)	Pt. had serious drug abuse (non-alcohol problem at time of admission
23% (6)	4% (1)	8% (18)	Pt. was member of family where there was recent physical abuse
23% (6)	8% (2)	7% (16)	Pt. (or immediate family) in process of separation/divorce during stay
8% (2)	0% (0)	2% (5)	Pt. was mentally retarded
15% (4)	8% (2)	15% (33)	Pt. had organic mental disorder
15% (4)	31% (8)	23% (50)	Pt. had no involved/available family
65% (17)	58% (15)	54%(115)	Pt/family had history of non-adherence to discharge plans, or were not cooperative with planning
35% (9)	35% (9)	32% (59)	Another immediate family member had a serious mental or medical illness while pt. was hospitalized
12% (3)	4% (1)	7% (15)	Other factors written in
152 (5.8/pt.)	156 (6/pt.)	1 244 (5.8/pt)	Total factors checked in sample

Table 10.9: Distribution of High Risk Factors

	Placed on ALC Status	# of ALC Days
# Patients - 1985	3	174
# Patients - 1987	3	58

Table 10.10: Distribution of ALC Days in the Two Studies

Number of Resources Needed	Number Patients 1987	Percent Arranged 1987	Number Patients 1985	Percent Arranged 1985
1	0	N/A	0	N/A
2	0	N/A	0	N/A
3	0	N/A	0	N/A
4	4	75% (12)	3	83% (10)
5	7	94% (33)	9	69% (31)
6	8	96% (46)	8	56% (27)
7	5	97% (34)	6	50% (21)
8	2	94% (15)	0	N/A
Totals	26	93% (140)	26	61% (89)

Table 10.11: Comparison of Resources Needed vs. Resources Actually Arranged.

In DP Program ?	# of Resources Arranged	# of Resources Not Arranged	Totals
Yes (1987 group)	140 (93%)	10 (7%)	150
No (1985 group)	89 (60.5%)	58 (39.5%)	147
Totals	229	68	N=297

Table 10.12: Success Rate for the Arrangement of Resources.

was done for each patient of the number of aftercare resources required versus the number of resources actually obtained during the hospital stay. The results are summarized in Tables 10.11 and 10.12.

In 1985, a total of 147 resources were deemed to be required for the 26 sample patients. Of these only 89 or 60.5% were documented in charts as actually arranged while the patient was hospitalized. For 1987, 150 total aftercare resources were assessed to be needed by the 26 sample patients. Of these 140 needed resources, 93.3% had been arranged by the point of discharge. Although the number of resources required per patient did not differ significantly between the two samples (1985 = 5/pt.; 1987 = 5.6/pt.), the number actually arranged had increased by 32% from 1985 to 1987. Using Chi-square, we find that the results obtained above

were significant at the .01 level. However, we cannot conclude definitively that the observed differences were due to the effects of the program alone because an experimental design was not used.

10.7 Establishment of Linkages

At discharge, social workers for the 26 1987 study group patients were asked to assess the degree to which linkages had been established among all aftercare providers (see Appendix N). (Similar information could not be gleaned from retrospective chart reviews of the 1985 group.) Questions regarding linkages were answered as noted below.

1. Are all participants in the aftercare plan aware of each other and able to have contact as needed?

   Yes - 23 No - 2 Partial - 1

2. Do all participants understand each other's roles — what to expect, who will do what?

   Yes - 22 No - 2 Partial - 2

3. Do all participants know how future problems or crises are to be managed?

   Yes - 18 No - 3 Partial - 5

The results indicated that connections among providers had been established for nearly all the 1987 study patients, and that mutual roles were understood. Staff believed that members of patients' networks were well aware of how to manage possible future crises in 69% of all cases, and that 19% had some preparation

	% of Patients	
	1985	1987
Adherence to All Parts of Plan	46% (12)	81% (21)
Partial Adherence	08% (2)	04% (1)
Failure to Adhere	19% (5)	08% (2)
Unknown	27% (7)	08% (2)
Total	100% (26)	100% (26)

Table 10.13: Adherence to Discharge Plan 2 Weeks Post Discharge

for handling serious problems. Social workers noted that some network members had considerable difficulty considering potential problems at the point of discharge because of their desire to believe that an acute episode would not recur.

10.8 Adherence to Plans Two Weeks Post-Discharge

At New York Hospital - Westchester Division, social work staff are required to make a follow-up call two weeks post-discharge to either the patient, family, or responsible professional to assess whether the aftercare plan is in place and whether any further social work service is needed. The results of follow-up contacts for the two samples are shown in Tables 10.13 and 10.14. Only 12 (46%) of the 1985 patients were fully adhering to aftercare arrangements in comparison to 21 (81%) of the 1987 sample. Part of this difference is due to the fact that 8 of the 1985 patients left the hospital AMA, and only one of these was contacted post-discharge. By contrast, only one of the 1987 patients left AMA and could not be contacted. The second patient in the 1987 sample who was not contacted had asked the social worker not to follow-up due to his concern about confidentiality. Table 10.14 gives a simpler summary of the above results.

A Chi-square test of the statistical significance of these results reveals that the

In DP Program ?	Adherence to Aftercare Plan	
	Full/Partial	None/Unknown
Yes (1987 group)	22 (85%)	4 (15%)
No (1985 group)	14 (54%)	12 (46%)
Totals	36	16

Table 10.14: Simplified Description of the Adherence to Discharge Plans

chance that the null hypothesis is true is less than 1% in 100 so that the results are significant. However, we cannot draw the conclusion that the program was solely responsible for the differences observed between the two samples because there may have been other uncontrolled variables in operation.

Unfortunately, it was not possible to ascertain how well patients were adhering to plans beyond two weeks post-discharge since hospital policy is to permit only this one contact. None-the-less, even during this early period following the inpatient stay, there were significant differences between the two groups in terms of following through on arranged resources. These results cannot be definitively attributed to the 1987 study interventions since practice and attitudes about discharge planning had changed in the two years, and because a controlled, experimental design was not used. However, it is highly likely that the program did contribute to the positive results noted above.

The large difference in the number of AMA patients between the two samples is more complex to explain. Senior and Kibbee suggest that "Leaving AMA is unilateral behavior, but it involves at least a dyadic relationship, i.e., between the patient and the staff ... it is clear that staff can and do either actively or passively, encourage patients that they do not like to leave AMA."[1] It is possible

[1]Neil Senior and Priscilla Kibbee, "Can We Predict the Patient Who Leaves

that social workers in the 1987 study contributed to patients' remaining in the hospital by involving them in early planning for community living, and by allying with them as collaborative partners. If the program actually relieved social work burden in dealing with the most difficult to discharge, then we would predict that staff would be less eager to see this population sign out against medical advice. The low number of AMA discharges in the 1987 study group was certainly one of the unanticipated results of the study which needs further research.

10.9 Quality of Discharge Planning Charting

All charts for the 1985 and 1987 study groups were reviewed by the program coordinator using a chart review form which addressed the major concrete requirements for discharge planning, known to all social workers practicing in this setting. Because it was not possible (given the resources of the coordinator) to establish reliability or validity for the form, the items it contains were kept objective and measurable so that the judgment required of the rater would be minimal. The forms were a reformulation of instruments which had been used for several years to survey charts for quality assurance purposes within the social work department (see Appendix F).

Items on the chart review form were rated as either present or absent and then a final score was tallied. The total possible score for a chart meeting all requirements was 15. The results of chart reviews for the two study groups are presented in Table 10.15 and in Table 10.16, with Table 10.16 giving a summary

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Against Medical Advice: The Search for a Method," *The Psychiatric Hospital* 17 (Winter 1986), p. 36.

Chart Review Score	# of Charts Scoring 1985 Group	1987 Group
1	0	0
2	0	0
3	2	0
4	4	1
5	3	0
6	2	0
7	3	0
8	4	2
9	2	1
10	2	3
11	3	3
12	1	8
13	0	3
14	0	3
15	0	2
Total	26	26

Table 10.15: Distribution of Results from the Chart Reviews

Chart Review Score	1985 Group	1987 Group
1- 5	34.6% (9)	3.8% (1)
6-10	50.0% (13)	23.0% (6)
11-15	15.4% (4)	73.0% (19)
Totals	100.0% (26)	99.8% (26)

Table 10.16: Summary of Distribution of Charting Scores in the Two Studies

of the results.

The mean charting scores for the groups was 7.12 for 1985 and 11.5 for 1987. The median score was 7 for 1985 and 12 for 1987. For the 1985 group, the major deficiencies in charts were that initial discharge plans had not been completed during the first week of the stay and did not cover the four areas specified in the chart (treatment, living arrangements, finances for medical and living expenses, and education/employment/vocational plans), and these initial plans were rarely

Time Period	Total # Complaints	# Discharge-Related Complaints
1/87 - 6/87	20	5
7/87 - 12/87	9	5
1/88 - 6/88	22	5
7/88 - 12/88	24	8
Total	75	23 (31%)

Table 10.17: Type of Complaints Received During the 1987 Study

updated. Discharge planning did not become more focused over time, nor were specific contacts and referrals described in progress notes. Charts in the 1987 study gave a much more comprehensive view of social work discharge planning efforts and indicated that work was timely, aggressive, and specifically focused. Further, while hospital charting requirements for social work were almost fully met in the 1987 sample, this was not the case for the 1985 cases.

10.10 Patient, Family, Community Complaints Concerning Discharge Planning

Beginning in January 1987, the program coordinator requested that the social work division coordinators and administrators document all complaints received from patients, their families, or community representatives as part of the department's quality assurance program. The results are presented in Table 10.17. Although senior staff may not have reported all problems brought to their attention, it was significant to note that none of the complaints involved any of the patients in the 1987 study group. (Comparable complaint reports were not done in 1985.) The 1987 study group patients were admitted between October 1987 and January 1988 and had all been discharged by the end of September 1988. Therefore the last 3 reporting periods encompassing 7/87 - 12/88 are relevant to the study group.

Typical complaints received during the two years cited were:

- Family members claimed that although the patient was about to be discharged, they weren't aware of the plan.

- Family members complained that the social worker was not spending enough time on discharge planning, and therefore there were delays in the patient's going to the facility of his choice.

- The Office of Disability Determinations had not received a medical report related to an SSI application which it had requested 2 months before.

- A community halfway house noted that the social worker had not formulated longer-range plans for a patient and wanted help with these.

- A mother called to state that her son had decompensated and returned to drugs while living with her for an interim period post-discharge.

- The county Department of Community Mental Health stated that a patient had been discharged with no referrals in place.

- A shelter called complaining that a patient had not been connected to the Department of Social Service at the point of discharge.

- A family complained that they did not get the discharge plan they had wanted and were dissatisfied.

- A family felt that a discharge had been premature and precipitous.

Although definitive conclusions cannot be drawn from the fact that no study patients were involved in the complaints (since all complaints may not have been documented), one of the planned outcomes of the program was to reduce the likelihood of dissatisfaction with the quality and timeliness of discharge planning services for high risk patients. It will be interesting to see whether this trend (fewer complaints for cases receiving intensive discharge planning efforts) continues in the future.

10.11 Responses of Social Work Staff to the High Risk Program

Since social workers had been promised (as part of the negotiations in having the high risk program accepted) that they would be required to do no extra paperwork, it was not possible to ask participants to complete a form concerning their opinions about the program. However, in February, 1988 after the program had been operating for 4 months, a brief questionnaire was distributed to all social work staff and students asking (anonymously) whether they had sought assistance through the Discharge Planning Coordinator and Resource Library staff, and whether they had been helped. Write-in comments were also solicited. Questionnaires were distributed to 32 inpatient staff and students, and responses were received from 27 persons (84% response rate).

Of the 27 respondents, 24 stated that they had requested assistance with discharge planning issues from the Discharge Planning Consultant and/or Resource Library staff. Their ratings of the helpfulness of these consultants are given in Table 10.18. Ten persons wrote in comments about the resource staff which are

Rating Scale	1	2	3	4	5
Meaning	not helpful		somewhat helpful	very helpful	
Staff Responses	0%	0%	12.5%	16.6%	71%

Table 10.18: Rating of the Helpfulness of the Departmental Resource Services

noted below (names have been changed to titles):

- "The [Discharge Planning Coordinator and Resource Consultant] have been very helpful - available, supportive and very knowledgeable. I really appreciate having this service for difficult discharge planning cases."

- "I always feel relieved when I consult with [the Discharge Planning Coordinator] and confident I will be helped with formulating adequate discharge plans for my patients."

- "It would be difficult to say which of the [resource staff] is the most helpful because they are all superlative."

- "With the exception of [the Discharge Planning Coordinator], assistance is too unfocused and lengthy."

- "I think all three [resource staff] should be commended for their very dedicated work in discharge planning."

- "Information was helpful but at times more information was given than actually needed. This tended to confuse the situation."

- "[The Discharge Planning Coordinator] has been extremely helpful."

- "I am very dependent on the resource staff and dislike using the room [Resource Library] if they are not there."
- "[The Discharge Planning Coordinator] has been fabulous and [the Resource Consultant] has been very helpful."
- "The Discharge Planning Committee meetings and minutes are really valuable."

Staff suggested that there be computerization of resource information, a volunteer to make site visits in the community, and clearer organization of the Resource Library collection.

Since 84% of the inpatient staff and students completed the questionnaire, it can be argued that the sample was representative of the feelings of the majority of the group. In addition, this general sense of support and appreciation has been repeated in meetings, and in personal comments. Hopefully at a later time it will be possible to conduct a more refined assessment of staff's evaluation of all program elements.

10.12 Summary of Findings

While patients in both study groups had 5 or more high risk factors present, there were differences in demographic characteristics. The 1987 group for example contained a greater proportion of minorities, and had fewer persons who resided in Westchester County. By 1987, the proportion of patients whose hospital stay was funded by Medicaid or Medicare had risen from 76% to 88%. At admission, 42% of the 1987 patients had involuntary admissions compared to 27% for 1985.

However, only 4% of the 1987 patients were discharged AMA whereas 31% of the 1985 sample left against advice. Lengths of stay were somewhat shorter for the 1987 group, reflecting cost containment efforts by third party payors. Both groups contained approximately the same proportion of persons with major psychotic disorders, but the 1987 sample contained twice as many persons with affective disorders, and three times as many persons with substance abuse disorders. There had also been a significant increase in persons with serious medical conditions (73% in 1987 as compared to 42% in 1985).

In terms of other high risk factors, the 1987 group had a larger proportion of patients with serious and prolonged impairment in major areas of performance, and patients with no involved/available families. In contrast, the 1985 group had a greater number of patients who: required arrangement of a different residence; had numerous and/or lengthy past hospitalizations; were mentally retarded or had an organic mental disorder; had a history of recent physical abuse; and had families in the process of separation or divorce. These differences in the combination of high risk factors between the two groups may simply be due to the fact that small numbers of patients were involved in the study.

The 1985 patients were not intended to serve as a control group for the study, but rather as a point of reference to document the state of discharge planning practice at that time. One of the weaknesses of the study is the fact that it was not possible to randomly assign patients to the program and then to compare them to a matched group of non-participating patients. Therefore findings cannot be definitively attributed to the effects of the program and may in fact be due to

other intervening variables. However, it should be kept in mind that many of the hypotheses set forth as the program was designed were borne out by subsequent results. This suggests that the program had the effects intended, but does not offer absolute proof of a causal relationship.

In terms of qualitative measures regarding discharge planning, the study found that there were significant differences between the 1987 and 1985 study groups along the following dimensions:

- There was only 1 AMA discharge from the 1987 group (4%) and 8 (31%) from the 1985 group.
- For 50% of the 1985 patients, no source of funding for aftercare living and treatment was mentioned in the chart. (Funding was specified for all 1987 patients.)
- For 1987 patients, 93% of needed resources had been arranged prior to discharge whereas this figure was 61% for the 1985 group.
- Two weeks post-discharge, 81% of the 1987 patients were fully adhering to aftercare plans; in 1985, 46% fully adhered.
- In 1987, 73% of the charts scored 11-15 on the quality assurance form while in 1985, only 15.4% of charts were in this range.
- Of the 23 complaints about discharge planning received while the study patients were hospitalized, none related to patients in the high risk program.

- In a questionnaire about Resource Library staff, 71% of the persons who had used these services rated them as very helpful.

The qualitative results of the program will be discussed in later chapters (i.e. Chapters 11, 12, 13, 14, and 15).

10.13 A Critique of the Evaluative Strategies Used with the High Risk Program

The project and evaluative structure are formative in nature in that an attempt has been made to assess and improve a specific program without regard to the generalizability of results.[2] The research methods used were intended to meet the informational needs of social workers, to be compatible with their practice, and to be of reasonable cost. Cause-effect relationships were not sought; rather the purpose was to provide prompt feedback of a practical nature to workers and administrators.

Weiss notes that for an evaluation to succeed, one must be clear about what decisions have to be made and what data is therefore required.[3] She describes three types of decisions - those at a policy level (whether the program should exist); those at a strategic level (what strategies of intervention should be used); and those involving tactics (day-to-day practices and procedures). The current study answers questions primarily in the latter two categories, though the cumulative

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[2]Tony Tripodi and Irwin Epstein, "Incorporating Knowledge of Research Methodology into Social Work Practice," *Journal of Social Service Research* 2 (Fall 1978), pp. 65 - 78.

[3]Carol Weiss, "Alternative Models of Program Evaluation," *Social Work* 17 (November 1974), pp. 675 - 681.

data does shed some light upon whether the program should continue, based upon its demonstrated effectiveness.

The study was longitudinal in nature and involved 52 high risk patients, 26 admitted during 1985 and 26 admitted in 1987. The design was quasi-experimental, using two non-equivalent comparison groups. Because of the nature of the setting and of practice, it was not possible to arrange random selection and assignment of patients. However, the two studies occurred within the same institution, and therefore many factors regarding the setting remained constant. It has also been possible to compare high risk patients identified in the two studies in terms of important demographic variables so that any important differences in the two samples could be ascertained.

Measures taken were both "tough and tender-minded"[4] since there was specification and measurement of some outcome measures (e.g. non-acute days, degree of adherence), while others dealt with subjective status and intrapsychic factors (e.g. patient complaints, worker attitude). In this way, the complex nature of the systems involved has been taken into account to some extent.

The program combined a goal attainment model and a systems model[5] in that there was evaluation of the degree to which predetermined objectives were reached, at the same time that an attempt was made to establish a working model of a social

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[4]Leonard Kogan and Ann Shyne, "Tender-Minded and Tough-Minded Approaches in Evaluative Research," *Welfare in Review* 4 (March 1966), pp. 12-17.

[5]Herbert Schulberg and Frank Baker, "Program Evaluation Models and the Implementation of Research Findings," *American Journal of Public Health* 58 (July 1960), pp. 1248 - 1255.

work task. The systemic view takes into account the particular organizational environment in which the program operates and such nuts and bolts items as how resources were acquired. In addition, in line with the systems model, staff in the 1987 study received ongoing feedback regarding their efforts — information which users defined as relevant to their values and needs.

Some of the difficulties with the design are suggested by Weiss.[6] A single project is always the prisoner of its setting – the results may indeed be confined to one time and place and lack generalizeability. It is possible that the population and environment for the two comparative studies do differ from each other along important rather than insignificant dimensions which have not been measured, making it difficult to distinguish what results accrue from the program alone. Instruments for measuring outcomes do not exist and have had to be developed by the author. Their reliability and validity are questionable since they have received only limited testing prior to the implementation of the program. Events within the setting, other than the experimental variables, have had potential for affecting outcome (e.g. policy changes, staff shifts, unit philosophy revisions, etc.). Given an action setting, it is likely that there was differential (rather than random) subject inclusion in the study due to such factors as social worker attitude towards discharge planning, relation to project coordinator, etc. Finally, the well-known Hawthorne effect may have contributed to positive results solely because staff's functioning in discharge planning was being studied.

However, despite all these caveats, the program is potentially useful to social

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[6]Carol Weiss, *Evaluative Research* (New Jersey: Prentice - Hall, 1972), p. 50.

workers, administrators and patients. It is a demonstration model which can be replicated or repeated thereby enhancing the reliability of results. It does not disrupt practice and in fact aids social workers in performing an essential service more effectively. To undertake a more rigorous experimental design would have seriously interferred with agency functioning (if approval could have been obtained), would have been very time-consuming and costly, and might have deprived patients of needed aspects of care. Although the design was necessarily flawed, it allowed us to examine multiple and reciprocal relationshps in a system which is constantly in flux. It has immediate utilitarian value, and with systematic observation over time, may eventually allow more powerful causal conclusions to be drawn.

The study contains objectives at the quantitative-descriptive and at the associational levels of social work knowledge. At the quantitative-descriptive level, answers to simple, factual questions were sought to give data about frequency counts and proportions within one variable. (For example, the proportion of high risk discharge planning patients present in all hospital admissions, the number of non-acute days for each unit, etc.) Such data was then used to make baseline comparisons between the 1985 and 1987 study groups.

At the associational level, empirical data was sought to demonstrate a relationship between two variables. An example was the relationship between the comprehensive discharge planning program and greater patient adherence. The positive associations found do not necessarily mean that the variables are causally related. There may well be intervening variables or contaminations in the research design (since it does not fulfill classic experimental requirements) which are actu-

ally producing the results.

For quantitative-descriptive knowledge, specific criteria which must be met are conceptual translatability and hypothesis researchability in addition to measurement accuracy and representative sampling. Concepts have been carefully defined and operationalized; hypotheses which can be tested through the design have been specified. The population tested was specified along important identifying parameters so that replicability is possible. Measurement accuracy has been addressed by pre-testing questionnaires and by having subjects comment on the extent to which items seem clear and logically related to the concepts being measured. The High Risk Indicator List, for example, was tested by the author in a pilot project using multiple raters.

The major problems with the study design are: the possibility that selection biases or other variables related to the dependent variable affected results; events other than the independent variable (history and maturation) may have affected outcome; and lack of generalizeability due to non-random selection of subjects. Ideally, it would be useful to replicate the study in similar settings several times to ensure that results are reliable, but this must be left for future investigations.

Chapter 11

Selected Patient Examples from the Study

11.1 Examples Illustrating Differences between the Two Study Groups

In order to illustrate the operation of the program for high risk psychiatric patients and to contrast it with usual discharge planning practices, two cases will be presented below which had many features in common.[1]

11.1.1 1985 Case Example

The patient, CM, was a 26 year old White, Italian male who was transferred to New York Hospital - Westchester Division from a community hospital in a nearby county. This was the patient's twelfth lifetime psychiatric hospitalization; he had a history of not taking medication post-discharge, and of eloping or leaving hospitals AMA. His diagnosis was schizophrenia, chronic paranoid type, with alcohol and marijuana abuse. He was unemployed, but a high school graduate who was receiving SSI and Medicaid.

The patient had just been released from another short-term psychiatric hospital two weeks prior to coming to New York Hospital. He had been living in an adult home and had attacked the manager and another resident. He was then taken to a local hospital by the police as an involuntary admission and was transferred

[1]All identifying information in case examples has been altered to preserve confidentiality.

here. It was found that he had discontinued his medication 10 days before and had therefore decompensated. He exhibited auditory hallucinations, hostility and potential violence. His parents refused to be involved when contacted by phone and stated that the patient could not live with them. Both were employed and described as upwardly mobile, middle class business persons. The patient was the second of four children - his other siblings were functioning well and achieving appropriately. His schizophrenic illness dated back to his sophomore year in high school when he had failed to be accepted to the varsity baseball team, and began exhibiting signs of a paranoid thought disorder.

After a month here in which he was treated with neuroleptic medication, the patient left AMA, returned the same day, remained another 12 days and then eloped. His physician persuaded him to accept a prolixin injection just prior to discharge which would prevent decompensation for 2-3 weeks. Since he left precipitously, his discharge plan was listed as a suggestion that he return to a community clinic where he had been seen previously. No referral summary was sent, however, and there was no indication in the chart that the clinic had been contacted by phone in advance of discharge. Because the patient left AMA, the social worker did not conduct a follow-up call to determine whether he had actually contacted the clinic.

The case of CM illustrates many of the reasons for the establishment of the high risk program. The patient had a history of repeated admissions with rapid decompensations, and the cycle seems to have been repeated during his New York Hospital stay. If he had been part of the high risk program, we would have at-

tempted to do the following:

1. Assessed and evaluated the multiple psychobiosocial precipitants to the readmission occurring at this particular time in order to formulate a discharge planning hypothesis which could be used to inform both the treatment and aftercare plan. (The chart only indicates that the patient decompensated after failing to take medication, smoking marijuana, and discontinuing sessions with his outside therapist, but does not describe psychosocial stressors.)

2. Contacted all those persons who had been involved in his care (the clinic, adult home, his parents and siblings, a past day hospital, staff of the referring hospital, etc.) to determine what was required for an aftercare plan to be more effective and more attractive to the patient.

3. Discussed the pattern of rapid cycling with the patient to help him understand reasons for his repeated readmissions, and difficulty in achieving community tenure. An attempt would have been made to understand the patient's goals and to engage him in decision-making about his options post-hospital.

4. Evaluated his comprehensive needs for services including: housing, day program or day training, psychosocial club, medical care, transportation, case management services, family supports, assistance in managing funds, referral to AA, long-term plans for vocational rehabilitation, etc.

5. Evaluated his willingness to use intramuscular medication so that daily medication monitoring would not be necessary.

6. Provided linkages and connections among all those involved in the aftercare plan prior to discharge so that communication was established.

7. Explored whether the parents might be willing to undertake some limited involvement if they were part of a larger, well-connected support system. At minimum the parents might have acted as sources of valuable information regarding what had gone awry and how their son might be best engaged.

When the patient persisted in his desire to leave AMA, he should at least have been provided with initial funds, transportation, connection with the Department of Social Service Homeless Unit, and help in making an appointment with a mental health clinic to which referral material would be given by phone and later by mail. DSS could also have been contacted about the patient's needs as well as the Community Support System Case Management Program. (In some cases such contacts may not be possible if the patient refuses to give permission, but this is relatively rare.) Staff's response to the patient's desire to leave abruptly has an almost punitive quality – "if you insist upon leaving us, we will also abandon you and take no further responsibility for your care."

11.1.2 1987 Case Example

The patient, BC is a 32 year old white, Irish male who was admitted following a near-lethal suicide attempt. He had been hospitalized 6 times during the past 18 months and had a history of not taking his medication, and of following through on discharge plans for only very brief periods. His diagnosis was bipolar disorder with psychotic features, and he had also abused cocaine for 8 years. The patient

had been living with his parents and 5 year old child at the time of admission. His wife was in the process of divorcing him and was also addicted to cocaine. His parents refused to permit him to return to their home.

The patient was the younger of 2 children; he had an adolescent brother who also lived with his parents. BC had had an erratic work history as an electrician's assistant, and was receiving no benefits. His stay was funded by Medicaid.

The social worker was helped to assess stressors which needed to be addressed during the hospital stay. Several of the major ones included his inability to maintain a job (he had kept one for 4 weeks prior to admission), an upcoming custody hearing regarding his child, his parents' refusal to support both the patient and his child; his son's emerging learning and emotional problems; his lack of understanding of his bipolar illness and the role of medication.

The worker identified that the patient was overwhelmed with demands for responsible, adult behavior which he could not fulfill. His frustration tolerance was poor, and he (as well as his estranged wife and parents) saw himself as having failed at important tasks in life. His immediate family did not understand his illness and were highly critical of the way he had managed work, family and finances. The discharge planning hypothesis included the need for the patient to be in a safe environment in which he could experience small successes (and failures) over time, thereby developing coping skills and the capacity to deal with frustration. Pressures from family members also needed to be removed through psychoeducation and through exploration of the patient's readiness to assume full responsibility for parenting.

The patient was helped to apply for State Disability Insurance, and because he had accumulated sufficient work quarters, for Social Security Disability Insurance. This removed immediate financial pressures and made it possible for the patient to consider a careful and planned recovery in which functions could be added gradually.

Child Protective Services was asked to be involved with the patient's son since there was a history of neglect, but this was handled in a supportive way. Treatment was obtained for the child, and psychoeducation provided for the grandparents. The patient was helped to negotiate his relationship with his parents so that while they remained firm in their wish not to have him live with them, they also agreed to care for his son until such time as the patient might be able to do so himself. Home care assistance was obtained for the parents as well.

Applications were made to halfway houses and day programs, and one halfway house director was able to be persuaded (through advocacy by the social worker) that the patient had made significant progress in understanding both his suicide attempt and his former drug abuse. The patient was enabled to visit both programs in advance, to meet staff and patients, and all providers were aware of each other and of mutual roles. Referrals were also made to the Community Support System case management program for longer-term follow and support, and to Narcotics Anonymous. After leaving New York Hospital, the patient was found to be in full compliance with the discharge plan. He was visiting his child regularly, and his parents were attending family sessions with him at the day hospital.

In reading the chart for BC, social work interventions and discharge planning

are comprehensive, timely and well-documented. There is evidence that an early alliance was formed with the patient around understanding the causes of his despair. Concrete assistance was offered at the beginning of the stay in the form of referrals for financial benefits, psychoeducation and home assistance for his parents as well as treatment for his son. These interventions probably served to enhance the working alliance with the social worker who was able to appropriately reduce some realistic sources of stress.

11.2 Comparison of the Two Case Examples

It might be argued that CM had a more malignant illness than BC, and that the latter was less dysfunctional since he had been able to marry, have children, and work sporadically. In addition, BC's support system was able to be engaged and had not abandoned him entirely, and he was a resident of Westchester County which meant that the worker was more familiar with community agency staff.

However, beyond these dissimilarities which may account for some of the variances, the differences in the timeliness, aggressiveness and comprehensiveness of social work intervention in both cases was striking. CM's chart did not indicate that an alliance had been formed with the social worker or that immediate attention was given to exploring (and perhaps alleviating) his immediate concrete problems.

The degree of investment in overcoming obstacles and in precluding the operation of negative factors in the case of CM did not appear strong. For example, the family's initial resistance to involvement was accepted at face value - there was no exploration about whether their expertise regarding the patient's illness

could be tapped by the treatment team, even if they did not want more extensive involvement. The treating physician might have chosen to make a case that the patient was a danger to himself and others (based on his recent outburst at the adult home) and have followed through with a 2-physician certificate and court hearing to retain him if necessary.

Providers in the patient's home county could have been contacted and asked to form a unified plan with him and his family which might have prevented his shuttling from agency to agency.

One of the strongest points which is illustrated by the case of CM is that staff tend to invest their energies in patients who can respond positively to the configuration of existing services. It is exceedingly difficult to help the system change to meet the needs of patients who do not fit what it has to offer. Since CM did not appear to want treatment, and had a history of multiple failures, medication was given, but no attempt was made to alter his downward spiralling course.

A key issue for the 1987 program was how to enable staff to invest in high risk cases which might simply leave AMA if they were not engaged. Staff tended to feel absolved of responsibility if the patient "chose to sign himself out against medical advice." This then became the patient's right and his decision as a competent adult which could not be abrogated.

By taking a passive stance, teams can allow difficult patients to leave, ostensibly so that resources may be better used for those who wish to take advantage of them. Preventing the cycle of community failure and readmission requires much

energy and persistance, and a belief that intensive discharge planning and casework services can make a difference. When workers were given substantial assistance and support in tackling these high risk cases, they became freed to take on the challenge, to become strong advocates with the team and outside systems. After succeeding at placing an exceptionally difficult adolescent, one worker stated to the program coordinator, "I never thought I would find discharge planning this challenging or rewarding. It took all the skill I had."

In a setting where there are not sufficient resources to meet all needs, those at highest risk must be assured of special attention through mechanisms which identify them promptly and offer additional help, or the natural course of events will be to avoid heroic measures.

11.3 Counter-Examples

Besides examining cases in which program interventions operated as planned, it is also instructive to look at instances in which intensive discharge planning services appeared to make little difference.

Such was the case with BD, a 24 year old Black male admitted for treatment of depression and substance abuse. The patient became suicidal in the context of a broken homosexual relationship, learning that a nephew had AIDS, and having his apartment robbed. He had had three previous psychiatric admissions to municipal hospitals in the past year for similar symptoms, and had always left AMA. The patient was receiving SSI and was living with an uncle at the time of admission. The way in which he supported his drug use was not known.

The patient's depression diminished rapidly after admission when his AIDS

test report was negative. The social worker approached him numerous times about contacting his family, but he refused. His father had abandoned him at age 2, and his mother had lived since with a series of three other men. He claimed that the family had disowned him because he was gay and used drugs, and that he did not want them to know about his hospital stay.

He was given assistance in renewing an expired Section 8 rent voucher and referrals to residential drug treatment programs which were explored but refused. Psychoeducation was offered about drug abuse and AIDS, and team members emphasized the need for longer-term rehabilitation. After an 11 day stay, the patient decided to leave AMA to return to his apartment. He refused any follow-up referrals and would not sign consents to release information. Post-discharge, he was never able to be reached by phone.

This is a patient who had seemed quite high risk at admission because he stated he might have AIDS, he claimed that he could not return to his apartment, he was believed to have a serious psychiatric disorder plus a drug abuse diagnosis, and he had a chronic medical condition (heart damage post rheumatic fever). However, a number of these factors proved not to be as critical as they seemed initially, and the primary issue preventing good discharge planning was the patient's inability to be engaged around longer-term treatment of his drug use.

As the patient left, the worker and team felt that BD had been given clear options and that there was truly no recourse to allowing him to leave without services in place. The patient claimed that he knew where to go for help if he wanted it, but he was no longer in crisis.

Among the 1985 study group, there were several patients who had comprehensive, well-formulated aftercare plans which were implemented and followed. An example would be RJ, an older adolescent with a diagnosis of childhood autism who had become unmanageable in a residential treatment center following the departure of a counsellor to whom he was strongly attached. Intensive work was done with the parents concerning their understanding of and response to this profound illness, and their own needs were attended to. Marital conflicts were reduced over the hospital stay, and the capacity of the couple to support each other was enhanced. While the chart reflected a high level of sophistication in psychoeducation and marital interventions, discharge planning was deficient in a number of areas: it began very late in the stay; there was no early attention to obtaining funding mechanisms; specific referral efforts were not mentioned; there were many missing weekly notes; and no follow-up care was noted for the parents.

Thus although a satisfactory long-term residential setting was located for the patient, (and he was reported to be doing well post-discharge), the quality and content of notes are inadequate as they pertain to discharge planning. The main point is that multiple goals must be met through the function of discharge planning – the patient's entire support system must be considered, institutional goals (such as reimbursement by third party payors) must be attended to through sound charting, and the tempo of efforts must indicate good stewardship of scarce resources (mental health dollars and inpatient days). These comments apply to most of the cases in the 1985 sample – while competent social work services may have been offered, there was usually not sufficient attention given to the multiple demands

of high quality discharge planning, especially that of accountability.

Chapter 12

Major Discharge Planning Problems Discovered among High Risk Patients

An interesting question raised by the study is why social workers find that the factors noted on the High Risk Indicator List usually require extraordinary discharge planning effort and time. One could imagine a different society in which social welfare programs had been created in such a fashion that a task such as locating housing for a mentally ill person would not be onerous or impossible. However, in examining the 1985 and 1987 study groups, patterns emerged which emphasized repeatedly the weaknesses, deficiencies, and unintended consequences of the current mental health delivery system. Major issues related to inadequacies in the structure of mental health services, revealed by the program, are discussed below.

12.1 Housing

The greatest impediment to discharge for many of the sample patients was lack of suitable housing with the appropriate degree of structure and support. In New York State, the Office of Mental Health licenses only 3 levels of community residences specifically for the mentally ill – intensive-supportive, supervised and supportive living. These provide varying degrees of staff supervision and services. Our own study of New York Hospital - Westchester Division discharges for a 6-month period indicated that 47% of all patients required the arrangement of housing

different from that present at admission. While there are 132,457 (1986 figure)[1] discharges from psychiatric facilities in New York State per year, there are only an estimated 6500 certified residential placements in the entire state.[2] If almost half of those discharged require special living situations, one can only conclude that a crisis situation exists.

Besides OMH facilities, Adult Homes (licensed by the Department of Social Services) can provide a minimal amount of structure for persons who are quite independent in their daily living skills, and who attend outside programs.[3] Suitable alternative lodging in rooming houses or Y's is extremely scarce and usually beyond the straightened means of the psychiatric patient receiving public benefits. Wait lists for housing are often months' long, and no temporary arrangements exist for the interim between acute hospital care and eventual placement in a community residence. If family members are unable or unwilling to accept a patient temporarily pending a bed in a community residence, the individual may remain in hospital for an extended period, or may go to an unsatisfactory arrangement such as a shelter.

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[1]New York State Office of Mental Health, *Statewide Comprehensive Plan for Mental Health Services 1989 - 1991*, p. 16.

[2]New York State Commission on Quality of Care for the Mentally Disabled, *Discharge Practices of Inpatient Psychiatric Facilities*, Appendix p. 2.

[3]The Community Support System Core Agency at New York Hospital - Westchester Division states that there are only 10 adult homes in Westchester County which will consider psychiatric patients. In New York State, there are 505 Adult Homes in operation and only 152 of these are classified as having a predominantly psychiatric population. (From Clarence Sundram, "Adult Homes," *Quality of Care* 38 (November - December 1988), p. 6.)

Each form of housing has stringent requirements for admission which many high risk patients cannot meet. Patients must be able to live successfully with others, to share chores, to care for themselves, and to manage their own programs and medication. Those patients who are disruptive, have low motivation, a dual diagnosis, or other undesirable traits are routinely rejected by community residences who are in a seller's market. Many of the high risk patients in the study had already spent time in community residences and had either been asked not to return, or were unwilling to consider this kind of living situation again.

For elderly psychiatric patients with serious medical conditions or physical disabilities, nursing homes are considered the facilities of choice; yet nursing homes are extremely reluctant to accept persons with psychiatric illnesses because of demands upon staff and reimbursement issues.[4]

For adolescents and children who require placement, there are three non-contiguous avenues of funding and entry (in addition to private pay). These are: the Committee on Special Education (CSE) which will fund residential treatment centers only if the child cannot be educated in existing community educational settings; the Department of Social Service (DSS) which requires that CSE have

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[4]Psychiatric patients usually score at the low end of the Patient Rating Instrument (PRI), which is used to assess qualifications for residential health care facility admission. PRI scores are then used to calculate the nursing home's rate of reimbursement which does not reflect the intensity of personal care that is often needed by the mentally ill. In addition, the Nursing Home Reform Act, implemented on 1/1/89, mandates special preadmission screening by the Office of Mental Health for all patients with psychiatric diagnoses who seek to enter nursing homes. (See Hospital Association of New York State, "OMH and OMRDD Announce Implementation Plans for Nursing Home Reform Law," *HANYS NEWS* 20 (December 23, 1988), pp. 2-3.)

already denied the patient, that the parent sign over guardianship of the child, and contribute financially to the living arrangement, (budgeted according to a welfare standard of living); and Residential Treatment Facilities (RTF's), funded by Medicaid for children requiring the equivalent of a long-term inpatient setting.

In sum, one can say that the patient must be able to fit the extensive requirements of the scarce housing available rather than the supportive housing being able to flexibly meet the needs of the patient. There are no settings which have the capacity to adjust to changes in the patient's condition – each shift up or downward in mental health status requires that the patient receive service at a different level of care, thereby promoting disruption and lack of adherence. Most patients want secure long-term housing which provides a safe base of operation for dealing with other major areas of functioning. The design of the mental health system does not permit this and unfortunately responds to progress or regression by insisting that the patient move to another setting.

12.2 Resource Wait Lists

In addition to the unavailability of housing, most other resources required by the seriously mentally ill are wait-listed. Day programs and mental health clinics, in particular, are in short supply, and are often not eager to accept the chronically mentally ill because they do not "move through the system" and represent a long-term commitment. An added complexity is that clinics and day programs cannot be applied to well in advance of discharge unless the housing situation is known and transportation ensured. Most community treatment facilities are not willing to act on referrals until the patient has been accepted at suitable housing within

their catchment area. This means that delays in discharge can occur at two levels – while housing is awaited, and then while treatment is arranged.

We found that it usually required several weeks for applications to treatment programs to be processed, often with requirements for personal interviews and previewing of the program. Aftercare service application processes are geared to a pace which existed prior to the implementation of penalties for overly-long inpatient stays. Unfortunately, community facilities are not prepared to conduct rapid evaluations and to provide the quick responses to requests for service that acute care hospitals require.

12.3 Benefits Programs

The majority of the patients in the 1987 study group for whom the program was implemented were eligible for SSI, SSDI or a combination of these plus Medicaid and/or Medicare. However, each of these funding mechanisms has developed independently of the others and has separate requirements. Further, when patients are receiving more than one benefit or are hospitalized, the relation of the funds to each other and the nature of the benefit itself becomes highly complex.[5] When study patients were only eligible for DSS funding for living expenses, or had meager private funds, options were severely limited. For example, DSS funding could not be obtained until the patient was discharged; yet discharge could not occur without adequate housing in place.

Application for benefits requires a high degree of technical expertise, specific

[5]See for example Appendix P which describes the interface of benefit programs with inpatient status.

personal documents and financial information from the patient, and 8-12 weeks minimum for approval. There were many exceptional cases in the study which required much effort to untangle (e.g. patients who received lump sum back payments of benefits which then made them ineligible for the benefit; patients in the process of divorce whose financial resources were in limbo; patients who had suddenly inherited funds through the death of a parent; patients who had been decertified for benefits because they had ignored a communication from the funding source, etc.). The regulations governing eligibility for benefits are so complex that even staff of the disbursing agencies were frequently confused or gave misinformation. It often required very sophisticated financial analysis and advice by our Resource Consultant to ensure that patients received benefits to which they were entitled, at the appropriate level, in a timely fashion. Clearly dealing with these bureaucracies is generally beyond the capacities of persons who are mentally disabled and lacking in skills of self-advocacy.

12.4 Services for the Multiply Disabled

Patients who had dual diagnoses (mental illness plus mental retardation, substance abuse, an organic disorder or serious medical problem) presented exceptional challenges for discharge planning because they were usually rejected by the subsystems delegated responsibility for each of their disabilities. For example, the Office of Mental Retardation and Developmental Disabilities (OMRDD) would claim inability to manage retarded persons with a mental illness, while the Office of Mental Health (OMH) would state that the retarded mentally ill were the purview of OMRDD. Such disputes were resolved eventually, but required energetic pursuit

and much social work time since there are no clearcut mechanisms for negotiating these turf issues. A typical attitude was expressed by a representative of the State Department of Education who said he hoped that a severely disabled 18 year old patient would remain in hospital till age 21 so that she would no longer be that agency's responsibility. State bureaucracies often took the point of view that patients were safe and well cared for while in the hospital and therefore did not need prompt placement assistance. A critical issue was the non-existance of a central coordinating body to bring together potential providers from all systems so that a joint care plan could be worked out. Instead, we had to explore and pursue each system serially, using whatever outside sources of influence we could muster (such as boro ombudsmen, state senators, the Alliance for the Mentally Ill, etc.).

A further example of resources which cannot respond to the needs of changing client characteristics are those for the substance abusing mentally ill. Very few day and residential programs for alcohol/substance abusers are willing to accept patients who require psychotropic medications, and conversely very few services for the mentally ill are prepared to deal with those who have also abused substances. Some few clinics and day programs do exist, but they are of little use unless housing is simultaneously in place.

12.5 Paperwork

The requirements for accountability, charting and reporting while the patient is hospitalized have burgeoned and only add to the chaotic non-system for accessing community resources. We found that each facility had its own application forms and procedures, so that one referral form, summary, and letter per patient could

not be used for multiple referrals. This caused much resistance among treating staff who delayed preparing numerous referral packets for one individual. Referrals for hard-to-place patients were especially burdensome since the numbers of applications could reach 20 – 40. (Applications per patient for residential health care facilities for the elderly were at times over one hundred, but the same forms could be sent repeatedly.) Again, the problem is a lack of coordination and systematization for most mental health resources which would permit a more coherent, less wasteful method for referrals.

Another difficulty experienced by inpatient therapists was the need to write specialized summaries and letters depending upon the resource sought. For SSDI, for example, the therapist needed to focus upon functional disabilities precluding gainful employment while for a halfway house, he needed to concentrate upon the patient's capacity to work and live with others, to follow structure and rules. Social workers found it difficult enough to nudge overworked clinicians to prepare one referral summary, let alone to obtain separately written reports.

12.6 Patient Resistance

The persistantly mentally ill are experienced users of the mental health system, yet they often feel that traditional services do not meet their needs. Many expressed boredom with day programs which they viewed as " holding operations" rather than facilities which could teach vital skills for living. Clinics offered brief once-per-week medication management interviews and occasionally groups, but few were prepared to serve patients who could not make and keep appointments in advance, who needed to "drop in," or have home visits.

12.7 Internal Systems Issues

Like external resources, the hospital infrastructure has not yet shifted to the demands of an environment which requires that it treat only the most seriously mentally ill within an acute (30 day) environment. Traditionally, the hospital has offered long-term stays and was therefore protected to some extent from problems at the interface with the outside environment. The hospital moves at a deliberate pace, and it is difficult to accelerate its processes, even for urgent cases. For example, to obtain an appointment in the hospital's outpatient department or day hospital can require 2-4 weeks (and there are very limited openings); outgoing referral material requires so many signatures that an expedited referral takes about 9 days; telephone lines are frequently unavailable; required unit meetings are held during "prime time" for making referral calls; there are many obstacles to implementing a discharge planning activities sheet which workers could use at their desks; the patient has to sign a separate release form for each referral made; it has not been possible to hire BSW's to assist with nursing home placements or other routine aspects of aftercare planning, etc.

The internal system serves many conflicting purposes and was not designed to treat and move patients rapidly. Its primary mandate is residency training followed by research and then patient care. Missing entirely has been the notion of giving priority to the development of a streamlined, cost-effective technology that would contribute to financial viability. The antiquated nature of the internal structure contributes greatly to social work frustration, in that tasks are more difficult than need be and add significantly to burden experienced in aftercare

planning. While the study has uncovered many impediments to effective discharge planning and has set in motion efforts to remedy a number of these, there remain additional issues for which action by hospital administrators will be required, since they cross departments and involve reallocation of resources.

12.8 Illustrations of Major Discharge Planning Dilemmas

During the period of the study (and since), staff have brought to the attention of the program coordinator discharge planning dilemmas for which there are no ready answers. Several of those which recur repeatedly are described below.

12.8.1 Whose Problem Is It, Anyway?

The major systems created to meet the needs of the mentally ill appear to have no interface. They have been designed to address the needs of persons with unitary rather than multiple problems and therefore are at a loss when confronted with patients who do not fit the design of their programs. Although mechanisms have been created to make decisions about which system should have primary responsibility for the care of an individual, they can be used only under particular circumstances, their operation is idiosyncratic, unpredictable, and above all, painstakingly slow.

An 18 year old adolescent, SW, had a diagnosis of organic psychosis which was not responsive to intensive psychopharmacology and behavioral treatment. The treatment team therefore made the decision that the patient required longer-term care in a state hospital. Since SW had been living in a residential treatment facility (RTF) prior to admission (which refused to take him back), we were advised by the Office of Mental Health to apply to the state hospital covering the area in which

the RTF was located. This state hospital refused the patient on the basis that the RTF was not the patient's legal address of origin.

After many calls to the Regional Offices of Mental Health which had jurisdiction over the involved state hospitals, it was decided that the patient had to be considered by the state hospital covering SW's original address in New York City.

An extensive referral packet was then prepared and sent to the appropriate state hospital (and to the Regional Office of Mental Health) which requested much additional material, tests, records, etc. Eventually our hospital was informed that SW could not be accepted since the state facility did not treat organic mental disorders. It was recommended that the Office of Mental Retardation and Developmental Disabilities be applied to, but this was not possible since the patient had an I.Q. of 80 which placed him well above the cut-off score of 70. The state hospital's denial was then appealed to the Regional Office of Mental Health which eventually presented the case to the Assistant Commissioner of Mental Health of New York State. The state hospital's decision was upheld, and we were advised to apply to out-of-state facilities which might accept young, organic patients.

The difficulty with this advice was that Medicaid (which must pay for placement) will not allow applications to out-of-state facilities until it has been demonstrated that no in-state facilities can be located. This means that about 20 equivalent agencies (skilled nursing facilities) must be applied to and subsequently deny admission to the patient. To apply for a skilled nursing facility, the patient must achieve an appropriate score on a Patient Review Instrument which measures severe physical impairment and need for skilled nursing care. Since SW was not

medically ill enough to score for nursing home placement, this level of care was deemed inappropriate by the approving agency, the Office of Psychiatry.

The mechanism for dispute resolution in New York State could not be used because the patient must have had applications made to and denied by two state agencies for which he was eligible. Because SW did not meet requirements for entry into the mental retardation system, there was technically no dispute between systems.

While this particular case has not yet been resolved, it is likely that we will have to demonstrate strongly that no other option beside the state hospital is appropriate, and we will have to request on-site review of the record and in-person interviewing of the patient. Eventually, SW will probably be transferred to the state hospital, but meanwhile, our hospital will be paid at the alternate care rate ($147 per day versus the full rate of $588) while these issues are ponderously examined.

The impression given by aftercare agencies is that such a patient is considered "a hot potato" to be avoided at all costs since he requires life-long care. No agency sees itself as having ultimate responsibility for coordinating a comprehensive solution to a difficult but very human problem.

12.8.2 She Needs Services Which Don't Exist

An institution which treats the most severely ill will be bound to discover that there are patients for whom no other level of care exists. When this occurs, it is difficult to bring pressure to bear upon those who might authorize such services

because the allocation of resources is a political process, and the number of similar cases is generally quite few.

An example is elderly patients who require ongoing maintenance electroconvulsive therapy, either within a long-term hospital, or within a nursing home setting. One such patient, HL, was living in a nursing home, and had had multiple admissions in the past 4 years for major depression with psychotic features. She also has serious medical problems, including congestive heart failure which preclude her taking psychotropic medications, and she is responsive only to electroconvulsive therapy (ECT). When HL does not have ECT treatments for several weeks, she stops eating and eliminating and refuses to leave her bed. If ECT is continued on a maintenance basis, she functions at a level which would permit her to be cared for within a nursing home rather then within an acute care hospital.

The problem is that while a few community hospitals are willing to provide ECT, none will do so on a maintenance basis for someone in this age group with such profound medical problems. The risks are seen as too great since long-term ECT is not a well-researched modality of continuing treatment. Only one nursing home in the metropolitan area expressed possible willingness to take the patient in an ambulette for weekly outpatient ECT, but no services could be found within commuting distance.

The dilemma is that if the patient is discharged, she will become psychotic in a life-threatening manner. However, if she remains inpatient, she is at an overly restrictive level of care, the hospital is reimbursed at the nursing home rate, and an expensive, acute-care bed is utilized by a patient who needs community services

which do not exist.

A letter about this problem was sent to the New York State Commissioner of Mental Health who had no answers, and wrote only that the issue would be explored by his staff. The likelihood that HL will be able to leave the hospital in the near future appears to be exceedingly poor.

12.8.3 What's the Rush?

Community agencies are given no incentive to accept psychiatric inpatient referrals, nor to review applications and render decisions rapidly. Since there are so many more applicants than treatment openings, they restrict access through queues which serve to discourage all but the most intrepid. While we can let community agencies know that we are mandated to have patients discharged at the end of a short acute period, they do not view this constraint as their problem.

One example was SR who was referred to a large number of halfway houses and day hospitals. The day hospitals were not willing to consider her application until her post-discharge address was known, and the halfway houses responded at a leisurely pace. For example, on 2/5, an application was sent to S. halfway house. On 3/2, the patient was offered an initial interview appointment for 3/31. By 4/7, the halfway house had not yet made a decision. On 4/21, the patient was placed on the waiting list. On 5/27, S. halfway house stated that a bed might be available by August. The example is not atypical and illustrates the dual problem of insufficient community placement beds or treatment slots, and the slow pace at which the application procedure proceeds.

The dilemma for the inpatient social worker is that she cannot initiate applications shortly after admission because the patient's condition must be improved to the point that he/she can meet the criteria for entrance into the halfway house or day program. Such agencies will not consider predictive professional judgment about the likely outcome of treatment, but wait to see the level the patient actually achieves. This means that serious discharge planning has to be postponed until quite late in the stay, and that it is hampered by community agencies which are under no constraints to respond quickly.

Those patients for whom no interim arrangements exist must therefore wait in the hospital, at an inappropriately acute and restrictive level of care, until community beds are available. There is only one respite living facility in Westchester County, but it has few beds (8) and requires that the patient have a confirmed acceptance at a permanent facility to which he can go within 3 – 4 weeks.

Another patient, AL, with a dual diagnosis of conduct disorder and moderate mental retardation, was referred to a state hospital, the Office of Mental Retardation and Developmental Disabilities, and the Committee on Special Education. The state hospital was contacted on 10/8/86 and denied the patient on three occasions (12/17/86, 1/27/87 and 7/2/87). The Office of Mental Retardation receivied material on 5/28/87 and denied the patient on 8/26/87. Applications were filed with the Committee on Special Education on 12/17/86, and it was not until 2/25/87 that we were informed that the patient had been approved for funding for a residential treatment center. After many delays and letters from New York Hospital to state agencies, the patient was finally placed at a residential treatment

center on 7/6/88. The elongated process was very stressful for the patient, and extremely time-consuming for staff who had to advocate with officials in multiple agencies.

12.8.4 Courts Have Become Psychiatrists

The court system has been increasingly involved in making decisions about patient care since the civil rights movement. Hearings must be held to retain patients against their will, to medicate patients who do not consent, and to send patients to state hospitals who do not wish to go.

However, judges are not trained in mental illness and at times render decisions which make little sense to hospital staff. For example, CR, a middle-aged paranoid, assaultive patient wanted to sign out of the hospital against advice. The hospital requested a hearing to both retain him and to initiate medication. The judge decided that the hospital could retain the patient for up to 60 days, but that it could not medicate him. Needless to say, the patient did not improve on this regimen, and continued to exhibit dangerous behavior while here. After his discharge, he again promptly became assaultive and had to be taken by the police to an emergency room.

Another patient, HM, with a chronic schizophrenic diagnosis, refused medication and asked to leave against medical advice. The hospital requested a hearing at which time the judge ordered minor tranquilizers because these had not been tried first.

While court decisions can be appealed, the process requires at least several

weeks in which the patient receives only custodial care. The lack of prompt response means that inpatient benefits are used up, and that active discharge planning also has to be delayed.

12.8.5 Trying to Avoid the Inevitable

Occasionally, patients are sent from the hospital to the shelter system because there is no other choice. We insist that responsible referrals for follow-up are made so that the patient is not abandoned. However, the fragmented care system mitigates against these recommendations being followed.

MH was a chronic paranoid schizophrenic woman who had lived in the shelter system or on the streets most of her adult life. She strongly refused to consider referrals to an adult home, and made it clear that she wished to go back to a shelter. She decided to sign herself out of the hospital against medical advice, and the social worker was concerned that she have immediate follow-up since she was taking psychotropic medication. In Westchester County, all homeless persons are handled through the Department of Social Service's Homeless Unit which decides whether to send them to a motel or shelter based upon available space. The worker called the appropriate homeless unit to explain the patient's situation and asked where MH would be placed so that we could make clinical referrals. The homeless unit could not predict this. The psychiatric liaison at the Department of Social Service was called, as well as the county Department of Mental Health. They were told that we would offer interim appointments with the hospital therapist until the patient could be referred to a clinic, but that she had to have transportation

back to us. While they appreciated the dilemma, they could only say that they would alert the Homeless Unit to the patient's need to keep these appointments. (It should be noted that to see the patient post-discharge, the inpatient therapist had to go through an extensive process to register the patient in the hospital's outpatient department.)

The Community Support System had been contacted earlier, but could not accept the patient as a client until she had a residence and her catchment area was known. Thus she was unable to be placed on the wait list so that this vital service might become available soon after discharge.

The patient was sent by cab to the Homeless Unit which placed her in a local shelter. Through many phone calls, the social worker was able to find out from the Homeless Unit where the patient had been sent; she called the shelter and informed staff of the patient's follow-up appointment and need for transportation. With this cumbersome effort, the patient indeed did keep her first appointment at the OPD, and was subsequently referred to a clinic much nearer the shelter.

The real problem illustrated by these examples is that client needs do not define services; rather agencies narrowly define what services they will provide, under what circumstances. For vulnerable, impaired, chronic psychiatric patients, the hurdles and impediments placed in the way of receiving necessary care are daunting and overwhelming. Unfortunately, it is only those few with skilled advocates to aid them who are likely to be connected to facilities ostensibly established to meet their needs.

The case illustrates the effect of boundaries and admission policies which pre-

vent community agencies from meeting the urgent needs of clients. Systems do not follow clients, especially those who lack the skills to negotiate the hurdles placed in the way of receiving necessary care.

Chapter 13

Legal Issues in Discharge Planning with High Risk Patients

Because many key issues related to discharge planning have not yet been clearly defined through the courts, social workers often find themselves operating without clear guidelines for avoiding legal risk. The American Hospital Association's Task Force on Legal Issues in Discharge Planning states:

> All health care providers are under a general duty to patients to exercise reasonable care in treatment, to protect the patient from reasonably forseeable harm, and to provide medically necessary care. In the context of discharge planning, this duty prohibits "abandonment" — the discharge of the patient before the patient is "medically ready." A patient is "medically ready for discharge" when (1) the patient no longer needs acute care services, and (2) the appropriate health care professionals have identified, developed, and taken reasonable steps to implement a plan to meet those post-hospitalization needs which, if not addressed, may have a reasonably foreseeable negative effect upon the patient's medical status.[1]

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[1]American Hospital Association, Task Force on Legal Issues in Discharge Planning, Office of General Counsel, *Legal Memorandum Number 9, Discharging Hospital Patients: Legal Implications for Institutional Providers and Health Care Professionals* (Chicago: American Hospital Association, 1987), p. 25.

The Task Force goes on to note that the obvious problem is how to determine the extent of a hospital's duty in discharge planning — establishing what are reasonable and appropriate steps under a given set of circumstances. At minimum, the hospital has to assess the patient's readiness for discharge, identify community facilities that can meet the patient's post-hospital needs, and undertake reasonable efforts to make these facilities and services available to the patient. The hospital is not required to ensure that ideal services are in place, nor must it guarantee the quality of services the patient will receive post-discharge.

Of course decisions regarding high risk patients are made not only on the basis of legal considerations, but also according to professional standards and judgment. Since the law does not offer absolute guidelines, there were many occasions throughout the study in which decisions had to be made to the best of our ability, with careful chart documentation.

In a number of instances, high risk patients or their legal guardians refused to sign consents which would permit the social worker to make necessary referrals. This caused delays and frequently jeopardized the hospital's reimbursement for inpatient days. Social workers expended much effort in trying to persuade patients or families to allow material to be sent out, and in convincing them that this was not the same as ultimately agreeing to the placement or referral. To resolve this dilemma, we are now implementing an omnibus discharge planning consent, to be signed at admission, which eliminates the need for an individual signature for each referral.

Medicaid regulations in New York State mandate that for each patient hospitals apply to all available and appropriate resources within a 50 mile radius.[2] However, some study patients and families objected to certain resources and wanted to exercise choice. Workers attempted to apply to preferred facilities first because they empathized with the patient's wish to have control over this process. Nonethe-less, it was an uncomfortable compromise since continued Medicaid funding must be denied if the patient does not accept the first available opening.

When patients left AMA, teams had mixed feelings about how much assistance should be provided. Some members felt that if the patient were going to leave against advice, we were placing ourselves at risk by offering any further assistance. We were able to establish that all AMA patients should be offered, at minimum, information about sources of assistance before leaving the institution. Patients on medication were given a few days' supply and the names and numbers of clinics. For homeless patients, the appropriate DSS office and shelter were called about their aftercare needs. At times, patients might not have signed consents for these connections prior to a precipitous departure, but if we believed that greater harm might come from not contacting providers, we would take this step.

Some of the most difficult dilemmas arose with children and adolescents in cases where the treatment team felt very strongly that a child belonged in a residential treatment center, but the parents' disagreed. Teams had to be helped to understand that either the evidence for not returning the patient home was so strong

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[2]N. Y. State Department of Health *Hospital Memorandum 86-97, "Hospital Procedures for Completing and Using the Long Term Care Patient Review Forms and Criteria for Level of Care"* (10/2/86), p. 8.

that Child Protective Services should be called and the case taken to court for a decision, or we had to provide as structured and secure a plan in the community as possible. Sometimes a child was sent home on passes so that parents could more realistically evaluate their ability to manage, and this would convince them to work with the team. In other instances, patients were discharged to home at parents' insistance, but regressed in a less structured setting.

Occasionally, patients were admitted who refused to provide correct identifying information about themselves. This of course precluded payment for inpatient days and discharge planning. One elderly woman was admitted with only her Medicare card. She claimed to have no living relatives or friends, would not share her financial circumstances, or the name of her landlord. We were very concerned that she might not have paid her rent and that her landlord might use this as an opportunity to evict her. By using her Social Security number, we were able to obtain the patient's legal address from a colleague at the local Social Security Office. The social worker then made a visit to the address and was able to find and speak to the landlord who indeed wished to evict the patient. Later, as the patient improved, the worker was able to get her written permission to enter the apartment and bring back her mail. Through this, we obtained her Social Security check, drafted a money order, and paid the rent. We also learned from envelopes in the patient's apartment that there was a niece within travelling distance who could be contacted. The landlord was informed that he could not evict the patient without due legal process, and the patient returned home prepared with knowledge of her rights and referrals to legal counsel.

There have been several patients who have refused to leave the hospital even when appropriate discharge plans were in place. While we are permitted by law to use civil eviction procedures against such persons, teams preferred to work intensively with the patient and his family, and in each instance, persuaded the patient to leave. There is frequently considerable pressure because outside providers (such as nursing homes) will not keep beds open beyond one day, and third party payors will not reimburse days after such a refusal to leave. In one instance, the financial officer met with the family and showed them a potential bill for one week's stay at the private pay rate. He stated that they would be held responsible for the bill since they had signed forms at admission.

In many instances, had a lawyer been consulted, we would have been advised to take a very conservative approach which would not have served the best interests of the patient and the hospital. Social work in discharge planning will always involve taking carefully considered risks, and balancing institutional versus patient needs. However, this decision making should not be left to the individual worker but should take place with senior-level social work consultation.

Chapter 14

Unanticipated Consequences of the Program

At its inception, the high risk program was envisioned as a circumscribed effort to ensure that a small number of study patients (26) received a systematic and comprehensive set of interventions designed to enhance the quality of and adherence to discharge plans. As was mentioned previously, there was substantial resistance to participation in the program, and although social workers for 138 cases were invited to participate, only 26 consented. Concerns ranged from exposing work to a senior administrator, to fears that a great deal of additional time would be required. Workers were told that whether or not they agreed to participate in the study, the assistance of the program coordinator with discharge planning problems, was available to them.

Once the program was initiated in September 1987, many more workers consulted the coordinator informally than were actually involved in the study. Each month following the program's inception, the coordinator has received 60 – 80 requests for assistance. Staff indicate that what they appreciate is informality and availability — they can drop in or call to discuss a patient whenever they experience difficulty. Further, they are given hands-on assistance where necessary (e.g. focused information on specific resources for patients, application forms and procedures, calls made by the coordinator to negotiate impasses). Over time, the program coordinator's job description has changed substantially so that up

to 25 hours per week are often spent in functions related to discharge planning. This shift evolved gradually and has resulted in the reassignment of some of the coordinator's adminstrative tasks to other senior staff.

A further outcome of the program has been an increasingly positive attitude towards discharge planning on the part of the hospital's medical leadership. Hospital administrators now express greater willingness to hear about and attend to impediments in patient flow, and to provide necessary supports because they are aware of the critical importance of high quality discharge planning. Recently, the Director of Social Work was able to increase the time allocated to Resource Library staff by culling out full-time equivalents from other areas. This represented an affirmation that providing discharge planning resources to the department is indeed a priority among many pressing needs. Other signs of the change in discharge planning's status include the following: the program coordinator has been asked to present high risk cases to a special committee chaired by the Medical Director; the hospital's Steering Committee invited the coordinator to make a number of presentations about critical issues in discharge planning along with suggestions for their remediation; the Medical Records Department has agreed to give priority to referral materials needed for high risk cases; the coordinator was requested to offer seminars on discharge planning regulatory and charting requirements to all inpatient units, to social work students and within the social work inservice education program. Overall, the operation of the high risk program has enhanced awareness of the vital role that excellent discharge planning, embedded in a supportive casework relationship, can play in meeting the goals of the entire institution.

Although not a direct result of the program, hiring practices and the value system of the Social Work Department have shifted. It is now a requirement that applicants for positions have commitment to and demonstrated skill in discharge planning. This function, plus family assessment and treatment, is seen as the primary focus of social work within the hospital. There has also been a qualitative increase in interdisciplinary staff acknowledgement that discharge planning is a complex intervention requiring the highest level of social work competence. As workers have experienced success with very difficult disposition problems and have received recognition for this, expertise in discharge planning has been accorded greater value both within and outside the Social Work Department.

Since the program was implemented, additional hospital units have decreased their length of stay and are treating dysfunctional, acutely ill patients within a shorter period. As a result, those social workers whose investment lay in the area of long-term family and individual interventions have left for private practice or settings where fewer constraints upon practice exist. While staff turn-over has been disruptive, newer workers do not feel that an implicit contract with the hospital is violated when they must work within a brief model and spend a large proportion of their time in aftercare planning.

For the program coordinator, there has been a substantial increase in knowledge about and skill in discharge planning. By actually "doing the work" and experiencing the frustrations, I was in a much better position to appreciate what would be helpful, what needed to be changed, etc. Staff initially found it puzzling that an administrator would undertake "line work," but they eventually understood

that this was in effect a powerful educational tool which enabled the program co-ordinator to make much more relevant and useful interventions. For example, the Discharge Planning Manual and the organization of the Forms File grew out of experience in trying to find instructions for the most common discharge planning operations; new guidelines for state hospital referrals have evolved out of numerous difficulties experienced in dealing with transfers to that system, etc.

Perhaps the most unexpected outcome of the program was the gratification the program coordinator experienced in once again returning to vital "hands-on" work. Administering a department for a long period can put one out of touch with the day-to-day functions of social workers – their dilemmas, frustrations and triumphs. In contrast, working behind the scenes with staff to create solutions and to decrease impediments on behalf of patients and families brought back the satisfactions which had initially drawn the coordinator to social work in the first place. The program in effect served as a an incentive for getting back in touch with the practical realities of social work at the micro level. It indeed placed the issues of hiring, budgeting, policy making and program planning into perspective and brought new life to the position of second-in-command. The experience has convinced the coordinator that an unrelieved regimen of administration, supervision or teaching is in the end depleting, and that revitalization comes from involvement in direct social work practice.

Another outgrowth of the study was the author's appointment as Discharge Planning Coordinator for the hospital — a title which offers recognition, greater influence, and invitations to speak and consult in other settings. Institutional

psychiatry is now experiencing the impact of the outside regulatory and payment systems upon its organization and functioning whereas it had previously been reasonably insulated from such intrusions. Therefore ideas such as the High Risk Psychiatric Discharge Planning Program which may increase the quality and efficiency of discharge planning and contribute to financial viability, are of considerable interest to the larger professional community.

Chapter 15

Current Status of the Program and Recommendations for the Future

15.1 The High Risk Program - 18 Months Later

The High Risk Psychiatric Discharge Planning Program was initiated in September, 1987 and officially concluded in September, 1988 when the last of the study patients had been discharged. Staff, however, were not aware of this termination date because the services provided by the program have continued uninterupted. While longevity is not always an accurate measure of program value, it is one indication that support continues to exist.

Resource Library staff are being consulted about an ever larger number of patients, (see Table 15.1) and are asked to provide numerous educational seminars to interdisciplinary staff (the Discharge Planning Coordinator made 17 such intrahospital presentations during 1988).

At present, while social work staff are not required to review high risk cases with Resource Library staff, it is an optional service whose use is determined by professional judgment. Workers place high value upon autonomous practice, and

Year	Number of Requests Received
1985	849
1986	940
1987	1109
1988	2061

Table 15.1: Requests for Assistance Received by Resource Staff

upon being able to assess their own need for assistance. This voluntary system seems to be operating effectively in that there are few emergencies, or cases where the worker seeks help only in the final phases of the inpatient stay. Because of the high volume of requests received by resource staff, we have ceased sending routine notes offering help when workers are assigned high risk cases.[1]

15.2 Status of Program Elements

15.2.1 The High Risk Indicator List

The High Risk Indicator List (see Appendix A) continues to be used by social workers at New York Hospital - Westchester Division to rate all incoming patients within 72 hours of admission. The rating is a required part of social work charting, and serves to alert workers as well as Resource Library staff when exceptional discharge problems can be anticipated. A second high risk rating is completed at discharge which can be compared with that done at admission. Because the rating has been adopted by the institution, the program coordinator is able to track high risk cases through the system, and to assess any changes in numbers being admitted.

The high risk rating has also been used in the social work department's annual study of time devoted to discharge planning by staff. This report permits administration to know how much time is being spent per worker and per unit on

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[1]In 1988, requests for assistance received by the Discharge Planning Coordinator were added to Resource Library statistics for the first time. Prior to that, statistics included only requests to the Resource Consultant and the Resource Librarian.

discharge planning functions, and what proportion of cases are high risk.

15.2.2 The Focused Assessment

The critical discharge planning assessment which looks at past efforts and community arrangements, actual and potential financial resources, the support network and the degree of structure, stimulation and demand most appropriate for the patient, are ideas which have been incorporated into the culture of social work functioning within the hospital. Awareness of these elements is maintained through training programs, and through the guidance of resource staff during consultations. Staff's awareness of the importance of a comprehensive assessment is illustrated through their keen interest in keeping discharge planning skills up to date via attendance at relevant inservice serminars.

Both the Discharge Planning Coordinator and Resouce Consultant find that staff still tend to overlook less obvious elements of the program such as strengthening existing patient networks, or attending to burden upon relatives. However, such potential interventions are brought to staff's attention during consultations on a one-to-one basis. Since the program began, social workers have become more sophisticated in understanding the demands and requirements of various aftercare facilities so that they can better match patient and family to resources. There appear to be fewer unrealistic plans, and more emphasis upon discussing viable options with patients.

15.2.3 The Discharge Planning Hypothesis

Formulation of a Discharge Planning Hypothesis is a technique which has been taught by the Discharge Planning Coordinator in seminars for staff and students. While the concept has been been greeted with interest, staff do not use the form that was devised specifically for the program. When consultations regarding high risk patients are offered, the biopsychosocial factors that contributed to the admission are discussed and objectives important to the discharge plan are suggested.

The discharge planning hypothesis has not become institutionalized, probably because staff are already required to conduct a psychosocial evaluation for each case which concentrates upon family assessment and intervention. Also, the amount of paperwork required of staff is so onerous that they are most unwilling to add to this burden. As a result, while there is no systematic use of the discharge planning hypothesis, some aspects of this framework for organizing interventions have been incorporated into practice. Most important, staff have learned that discharge planning must inform treatment as well as vice versa.

15.2.4 Establishment of Linkages

Time pressures and the geographic spread of our patients have prevented staff from regularly establishing in-person linkages among all elements of the patient's aftercare environment. We have instead suggested that workers use phone contacts to ensure that all involved parties are aware of each other and clear about roles in advance of the discharge. When permitted by third party payors, patients are helped to visit facilities on pass in order to become familiar with the next setting.

While staff share what has been learned in the care of the patient with those who will assume responsibility in the community, there has not been enough organizational slack to permit us to offer on-site psychoeducation to community agencies regarding a particular patient's management. For the future, the development of such capability might enable agencies to accept patients who do not "fit" all admission criteria.

15.2.5 Consultation and Advocacy

As the figures given in the first section of this chapter indicate, the demand for consultations with resource staff has more than doubled since 1985 and has shown no sign of diminishing following the study's official end.

Advocacy with outside systems such as Regional Offices of Mental Health, the Residential Treatment Facility Offices, Departments of Social Service, etc., takes place daily through the Discharge Planning Coordinator. Having such contacts centralized in one senior person has been helpful in that outside coordinating agencies have a single individual to deal with, rather than a staff of fifty. We have found that useful personal relationships can be established in this fashion. From experience, we would recommend that the Discharge Planning Coordinator be an individual who is highly skilled in discharge planning, knowledgeable about systems, and influential within the institution. On many occasions, using the title, "Associate Director of Social Work" has produced results which staff workers could not achieve on their own. We have also found that it is vital for the Discharge Planning Coordinator to be maximally available by phone to receive call-backs

from senior agency staff. This avoids the frustrating "telephone chase syndrome" experienced by line staff who are frequently on units or in sessions with families. Such unavailability can mean that days are wasted in back and forth calls.

15.2.6 Resource and Referral Information

Because of the volume of requests for assistance to Resource Library staff, we have not been able to offer as much individual assistance in "looking up" descriptive material on facilities as would be ideal. For high risk cases, the Discharge Planning Coordinator will research information to meet the particular patient's needs (e.g. resource names, addresses, phone numbers, descriptions, referral forms, etc.). If more hours were available, it would be helpful to offer the same level of service to workers for all cases.

Although new students and staff are given an orientation to the Resource Library, many have only a marginal level of skill in retrieving information and do not use the facility as frequently as they should. Wherever possible, resource staff try to aid workers to locate information in the Library so that their own competence is increased.

15.3 Suggested Changes in the Program

15.3.1 Improving the Identification of High Risk Patients

During the course of the program, staff indicated that some of the items on the High Risk Indicator List were difficult to assess accurately within 72 hours following admission, and some could be eliminated because they were redundant. (For

example the item, "Patient is in the process of separation or divorce," was not critical unless it led to a need to find new housing, or to apply for financial benefits.) As a result of experience with the list, we have now been able to shorten it to the 8 elements noted below. If two are checked, the patient is considered to present more than usual discharge planning difficulties. The revised list will be tested over coming months to see if staff find that it can accurately predict unusual problems in arranging aftercare.

- Patient likely to require arrangement of a residence different from that present at admission.

- Patient's current financial resources are unlikely to cover the cost of necessary treatment and living aftercare arrangements.

- Patient has had recent, serious difficulty in impulse control (e.g. assaultiveness, suicidal behavior, firesetting, violent threats).

- Patient has a history of severe and prolonged (more than 6 months) impairment in activities of daily living (i.e. self-care, self-direction, daily routine).

- Patient has had 3 or more psychiatric hospitalizations within the past 5 years (including this admission).

- Patient has a dual diagnosis (a major Axis I psychiatric disorder) plus: mental retardation, a severe, chronic medical condition/physical disability, or substance abuse.

- Patient has history of non-adherence to discharge plans (including non-compliance with medication).

- Patient has no involved or available family/significant other (includes patients who refuse to permit family involvement and families who refuse contact).

The high risk list could not be evaluated statistically since the frequency with which items appear is not always associated with whether the factor is a good predictor of the degree of difficulty the social worker will have with discharge planning. The item, "Patient has a diagnosis of mild or greater mental retardation (I.Q. 70 or below)," occurred in only 5 cases (or 2% of the entire hospital's high risk population); yet workers state that when this factors is present in combination with a serious psychiatric illness, and the patient will require a change of residence, severe problems in making aftercare arrangements inevitably result.

An unfortunate problem has been the lack of other independent ratings or measures of discharge planning high risk. In addition, resources were not available to conduct a study of the actual amount of time high risk cases required over the course of their stay. Because of this, we were confined to relying upon workers' ratings of each case at admission and discharge, and their feedback to the Discharge Planning Coordinator.

While no other high risk indicator lists for psychiatric inpatients could be found, the factors we have identified are similar to criteria for New York State's Community Support System Intensive Case Management Program which serves those patients who are both seriously and persistently mentally ill and heavy users of

mental health inpatient and emergency resources,[2] and with the Global Assessment of Functioning Scale[3] used as Axis V of the psychiatric diagnosis.

15.3.2 Providing Liaison to the Admissions Office

Although the High Risk Indicator List must be completed within 72 hours of admission, it has to be processed and logged-in by secretaries, so that the program coordinator may not have immediate access to these ratings. Since early intervention is vital to preserve existing housing and to initiate applications for financial benefits, the best point at which to identify patients posing diposition problems would be during the pre-admission screening call.

The program coordinator has recently presented this idea to the Admissions Department which is enthusiastic about having the Resource Consultant or Discharge Planning Coordinator attend daily admission rounds. This would enable cases to be identified at the point they are about to enter the hospital and for assistance to be offered from the outset. Admission staff often do not recognize signs of incipient homelessness, or indicators of difficult discharge planning at the point when the hospital has the greatest degree of leverage with referring agencies. Also by anticipating potential problems with the patient's support network at the point of entry, it may be possible to address concerns openly and to negotiate aftercare

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[2]Zelda Damashek, "List of Potential Clients for Intensive Case Management," (White Plains, New York: Westchester County Department of Community Mental Health, April 8, 1988), unpublished memorandum.

[3]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed., Revised, (Washington, D.C.: American Psychiatric Association 1987), p. 12.)

contracts.

15.3.3 Increaseing Time for the Resource Library

The High Risk Program has greatly increased demands for assistance from Resource Library staff (which includes the Discharge Planning Coordinator, the Resource Consultant, and the Resource Librarian). Time for the Resource Library has recently been augmented by shifting some functions of the Discharge Planning Coordinator to other administrative staff, and by combining partial lines to add an additional half-time line to the Resource Consultant's hours.

While it has not been possible to increase the Resource Librarian's 10 hours per week, he has made excellent use of a devoted volunteer.

15.3.4 Keeping Discharge Planning Skills Current

Because the field of psychiatric discharge planning is so volatile, changes in procedures appear to occur daily. An ongoing function which has developed for both the Discharge Planning Coordinator and the Resource Consultant has been to disseminate information to staff promptly and to update the Discharge Planning Manual as needed.

Both the Discharge Planning Coordinator and Resource Consultant have spent increasing amounts of time providing inservice education for social work staff, social work students, and members of other disciplines. Although this function is quite time-intensive, dividends are reaped in workers maintaining a good baseline level of knowledge about regulations, financial benefits, and changes in procedures.

To keep themselves current, the Discharge Planning Coordinator and Resource

Consultant have found that it is crucial to attend meetings where the latest developments are discussed. Forums which have proven valuable are meetings of the Discharge Planning Association of New York City, the New York Regional Psychiatric Discharge Planning Committee, and the Society of Hospital Social Work Directors' Discharge Planning Committee.

15.3.5 Changing the Infrastructure

For the program coordinator, the study has brought to the fore impediments to discharge planning which exist within the hospital setting and unnecessarily frustrate social work staff. Areas which need urgent attention are:

- Unit philosophies regarding length of stay (on the intermediate and long-term services) are in conflict with state regulations defining acute and continuing care. This discrepancy leads to confusion about the appropriate timing of discharge planning and to a lack of coordination of effort among team members. On units where length of stay is clear (30-day services), teams are in concert about the tempo of treatment.

- Knowledgeable and responsive legal assistance is not readily available to staff for the many cases in which a legal opinion or court order related to discharge planning is required. Further, clinicians are not trained in how to present cases effectively in court so that adverse decisions are unnecessarily rendered, thereby causing delays in treatment or discharge.

- Social workers are severely hampered by not having the proposed omnibus discharge planning consent in place. This form would be signed at admission

and give permission for all contacts essential to effect an aftercare plan. The current system involves having the patient and worker complete a separate sheet for each referral, describing the material to be sent to that facility.

- The hospital has no standards for the timely completion of referral material by clinicians. This means that social workers (who are not in a position of power) must try to persuade, remind or cajole therapists regarding completion of paperwork required by outside resources.

- Because of requirements for multiple reviews, signatures for all outgoing material, and understaffing in Medical Records, referral materials require at least two weeks from preparation to mailing. This creates severe time pressures when patients are in-house for short stays.

- Unit chiefs do not give adequate support to discharge planning needs. They do not set aside specific time in rounds for discussion of discharge plans, ensure that associated tasks are given priority, or back up workers with their authority.

- The findings of hospital utilization review staff (who look at all charts weekly) are ignored by treatment teams because there are no consequences. Utilization review case managers can be very helpful in alerting clinicians to charts which do not meet payment criteria so that financial losses may be avoided.

- The hospital does not provide "bridging services" which would enable inpatient staff to be available to patients for a short period post-discharge.

Such follow-up service might prevent some instances of rapid readmission of fragile, high risk patients.

In addition to these serious internal issues, social workers experience major problems with the community in discharge planning. Some recurrent issues are:

- Each community facility and resource has its own referral form(s) and unique referral procedure. Because most patients require multiple referrals, paperwork for social workers and therapists burgeons.

- Despite the fact that New York Hospital - Westchester Division serves a large proportion of seriously and persistently mentally ill persons, the state hospital system is virtually unavailable for transfer of those who do not respond to acute treatment and are too ill for lower levels of care. In 1988, only 15 patients were transferred to state facilities.

- Community providers are in a seller's market and have no incentive to respond rapidly to referrals. Benefit programs typically require at least 3 months to approve applications, and supportive living facilities often have months' long wait lists.

- Exceedingly few community services (especially residential) exist for patients with multiple disabilities (e.g. drug or alcohol abuse, mental retardation or serious medical condition plus major psychiatric disorder). There are very few programs which will accept the 45 - 65 age group. Patients in these categories are often forced to remain inpatient for much longer than required while resources are awaited.

- The hospital does not have any interim beds available on campus to house those awaiting a lower level of care. Thus acute beds can be blocked, and patients who are ready to leave are kept in an unnecessarily restrictive environment. This situation also increases the number of alternate level of care days which are reimbursed at a token level.

- Although 58% of our patients were discharged to live in private homes or apartments (usually with relatives), only four professionally-led family support groups exist in Westchester County, and these are at the hospital's outpatient department. Families receive little in the way of service or respite in managing patients post-discharge from other community agencies.

- Proliferating regulations from state agencies require increasing amounts of staff time to ensure compliance. These hours are usually diverted from direct patient care and discharge planning.

The project coordinator has presented these issues to hospital administration and to the social work department. They are being reviewed carefully, and action to address many of them is under consideration. The social work department has convened a special task force to deal with problems which it may able able to change with little outside assistance.

In sum, the obstacles and constraints experienced by discharge planners are embedded in all levels from patient/family demands to state and federal policies. While many issues are exceedingly difficult to address, others may be amenable to internal action. Most important to social work staff is the knowledge that concerns

which became apparent during the course of the High Risk Psychiatric Discharge Planning Study have been heard at the highest levels within the hospital, and are being taken seriously.

15.4 Future Directions for the High Risk Program

The comprehensive discharge planning program was limited to patients identified as high risk because they were the most in need of scarce resources (and in many instances, the least likely to receive their share). Questions can be raised about whether the methods described in the study should be expanded to include patients who present fewer discharge planning dilemmas.

The philosophy underlying the program was that if the interventions proposed proved useful, staff would adapt those that were appropriate for other patients. It is difficult to assess whether this has happened, except to note that workers are much more aware of what constitutes both a high quality discharge planning process, and comprehensive aftercare arrangements. They are attuned to incipient signs of difficulty and seek consultation much more readily than in the past.

The degree of use of the Discharge Planning Coordinator's and Resource Consultant's time by staff is testimony to the fact that workers find this assistance of value. However, the subjective impression of the Coordinator is that social work students (in contrast to experienced workers) are much more likely to attempt to use such constructs as "the discharge planning hypothesis" and "the establishment of linkages among all members of the support network." More seasoned workers want assistance when they have exhausted their own resources and are stymied about how to proceed. For this group, we have tried to suggest interventions they

might not have considered. Senior workers expecially have had concerns about exposure of possible deficits in practice, even though many of them required much more updating than did junior workers. It has been very important that there be no administrative or evaluative consequences for social workers in consulting with Resource Library staff — rather the desire to enhance skills in itself is seen as positive.

Staff morale has been addressed not only through the concrete help that is offered, but also through attempts by the Discharge Planning Coordinator and Resource Consultant to make sure that supervisors, social work administrators, and staff of other disciplines know about excellent work and "aborted disasters" for which our staff are responsible. For example, presentations have been made by staff workers of difficult disposition problems in the Utilization Review Committee, and in social work staff meetings, we have announced how much money (over $600,000 in two years) our staff have saved the hospital by ensuring that we received payment for nearly all alternate level of care days. Over time, it has become desirable to be described as highly skilled in discharge planning.

The program will not continue with the same formal structure as outlined under the 1987 study interventions, but the ideas continue to be used with workers in consultation, and in teaching both new staff and social work students. It is recommended that the program remain voluntary — assistance is offered freely, but is not required to be used. This structure would seem to interfere least with workers' strongly held ideas about autonomous practice and their ability to exercise professional judgment.

Above all, what has been learned is that identifying high risk patients alone is not sufficient; this function must be embedded in a multi-faceted program which supports and aids staff in all aspects of their work with this challenging population. Finally, the program must always be open to learning from the staff who use it and from the patients whom it is intended to serve.

Chapter 16

Conclusions

16.1 Introduction

Disenfranchisement has been defined as "a pattern of exclusion and marginalization ... a fundamental disjuncture between specific individuals/populations and the material, social, and psychological resources from which the course and quality of life experience is derived."[1] Three dynamics drive disenfranchisement, and all of these apply to the mentally ill – impoverishment, discrimination, and bureaucratization (complexity and formalization of organizations which lead to delay or denial of service).

The Discharge Planning Program for High Risk Psychiatric Inpatients has brought into focus many of the profound difficulties experienced by the seriously mentally ill in making required transitions to another level of care, or to the community. The plight of the high risk patient results not only from the chronicity and disabling effects of serious mental illness, but also from the lack of basic and relevant community resources, and the limited availability of long-term coordination and case management. Psychiatric hospitals are, of course, only one discrete element in a entangled, bewildering, and uncoordinated system of care. While inpatient units can treat acute symptoms, they are unable to act as asylums to the

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[1]Jerald Shapiro, "Commitment to Disenfranchised Clients," in *Handbook of Clinical Social Work*, eds. Aaron Rosenblatt and Diana Waldfogel (San Francisco: Jossey-Bass, 1983), p. 890.

high risk population – providing a buffer between the patient and the community until such time as adequate and safe relocation can be achieved. Further, while psychiatric hospitals can be responsible for arranging aftercare, they do not have the resources to follow-up each discharge to confirm that individual needs are being met adequately.

The program also illustrates the dichotomy in our profession between "clinical social work" and "environmental manipulation" or "the provision of concrete services." Just like the terms "chronically mentally ill" or "severely and persistently mentally ill," the phrases used to describe discharge planning have always had a prejudicial connotation, suggesting both a lower status and required degree of skill. Despite evidence that discharge planning with those most at risk is an exceedingly complex task, it remains an undervalued function which does not command the same respect as "clinical work." The distinctions between the two practice perspectives described by Shapiro are summarized below.[2]

16.1.1 Clinical Social Work

- Treatment is the underlying dynamic guiding the worker; the generalized goal is the adaptive functioning of the client.
- Relies heavily upon diagnosis to structure the treatment relationship.
- Focuses upon the client's command of himself as the means for structuring life experience.

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[2]Ibid., pp. 897-900.

- Tends to be analytic and scientific in its conceptual methodologies.
- The basic skill is identified as the ability to conduct an interview in the one-to-one context with supplementation in the areas of family and group interventions.
- Derives much of its methodology from a psychodynamic understanding of the individual and a biopsychosocial appreciation of the individual's experience in meeting basic needs in a complex world.

16.1.2 Social Work with the Disenfranchised

- The dynamic is one of facilitation; the generalized goal is empowerment.
- Focuses upon circumstances from which disenfranchisement emerges and the processes through which individuals can act to change these circumstances.
- Combines an understanding of the client's environment, the nature of the client's immediate goal and the character of the working relationship to arrive at a progression of exchanges between client and environment that the worker facilitates.
- Tends to be synthetic and phenomenological.
- Both worker and client take a variety of action roles, with the worker using the client's involvement in the change effort as a natural context for the client's consideration of the personal dimensions of disenfranchisement and the process of pursuing planned change.

- Methodologically, the work promotes the empowerment of the client and focuses upon the process of gaining command over the environment as a means for increasing skill and direction and structuring life experience.

Because disenfranchisement brings individuals to a common state of powerlessness, marginality and deprivation, the social worker who would work with this population must be prepared to deal with processes that are highly complex and obscured in multiple levels of social, economic and interpersonal exchange.[3] Not only must the worker understand the agents and mechanisms which structure disenfranchisement, but he must also be able to "negotiate with institutional agents for both resources needed by the client and the modification of the disenfranchising micro-policies."[4] The worker is required to take on the combination of roles required by each disenfranchised person so that he serves as a multi-role practitioner. The intellectual demands upon the worker are therefore substantial and draw upon the entire field of social work.

What is required is not the elimination of either the psychodynamic or the environmental perspective, but the informed blending of these methodologies according to client need. In effect, the social worker is obligated "to begin with a consideration of the manner in which both the client's stated need and the disenfranchising circumstances surrounding this need can be addressed."[5] Discharge planning might indeed serve as a forum for the reconciliation of these two dimen-

[3]Ibid., p. 894.

[4]Ibid., p. 895.

[5]Ibid., p. 899.

sions in social work practice since it requires psychodynamically informed interventions with the patient, his family, the institution, and the outside environment to enhance the functioning of each in relation to the other.

16.2 Summary

Like all that is organic, the High Risk Psychiatric Discharge Planning Program has evolved over time, extruding or modifying certain elements and incorporating others. Its strength lies in its ability to be adapted to changing conditions and client need. In many respects, the program does not represent a new development so much as an increased emphasis upon what originally gave social work its legitimacy — practical problem-solving, the provision of concrete services, and the bridging of gaps between domains. The author likes to believe that the program's philosophy is based upon the principle well-stated by a social work educator, "Most problems are potentially solvable through psychoanalysis or salve. We usually start with salve."[6] In other words, "people's needs must define the method we use, and not the other way around."[7]

Discharge planning was originally embraced by social work because of our historical commitment to deal with the interface between people and environments. "It is difficult to envision a time when the intervention of a social worker is more needed than when an individual is unable to exit from an institution he would like

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[6]Hazel Osborne, quoted by Harold Weissman in "Knowledge Base of Clinical Social Work,"in *Handbook of Clinical Social Work,* eds. Aaron Rosenblatt and Diana Waldfogel (San Francisco: Jossey-Bass, 1983), p. 4.

[7]Harold Weissman, "Knowledge Base of Clinical Social Work," p. 4.

not to have entered in the first place."[8] We have now begun to come full circle to recognize the potential in this area of practice for meeting social work's broad mission — to liberate, support and enhance adaptive capacities, and to increase the responsiveness of social environments to people's needs.[9] Grace Fields has summarized the philosophy which informed the High Risk Psychiatric Discharge Planning Program in these words: "Discharge planning is where medical care interfaces with quality of life concerns. It is where human care needs clash or mesh with our technical cure capability. It is where institutions must validate their mission and raison d'etre. It is where the action is, and we belong there. Let us hold that territory with courage, compassion, resourcefulness, and pride."[10]

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[8]Grace Fields, "The Anatomy of Discharge Planning," *Social Work in Health Care* 4 (Fall 1978), p. 5.

[9]Carel Germain, "The Social Context of Clinical Social Work," *Social Work*, 25 (November 1980), p. 483.

[10]Fields, "The Anatomy of Discharge Planning", p. 5.

Appendix A

High Risk Indicator List for Discharge Planning

The initial high risk indicator list is completed within 72 hours of each patient's admission. A second rating is completed within 24 hours following the patient's discharge.

NEW YORK HOSPITAL – WESTCHESTER DIVISION

HIGH RISK INDICATOR LIST FOR DISCHARGE PLANNING

Rater's Name _____

Unit _____

FIRST RATING AT POINT OF ADMISSION

	Probably Present	Probably Absent	
1.	_____	_____	Patient likely to require arrangement of a residence different from that present at admission.
2.	_____	_____	Patient likely to require assistance in financing discharge plan (e.g. may need to apply for SSI, Medicaid, etc.).
3.	_____	_____	Patient has serious difficulty in impulse control (e.g. assaultiveness, suicidal behavior, firesetting, threats and verbal abuse) at time of hospitalization.
4.	_____	_____	Patient has history of serious and prolonged impairment in performance at work, school, or in activities of daily living.
5.	_____	_____	Patient has previously left this or other psychiatric facilities AMA.
6.	_____	_____	Patient has had numerous and/or lengthy past psychiatric hospitalizations.
7.	_____	_____	Patient has non-voluntary legal status at admission.
8.	_____	_____	Patient has serious medical condition or physical disability.
9.	_____	_____	Patient has serious drug abuse problem (non-alcohol).
10.	_____	_____	Patient is member of a family where there has been recent actual or suspected physical abuse.
11.	_____	_____	Patient (or patient's family) is in the process of separation/divorce.
12.	_____	_____	Patient has diagnosis of mild or greater mental retardation (I.Q. 70 or below).
13.	_____	_____	Patient has a suspected organic mental disorder.
14.	_____	_____	Patient has no involved or available family/significant other (includes patients who refuse to permit family involvement & families who refuse contact).
15.	_____	_____	Patient/family has history of non-adherence to discharge plans (include non-compliance with medication).
16.	_____	_____	Patient whose immediate family has another member with a serious, current mental or medical illness.
17.	_____	_____	Other (please specify) _____

Anticipated Amount of Social Work Time Needed to Acquire Aftercare Resources for This Patient

18. ____ Below Average (0-2 items checked)*
19. ____ Average (3-4 items checked)*
20. ____ Above Average (5 or more items checked)*

*If the rating at left does not agree with your clinical judgement, please check box and note reasons on reverse.

21. ☐

NEW YORK HOSPITAL – WESTCHESTER DIVISION

HIGH RISK INDICATOR LIST FOR DISCHARGE PLANNING

Rater's Name _____

Unit _____

Date of Discharge _____

FINAL RATING AT POINT OF DISCHARGE

Patient left AMA ☐ Yes ☐ No
Patient died while on rolls ☐ Yes ☐ No
Patient eloped ☐ Yes ☐ No

	Present	Absent	
1.	_____	_____	Patient has required the arrangement of a residence different from that present at admission.
2.	_____	_____	Patient required assistance in making financial arrangements to support the discharge plan (e.g. needed to apply for SSI, Medicaid, etc.).
3.	_____	_____	Patient had serious difficulty in impulse control (e.g. assaultiveness, suicidal behavior, firesetting, threats and verbal abuse) at time of hospitalization.
4.	_____	_____	Patient has serious and prolonged impairment in performance of work, school, or in activities of daily living.
5.	_____	_____	Patient left this or other psychiatric facilities AMA.
6.	_____	_____	Patient has had numerous and/or lengthy psychiatric hospitalizations (including this stay).
7.	_____	_____	Patient had a non-voluntary legal status during this admission.
8.	_____	_____	Patient has a serious medical condition or physical disability.
9.	_____	_____	Patient had serious drug abuse problem (non-alcohol) at time of hospitalization.
10.	_____	_____	Patient is member of a family where there has been recent actual or suspected physical abuse.
11.	_____	_____	Patient (or patient's family) has been in the process of separation/divorce around the time of this hospitalization.
12.	_____	_____	Patient has diagnosis of mild or greater mental retardation (I.Q. 70 or below).
13.	_____	_____	Patient has organic mental disorder.
14.	_____	_____	Patient has had no involved or available family/significant other (includes patients who refused to permit family involvement or families who refused contact).
15.	_____	_____	Patient/family has history of non-adherence to discharge plans and/or were not cooperative with present discharge planning.
16.	_____	_____	Patient's immediate family has another member with a serious, current mental or medical illness.
17.	_____	_____	Other (please specify) _____

Actual Amount of Social Work Time Expended Acquiring Aftercare Resources for This Patient

18. _____Below Average (0-2 items checked)*
19. _____Average (3-4 items checked)*
20. _____Above Average (5 or more items checked)*

*If the rating at left does not agree with your clinical judgement, please check box and note reasons on reverse.

21. ☐

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Appendix B

Patient Financial Profile

During the first week post-admission, a patient financial profile sheet is completed which ensures that all resources for aftercare medical and living expenses are considered.

THE NEW YORK HOSPITAL - CORNELL MEDICAL CENTER
WESTCHESTER DIVISION

Patient Financial Profile

PATIENT NAME_____ DATE OF ADMISSION_____

SOCIAL SECURITY NUMBER_____

INSURANCE COVERAGE_____ EXPIRATION_____
(carrier name)

MEDICAID #_____ (Inpatient) APPLYING_____ PENDING_____
(Outpatient) APPLYING_____ PENDING_____

MEDICARE #_____ APPLYING_____ PENDING_____

	YES	NO	APPLYING	PENDING	AMOUNT OF CHECK
SSI					
SSDI					
PRIVATE DISABILITY					
COMMITTEE ON SPECIAL EDUCATION					

PRIVATE FUNDS, ASSETS, RESOURCES_____

	APPLYING	IN PLACE	AMOUNT
VETERANS BENEFITS			
STATE DISABILITY INSURANCE EXPECTED TERMINATION DATE			
SOCIAL SECURITY RETIREMENT			
PENSION			
SOCIAL SECURITY SURVIVORS BENEFITS			
DSS AID			
WORKER'S COMPENSATION			
*UNEMPLOYMENT INSURANCE EXPECTED TERMINATION DATE			

OTHER SPECIAL FINANCIAL CONSIDERATIONS (Please note)

*Note inpatients who have been receiving unemployment compensation should be assisted to switch to state disability insurance. There is a maximum of 26 weeks benefits available for either or the two combined.

Appendix C

Table of Contents for Discharge Planning Manual

The following pages contain the table of contents and index of forms for the Social Work Discharge Planning Manual. This guidebook has been distributed to all social work staff and students for reference.

Social Work Services
Discharge Planning Manual

Table of Contents

Index of Forms

The New York Hospital – Cornell Medical Center
Payne Whitney Clinic & The Westchester Division

SOCIAL SERVICE CLOSING SUMMARY
PART I: DISCHARGE PLAN INFORMATION

Name of Social Worker_____

Date of Discharge ____ / ____ / ____ Unit _____

Confidential Information Intended Solely For Your Professional Use

Patient Name			**Consecutive/Episode #**
Address Where Patient Can Be Reached (After 2 weeks)	**Street**		
City	**State**	**Zip Code**	**Telephone No.** ( )
Name of Responsible Relative/Other		**Street**	
City	**State**	**Zip Code**	**Telephone No.** ( )

WAS DISCHARGE REFERRAL MADE FOR PATIENT?

☐ **NO** **If NO, Check Reason, and Answer Question K**

- ☐ Referrals Refused
- ☐ Patient Died in NYH
- ☐ Patient Eloped
- ☐ Patient Left AMA
- ☐ Other (Specify) _____

☐ **YES** **If YES, Complete Final Discharge Plan Questions A – K**

A. Type of Referrals Made for PATIENT'S Further Treatment (X in all that apply)

- ☐ None (If "None" Skip to Section D)
- ☐ Type To Be Determined by Facility
- ☐ Individual Psychotherapy
- ☐ Group Therapy
- ☐ Family Therapy (Including Patient)
- ☐ Couples Therapy
- ☐ Psychopharmacology
- ☐ ECT
- ☐ Psychiatric Rehabilitation
- ☐ Other (Specify) _____

B. Setting(s) For Treatment(s) Selected in Section A (X in all that apply)

- ☐ Private Therapist – NYH
- ☐ Private Therapist – Non-NYH
- ☐ Outpatient Clinic – PWC Adult
- ☐ Outpatient Clinic – PWC Child
- ☐ Outpatient Clinic – West. Div. Adult
- ☐ Outpatient Clinic – West. Div. Child
- ☐ Outpatient Clinic – Non-NYH
- ☐ Social Service Agency or Family Institute
- ☐ Day Hospital – PWC
- ☐ Transitional Treatment Program – PWC
- ☐ Day Hospital – West. Div. Adult
- ☐ Day Hospital – West. Div. Child
- ☐ Other Day Program/Day Hospital
- ☐ Health Related Facility
- ☐ Skilled Nursing Facility
- ☐ Residential Treatment Facility
- ☐ Group Home and Institution
- ☐ State Psychiatric Center
- ☐ Other Psychiatric Hospital
- ☐ Psychiatric Unit of General Hospital
- ☐ Medical/Surgical Unit of General Hospital
- ☐ Other Hospital
- ☐ Correctional Facility
- ☐ Other (Specify) _____

Appendix D

Discharge Planning Hypothesis Form

As part of the initial assessment, a discharge planning hypothesis form is completed which lists all factors deemed to be associated with the current admission. At discharge, each of these factors is rated according to whether or not it has been resolved during the course of the inpatient stay.

Discharge Planning Hypothesis Form

Factors Associated with Current Admission Rate	Required	Contri-buting	Permi-tting	Dschg Rating
1 _____	----	----	----	----
2 _____	----	----	----	----
3 _____	----	----	----	----
4 _____	----	----	----	----
5 _____	----	----	----	----
6 _____	----	----	----	----
7 _____	----	----	----	----
8 _____	----	----	----	----
9 _____	----	----	----	----
10 _____	----	----	----	----
11 _____	----	----	----	----
12 _____	----	----	----	----
13 _____	----	----	----	----
14 _____	----	----	----	----
15 _____	----	----	----	----

Summary of Status of Factors at Discharge ___Resolved ___Partially Resolved ___Unresolved

Instructions

List all factors associated with current admissions on lines 1-15. Rate each factor according to whether it was required in order for the admission to occur (e.g. pt. ceased meds); contributed to the admission taking place (e.g. outside therpist didn't pursue patient); or permitted the current admission (e.g. relatives had distanced themselves from patient). At the point of discharge, place a rating of 1, 2 or 3 in the far right column (1 indicates that the issue was resolved, 2 indicates partial resolution, and 3 denotes lack of resolution).

Appendix E

Discharge Needs Assessment Form

The discharge needs assessment form is used to list all areas of aftercare need for both the patient and his family. At discharge, the form is rated according to whether these resources have been arranged.

Discharge Needs Assessment Form

(Resources Needed - To be completed within 7 days after admission
Resources Arranged - To be completed at the point of discharge)

	Resources Needed	Resources Arranged
A. Resources for the Patient		
1. Further treatment post-discharge	___	___
2. Interim living arrangement	___	___
3. Long-term living arrangement	___	___
4. Employment/vocational training	___	___
5. Educational resources (academic)	___	___
6. Financial benefits	___	___
7. Transportation	___	___
8. Medication arrangements	___	___
9. Medical/dental services	___	___
10. Supportive home services (homemaker, meals-on-wheels, visiting nurse, etc.)	___	___
11. Social recreational resources	___	___
12. Other special resources (AA, CSS, Legal Aid, etc.)	___	___
B. Resources for Family Members (Other than Patient)		
1. Further treatment	___	___
2. Assistance with living arrangements	___	___
3. Employment/vocational training	___	___
4. Educational resources (academic)	___	___
5. Financial benefits	___	___
6. Transportation	___	___
7. Medication arrangements	___	___
8. Medical/dental services	___	___
9. Supportive home services (homemaker, meals-on-wheels, visiting nurse, etc.)	___	___

10. Social recreational resources	___	___
11. Other special resources (AA, CSS, Legal Aid, etc.)	___	___
Total Resources Needed and Arranged	___	___

Appendix F

Discharge Planning Quality Assurance Form for Chart Reviews

The discharge planning quality assurance form is used to conduct focused, retrospective chart reviews. The sum of all criteria met is the final score for the chart.

Discharge Planning Quality Assurance Form for Chart Reviews

Patient's Name_____MR#_____
Social Worker's Name_____Unit_____

Criterion	Yes	No	Score
1. High Risk Rating listed in multi-disciplinary treatment plan (MDTP) within 72 hours of admission	___	___	_____
2. Social work discharge plan listed in MDTP within 7 days of admission	___	___	_____
3. Plan specifies following areas:			
a) Further treatment	___	___	_____
b) Living arrangements	___	___	_____
c) Finances for medical and living expenses	___	___	_____
d) Education/employment/vocational plans (If inapplicable, N/A is used)	___	___	_____
e) Other (Social/leisure/recreational plans CSS, AA, transportation, etc.) Below	___	___	_____
4. Plans clearly reflect accurate and comprehensive assessment of patient's current situation and future needs	___	___	_____
5. Written evidence exists in chart of patient/family participation in development of discharge plan	___	___	_____
6. Treatment plan updates for discharge plan completed as required for Division	___	___	_____
7. Updates reflect greater specificity of discharge plans over time	___	___	_____
8. Discharge planning is mentioned in social work progress notes each week	___	___	_____
9. Progress notes give specifics of discharge planning efforts (specify contacts, status of referrals, reasons for level of aftercare, any changes in plan and reasons for these)	___	___	_____
10. The final DC plan is clearly stated with specific names, addresses, phone numbers	___	___	_____

11. The final DC plan is comprehensive - refers to all areas of identified need ___ ___ ____

Final Chart Score (sum of all items marked yes) (An N/A under item 3d is counted as a yes) ____

(Above average = 13-15; average = 9-12; below average = 0-8)

Comments:

Date of Review _____

Name of Reviewer _____

Appendix G

Social Service Closing Summary

The Social Service Closing Summary Part I is completed by the social worker within 24 hours after the patient's discharge. Part II must be submitted on the 13th day post-discharge. Information from both Parts I and II are entered into the hospital's computer by secretarial staff.

SOCIAL SERVICE CLOSING SUMMARY – SOCIAL SERVICE INFORMATION

Patient Name	Consecutive/Episode #

C. Primary Responsible Mental Health Professional(s) For Patient Post-Discharge

1. Name of Practitioner, Agency or Institution			Discipline
Street			Suite No.
City	State	Zip Code	Telephone No. ( )
2. Name of Practitioner, Agency or Institution			Discipline
Street			Suite No.
City	State	Zip Code	Telephone No. ( )
3. Name of Practitioner, Agency or Institution			Discipline
Street			Suite No.
City	State	Zip Code	Telephone No. ( )
4. Name of Practitioner, Agency or Institution			Discipline
Street			Suite No.
City	State	Zip Code	Telephone No. ( )

D. Were Long Term Living Arrangements Made?

☐ Yes, Complete Sections D1 and D2
☐ No, Skip to Section E

1. Setting For Long Term Living Arrangements (X in one only)

☐ Private House, Apartment
☐ Rooming/Boarding House
☐ Y Residence
☐ Adult Home (PPHA)
☐ Foster Home
☐ Halfway House
☐ Group Home
☐ Supportive Living Arrangement
☐ Boarding School or College
☐ Residential Treatment Center
☐ Health Related Facility
☐ Skilled Nursing Facility
☐ State Psychiatric Center
☐ Other Long Term Psychiatric Hospital
☐ Other (Specify) _____

2. Person(s) With Whom Patient Will Live in Section D1 (X in all that apply)

☐ Alone
☐ With Spouse/Mate
☐ With Children
☐ With Parent(s)
☐ With Foster Family
☐ With Sibling(s)
☐ With Other Relative(s)
☐ With Roommate(s) / Companion(s) / Other Residents
☐ Other (Specify) _____

E. Were Interim Living Arrangements Made?

☐ Yes, Complete Sections E1 and E2
☐ No, Skip to Section F

1. Interim Living Arrangements (X in one only)

☐ Private House/Apartment
☐ Rooming/Boarding House
☐ Y Residence
☐ Psychiatric Unit of General Hospital
☐ Medical/Surgical Unit of General Hospital
☐ Other Short-Term Psychiatric Hospital
☐ Other (Specify) _____

2. Person(s) With Whom Patient Will Live in Section E1 (X in all that apply)

☐ Alone
☐ With Spouse/Mate
☐ With Children
☐ With Parent(s)
☐ With Foster Family
☐ With Sibling(s)
☐ With Other Relative(s)
☐ Other (Specify) _____

SOCIAL SERVICE CLOSING SUMMARY – SOCIAL SERVICE INFORMATION

Patient Name	Consecutive / Episode #

F. Psychiatric Rehabilitation (Specify Type of Service – X in all that apply)

1. ☐ Evaluation (e.g. Private/Agency/OVR Assessment)
2. Treatment
   - A. ☐ Prevocational (e.g. Guidance Center Industries)
   - B. ☐ Vocational (e.g. Sheltered Workshop, Fountain House)
   - C. ☐ Social (e.g. Mental Health Assoc. Social Club, Fountain House)
   - D. ☐ To Be Determined by Agency
   - E. ☐ Other (Specify) _____
3. ☐ Vocational Training (e.g. FEGS, BOCES)
4. ☐ Job Placement Agency (NYS Employment, OVR, EPRA)
5. ☐ Volunteer Placement
6. ☐ Transitional Employment Placement
7. ☐ None
8. ☐ Other (Specify) _____

G. Employment (X in one only)

☐ None
☐ Returned to Former Job
☐ Employed at New Job
☐ Seeking New Job Independently
☐ Other (Specify) _____

H. Education (X in all that apply)

☐ Regular Elementary or Secondary School
☐ Special Education
☐ Education in a Residential Treatment School
☐ General Equivalency Diploma Program (GED)
☐ Vocational or Technical School
☐ College (Full or Part-Time)
☐ Graduate or Professional School
☐ Non-Matriculated Adult Education Courses
☐ Unknown
☐ None
☐ Other (Specify) _____

I. Other Resources (X in all that apply)

☐ Community Support System
☐ Alcoholics Anonymous (AA)
☐ Other Self-Help Organization
☐ Legal Aid
☐ Traditional Healers
☐ Homebound Services (e.g. Meals-on-Wheels)
☐ Community Recreation Programs (e.g. Y's, Church Groups, etc.)
☐ Leisure-Type Adult Education
☐ None
☐ Other (Specify) _____

J. Finances For Discharge Plan

1. For Medical Expenses (X in all that apply)
   - ☐ Private Funds
   - ☐ Blue Cross/Blue Shield
   - ☐ Other Private Medical Insurance
   - ☐ Medicare
   - ☐ Medicaid
   - ☐ Unknown
   - ☐ Other (Specify) _____
2. For Other Expenses (X in all that apply)
   - ☐ Earnings or Other Private Funds
   - ☐ Social Security Retirement/Survivors
   - ☐ Social Security Disability Insurance
   - ☐ Supplementary Security Income
   - ☐ Public Assistance
   - ☐ Unknown
   - ☐ Other (Specify) _____

K. Discharge Plans Formulated For Family – Referrals For Family Members (X in all that apply)

☐ Mental Health Professional
☐ Mental Health Clinic
☐ Family Agency or Institute
☐ Family Support Group
☐ None
☐ Other (Specify) _____

Primary Mental Health Professional(s) For Family At Discharge (If applicable)

Name of Practitioner, Agency or Institution		Discipline
Street		Suite No.
City	State / Zip Code / Telephone No. ( )	

Signature _____ Degree _____ Date _____

The New York Hospital – Cornell Medical Center
Westchester Division

SOCIAL SERVICE CLOSING SUMMARY

PART II: NARRATIVE SUMMARY

Date of Hospital Admission _____ Date of Discharge _____

Discharge Unit _____

1. Summary of Social Work Interventions (include work with family, patient and disposition planning):

2. Response to Social Work Interventions (by family and patient):

3. Additional Pertinent Data (if any):

4. Post-Discharge Follow-up of Referral Plan

   A. If No Post-Discharge Contact (check most important reason:)
      1) ☐ Patient refuses follow-up
      2) ☐ Patient, family or professional unavailable for contact
      3) ☐ AMA Discharge
      4) ☐ Other (state reason) _____

   B. Follow-up Contact Completed (specify persons, dates and content of contacts below):

SOCIAL SERVICE CLOSING SUMMARY

C. Check any of the following which have occurred since discharge:

1) ☐ Serious exacerbation of symptoms
2) ☐ Significant noncompliance with meds
3) ☐ Rehospitalization
4) ☐ Suicide attempt
5) ☐ Completed suicide
6) ☐ Other significant event (specify) _____

D. If lack of completion of referral plans is reported, specify which aspects of patient's plan have not been followed to date:
Place Letter of referral item in box using the code below and specify the item on the line to the right –

e.g. [D] Rooming House

CODE KEY

[A] Referrals for Patient's Further Treatment
[D] Long Term Living Arrangements
[E] Interim Living Arrangements
[F] Psychiatric Rehabilitation
[G] Employment
[H] Education
[I] Other Resources
[J] Finances for Discharge Plan
[K] Referrals for Family Members

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____

Please note reasons for incompletion of discharge plan:

E. Rate your impression of how well the patient is doing post-discharge (circle 1):

0	1	2	3	4	5
Unknown	Very Poor	Poor	Fair	Good	Very Good

Date _____ Signature and Degree _____

THE NEW YORK HOSPITAL - CORNELL MEDICAL CENTER
WESTCHESTER DIVISION

1808.25 Financial Benefits Programs and Inpatient Status

When patients are hospitalized, procedures for financial benefits (and for their interaction) are different than for patients in the community. Some typical situations and guidelines for managing them are noted below. In brief, the Finance Office should always be consulted when a patient has any change in financial status or is applying for any benefits.

Applications for Westchester County and for New York City Medicaid can be made at the Finance Office. Patients from other areas should also be referred to the Finance Office for advice before being sent to their local Departments of Social Services Medicaid Unit.

A. Inpatient Applies for Medicaid Only, to Pay All or Part of the Hospital Bill
   1. The patient is permitted to have $3100 in assets, an optional burial fund of $1500 and no more than $434/month in income.
   2. If the patient has surplus assets (above $4600), these must be paid to the Finance Office. This is because Medicaid will subtract surplus assets from the amount it reimburses the hospital.
   3. If the patient has excess income (over $434/month), this excess must be paid to the Finance Office each month. Medicaid will not pay this part of the bill.
   4. If a patient was terminated from his job at the point of hospitalization and applies for Medicaid while here, Medicaid surplus will be calculated based upon whatever severance, sick or vacation pay the patient receives, or is expected to receive. (See also A5.)
   5. If the patient was working prior to his hospitalization and has his job to return to, he will be held responsible for paying the hospital a Medicaid surplus equivalent to the amount he was earning above the Medicaid level for the prior 6 months. (Example: patient has job paying $634/month and no other assets. Upon application for Medicaid, he will be deemed to have a $200 monthly surplus and will have to pay the hospital $1200.)

B. Inpatient Had Medicaid While Outside the Hospital, and Was Deemed to Have Excess Income (Medicaid Surplus Program)
   1. In this case, the patient is usually required to pay the hospital the amount of the excess income calculated over a 6 month period. (Example - patient has a $534 income/month and therefore has an excess of $100/month. He is required to pay the hospital $600. This amount - $600 - is deducted by Medicaid from the sum it reimburses the hospital) but see B2.
   2. If the patient had been meeting the Medicaid surplus amount regularly for medical expenses before being hospitalized (e.g. above patient had been paying $100/month to a day hospital), he would not have to pay the 6 month surplus. The patient must have been verifying with Medicaid monthly that he has incurred these outpatient bills.

C. Inpatient Applies for Both Medicaid and SSI While Hospitalized
   1. The same rules as in "A" apply for the Medicaid application which should be made first if needed to pay the hospital bill. Any resources above the Medicaid level will have to be paid to the hospital.
   2. Note that if the patient had applied for Medicaid before coming to the hospital, he would have been able to use excess resources in various ways to pay legitimate debts or purchase needed items (e.g. clothing, household equipment, but not luxury items).
   3. If the patient does not need Medicaid for the hospital bill, he should spend down resources above the SSI level of $1900 and optional burial fund $1500, and apply for SSI. When SSI is granted, he will automatically be eligible for Medicaid. (It may be offered to him or he may have to apply.)
   4. If the patient has turned over resources above the Medicaid level to the hospital, he can then spend down resources above the SSI level in other ways before applying for SSI. Resources must be within the SSI limits when he applies or he will be refused.

Appendix H

Job Description for Discharge Planning Coordinator

The author is the Associate Director of Social Service and also has been appointed Discharge Planning Coordinator for the hospital. Responsibilities for the Discharge Planning Coordinator role are outlined in the following sheet.

Job Description for Discharge Planning Coordinator

Position Title: Associate Director of Social Work Services Reports to Director of Social Work Services

Specifications:

- Education
  Master's degree in social work from graduate school accredited by the Council on Social Work Education
- Professional Accreditations
  New York State Certification
  Member of Academy of Certified Social Workers

Qualifications:

- Demonstrated skill in administration, supervision, and practice.
- Proven effectiveness in establishing and maintaining advanced level of social work practice in a psychiatric teaching hospital.
- Demonstrated leadership capacities.
- Advanced knowledge of human behavior and its application to social work practice.
- Advanced knowledge of systems theories.
- Skill in teaching supervisory theory and practice.
- Demonstrated objectivity, sensitivity, flexibility, creativity, and self-awareness in work with patients, multi-disciplinary staff, and community leaders.
- Organizational skills, including familiarity with budgeting, staffing patterns, salary scales, program planning, monitoring, standard setting and statistics collection.
- Excellent understanding and working knowledge of community resources.

Duties and Responsibilities:

- Is responsible for ensuring the overall quality, timeliness, and comprehensiveness of discharge planning within the institution.
- Identifies and resolves systemic problems in aftercare planning.
- Acts as liaison to community agencies regarding discharge planning and referral issues.
- Chairs the hospital's Discharge Planning and Community Liaison Committee.

- Supervises Resource Library staff. Oversees the development and organization of the collection.
- Is responsible for quality assurance in the area of discharge planning.
- Plans and implements inservice training seminars in discharge planning for social work staff, students, and trainees of other disciplines.
- Represents the social work department on the Utilization Review Committee.
- Is responsible for the Discharge Planning Manual.

Appendix I

Job Description for Resource Librarian

This sheet describes the major functions of the 10 hour per week Resource Librarian who works within the Social Work Resource Library.

Job Description for Resource Librarian

Position Title: Social Work Services Resource Librarian Reports to Associate Director of Social Work Services

Specifications:

- Education
  Master's degree in library science from a graduate school accredited by the American Library Association
- Professional Accreditations
  Public Librarian's Professional Certificate

Qualifications:

- Demonstrated skill in developing, building, and maintaining a specialized collection.
- Experience in both reference and circulating collections.
- Understanding of the functions of social workers in a psychiatric hospital and the nature of discharge planning.
- Well-developed knowledge of federal, state, and local governmental agencies, documents and social welfare policy.
- Familiarity with social and mental health facilities and resources.
- Excellent search techniques to locate resource information through diverse sources.
- Capacity to work collaboratively with social work staff and with members of other disciplines in specifying and locating needed information.
- Ability to orient hospital staff and students to the Resource Library.
- High degree of organizational ability, capacity co communicate ideas with clarity and respect for confidentiality are also required.

Dutues and Responsibilities:

- Acquires resource information by phone, letter, and site visit from pertinent community agencies and government departments.
- Organizes and categorizes resource information into a system which permits easy retrieval by staff.
- Provides specific information about resources to staff upon request.
- Conducts searches via phone, through other libraries and information services when data sought is not contained in Resource Library.

- Is responsible for keeping the Resource Library's collection current and comprehensive by reviewing holdings and by acquiring new materials.
- With Resource Consultant, reviews and evaluates all incoming resource information; catalogues, files, and informs relevant staff.
- Conducts Resource Library orientations to acquaint social work and hospital staff with the collection and with available services.
- Maintains current application forms for metropolitan area resources.
- Participates in relevant committees (e.g. Discharge Planning and Community Liaison Committee).

Appendix J

Job Description for Resource Consultant

This sheet describes the major functions of the half-time Resource Consultant who works within the Social Work Resource Library.

Job Description for Resource Consultant

Position Title: Social Work Services Resource Consultant Reports to Associate Director of Social Work

Specifications:

- Education

  Master's degree in social work from graduate school accredited by the Council on Social Work Education

- Experience

  A minimum of 4 years experience after completion of M.S.W., or 2 years post-master's plus at least 2 years of pre-professional experience. N. Y. State Certification.

Qualifications:

- Extensive experience in discharge planning within a psychiatric setting.
- Comprehensive knowledge of community resources.
- Expertise in aftercare financial benefits which are applicable to the psychiatric population.
- Demonstrated capacity for evaluation of and consultation about a broad range of discharge plans.
- Ability to teach the components of effective discharge planning and patient advocacy.
- Creativity and resourcefulness in finding solutions to complex discharge planning problems.
- Strong commitment to the delivery of the highest quality discharge planning services to patients and families.
- Excellent skills in organizational tasks essential to maintaining an effective and responsive Resource Library.

Responsibilities:

- Provides both resource information and discharge consultation to social work staff, students, and members of other disciplines.
- Confers with staff regarding the preparation of outgoing referral material.
- Conducts inservice seminars for staff and students.
- With the Resource Librarian, maintains a system for discharge information storage and delivery.

- Offers instruction to staff and students about the use of the Resource Library and the functions of its personnel.
- Keeps abreast of developments in the mental health system—laws, regulations, trends, etc. which pertain to discharge planning. Keeps up to date with all financial benefits programs (money for living expenses and money for medical expenses).
- Establishes liaisons with private and public mental health providers in order to maintain good referral alliances.
- Collects information on new resources (through in-person visits and calls) and makes this available to staff. Maintains the department's resource bulletin board.
- Documents and suggests remediation for difficulties with internal or external policies and procedures concerning discharge planning.
- Aids in the preparation of relevant sections of the Social Work Discharge Planning Manual.
- Participates in selected departmental and hospital committees (e.g. Discharge Planning and Community Liaison Committee, Community Support System meetings).
- Provides pre-admission discharge screening consultations to Admitting Service staff.

Appendix K

Assessing Patient Networks and Supports

Critical questions for locating and assessing the patient's and family's actual and potential support networks are contained within this sheet. (Questions used for assessing the patient's network have been adapted from Robert Sokolove and David Trimble, "Assessing Support and Stress in the Social Networks of Chronic Patients," *Hospital and Community Psychiatry* 37 (April 1986), pp 370-372.)

Assessing Patient Networks and Supports

1. Whom in your family (immediate and extended) do you enjoy seeing, visiting? How often?
2. Whom do you enjoy seeing or visiting outside the family? How often?
3. Whom do you see every day? Once a week? Once a month?
4. Who notices when you are having a hard time? Whom do you worry about?
5. Where do you spend most of your time?
6. Who lends you money? Who borrows from you?
7. When you get upset, with whom do you like to talk?
8. If you drink or smoke, with whom do you do these things?
9. Do you eat with other people? Who? Where do you eat?
10. Where do you get your clothes? Does anyone shop with you?
11. Who criticizes you? Who bothers you? With whom do you argue?
12. Do you ever go to a church, synagogue, the Y, a soup kitchen, or any other organization?

Assessing Family Networks and Supports

1. Draw a genogram of all living members of the extended family.
2. What is the extent of contact among them? What contact does each have with the patient? What might each individual offer the patient?
3. To whom does family turn for help with problems? With whom have they discussed patient's illness? Are there any close family friends or neighbors (including clergy)?
4. Do family members belong to any organizations - church, synagogue, AMI, support groups?
5. What are family financial resources? Can family contribute to patient's support, and if so, in what amount? In kind?
6. What community resources might be available to assist family with specific needs (financial, medical, transport, support, treatment, etc.)?

Appendix L

Resource Consultation Form

The Discharge Planning Coordinator uses the following form to record initial information about discharge planning needs.

Resource Consultation Form
Social Worker's Name _____ Tel _____ Date _____
Patient's Name_____MR #_____Unit_____DOB_____
Marital_____ GAS ____ SS#_____Medicaid #_____
Address_____
Funding Sources_____
Race, Religion_____DC Date_____
Diagnosis_____
Patient Characteristics

Presenting Situation

Initial Discharge Planning Assessment and Recommendations

Appendix M

The Resource Library — Description of Services

The description of the Resource Library which is distributed to social work staff and students is contained on the following page.

The Resource Library — Description of Services

The Resource Library is staffed by a half-time M.S.W. Resource Consultant and by a part-time Resource Librarian, who provide assistance for a limited number of hours each week. Information about the specific hours these staff members' services are available can be obtained from the Social Work Services secretaries. To reach the Resource Library by telephone, call Ext. 5784. The Librarian can provide factual information and assistance in using the directories and files, while the Resource Consultant can offer a fuller consultation about discharge planning for specific patients. Staff members are asked to fill out a Resource and Discharge Information Request Form, available at the Social Work Services Office, when requesting assistance. Orientation to the use of the files and directories is offered as needed to small groups of staff. Periodically, training meetings and seminars are scheduled to familiarize staff and students with principles of disharge planning and to update their knowledge of resources and benefits.

Staff members are asked to keep in mind that an evaluation of each patient's financial resources and eligibility for benefits is essential for the development of sound discharge plans. The Resource Consultant is available for help with this basic first step which should be explored before information is sought regarding specific facilities.

Appendix N

Rating of Linkages Among Elements of Aftercare Plan

At discharge, this form is used in consultation with the social worker to assess the degree to which linkages have been established among all aftercare providers.

Rating of Linkages Among Elements of Aftercare Plan

Patient's Name_____ Unit_____ Date _____

	Yes	No	Partial
1. Are all participants in the aftercare plan aware of each other and able to have contact as needed?	___	___	___
2. Do all participants understand each other's roles - what to expect, who will do what?	___	___	___
3. Do all participants know how future problems or crises are to be managed?	___	___	___

Appendix O

Discharge Planning Flow Sheet

This sheet is used in teaching social work staff and students about the appropriate tempo of effective discharge planning.

Discharge Planning Flow Sheet

DP Assessment
Review of past plans
Preserving existing resources
(housing, finances, relatives,
day hospital, etc.)

→ Financial evaluation and application → Formulation of 3 levels of plans based on informed projection of best, average and worst patient outcome →

Gather information about the 3 possible levels of aftercare including application material. Stop here only if patient's clinical condition precludes taking next steps.

→ As soon as patient's clinical condition begins to improve, referral summary should be prepared. Document reasons for level of care, exact services patient will require → Send applications to all appropriate resources simultaneously →

Conduct weekly follow-up calls and document status of each referral. Arrange interviews. Prepare patient for these.

→ Move to contingency plans if needed. Appeal any denials if possible. No day should be without an active discharge plan. → Once acceptance/admission date is received, make arrangements for transportation, obtaining personal items, initial funds.

W. Christ, 8/88

Appendix P

Financial Benefits Programs and Inpatient Status

This document summarizes the relationship of the major financial benefit programs and inpatient status. It is included in the Social Work Discharge Planning Manual.

D. Inpatient on Medicaid Begins to Receive SSI while Here - is Given a Lump Sum for Back Payments

1. If the patient's hospitalization has already been approved and funded by Medicaid, the fact that SSI has been granted should be reported to his Medicaid office. His case will be transferred from a Medical Assistance unit to the SSI Medicaid unit. He will no longer be recertified by Medicaid. He is given 6 months (under some circumstances 9 months) to spend down any money he has received which places him above the SSI resource level. His SSI aware letter will indicate the length of time he is given.
2. If the fact of having been granted SSI has not been reported to Medicaid and the patient comes up for recertification for Medicaid while in the hospital, his case should still be transferred to the SSI Medicaid unit at the DSS. If he is within the SSI time frame of 6 or 9 months for spending down excess back payments of SSI, this has no bearing on his continued Medicaid eligibility. If the time frame has passed, he needs to spend down in order to maintain his eligibility for SSI, and hence his automatic eligibility for Medicaid. The situation should be discussed with the Finance Office since, at this point, he may be required by Medicaid to utilize his assets above the Medicaid level ($4600) towards the hospital bill. He may need advice and help re spending down any other surplus above the SSI level ($1900 plus $1500). To avoid these complications, social workers should be aware of the problems which may arise when a patient receives a lump sum of money from any source and should seek advice from the Resource Consultant.

E. Inpatient Receives SSD Plus SSI with Medicaid Paying over 50% of Hospital Bill

1. Patient may keep the combined payment of SSI and SSD for the first full calendar month he is here. (Example: if he comes into the hospital on October 1 he may keep the entire amount for that month. If he comes in on September 25, he may also keep the entire money for the month of October.)
2. After the first calendar month, the patient will receive only the SSD. If the SSD is more than $30/month, he will get no SSI while in the hospital.
3. If SSD is in excess of $434/month, he will be put in the Medicaid surplus program and will have to pay the difference between $434 and his SSD to the hospital each month. (Example: patient with $534 a month SSD must pay $100/month to the hospital.)
4. The usual Medicaid resource limitations apply. The patient can have $3100 plus a $1500 burial fund. But if he accumulates assets above the SSI level ($1900 plus $1500), he will lose eligibility for SSI to fund his discharge plan. He may need help in spending down his assets which fall above the SSI level and below the Medicaid level as he nears discharge.

F. Inpatient on SSD with Medicaid Paying over 50% of Hospital Bill

1. The patient is allowed to keep $434/month (the allowable monthly income under Medicaid).
2. Any excess over $434 must be paid to the hospital since it is considered excess income.
3. After a SSD patient has been in the hospital for 6 months, Medicaid may deem him to be chronic and require him to give all his income except a $50/month personal allowance to the hospital. The patient can dispute this decision through a Fair Hearing process if he chooses.
4. He can use part of his income for medical expenses not included in the hospital bill (dentist, glasses, etc.) if carefully documented. Such arrangements must be worked out with the Finance Office and with Medicaid.

G. Patient Receives SSD Back Payment while Hospitalized with Medicaid Paying over 50% of the Bill

1. The patient has to spend down the back payment before his next Medicaid recertification. He may pay off his own legitimate debts, back medical bills from non-Medicaid vendors, college loans and credit cards. He may also purchase things he needs such as clothing, household furnishings. He must be prepared to document these expenditures for Medicaid.
2. If Medicaid recertification comes up before the patient has spent down his surplus, Medicaid may assign the surplus or whatever remains to the hospital bill.

H. Inpatient Applying for SSI, but Not Applying for Medicaid, with Hospitalization Funded Entirely by Private Insurance and/or Private Pay

1. If a patient with resources in excess of allowable SSI limits wants to apply for SSI, he should first spend down his excess assets in a legitimate and systematic manner. He must document these expenditures for Social Security when applying. If he applies without first spending down, he will be refused SSI as financially ineligible. Social workers should not refer patients to apply for SSI without first making certain they are financially eligible.
2. If granted SSI, a patient in the hospital on private insurance or private pay may receive the full federal benefit of SSI while in the hospital (1988 - $354/month).
3. The social worker should caution the patient about accumulating excess assets while in the hospital so as to become ineligible for SSI to fund a discharge plan.
4. Social workers on longer-term halls should counsel staff against encouraging inpatients with substantial SSD or SSI income to set a pattern of luxury spending. If the patient expects to live on SSI after leaving the hospital, it is in his interest to develop habits of careful budgeting. The Resource Consultant can make suggestions about the handling of money to avoid accumulation of excess assets including the possibility of setting up a PASS (Plan to Achieve Self-Support). TA personnel may also be able to help with PASS procedures.
5. The patient who begins to receive SSI while in the hospital may be offered Medicaid by letter from the local district office of DSS. However this does not always happen and he may need to apply to the Medical Assistance unit of the DSS where his home address is located.
6. Private insurance is the first line of resource for a patient with both private insurance and Medicaid. However Medicaid may come into play in meeting co-payments (or exempting the patient from co-payments if the co-payment would bring the total payment together with the private insurance above the Medicaid payment level.)
7. Patients whose responsible family members have signed an agreement to meet co-payment charges above private insurance are still legally obligated to the hospital even if Medicaid is obtained at a later date.

I. Patient on SSD Who Will Need SSI also to Fund Discharge Plan - Private Insurance Paying over 50% of the Hospital Bill (Patient May or May Not Be Receiving Some Medicaid to Supplement Insurance)

1. If patient's SSD or other income is less than the federal benefit level of SSI ($354/month in 1988), he can apply for and receive SSI while in the hospital, provided his assets are within the SSI limitations. Since there is little delay in approving SSI to establish disability status (already proven for SSD), back benefits are likely to be minimal.
2. If the patient's SSD is at or above $354/month, he cannot apply for or receive SSI until he has been discharged to a living level paying a higher SSI benefit (e.g. Level II facility or living alone). He can apply as soon as he is discharged, with written verification from his facility or landlord and proof of his SSD, provided his assets are within SSI limits.
3. The patient seeking SSI to supplement SSD for a Level II discharge plan will experience delays in actually receiving payment of SSI. He may require other interim funding to meet the Level II facility costs. This can be from his own assets, from family or, if he is eligible, from public assistance. Patients must be 21 in New York State to apply for PA and must meet strict asset limitations. (See Discharge Planning Manual Section 1808.1 for details).
4. Note that patients who cannot qualify for PA for part or all of interim funding can be referred to Level II facilities only with private interim funding. For reimbursement by SSI for this period, such temporary private funding (e.g. from parents) needs to be set up in the form of a written loan to the patient. (The Resource Consultant can advise).

Special Note

Under certain circumstances, it is possible for a patient to spend down excess assets to either the Medicaid or the SSI level by repaying debts to family members. These must be legitimate debts and the repayment process must be carefully and legally documented. Social workers should not attempt to advise families to do this without guidance from the Resource Consultant, an attorney specializing in administrative law, or other knowledgeable person. An inappropriate attempt can result in a refusal of Medicaid on grounds of transfer of assets and/or in serious financial loss to the hospital.

Appendix Q

Discharge Plan Information Form

The Discharge Plan Information Form is given to each patient (or responsible relative) at the time of discharge. It contains the specifics of the actual discharge plan. A copy is placed in the chart.

New York Hospital - Westchester Division

DISCHARGE PLAN INFORMATION

Patient Name_____ Unit_____ Anticipated Date of Discharge_____

Plans for discharge (include all living arrangements, facilities, agencies and practitioners with addresses and phone numbers, dates of any appointments):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Social Worker

Co-signature (if required)

Date

I have received a copy of the discharge plan for _____
(Patient's Name)

_____ _____

Signature (Relationship to Patient)

Appendix R

Functional Assessment Form

The Functional Assessment Form is used in determining the level of structure and demand most appropriate for the patient in the aftercare environment.

Functional Assessment of Patient

	Independently	With Difficulty Needs Ass'tance	Unable or Unwilling
Bathes and grooms self appropriately	____	____	____
Dresses self appropriately	____	____	____
Performs basic household chores	____	____	____
Obtains food, prepares own meals	____	____	____
Maintains adequate diet	____	____	____
Can shop for food and clothes	____	____	____
Manages own money	____	____	____
Can take meds on own	____	____	____
Can keep treatment appointments	____	____	____
Maintains daily structure	____	____	____
Socializes with others	____	____	____
Can arrange leisure activities	____	____	____
Can arrange own transportation	____	____	____
Can take initiative to seek help as needed	____	____	____

Bibliography

1 Altman, Helen. "A Collaborative Approach to Discharge Planning for Chronic Mental Patients." *Hospital and Community Psychiatry* 34 (July 1983), pp. 641-642.

2 American Hospital Association. Committee on Discharge Planning of the Society for Hospital Social Work Directors. *Reference Article on Discharge Planning.* Chicago: American Hospital Association, 1980.

3 American Hospital Association. "Introduction to Legislation and Regulations Governing Discharge Planning." *Discharge Planning Update* 1 (Fall 1980), pp. 11-12.

4 American Hospital Association. Task Force on Legal Issues in Discharge Planning. Office of General Counsel. *Legal Memorandum Number 9 - Discharging Hospital Patients: Legal Implications for Institutional Providers and Health Care Professionals.* Chicago: American Hospital Association, 1987.

5 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 3rd edition. Washington, D. C.: American Psychiatric Association, 1987.

6 Ames, David. "The Limits of General Hospital Care: A Continuing Role for State Hospitals." *Hospital and Community Psychiatry* 24 (February 1983), pp. 145-149.

7 Anderson, Carol and Meisel, Susan. "An Assessment of Family Reaction to the Stress of a Psychiatric Illness." *Hospital and Community Psychiatry* 27 (December 1976), pp. 868-871.

8 Arnstein, Sherry. "Reagan Proposes FY 1984 Budget with Few Surprises for Health." *Washington Report* 9 (February 1, 1983), pp. 1-21.

9 Bachrach, Leona. *Deinstitutionalization: An Analytic Review and Sociological Perspective.* Rockville, Maryland: U.S. Department of Health, Education and Welfare, 1976.

10 Bachrach, Leona. "Continuity of Care for Chronic Mental Patients: A Conceptual Analysis." *American Journal of Psychiatry* 138 (November 1981), pp. 1449-1456.

11 Baker, Frank and Intagliata, James. *CSS Evaluation: Final Report.* Albany, New York: New York State Office of Mental Health, 1981.

12 Beis, Edward. *Mental Health and the Law.* Rockville, Maryland: Aspen Systems Corporation, 1984.

13 Berkman, Barbara; Rehr, Helen; and Rosenberg, Gary. "A Social Work Department Develops and Tests a Screening Mechanism to Identify High Social Risk Situations." *Social Work in Health Care* 5 (Summer 1980), pp. 373-385.

14 Berlin, Sharon. "Cognitive-Behavioral Approaches," in *Handbook of Clinical Social Work,* pp. 1095-1119. Edited by Aaron Rosenblatt and Diana Waldfogel. San Francisco: Jossey-Bass, 1983.

15 Brager, George. "Helping vs. Influencing: Some Political Elements in Organizational Change," in *Social Administration: the Management of the Social Services,* pp. 567-569. Edited by Simon Slavin. New York: Haworth Press, 1978.

16 Bristol, Opal; Stickney, Carol; and Thompson, Shirley. *Discharge Planning for Continuity of Care.* New York: National League for Nursing, 1976.

17 Caplan, Gerald. *Principles of Preventive Psychiatry.* New York: Basic Books, 1964.

18 Caroff, Phyllis. "Clinical Social Work: Present Role and Future Challenge." *Social Work in Health Care* 13 (Spring 1988), pp. 21-33.

19 Christ, Winifred. "Factors Delaying Discharge of Psychiatric Patients." *Health and Social Work* 9 (Summer 1984), pp. 178-187.

20 Christ, Winifred and Hayden, Sharon. "Discharge Planning Strategies for Acutely Homeless Inpatients." *Social Work in Health Care* 14 (Winter 1989), forthcoming.

21 Cochrane, Edward. "Editorial Comments." *Discharge Planning Update* 1 (Fall, 1980), p. 1.

22 Cochrane, Edward. "Discharge Planning, the Central Role of Social Work." *NASW News* 26 (February 1981), pp. 14-15.

23 Cohen, Lawrence H. and Nelson, Dean W. "Crisis Intervention: An Overview of Theory and Technique," in *Crisis Intervention.* 2nd edition, pp. 13-26. Edited by Lawrence Cohen, William Claiborn, and Gerald Specter. New York: Human Sciences Press, 1983.

24 Cohen, Rita. "Crisis Intervention for Medical Problems," in *Crisis Intervention.* 2nd edition, pp. 131-133. Edited by Lawrence Cohen, William Claiborn and Gerald Specter. New York: Human Sciences Press, 1983.

25 Compton, Beulah R. "Traditional Fields of Practice," in *Handbook of Clinical Social Work,* pp. 983-1023. Edited by Aaron Rosenblatt and Diane Waldfogel. San Francisco: Jossey-Bass, 1983.

26 Corn, Ruth. "Minutes of the ATSD Social Work Staff Meeting." White Plains, N. Y.: New York Hospital - Westchester Division, Social Work Department, 9/21/87. Unpublished memorandum.

27 Coulton, Claudia. *Social Work Quality Assurance Programs: A Comparative Analysis.* Washington, D.C.: NASW, 1979.

28 Coulton, Claudia. "Social Workers in Discharge Planning." *Social Work* 25 (January 1980), pp. 81-82.

29 Coulton, Claudia, et al. "Discharge Planning and Decision Making." *Health and Social Work* 7 (July 1982), pp. 253- 261.

30 Crittendon, Faith Jackson. *Discharge Planning for Health Care Facilities.* Bowie, Maryland: Robert J. Brady Co., 1983.

31 Cunningham, Louise. "Early Assessment for Discharge Planning." *Quality Review Bulletin* (Special Edition, Spring 1982), pp. 66-71.

32 Cutler, David and Tatum, Ellie. "Networks and the Chronic Patient," in *Effective Aftercare for the 1980's,* pp. 13-21. Edited by David Cutler. San Francisco: Jossey-Bass, 1983.

33 Cutler, David; Terwilliger, Wesley; and Faulkner, Larry. "Integrating an Aftercare Plan for the Chronic Patient," in *Effective Aftercare for the 1980's,* pp. 95-104. Edited by David Cutler. San Francisco: Jossey-Bass, 1983.

34 Damashek, Zelda. "List of Potential Clients for Intensive Case Management." White Plains, New York: Westchester County Department of Community Mental Health, April 8, 1988. Unpublished memorandum.

35 Duehn, Wayne D. "The Process of Social Work Practice and Research," in *Social Work Research and Evaluation,* pp. 11-34. Edited by Richard M. Grinnell. Illinois: F. E. Peacock, 1981.

36 Edwards, Richard. "Professionals in 'Alliance' Achieve More Effective Discharge Planning," *Hospitals* 52 (June 1, 1978), pp. 71-72.

37 Epstein, Irwin and Tripodi, Tony. *Research Techniques for Program Planning, Monitoring and Evaluation.* New York: Columbia University Press, 1977.

38 Eisenthal, Sherman, et al. "Adherence and the Negotiated Approach to Patienthood." *Archives of General Psychiatry* 36 (April 1979), pp. 393-398.

39 Feder, Harry, Senior Vice President, Island Peer Review Organization. "Report on ALC Approvals and Denials by the Island Peer Review Organization." New York City: Discharge Planning Association of New York City, 12/14/99. Unpublished report.

40 Fields, Grace. "Anatomy of Discharge Planning." *Social Work in Health Care* 4 (Fall 1978), pp. 5-6.

41 Flaherty, John. *Literature Review and Background Paper for Discharge Planning Program Development.* Albany, New York: New York State Office of Mental Health, Division of Policy Planning and Program Development, 1980.

42 Germaine, Carel B. *Social Work Practice: People and Environments.* New York: Columbia University Press, 1979.

43 Germaine, Carel B. "The Social Context of Clinical Social Work." *Social Work* 25 (November 1980), pp. 483-488.

44 Gil, David. *Unraveling Social Policy.* Cambridge, England: Schenkman Publishing Company, 1976.

45 Glassberg, Anita and Fallik, Sheila. *Hospital Discharge Planning: A Function in Search of a Focus.* New York: Greater New York Hospital Association, April 1982.

46 Goldman, Howard. "Mental Illness and Family Burden: A Public Health Perspective." *Hospital and Community Psychiatry* 33 (July 1982), pp. 557-560.

47 Goldman, Howard, Guest Editor. "Special Section on Prospective Payment." *Hospital and Community Psychiatry* 35 (May 1984), pp. 447-464.

48 Goldman, Howard; Adams, Neil; and Taube, Carl. "Deinstitutionalization: The Data DeMythologized." *Hospital and Community Psychiatry* 34 (February 1983), pp. 129-134.

49 Goldman, Howard; Gattozia, Antoinette; and Taube, Carl. "Defining and Counting the Chronically Mentally Ill." *Hospital and Community Psychiatry* 32 (January 1981), pp. 21-27.

50 Goldstein, Eda. "The Knowledge Base of Clinical Social Work." *Social Work* 25 (May 1980), pp. 173-178.

51 Goldstein, Eda. "Issues in Developing Systematic Research and Theory," in *Handbook of Clinical Social Work*, pp. 5-25. Edited by Aaron Rosenblatt and Diana Waldfogel. San Francisco: Jossey-Bass, 1983.

52 Goldstein, Eda. *Ego Psychology and Social Work Practice.* New York: Free Press, 1984.

53 Gottron, Martha, ed. *A Review of Government and Politics.* Vol. 5: *Congress and the Nation.* Washington, D.C.: Congressional Quarterly, Inc., 1980.

54 Hatfield, Agnes B. "Families as Caregivers: A Historical Perspective," in *Families of the Mentally Ill,* pp. 3-29. Edited by Agnes B. Hatfield and Harriet P. Lefley. New York: Guilford Press, 1987.

55 Hospital Association of New York State. "OMH and OMRDD Announce Implementation of Plans for Nursing Home Reform Law." *HANYS News* 20 (December 23, 1988), pp. 1-3.

56 Joint Commission on Accreditation of Health Care Organizations. *Accreditation Manual for Hospitals, AMH/88.* Chicago: JCAHO, 1987.

57 Kirk, Stuart, and Greenley, James. "Denying of Delivering Services?" *Social Work* 19 (July 1974), pp. 439-477.

58 Kirk, Stuart, and Therrien, Mark. "Community Mental Health Myths and the Fate of Former Hospitalized Patients." *Psychiatry* 38 (August 1975), pp. 209-217.

59 Kogan, Leonard, and Shyne, Ann. "Tender-Minded and Tough-Minded Approaches in Evaluative Research." *Welfare in Review* 4 (March 1966), pp. 12-17.

60 Kolber, Leatrice. "Discharge Planning: A Process for Continuity of Care." *Discharge Planning Update* 3 (Winter 1983), pp. 26-33.

61 Lamb, H. Richard. *Treating the Long-Term Mental Patient.* San Francisco: Jossey-Bass, 1982.

62 Lewis, Harold. *The Intellectual Base of Social Work Practice.* New York: Haworth Press, 1982.

63 Lewis, Harold. Hunter College School of Social Work, New York, New York. Interview, 20 September 1982.

64 Lindenberg, Ruth and Coulton, Claudia. "Planning for Posthospital Care: A Follow-Up Study." *Health and Social Work* 5 (May 1980), pp. 45-50.

65 Lurie, Abraham; Pinsky, Sidney; and Tuzman, Leonard. "Training Social Workers for Discharge Planning." *Health and Social Work* 6 (Fall 1981), pp. 12-18.

66 McCranie, Edward, and Mizell, Terrence. "Aftercare for Psychiatric Patients: Does It Prevent Rehospitalization?" *Hospital and Community Psychiatry* 29 (September 1978), pp. 584-587.

67 McKinney's Consolidated Laws of New York (Annotated). Book 34A. *Mental Hygiene Law, Article 29.15.* "Discharge and Conditional Release of Patients to the Community." Minnesota: West Publishing Co., 1988, pp. 290-296.

68 Meyer, Carol H. *Social Work Practice,* 2nd ed. New York: Free Press, 1976.

69 Minkoff, Kenneth. "A Map of the Chronic Mental Patient," in *The Chronic Mental Patient,* pp. 11-37. Edited by John Talbott. Washington, D.C.: American Psychiatric Association, 1978.

70 Nacman, Martin. "Social Work in Health Settings: A Historical Review." *Social Work in Health Care* 2 (Summer 1977), pp. 407-418.

71 New York State Commission on Quality of Care for the Mentally Disabled. *Discharge Practices of Inpatient Psychiatric Facilities.* Albany, New York: New York State Commission on Quality of Care for the Mentally Disabled, August, 1988.

72 New York State Department of Health. *Hospital Memorandum, Series 77-86, Criteria and Standards for Admission of Persons Over the Age of 16 Years to Psychiatric Units of General Hospitals.* Albany, New York: New York State Department of Health, July 3, 1986.

73 New York State Department of Health. *Hospital Memorandum, Series 86-64, Hospital Discharge Planning.* Albany, New York: New York State Department of Health, July 3, 1986.

74 New York State Department of Health. *Hospital Memorandum, Series 86-97, Hospital Procedures for Completing and Using the Long Term Care Patient Review Forms and Criteria for Level of Care.* Albany, New York: New York State Department of Health, October 2, 1986.

75 New York State Office of Mental Health. Alternate Reimbursement Methodologies Project Task Force. *Reimbursement of Psychiatric Inpatient Stays:*

Proposed Regulatory Revisions, Part 86 of Title 10 NYCRR, Section 86. Albany, New York: New York State Office of Mental Health, August 3, 1988.

76 New York State Office of Mental Health. *1988 Update and Progress Report for the Five Year Comprehensive Plan for Mental Health Services, 1985 - 1990.* Albany, New York: New York State Office of Mental Health, 1987.

77 New York State Office of Mental Health. *Statewide Comprehensive Plan for Mental Health Services 1989 - 1991.* Albany, New York: New York State Office of Mental Health, 1988.

78 New York State Office of Mental Health. *Reimbursement of Psychiatric Inpatient Stays: Proposed Regulatory Revisions, Part 86 of Title 10 NYCRR, Section 86-1.57.* Albany, New York: New York State Office of Mental Health, 8/3/88.

79 New York State. *Public Health Law.* Chapter V, Title 10, Section 405.9 (f) (2). "Admission/Discharge." Amended 6/9/88.

80 New York State Service Planning Committee. *Committee Report to the Commissioner of Mental Health on the Need for Discharge Planning Procedures and Follow-Up Services for Patients Released from Facilities Licensed or Operated by the Office of Mental Health.* Albany, New York: New York State Office of Mental Health, 1982.

81 Nichols, William and Everett, Craig. *Systemic Family Therapy: An Integrative Approach.* New York: Guilford Press, 1986.

82 O'Sullivan, Anne and Brody, Michael. "Discharge Planning for the Mentally Disabled." *Quality Review Bulletin* 12 (February 1986), pp. 55-67.

83 Osborne, Hazel. Quoted by Harold Weissman in "Knowledge Base of Clinical Social Work," in *Handbook of Clinical Social Work,* p. 4. Edited by Aaron Rosenblatt and Diana Waldfogel. San Francisco: Jossey- Bass, 1983.

84 Patti, Rino. "Organizational Resistance and Change: the View from Below." *Social Service Review* 48 (September 1974), pp. 367-383.

85 Pattison, E. Mansell, et al. "A Psychosocial Kinship Model for Family Therapy." *American Journal of Psychotherapy* 132 (December 1975), pp. 1246-1251.

86 Peterson, Carolyn; Wolkon, George; and Wirth, Bonita. "A Comparative Study of Referral Success in First Appointments Made by Patients and by Staff," *Hospital and Community Psychiatry* 32 (November 1981), pp. 800-801.

87 Pilisuk, Marc and Parks, Susan Hillier. "Caregiving: Where Families Need Help."a *Social Work* 33 (September - October 1988), pp. 436-440.

88 Prevost, James A., Commissioner. *Information Memorandum: Discharge and Release of Psychiatric Patients to the Community.* Albany, New York: New York State Office of Mental Health, March 11, 1981.

89 Public Information Department, New York Hospital - Westchester Division. *The New York Hospital - Cornell Medical Center, Westchester Division.* White Plains, N. Y.: N. Y. Hospital - Westchester Division, January, 1982.

90 Ramos, Reyes. "Participant Observation," in *Social Work Research and Evaluation,* pp. 348-360. Edited by Richard M. Grinnell. Illinois: F. E. Peacock, 1981.

91 Rehr, Helen. "Discharge Planning: An Ongoing Function of Quality Care." *Quality Review Bulletin* 12 (February 1986), pp. 47-49.

92 Rosner, Martin. "Economic Determinants of Organizational Innovation." *Administrative Science Quarterly* 12 (March 1968), pp. 614-625.

93 Rudder, Cynthia. *Case-Mix Reimbursement and Resource Utilization Groups (RUGS) - What Consumers Should Know.* New York: Nursing Home Community Coalition of New York State, November 1985.

94 Schinke, Steven Paul. "Ethics," in *Social Work Research and Evaluation,* pp. 57-70. Edited by Richard M. Grinnell, Jr. Illinois: F. E. Peacock, 1981.

95 Schulberg, Herbert and Baker, Frank. "Program Evaluation Models and the Implementation of Research Findings." *American Journal of Public Health* 58 (July 1960), pp. 1248-1255.

96 Schwitzgebel, Robert and Schwitzgebel, R. Kirkland. *The Law and Psychological Practice.* New York: John Wiley and Sons, 1980.

97 Senior, Neil and Kibbee, Priscilla. "Can We Predict the Patient Who Leaves Against Medical Advice: The Search for a Method." *The Psychiatric Hospital* 17 (Winter 1986), pp. 33-36.

98 Shapiro, Jerald. "Commitment to Disenfranchised Clients," in *Handbook of Clinical Social Work,* pp. 888-903. Edited by Aaron Rosenblatt and Diana Waldfogel. San Francisco: Jossey- Bass, 1983.

99 Simon, Fritz; Stierlin, Helm; and Wynne, Lyman. *The Language of Family Therapy: A Systemic Vocabulary and Sourcebook.* New York: Family Process Press, 1985.

100 Solomon, Phyllis; Gordon, Barry; and Davis, Joseph. "Assessing the Service Needs of the Discharged Psychiatric Patient." *Social Work in Health Care* 10 (Fall 1984), pp. 61-69.

101 Sommer, Robert and Sommer, Barbara A. *A Practical Guide to Behavioral Research: Tools and Techniques.* New York: Oxford University Press, 1980.

102 Spivack, George et al. "The Long-Term Patient in the Community: Life Style Patterns and Treatment Implications." *Hospital and Community Psychiatry* 33 (April 1982), pp. 291-295.

103 Stickney, Sondra; Hall Richard; and Gardner, Gail. "The Effect of Referral Procedures on Aftercare Compliance." *Hospital and Community Psychiatry* 31 (August 1980), pp. 567-569.

104 Surber, Robert et al. "Medical and Psychiatric Needs of the Homeless–A Preliminary Response." *Social Work* 33 (March - April 1988), pp. 116-119.

105 Taube, Carl A. et al. "The Chronic Mental Hospital Patient." *Hospital and Community Psychiatry* 34 (July 1983), pp. 611-615.

106 Tessler, Richard and Mason, John. "Continuity of Care in the Delivery of Mental Health Services." *American Journal of Psychiatry* 136 (October 1979), pp. 1297-1301.

107 Tessler, Richard et al. "The Chronically Mentally Ill in Community Support Systems." *Hospital and Community Psychiatry* 33 (March 1982), pp. 208-211.

108 Thompson, Edward Jr. and Doll, William. "The Burden of Families Coping with the Mentally Ill: An Invisible Crisis." *Family Relations* 31 (July 1982), pp. 379-388.

109 Tripodi, Tony and Epstein, Irwin. "Incorporating Knowledge of Research Methodology into Social Work Practice." *Journal of Social Service Review* 2 (Fall 1978), pp. 65-78.

110 U.S. President. "Medicare and Medicaid Conditions of Participation for Hospitals." *Federal Register*. 51, no. 116, 17 June 1986, 22043.

111 Volland, Patricia, ed. *Discharge Planning: An Interdisciplinary Approach to Continuity of Care*. Maryland: National Health Publishing, 1988.

112 Wasylenki, Donald et al. "Psychiatric Aftercare: Identified Needs Versus Referral Patterns." *American Journal of Psychiatry* 138 (September 1981), pp. 1228-1231.

113 Wasylenki, Donald; Plummer, Elizabeth; and Littmann, Sebastian. "An Aftercare Program for Problem Patients." *Hospital and Community Psychiatry* 32 (July 1981), pp. 493-496.

114 Weiss, Carol. *Evaluative Research.* New Jersey: Prentice-Hall, 1972.

115 Weiss, Carol. "Alternative Models of Program Evaluation." *Social Work* 17 (November 1974), pp. 675-681.

116 Weissman, Harold. "Clients, Staff and Researchers." *Administration in Social Work* 1 (Spring, 1977), pp. 43-51.

117 Weissman, Harold. "Knowledge Base of Clinical Social Work," in *Handbook of Clinical Social Work*, pp. 1-4. Edited by Aaron Rosenblatt and Diane Waldfogel. San Francisco: Jossey-Bass, 1983.

118 Williams, George; Hsu, Fu-tong; and Lin, Tsung-yi. "Prediction of the Burden of Released Mental Patients." *Community Mental Health Journal* 9 (September 1973), pp. 303-315.

119 Wilson, Suanna J. *Field Instruction Techniques for Supervisors.* New York: Free Press, 1981.

120 Wolkon, George; Peterson, Carolyn; and Rogawski, Alexander. "A Program for Continuing Care: Implementation and Outcome." *Hospital and Community Psychiatry* 29 (April 1978), pp. 254-256.

121 Zeldow, Peter and Taub, Harvey. "Evaluating Psychiatric Discharge and Aftercare in a VA Medical Center." *Hospital and Community Psychiatry* 32 (January 1981), pp. 57-58.

122 Zolik, Edwin and Lantz, Edna. "Hospital Return Rates and Prerelease Referrals." *Archives of General Psychiatry* 18 (June 1960), pp. 712-717.