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INTERVENÇÕES PROMOTORAS DA TRANSIÇÃO E CONTINUIDADE DE CUIDADOS EM CONTEXTO PSIQUIÁTRICO: SCOPING REVIEW

INTERVENTIONS TO PROMOTE TRANSITION AND CONTINUITY OF CARE IN PSYCHIATRIC SETTINGS: SCOPING REVIEW

INTERVENCIONES QUE PROMUEVEN LA TRANSICIÓN Y LA CONTINUIDAD DE LA ATENCIÓN EN UN CONTEXTO PSIQUIÁTRICO: SCOPING REVIEW

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RESUMO

Introdução: A transição entre o internamento e o ambulatório, em serviços de psiquiatria, é um período de elevada vulnerabilidade, particularmente quando existe sintomatologia psicótica. São recomendadas intervenções para garantir a transição segura e promover a continuidade dos cuidados, nomeadamente intervenções tipo ponte.
Objetivo: Mapear as intervenções realizadas durante a transição de cuidados entre o internamento e o ambulatório, para pessoas com sintomatologia psicótica.
Métodos: Revisão *scoping* segundo metodologia do JBI. Realizada em bases de dados, desde 2010, em inglês, português e espanhol. Seleção de estudos e extração de dados concretizada por dois autores independentes.
Resultados: Foram identificadas 12 intervenções classificadas relativamente às características (formato, tipo de abordagem, *setting* e duração) e às componentes (conteúdos, estratégias de transição e consulta pós-alta) promotoras da transição de cuidados após internamento de psiquiatria a pessoas com sintomatologia psicótica.
Conclusão: É consensual que intervenções ponte devem integrar intervenções educativas e relacionais, mediadas por um gestor de transição, papel maioritariamente desempenhado por enfermeiros. É importante a conceção de orientações a implementar nos serviços para facilitar a transição entre o internamento e o ambulatório.

Palavras-chave: sintomatologia psicótica, intervenções ponte, alta, transição, ambulatório, enfermagem

ABSTRACT

Introduction: The transition between inpatient and outpatient psychiatric care is a highly vulnerable period, particularly when psychotic symptoms are present. Interventions are recommended to ensure a safe transition and promote continuity of care, particularly bridging interventions.
Objective: To map the interventions carried out during the transition between inpatient and outpatient care for people with psychotic symptoms.
Methods: Scoping review according to JBI methodology. Performed in databases, since 2010, in English, Portuguese and Spanish. Study selection and data extraction carried out by two independent authors.
Results: 12 interventions were identified, classified in terms of characteristics (format, type of approach, setting and duration) and components (content, transition strategies and post-discharge consultation) that promote the transition of care after psychiatric hospitalization for people with psychotic symptoms.
Conclusion: There is a consensus that bridging interventions should include educational and relational interventions, mediated by a transition manager, a role mostly played by nurses. It is important to design guidelines to be implemented in services to facilitate the transition between inpatient and outpatient care.

Keywords: psychotic symptomatology, bridge interventions, discharge, transition, outpatient, nursing

RESUMEN

Introducción: La transición entre clínicas hospitalarias y ambulatorias en los servicios psiquiátricos es un período de alta vulnerabilidad, particularmente en términos de síntomas psicóticos. Se recomiendan medidas preventivas para garantizar una transición segura y promover la continuidad de la atención, incluidas intervenciones puente.
Objetivo: Mapear las intervenciones realizadas durante la transición de la atención entre la atención hospitalaria y ambulatoria, para personas con síntomas psicóticos.
Métodos: Revisión del alcance según metodología del JBI. Realizado en bases de datos, desde 2010, en inglés, portugués y español. Selección de estudios y extracción de datos realizada por dos autores independientes.
Resultados: Se incluyeron seis estudios con intervenciones clasificadas según características (formato, tipo de abordaje, ámbito y duración) y componentes (contenidos, estrategias de transición y consulta posterior al alta).
Conclusion: Existe consenso en que las intervenciones puente deben incluir intervenciones educativas y relacionales, mediadas por un gestor de transición, papel desempeñado mayoritariamente por enfermeras. Es importante diseñar directrices que se apliquen en los servicios para facilitar la transición entre la atención hospitalaria y la ambulatória.

Palabras clave: sintomatología psicótica, intervenciones puente, alta, transición, ambulatorio, enfermería

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INTRODUCTION

The person's return home after an episode of hospitalisation in an acute psychiatric service represents a transitional challenge to which they must respond. This transition is considered a critical process (Raluthaga et al., 2023), and one of particular vulnerability due to the lack of continuity of care (Lam et al., 2019). The challenges are related to the long waiting times to access outpatient services, the lack of psychoeducation, difficulties with medication administration and adherence (Tyler et al.,2019; Vigod et al., 2013). People's failure to attend appointments after hospitalization has been identified as a widespread problem that increases the likelihood of hospitalization and costs (Batcha et al., 2011), and also affects people's quality of life (Owusu et al., 2022). This is exacerbated when there is no appointment scheduled in the discharge plan, which leads to significantly lower appointment adherence rates (Smith et al., 2020). The risk of readmission thirty days after discharge is related, among other factors, to the lack of adequate follow-up by health services and non-adherence to medication (Habit et al., 2018). These difficulties are exacerbated when there is psychotic symptomatology, which has been identified as a predictor of hospital readmission (Moitra et al., 2021; Owusu et al., 2022). Given the scientific evidence, it is imperative for health systems to provide coordinated care in the transition from inpatient to outpatient care (Virgolesi et al., 2017). This process is defined as an uninterrupted flow of services, information, and care through bridge-type interventions, developed from the pre-discharge to post-discharge periods (Hansen et al., 2011), which have been shown to be the most successful in reducing hospital readmission (Vigod et al., 2013). In this study, bridge-type interventions will be referred to as "bridging" interventions. Prior to carrying out this scoping review, a search was carried out for reviews on this topic in the MEDLINE (via PubMed), CINAHL Complete (via EBSCO) and JBI Evidence Synthesis databases, where two systematic reviews were found, Tyler et al. (2019) and Hegedüs et al. (2020). However, these do not answer the question of the review because they do not clarify in detail the characteristics or the type of components of the interventions carried out, thus justifying the need for this mapping. Therefore, the aim of this scoping review is to map the interventions that promote the transition of care after hospitalization in acute psychiatric units for people with psychotic symptoms.

1. METHODS

This review was developed according to the JBI methodology for scoping reviews, which aim to map the key concepts that underpin the research area (Peters et al., 2020).

1.1 Inclusion/exclusion criteria

The inclusion criteria were defined using the PCC mnemonic (Population, Concept and Context). For the population, we considered people (aged 18 to 65) admitted to acute psychiatric units with psychotic symptoms; for the concept, studies that addressed interventions to promote the transition of care; and for the context, we considered interventions carried out between inpatient and outpatient care. Exclusion criteria included people with neurocognitive disorders, intellectual development disorders and/or a first episode of the disease. In addition, criteria related to study design were included (primary, qualitative, and quantitative studies, as well as systematic reviews, in light of the review question formulated); languages (Portuguese, English and Spanish); and time frame (studies made available since 2010 were included, considering the increase in the publication of studies reporting the use of digital tools since this period).

1.2 Search strategy and identification of information sources

In the first stage of the search strategy and identification of information sources, the most frequently used keywords in titles and abstracts were identified, as well as the indexing terms used in the literature in the MEDLINE (via PubMed) and CINAHL Complete (via EBSCO) databases. In the second stage, the natural terms and keywords listed were combined to form a search expression. The following electronic databases were used: MEDLINE (via PubMed), CINAHL Complete (via EBSCO), Scientific Electronic Library Online (SciELO). For unpublished studies, the search was carried out in the Portuguese Open Access Scientific Repositories (RCAAP). The search strategies were adapted to each database. As an example, the search strategy adopted for the MEDLINE database (via PubMed) is shown in Table 1. In the third phase, the bibliographical references of all the articles and studies selected were analyzed in an attempt to identify others that could be included in this review.

Table 1 - Search strategy - MEDLINE via PubMed - date: 26/09/2022

Results: 343
(((Psychotic[Title/Abstract] OR "Psychiatric patient"[Title/Abstract] OR "Psychiatric patients" [Title/Abstract]) OR ("Affective Disorders Psychotic" [Mesh] OR "Psychotic Disorders" [Mesh] OR "Schizophrenia Spectrum and Other Psychotic Disorders"[Mesh] OR "Schizophrenia" [Mesh])) AND ((Intervention*[Title/Abstract] OR Program*[Title/Abstract])OR ("Crisis Intervention"[Mesh] OR "Psychosocial Intervention"[Mesh]))) AND ((Discharge [Title/Abstract] OR Postdischarge [Title/Abstract] OR Post-discharge [Title/Abstract] OR "home transition"[Title/Abstract] OR predischarge [Title/Abstract] OR Pre-Discharge [Title/Abstract]) OR ("Patient Discharge" [Mesh])

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1.3 Information source selection process

The process of selecting information sources was carried out by two authors independently, and any differences were resolved by consensus, using the Mendeley bibliographic manager version 1.19.8 (Mendeley Ltd., Elsevier, Netherlands) and the Rayyan online software by Qatar Foundation. Based on the inclusion criteria, the titles and abstracts of the articles identified were first analyzed and then the full text.

1.4 Data extraction

Data was extracted using an instrument developed by the authors. The data was extracted and synthesized by two authors independently. Any differences between them were discussed/analyzed, reaching a consensus between the authors, and if in doubt the authors of the studies could be consulted.

1.5 Data overview

The data was summarized in a narrative form using four tables.

2. RESULTS

The search identified 832 records (343 results in MEDLINE (via PubMed), 434 in CINAHL (via EBSCO), 36 in SciELO, and 19 in RCAAP). Of these, 147 duplicates were eliminated, resulting in 685. After reading and analyzing the abstracts, 646 were excluded. 39 articles were analyzed in full and five were excluded because they did not meet the inclusion criteria for the population, 10 because they did not meet the context of interest of this review, and 18 because they did not correspond to the concept. As a result, six articles were included in the scoping review. Figure 1 illustrates the article selection and inclusion process, following the PRISMA 2020 guidelines (Page et al., 2021).

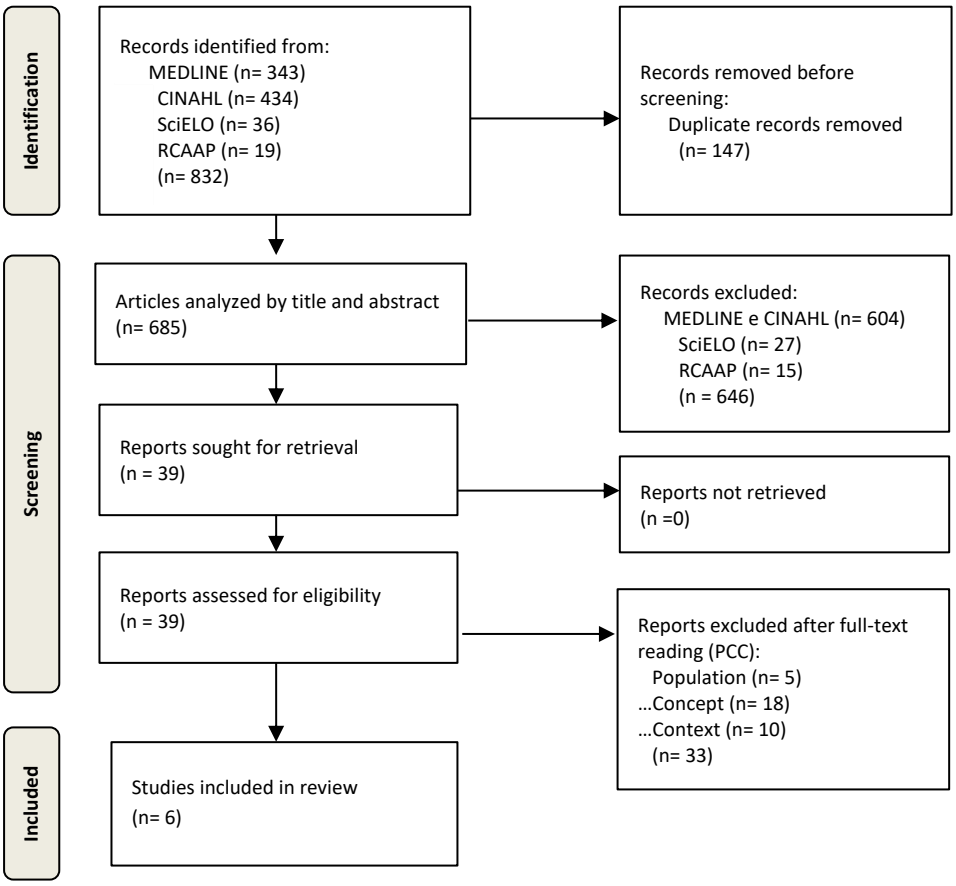

Figure 1 - Flowchart of the study selection process

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The data extracted from the six articles included will be presented in three tables: table 2 (list of included studies); table 3 (characteristics of the interventions), and table 4 (type of components of the interventions), respectively. Table 2 shows the studies (E) included (E1 to E15), with the authors, year of publication, country where the study was carried out and study design. Study E4 corresponds to a systematic review, in which 9 studies implemented bridging interventions, so these were included for analysis in this review (E5 to E13). The studies were carried out in Italy (1), Scotland (1), Finland (1), Canada (1), Iran (1) and the United States of America (9).

Table 2 - List of included studies

Author, year	Study country	Study design
Moitra et al., 2021 [E1]	USA	Pilot study
Virgolesi et al., 2017 [E2]	Italy	Prospective correlational
Khaleghparast et al., 2013 [E3]	Iran	Longitudinal clinical trial
Vigod et al., 2013 [E4]	USA [E5, E6, E7, E10, E12, E13], Canada[E8], Filand [E9], Scotland [E11]	Systematic review
Maples et al., 2012 [E14]	USA	Non-randomised clinical trial
Batscha et al., 2011 [E15]	USA	Prospective study

Study legend: [E5] Dixon et al., 2009, [E6] Price, 2007, [E7] Kasprow et al., 2007, [E8] Forchulk et al., 2005,[E9] Reynolds et al., 2004, [E10] Cuffel et al., 2002, [E11] Shaw et al., 2000, [E12] Chiverton et al.,1999, [E13] Olfson et al.,1998

Table 3 shows the format of the intervention, the type of approach used, the setting and the duration. One study included a reference family member in the preparation for discharge [E3]. Another used a smartphone app as a technological resource [E1]. In one, transition nurse managers were given 10 hours of training [E2], organized into five modules, where they were trained to answer questions commonly asked by patients, such as: duration of medication prescription, effects of medication on sexuality, the body and activities of daily living, and interactions between medication and food and alcohol. The systematic review[E4] included studies in which transition managers were trained beforehand [E13, E5, E12, E8]. Regarding transition interventions, only one study reports on the number of sessions (six one-hour sessions) and the time spent on them [E3]. All interventions are individualized, except for two studies that also included peer education [E8, E9]. All the studies use a cognitive-based approach and eleven also use an emotional approach. All the interventions begin in hospital and continue in the outpatient clinic or at home. There was heterogeneity in the duration of the interventions, with 3 months being the most prevalent period [E3, E5, E12]. In two studies, the intervention took place between discharge and the first outpatient appointment [E15, E2]. In two others, the intervention took place during the discharge period[E11, E13]. The longest intervention lasted 12 months[E8].

Table 3 - Characteristics of the interventions

Study	Format	Approach	Setting	Length
E1	Individual	Cognitive and behavioural	1, 3	1 month
E2	Individual	Cognitive and emotional	1, 2	Between discharge and the first outpatient appointment
E3	Individual	Cognitive, emotional and behavioural	1, 3	Up to 3 months
E4	Individual and peer education	Cognitive and emotional	1, 2	At discharge [E11, E13], 6 weeks [E6], 3 months [E5, E10, E12], 5 months [E9], 7 months [E7], 12 months [E8]
E14	Individual	Cognitive	1, 2	6 months
E15	Individual	Cognitive	1, 2	Between discharge and the first outpatient appointment

Note. 1- Inpatient; 2- Outpatient; 3- Home

In all the studies there is a transition manager, a role that is performed by a nurse[E2, E3, E6, E9, E8, E12]. The designation of the role of transition manager and the training of the professionals differed according to the authors: discharge nurse managers[E2], nurses[E3], specialist nurses[E6], inpatient nurses[E8], transition nurses[E9] and external nurses[E12] recruited for this role. In study E1 there is no transition manager because an application developed for smartphones is used. In the other studies, transition management was carried out by other health professionals, including E7 and E14, where it was provided intensive training on severe mental illness and psychopharmacology. Regarding the components of the interventions (content, transition strategies and post-discharge consultation(s)) (Table 4), the information content provided was diverse: seven studies addressed content on medication[E2, E3,E5, E6, E10, E11, E14]; six on psychosocial skills[E6, E7, E8, E9, E12, E13]; three studies on adherence and barriers to treatment[E1, E15, E14]; one on the illness and acting in crisis[E3]; one on self-care training skills (leisure activities, managing economic resources, well-being and self-care, household tasks and management, safety skills and work skills)[E3]; and one on coping strategies for managing the disease[E1]. The

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most frequent transition strategies were: pre-discharge interview[E2, E15]; visit by outpatient professional before discharge[E13,E14]; prior assessment of discharge needs and resources[E5, E6, E12]; communication between discharge manager and inpatient team to ensure an appropriate discharge plan[E6,E7,E9,E10]; individualized discharge plan[E3, E5, E10, E11, E12, E13]; face-to-face follow-up consultations[E2, E5, E10, E15] and telephone consultations[E2, E6, E7, E8, E10, E12]; home visit after discharge[E3, E8, E9, E11, E12]; direct contact telephone line after discharge[E6, E9]; a high level of contact after discharge, with contact instructions in SOS[E5, E6] and peer support[E8, E9]. The first appointment after discharge took place: up to 24 hours after discharge[E10]; one week after discharge[E11]; two weeks after discharge[E3, E6]; between the first and nineteenth day[E15]; between the seventh day and the first medical appointment[E2]; up to one month after discharge[E7]; or according to the patient's needs[E12, E14], the latter over a period of 6 months. There are studies in which the date of the post-discharge appointment is not specified[E5, E8, E9, E13].

Table 4 - Components of the interventions

Study	Contents	Transition strategies	Post-discharge appointment(s)
E1	Adherence to treatment; symptoms; substance use; coping strategies for managing the disease; quality of life	Application for smartphone use ("App"MACS - Mobile After-care Support): 3 random messages (9am to 9pm) and by self-initiative; brief interventions, via the application	N/a
E2	Medication	Pre-discharge information interview; simplified drug regimen; distribution of drugs from the hospital pharmacy; motivational telephone follow-up and assessment of adherence to therapy; face-to-face post-discharge consultation	Between the 7th/10th day after discharge and the first medical appointment
E3	Illness; causes; treatments; crisis management; self-care skills training	Psychoeducation: 6 one-hour training sessions (30 minutes of content exposition and 30 minutes of individual experience sharing); individualized discharge plan; fortnightly one-hour home visits to review content; family intervention/education	Fortnightly, up to 3 months
E4	Psychosocial skills[E6, E7, E8, E9, E12, E13]; medication[E5, E6, E10, E11]	Assessment of needs and resources[E5,E6,E12]; individualized discharge plan[E5,E10,E11,E12, E13]; communication between discharge manager and inpatient team[E6, E7, E9, E10]; visit/interview by outpatient mental health professional before discharge[E13]; provision of pre-paid telephones[E6] and direct contact telephone line after discharge[E6, E9]; high level of contact after discharge, with contact instructions in SOS[E5,E6]; face-to-face follow-up consultations[E5,E10] and telephone consultations[E6, E7, E8, E10, E12]; home visits[E8, E9, E11, E12;] and peer support[E8, E9]	24h and every 3 weeks for 12 weeks[E10]; 2 weeks[E6] ;1, 4 and 12 weeks[E11]; monthly teleconferences and quarterly interviews[E7]; according to the user's needs[E12]; N/s[E5, E8, E9, E13]
E14	Medication; adherence barriers	Visit by the coordinator before discharge; appointment card; map showing the location of the clinic	For 6 months
E15	Barriers to attending appointments	Pre-discharge transition interview; reminder card with contact details (phone and email); list of topics to be covered at the post-discharge appointment; appointment guidance letter (by post); post-discharge interview	Between the 1st and 19th day

Note. N/a = Not applicable; N/s = Not specified

3. DISCUSSION

The analysis of the included studies made it possible to map the interventions that promote the transition of care after acute psychiatric hospitalization.

The knowledge available to date has made it possible to identify the characteristics and components of interventions promoting transition of care in terms of: the format; the type of approach; the setting; the duration of the intervention; the transition manager; the contents; the transition strategies; and the post-discharge appointment(s). This study is relevant in that it specifically details "bridging" interventions that take place in inpatient, outpatient, and home settings. The designs of the interventions analyzed are heterogeneous, which may be due to the complexity and multiple components of bridging interventions (Xiao et al., 2019). As for the format, all the interventions are individual, which could be justified by the different stages of recovery, which makes group intervention difficult. Peer education was used in two studies and, although some findings point to its benefits, there is no consensus on its applicability (Corrigan et al., 2022; Tyler et al., 2019). Regarding the type of approach, the cognitive-based approach is common to all the studies, described as the most successful in increasing people's and family members' knowledge, which emphasizes the importance of educational intervention in managing the disease (Tyler et al., 2019; Xiao et al., 2019). It should be started as early as possible, while the patient is still in hospital, according to the needs identified at the time and the person's availability and included in the discharge plan. The emotionally based approach, grounded on the therapeutic relationship, is present in eleven studies. Lam et al. (2019), also emphasize that interventions to promote continuity of care should be based on the therapeutic relationship, including its impact on hospital readmission, also supported by Tyler et al. (2019). Regarding the duration of the interventions, there is diversity, with the majority ending after 3 months. Those that were extended

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lasted until the therapeutic relationship with the outpatient professionals was established[E8, E9]. The role of transition manager was taken on by nurses in six studies. The intensity and continuity of the relationship provides nurses with a more contextualized, and therefore more understandable, knowledge of the person's and family's response to health and illness processes (Meleis, 2010). Lin et al. (2018) adds that nurses can coordinate the assessment, planning, referral, and provision of the necessary care in this period, with better results, such as lower readmission rates. The contents most frequently covered in the studies are related to medication adherence and management, and psychosocial skills, also topics widely included in psychoeducational interventions for people with psychotic symptoms (Hegedüs et al., 2020; Xiao et al., 2019). In relation to intervention strategies, although the most prevalent was the individualized discharge plan, follow-up appointments and home visits were also identified. This variability may reflect the individual needs identified in the pre-discharge period, as well as the complexity of the risk factors. Although structured psychoeducation did not feature in this review (it was only used in one study), interventions that focus on transmitting information and interpersonal relationships are the ones that allow people to express their individuality and take the lead in managing the disease[E2], being also preferred by users (Hegedüs et al., 2020). In all the studies, post-discharge appointment(s) were scheduled, which took place between 24 hours and 15 days, very close to the quality recommendations for follow-up after discharge, which is between 7 and 30 days (HEDIS, 2021).

This review has limitations associated with the lack of a record of the review protocol, which may limit its reproducibility and dissemination prior to the review being carried out. Also, only studies conducted in Portuguese, English and Spanish were included, so other languages could also have been useful for analyzing this concept of interest.

CONCLUSION

This mapping revealed a diversity of interventions that promote the transition of care in the scientific evidence, and it can be concluded that there are several "bridge" interventions that facilitate the transition between inpatient and outpatient care. These strategies include the individualized discharge plan, follow-up consultations and home visits. There was a consensus in this analysis that "bridging" interventions should include educational and relational interventions. The role of the "transition manager" as a coordinator and liaison between care settings was highlighted, which was mostly carried out by nurses. As implications for clinical practice, this review contributes to the design of specific clinical guidelines and/or structured programs with "bridging" interventions to promote transition and continuity of care between inpatient and outpatient settings. As implications for research, this scoping is the first stage of a project that aims to build and assess the feasibility of a transition and continuity of care program in psychiatric settings.

AUTHORS' CONTRIBUTION

Conceptualization, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; dada curation, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; formal analysis, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; funding acquisition, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; ; investigation, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; methodology, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; project administration, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; resources, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; software, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; supervisionL.N., S.F., V.F., F.P., J.G., D.S. and C.M.; validation, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; visualization, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.; writing-original draft, LL.N., S.F., V.F., F.P., J.G., D.S. and C.M.; writing-review and editing, L.N., S.F., V.F., F.P., J.G., D.S. and C.M.

CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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