National Quality Improvement Conference

# Transitional Care Programme for Patients Discharged from a Psychiatric Hospital

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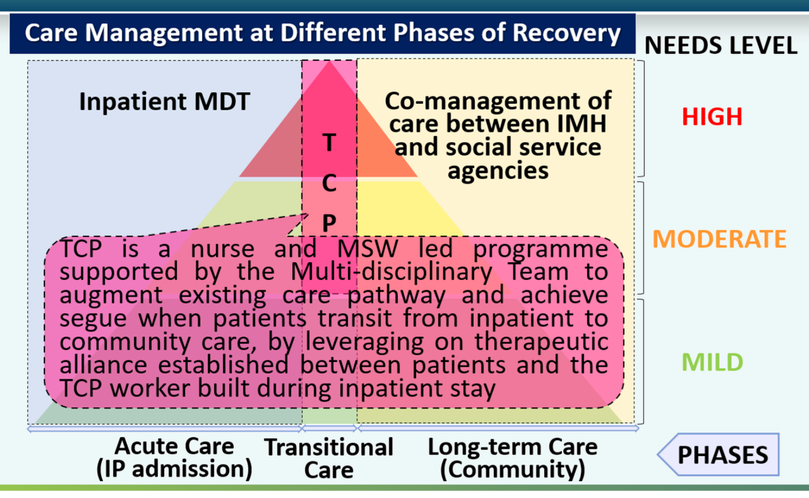
## Problem Statement

The post-discharge period following a psychiatric admission is a vulnerable phase for patients and caregivers. Complex mental disorders, ongoing psychosocial stressors and a change in care setting often challenges transition and reintegration back into the community. Take-up rate of community services from patients was low. This stems from ineffective care coordination due to changes in care partner and a lack of trust amongst other reasons. Close and effective needs-based support, and linkage to community resources are crucial to reduce readmissions and augment recovery.

## Project Aim




## Lessons Learnt

1. Managing staff burnout as they are handling more complex cases in the community. We established monthly TCP practice circle where staff met to raise challenges and learn from one another. Supervisors attend these meetings to identify and resolve administrative hurdles.

2. Transfer of TCP cases to community partners is challenging as there are varying competencies of community partners in managing mental health-related cases. This provides an opportunity to engage and upskill partners through trainings provided by IMH for the community partners to enhance their capabilities in handing clients with mental health issues.

3. Caregivers' feedback was encouraging and attests to the positive impact of TCP.

## Potential Solutions

**Phases of TCP Interventions**

**Prior to Inpatient Discharge**

Admission → Inpatient treatment

**TCP engagement in inpatient ward**
1. Triage, needs assessment & collection of pre-test with psychometric tools
2. Discharge planning including co-creating recovery goals with patient
3. Rapport building & secure commitment for post inpatient discharge follow-up

**Community Interventions** (Within and up to a 6-month period after inpatient discharge)

**Targeted interventions to enhance treatment continuity through**
**(Intensive visit frequency as short as weekly)**

| | | |
|---|---|---|
| 1. Psychosocial treatment support | → | E.g., Illness management |
| 2. Family involvement | → | E.g., Reinforce crises management skills |
| 3. Medication support | → | E.g., Pill box filling guidance |
| 4. Community living skills | → | E.g., Independence in community navigation |
| 5. Establish and strengthen community linkages | → | E.g., Bridge relationship between patient and community partners |
| 6. Practical assistance | → | E.g., Financial assistance |

**End of Interventions (6 months)**

**Disengagement**
When the following are met:
1. 80% medications adherence
2. 2 TCUs actualised
3. Social Acuity at mild or moderate
4. Warm hand-off* to caregivers/community partners

## Outcomes & Impacts