Comments on Zhang, "Strategies Used by Managed Behavioral Health Organizations to Reduce Hospital Care" A Literature Review Submitted to the Myers-JDC-Brookdale/Brandeis Collaboration on Mental Health

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1. *Psychiatric hospitalization may stem from growing pressure in a patient's external surroundings, causing a depressive or sharply anxious response, or exacerbation of an existing psychiatric condition. In such cases, the transition from hospital to community warrants multi-system intervention in the patient's life.*
2. *At the time of discharge from hospital, it would be wise to equip a patient with an appointment for psychiatric follow-up and, if need be, also continued ambulatory care from a psychologist/social worker.*
3. *Preferably, the waiting time between discharge and follow-up/ambulatory care will be no longer than a week. In practice, however, due to limited ambulatory resources, there is generally a wait of a few weeks. In an attempt to shorten waiting time, a first follow-up appointment in many cases can be made with the clinic nurse.*
4. *Choosing suppliers of external care that are cheaper, and based on experience, offer less intensive patterns of care, is likely to seriously impair the quality of care and therefore lead to re-hospitalization.*
5. *For patients requiring repeat hospitalization, the policy of choosing a hospital each time according to financial criteria is problematic in every sense. As regards care, it is important that the patient use the same hospital each time to maintain continuity. Financially, a lack of prior knowledge on the patient might lengthen the duration of hospitalization.*
6. *For patients entitled to the Ministry of Health "Rehabilitation Basket" (40% mental disability recognized by the National Insurance Institute), many varied services are available to ease the transition from hospital to community, including mentoring, sheltered housing, supported/sheltered employment, extracurricular activities, a social club and more. Mentoring is often provided by rehabilitant service-providers. Preferably, the member of staff who supported the patient during hospitalization will participate in the Rehabilitation Basket committee so as to match the services offered to the patient's needs. The provision of some services (e.g., supported housing) involves intensive contact between the patient and the multi-disciplinary team in the community. The continued provision of these services is subject to constant supervision but is not limited in time.*

7. *To ease the transition between hospital and community for patients who are entitled to services provided by the Rehabilitation Basket but didn't receive them prior to hospitalization, the requisite forms should be completed and the bureaucratic process begun during hospitalization.*
8. *The existing insurance system in Israel does not permit short, pre-planned hospitalization for chronic patients suffering from severe mental illness, such as schizophrenia, if there is no deterioration in their condition. While this model exists is several countries, there is no evidence that it benefits patients or prevents longer hospitalizations.*
9. *For patients unable to make the transition directly from hospital to the community, there exists a framework of psychiatric daytime hospitalization that provides an intensive care program for three months, five days a week.*
10. *In some cases, patients are administered forced care in the community at the instruction of the District Psychiatrist (should the patient refuse the treatment s/he requires), or by court order (in cases of criminal offense).*
11. *There exists a regional center of support for families of patients with mental illness. The staff of the center includes a social worker and rehabilitation service-providers.*
12. *In principle, for purposes of rehabilitation, the period of hospitalization should be reduced as much as possible and the patient returned to the community as soon as possible. However, in practice, this depends on the extent and quality of community resources. In some areas in Israel, social services are highly developed and in others, they are inadequate. Consequently, during hospitalization, the community resources should be examined and contact be established with the patient prior to discharge. Discharging patients without arranging for continued support in the community is likely to lead to deterioration and their return to hospital.*

The views expressed here are the personal views of the author and do not necessarily reflect the position of the organization in which the author works or of the Myers-JDC-Brookdale Institute.