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A survey to identify discharge criteria used by psychologists in New York State inpatient psychiatric facilities with chronic schizophrenic patients

Kayne, Robert L., Psy.D.

Pace University, 1989

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A Survey to Identify Discharge Criteria Used by Psychologists in New York State Inpatient Psychiatric Facilities with Chronic Schizophrenic Patients

by

Robert L. Kayne

A Doctoral Project Submitted in Partial fulfillment of the Requirements for the Degree of Doctor of Psychology in the Department of Psychology at Pace University.

NEW YORK

1989

PACE UNIVERSITY

PSYCHOLOGY DEPARTMENT
PSY.D. PROJECT
FINAL APPROVAL FORM

(Please type all information)

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TITLE OF PROJECT: A Survey to Identify Discharge Criteria Used by Psychologists in New York State Inpatient Psychiatric Facilities with Chronic Schizophrenic Patients

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I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Community Psychology.

Leonard E. Bart 8/11/89
(Project Advisor's Signature) (Date)

John Stokes 8/29/89
(Project Consultant's Signature) (Date)

TABLE OF CONTENTS

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To anyone I have inadvertently omitted (and I'm sure there are many) - Friends, relatives, colleagues - To all of you, thank you for being on my side, and thank you for your confidence in me. I hope I've made you proud.

LIST OF TABLES

Abstract

The process involved in the determination of discharge readiness of psychiatric inpatients has not been adequately examined. There exist studies in the fields of Psychiatry and Social Work, but little has been done in Psychology. This project was constructed as a survey of psychologists working on inpatient psychiatric units in New York State psychiatric centers or in NY Veterans' Administration facilities. The project's goal was to try to provide a means of quantitatively determining those discharge criteria considered to be of greatest importance to such psychologists when they assess the discharge readiness of a chronic schizophrenic patient.

Thirty-five long-term facilities were contacted, providing a total of two hundred thirty-six psychologists. More than seventy percent of psychologists contacted completed the survey. A three-page survey form was sent to these identified psychologists. The first two pages consisted of lists of specific behaviors that had been identified in the professional literature as having an influence on the discharge decision. The first page was composed of fourteen "positive" indicators, behaviors that demonstrated social competency, while the second page listed fourteen "negative" factors, behaviors indicating psychopathology. Respondents were asked to rank ten of the listed behaviors on each page, in terms of importance with

regard to "discharge of a chronic schizophrenic patient from your facility". The final page of the survey requested demographic and professional characteristics of the respondents, and also asked the respondent to select the "three items you consider most important in discharge readiness".

The results of the survey demonstrated that certain discharge criteria were chosen more frequently and given a higher ranked position by psychologists in New York State psychiatric facilities. No significant differences between groups was obtained when respondent or facility characteristics were examined. No significant differences were found among the various demographic groups, nor did professional characteristics of psychologists produce significant differences.

The obtained results of this survey have permitted the development of a checklist of important discharge readiness criteria. This checklist, consisting of seven identified behaviors, can be used in the assessment of a patient's readiness for discharge, can facilitate a patient's more rapid return to the community and can permit more constructive and efficient communication among staff.

A Survey to Identify Discharge Criteria Used by Psychologists in New York State Inpatient Psychiatric Facilities with Chronic Schizophrenic Patients

INTRODUCTION

Discharge procedures are a major problem within psychiatric facilities. The focus of this survey is to determine those criteria considered to be of greatest importance when psychologists working on inpatient psychiatric units assess the discharge readiness of a chronic schizophrenic patient. As soon as a psychiatric patient enters an institution, the discharge planning process begins. There exists only a limited number of inpatient beds for use by psychiatric patients, and the demand for them is unfortunately always at a high level. Yet, given the importance of the discharge aspect of the patient's treatment, the discharge planning process in many, if not most, institutions and facilities is frequently arbitrary and haphazard (Hogarty, 1972). There is no systematic procedure that is followed regularly and consistently when evaluating a patient's readiness for discharge from an inpatient setting (Archer, 1980, Becker, 1984). This visible lack of precision and objectivity serves to greatly heighten the anxiety experienced by both patient and family. The uncertainty of not being able to know when the patient will be deemed suitable for discharge, or what is required before the determination is made, places the

patient and family in a position of being constantly on the defensive. Often, thoughts of discharge are paramount in the patient's mind, overriding all others. However, this is often not considered by treatment teams, and the patient's questions are often left unanswered or inadequately addressed (Goldman, 1982). There is a definite need to clearly specify those behaviors that are necessary for discharge consideration.

The issue of who is appropriate for discharge cannot be separated from who requires further inpatient hospitalization, or who in the community ought to be hospitalized. There is little doubt that many patients in a psychiatric facility would not be assessed as requiring immediate hospitalization if they were seen out on the streets. Yet, while they are inside, they are not deemed appropriate for discharge. Conversely, many "street people" who marginally exist out in the community, if seen in a psychiatric admissions unit, would be admitted. Despite this fact, they remain on the streets. This raises issues that are outside the scope of this project, but are nevertheless important to keep in mind, and could easily be the focus of another study. The goal of this project is solely to determine those criteria considered to be of greatest importance when psychologists working on inpatient psychiatric units assess the discharge readiness of a patient.

A New York State agency report (Joint Commission on Mental Illness and Health, 1984), has stated that the main objective of the community mental health movement is deinstitutionalization, on the assumption that it offers the potential for improved patient care and better quality of life. Regardless of whether movement in this direction is governed primarily by social, economic or other reasons, it is vital that consistency be present when the question is approached as to who is discharged, when it occurs, and why it is to be done. The key emphasis must be to determine whether a patient is able to leave the hospital, even if the hospital's, or the system's, ineffectiveness prevents implementation of the decision at that given time, so that a psychiatric patient's length of stay as an inpatient is kept to the minimum clinically indicated duration.

The problem of determining at what point a patient can be considered for discharge has not been adequately addressed. The psychiatric literature reports numerous studies examining prediction of outcome, i.e., whether or not a discharged patient will remain out of the hospital, or require re-admission (Bene-Kociemba, 1979; Bond, 1985; DeFrancisco, 1980; Falloon, 1983; Goering, 1984; Kinard, 1981; Schanding, 1984; Solomon, 1984a). However, there has been a minimal amount of previous examination of the specific assessment techniques used to determine an inpatient's readiness for discharge (Kane, 1980; Hogarty, 1966; Hogarty & Ulrich, 1972; Archer, 1980). After

determining those discharge criteria that are of greatest importance, an organized, objective tool will be formulated for all clinicians, and particularly psychologists, so that the process of evaluation of a given patient's readiness for discharge from an inpatient setting becomes more systematic.

Discharge planning is often treated as a low-skill activity, not worthy of the time and efforts of most mental health professionals (Kane, 1980). In particular, the role of the staff psychologist in the discharge planning process has not been adequately examined. As discharge planning and preparation have traditionally been placed within the province of the social worker, most past articles and studies have focused on the role of the social worker, to the exclusion of any other team professionals (Altman, 1983; Christ, 1982; Coulton, 1982; Hogarty, 1966; McCreath, 1984; Segal, 1979; Smith & Smith, 1978). Yet, given the current state of the staffing in most facilities, where the number of professionals assigned to treatment is often insufficient, blurring of responsibility is inevitable and probably desirable. A patient's primary therapist must be aware of the status of many different aspects of his/her treatment, including the discharge planning. It is the contention of Hogarty (1966), that decision-making usually includes the input of psychologist and social worker more than any other staff, although the medical model of psychiatric facilities requires that primary responsibility for the actual discharge decision be placed with the

physician. Most psychiatrists are assigned to take care of a very large number of patients, and much of their efforts are inevitably devoted to proper medical management, medication, physical problems, etc. Therefore, the physician will often be quick to admit that his/her knowledge of a patient is not as comprehensive as that of other staff members. The psychologist frequently takes on a crucial role in maintaining an overview of all patients on a unit, and functions as a 'second-in-command' to the physician in many areas of ward administration.

The current state of discharge planning often relies heavily upon 'clinical judgment', which is certainly a valuable skill, but one that is highly subjective and personal. The clinician's intuitive sense of the patient's condition is extremely important, but such feelings are difficult to communicate to the patient, to the family, or even to the non-professional treatment staff, who spend the bulk of their time in direct contact and interaction with the patient. There is a clear need for the development of objective, observable behavioral criteria, which can be used by all staff to assist in their determination and evaluation of a particular patient's readiness, or lack of such, for discharge (Archer, 1980). Also, such criteria could be used by all the different staff who run groups on inpatient wards. If occupational therapists, recreation therapists, nurses, social workers, or psychologists can be provided with specific skills that the patient must display to be

considered appropriate for discharge, they can tailor activities to address those specific skills that will be examined.

It is strongly believed by Blackburn (1972), that the institutional role a hospital accepts or rejects contributes to patient movement. He claimed that psychiatric hospitals ought not be viewed solely as sanctuaries, where people unable to function with the pressures of every-day stresses can be protected and shielded from the outside environment, or as prisons, where those people whom society does not want mingling among the general population can be locked away. The goal of inpatient hospitalization ought to be to provide active treatment, and to alleviate the patient's acute symptoms during the crisis that he/she is experiencing at that time. Once the acute crisis has passed, treatment should focus upon discharge. Even a chronic schizophrenic, who has a history of many years of failure to function appropriately, may not require continued hospitalization, with the expectation that eventually all the symptoms will be eliminated. Such negative symptoms as flat affect, or social withdrawal, may never go away, but that does not mean that this patient can never be considered for release.

The goal of this project is to quantitatively determine those discharge criteria considered by psychologists to be most important when assessing the discharge readiness of a hospitalized chronic schizophrenic patient and to determine if consensus of choice exists among varying demographic

populations. If those behaviors that truly are considered of greatest importance in the determination of either discharge, or continued inpatient treatment, can be identified and utilized in the assessment process, only those patients who require the intensive, structured, expensive services that an inpatient ward offers, will be kept as inpatients. Those who can be discharged will be sent out, to settings where continued treatment will be made available, but at a much lower, more efficient cost, both in terms of money and self-esteem.

The psychologist will certainly not be the only person working on the inpatient ward who will benefit from the results of this project. Private practice clinicians will also benefit from the knowledge that certain criteria generally regarded as more important in the patient's discharge have been met. When they see their patient in out-patient treatment, they will know what can and cannot be expected, both in terms of pathology that should no longer be present, and in terms of social competency skills that should be available for use by the patient who is now not hospitalized. Similarly, families will be able to know what to expect from their still-fragile member.

Review of Literature

A review of the professional literature has shown that the decision-making process involved in the determination of readiness for discharge of a psychiatric inpatient has not been adequately addressed. Very few published articles have focused on the assessment of a patient's readiness for discharge or on the criteria used by clinicians in such an assessment. There are ample studies, reports, and predictions relating to outcome or risk of rehospitalization, with respect to psychiatric inpatient populations, but there are too few on the assessment of a patient's readiness for return to the community or to family. Many studies have suggested that significant numbers of inpatients could be treated as outpatients, a preferable, less costly, less traumatic alternative for most people. Discharge can be a highly stressful, critical event and requires closer examination than it has been given to date.

In 1980, Archer et al. stated that "... a review of the literature does not reveal research specifically investigating variables associated with staff judgment of readiness for discharge." This was reinforced by Becker and Banks (1984), who stated that "... there have been few attempts at statistically identifying the discharge readiness of psychiatric inpatients." They speak of the pressure exerted on staff at inpatient facilities to identify appropriate patients for discharge and prepare them

for the transition to alternative, outpatient, living settings. An article by Goldman (1982), noted that two-thirds of patients return to their families, and this considerable burden on patient and family must be taken into account. It was asserted by Hogarty (1972), that "Both the public health importance of accurately assessing new or promising treatments and the national goal to reduce inpatient beds are strong bases for seeking an objective criterion of discharge readiness". Williams et al. (1980), claimed that, as cutbacks in social services increase, due to government budgetary fluctuations, the minorities and the poor suffer the greatest impact. These are the segments of the population most represented in state psychiatric facilities, and are the ones most vulnerable. Thus, it can be seen that the issue of determination of discharge readiness has been identified as needing examination, but such examination has not yet been satisfactorily done.

As noted by Caton et al. (1984), the value of discharge planning as a therapeutic intervention has not been adequately assessed. They found that higher patient-staff ratios and smaller hospital size were related to increased patient discharge, and also stated that when discharge planning effectively connects the patient to the community treatment system, it serves to keep the patient out of the hospital for a longer time. Additionally, Kane (1980), asserted that it is a fallacy to consider discharge planning as a low-skill activity, and that, in fact, "... it is one

of the most intellectually demanding skill-dependent activities".

According to Growe et al. (1977), previous studies did not attempt to assess behaviors specifically relevant to successful functioning in the community. They noted that there was a positive correlation between length of hospital stay and the pre-discharge rating of belligerent behavior. They also stated that deviations from social norms are viewed as more personal and private, and not seen to infringe as directly on others as does aggressive behavior. Avoidance of aggressive behavior, as well as an ability to avoid gross difficulties in social functioning, were seen as quite important to remaining in the community.

Much has been written regarding both return to the community and need for continued hospitalization. In their published study, Rud and Noreik (1982), found that six variables correlated positively with long-term hospitalization, and an inability to discharge a patient. These are demented, organic, very young or very old, single, poorly educated, and socially isolated patients, all of whom became the discharge problems. In another review of problem discharges, Smith and Smith (1978), claimed that learned helplessness can serve a useful purpose for those patients who do not wish to be discharged. If they are discharged before they feel ready to leave, or if they believe that they can only function effectively in a hospital setting,

learned helplessness will aid them in continuing in the patient role.

It was reported by Kinard (1981), that fully one-fourth of discharged state mental patients indicated a desire to return to the hospital at some time within one year of their discharge. Those with low self-image, poor or no relations with others, poor use of leisure time, and recurrent psychiatric symptomotology were most likely to desire return. Reason for admission, chronicity of illness, living arrangements, source of support, role in household, employment status, or prescribed medications were found to have no relationship. Similarly, Segal (1981), claimed that rehospitalization can be positive if it serves to link the patient to the service system and allows the accrual of the newest treatment benefits. It can be an efficient means of "updating" the chronic patient's treatment.

A paper by Rabiner et al. (1983), suggested that more efficient techniques for assessing the likelihood of successful community re-entry following inpatient hospitalization are sorely needed. They speak of the need to identify patients whose prompt return to the community carries unwarranted risk of immediate readmission. They state that since one cannot directly observe patient responses to the demands likely to be encountered on release, one must depend upon history, clinical interview, and ward behavioral data to evaluate appropriateness for release. However, with history one must accept informant