Ideal to Real:
Challenges and Solutions in Implementing the Transitional Discharge Model

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The *Transitional Discharge Model (TDM)* has been used to facilitate effective psychiatric hospital discharge to the community for individuals with a mental illness.

BACKGROUND:

- TDM was developed through a Canadian participatory action project called the *Bridge to Discharge* project (Forchuk, Chan et al., 1998; Forchuk, Jewell et al., 1998). The pilot project successfully "bridged" 38 long-term stay clients from hospital to community, resulting in inpatient savings of almost $500,000 (CAN) in the first year (Forchuk, Chan et al., 1998).

- Forchuk, Martin, Chan & Jensen (2005) further tested the model in a randomized cluster design using 26 tertiary care psychiatric wards (13 intervention, 13 control). In the first year, the length of stay on intervention wards was decreased by 116 days per person for a savings of over $12 million (CAN) and patients reported significantly higher quality of social relations (Forchuk et al., 2005).

WHAT IS THE TRANSITIONAL DISCHARGE MODEL?

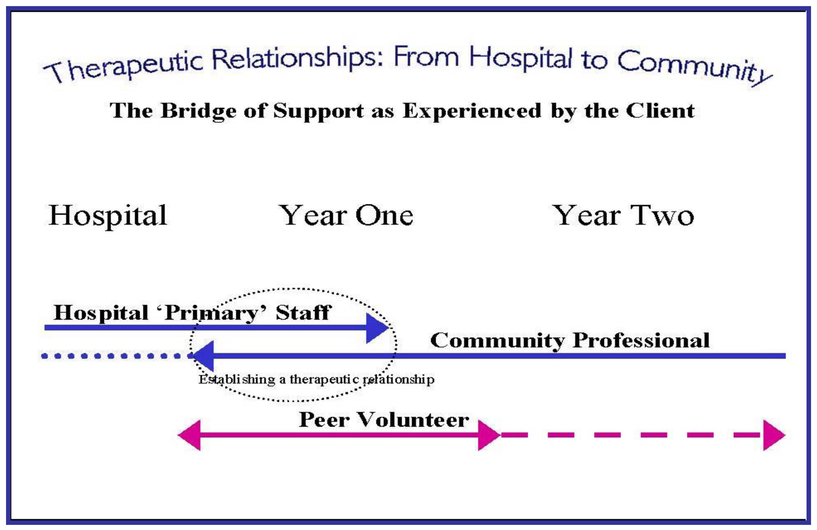
The model is based on the provision of therapeutic relationships to ensure a safety net throughout the discharge and community reintegration processes.

1) An *inpatient staff member* maintains contact with the client after hospital discharge until a therapeutic relationship is established with *a community care provider,* creating an overlap of care.

2) *Peer support* is offered from a mental health services consumer who is living in the community and who has had specialized training in support.

PURPOSE:

Despite the positive client and systems outcomes, TDM has not always been easy to implement. TDM requires many changes in traditional relational and policy practices. The Knowledge Integration Project examined the barriers to and facilitators of implementing a best practice related to transitional discharge care in selected psychiatric settings.



METHODS:

Design, Setting, Sample:

- Delayed implementation design.
- TDM implemented on 40 wards at six psychiatric hospitals.
- Implementation occurred in three waves; Groups A, B and C.
- After each group implemented TDM, focus groups were held with staff to identify barriers and strategies related to implementation.
- Strategies were then refined for each subsequent group.
- Ward level data was collected throughout.
- Clients were interviewed at discharge and one month post-discharge to determine the *degree* of implementation.

RESULTS:

- There was a significant negative correlation between time and total implementation, peer support, and continued support scores in Group A. The degree of implementation **decreased** over time.

- There was no significant correlation between time and total implementation, peer support, and continued support scores for wards in Group B. The second group of wards to implement TDM through the utilization of strategies suggested by A wards were able to **maintain** the intervention's implementation.

- For wards in Group C, there was a significant positive correlation between time and total implementation, peer support, and continued support scores. This group implemented the program using the strategies proposed by Groups A and B, and their ability to successfully implement TDM **improved** over time.

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INTEGRATING RESEARCH INTO PRACTICE:

Barriers

Work environment issues were the primary implementation barriers identified.

Feeling Swamped, Overwhelmed

- Feeling overwhelmed by workplace demands.
- Numerous new projects and educational programs.
- Increased paperwork demands – feeling burnt out.

Death by Process

- Frequent meetings that rarely lead to concrete plans.
- Interpersonal conflicts amongst team members.

Group Dynamics

- If team members were already in conflict, the model simply added fuel to the fire.
- Role issues, such as which disciplines should participate in discharge planning.

Change in Champion

- All wards acknowledged the importance of champions; problems often arose if the identified champion left.
- If there was a gap between champions, the degree of implementation suddenly dropped.
- Adjustment period resulting from changes in champions

Facilitators

Valuing Intervention

- Most wards valued the intervention.
- Those familiar with the model valued it prior to implementation while wards for which it was a new experience did not value it until after.
- Personal experience rather than literature was more influential.

Similarity/Difference to Current Practice

- Implementation was easier for wards that had already implemented some aspect of the model (i.e. already established relationships with community partners or existing collaborative staff relationships).
- The more TDM aspects already integrated, the smaller the changes required, and the less staff resistance.

Other useful key supports and tools identified:

- Documentation systems/check lists supporting the intervention.
- Clear protocols for ward transitioning.
- Accessible consumer groups/peer support information or consumer group presence on ward/at hospital.
- Quick, condensed staff training.

CONCLUSIONS:

- Evidenced-based practice initiatives must be planned & introduced carefully with investment of all stakeholders.
- On-going communication, support & education.

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