Continuity of forensic care,

Factors for discharge of forensic psychiatric patients within domains mental health and problem behaviour

Running head: factors for discharge in forensic psychiatry

Annelei Boer

University of Twente, MSc. Positive Psychology and Technology, in collaboration with Transfore (Forensic Psychiatry)

H. Kip & Dr. M. Schotanus-Dijkstra (University of Twente)

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Abstract

Background: Discontinuity of the care is a fundamental issue within forensic mental health care, early discharge planning is an important measure to solve this problem. This study aimed to identify factors for discharge in the domains mental health and problem behaviour, to contribute to a guide for discharge planning. **Methods:** semi-structured interviews were conducted with four clinicians and one mental health professional to lay the groundwork for discharge criteria within the mentioned domains. Interviews were thematically analyzed and coded using an inductive approach. **Results:** The identified factors in order of importance, are risk assessment, recognition problem behaviour, motivation of patient, unacceptable behaviour, self-reliance and skills, treatment adherence and substance use. **Conclusion:** This study is a first step into identifying criteria for discharge concerning domains mental health and problem behaviour. Future research should further specify the found factors into criteria and investigate the variations in the different facilities and security levels. Risk assessment for discharge planning was mentioned as one of the most important criteria. Furthermore, it was found not all factors could be measured systematically, it is thought forensic vigilance plays an important role in the assessment of criteria. This topic and its influence on the assessment of the criteria, should be further researched.

Introduction

Forensic mental health care is a particularly complex field in which both law and psychiatry play an important role (Carroll, Lyall & Forrester, 2004). It involves the assessment and treatment of those who both have a mental disorder and whose behaviour has led or could lead to offending (Mullen, 2000). The main goal of care within this field is to prevent problematic and delinquent behaviour by improving the patient's skills and capabilities within society (Arboleda-Florez, 2006). In the Dutch forensic care, a collaboration with several institutions, organizations and chain partners is necessary, since patients commonly require care for a longer period and in turn deal with a variety of chain partners. Since most organizations provide some form of care to the patient, a clear connection and continuation of the previous care is necessary. Examples of these organizations are the public prosecutor's office where the patient is sentenced, prisons where the patient serves its sentence, several forensic psychiatric inpatient services where the patient is treated, forensic out-patient services, rehabilitation services and services organized by municipalities to increase societal safety (Dienst Justitiële Inrichtingen, Ministerie van Justitie en Veiligheid, 2018). This abundance of chain partners who all need to give attention to the continuation of the previous care and, when applicable, each their specific level of security, visualises the complexity of the forensic care.

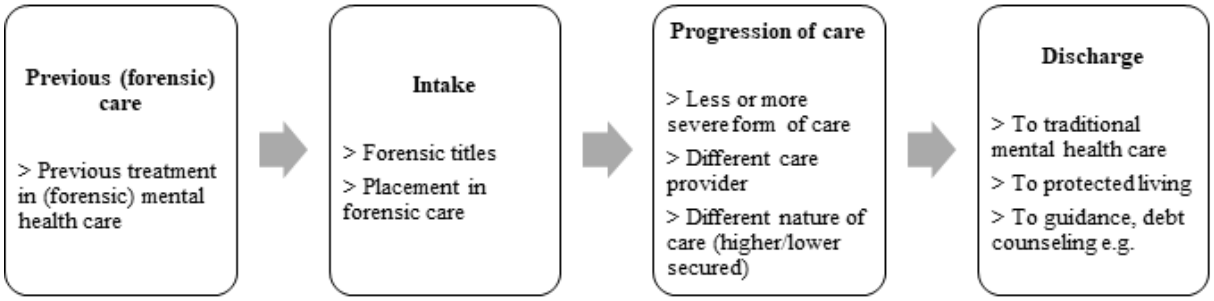
Regarding the security level of these forensic psychiatric services, four levels can be distinguished. The highest level concerns the Forensic Psychiatric Centre and Forensic Penitentiary Centre, which refers to detention under hospital orders in a closed facility and is related to severe delinquencies. The third level concerns the Forensic Psychiatric Clinic and Forensic Addiction Clinic, which is a closed facility for patients who need to reside for a longer period. Level two starts with a closed facility, but offers treatment and activities outside the facility, this includes among others the Forensic Psychiatric Department and several resocialisation departments of facilities in protection level three and four. In the final level of protection, level one, more freedom is given to the patient and all treatment is given outside of the facility. Examples are closed departments of non-forensic mental health facilities and resocialisation departments (Dienst Justitiële Inrichtingen, Ministerie van Justitie en Veiligheid, n.d.). All the mentioned facilities and previously mentioned partners, need to collaborate to realise a smooth transition for the patient to continue the patient's care after discharge. Continuity of care refers to ensuring the forensic psychiatric patients receive

the care they need and is most appropriate given their treatment and level of security, with due diligence (Mevis, Klappe, & Van der Wolf, 2019). This is found to be problematic: care is not always immediately available and during the patient transfer, important information can fall through. This results in discontinuity of care and treatment, which is one of the main current issues in the forensic mental health care (De Vogel, Schaftenaar, & Clercx, 2019a).

Although continuity of care is specifically relevant for the forensic care because of the various chain partners involved, discontinuity of care is a fundamental issue within all fields of mental health care (World Health Organization, 2001). Continuity of care concerns the quality of care and the stability of patient-provider relationships over time. This is best established by coordination of different services over time, preferably within a team (Gulliford, Naithani, & Morgan, 2006). This includes the use of a common care plan with a case manager who manages the continuity of contact and accessibility (Haggerty, 2003). This is currently not common practice in the forensic care: it is often uncertain who is responsible over time, the collaboration of care is found to be difficult and transparent communication is lacking (De Vogel, Schaftenaar, & Clercx, 2019b). A flexible transition to different forms of care is however crucial, it improves patient outcome and medication adherence, prevents rehospitalisation and saves costs (Steffen et al., 2009). Ideally, to realise a flexible transition, a forensic patient follows a pathway of care with lowered security with each step.

This pathway of continuity of care is visualized in Figure 1, in which both care with a criminal measure, care with forensic character (without criminal measures) and protective care is of importance (Nederlandse Zorgautoriteit, 2018). The placement in forensic care starts with investigating the previous care and, if possible, requesting information. After the initial placement, this care commonly transitions to different care providers and/or less or more severe forms of care, with higher/lower levels of security. During these transitions (also know as discharge), most problems with the continuation of care occur. Information is not always (transparently) communicated and the time between initiating the patient's discharge and the actual discharge is often undesirably long (De Vogel et al., 2019b). At the end of the pathway, the patient is discharged and re-integrates into society through good housing, work and social embedding (De Vogel et al., 2019a). This gradual resocialization is crucial in the prevention of relapse of offences (Philipse, 2005), which is currently not common practice.

Figure 1. Pathway in the continuity of forensic care.



Note. Adapted from Monitor Continuïteit van forensische zorg, by Nederlandse Zorgautoriteit, 2018. Retrieved from https://puc.overheid.nl/nza/doc/PUC_233358_22/1/

Reasons for the lack of continuation of forensic care can be categorized by laws and regulations, costs, collaboration (De Vogel, 2018). First, regarding laws and regulations, De Vogel (2018) mentions that given the numerous institutions that are involved in forensic care, there is often unclarity about the division of tasks, responsibilities, and authorities. For example, who is responsible for taking care of good housing? Furthermore, how are responsibilities divided when judicial authorization changes and a patient is discharged from a facility? Second, regarding costs, the issues on a governmental level play a big role in the discontinuation of care, for instance governmental cuts and decentralization of care tasks to municipalities (De Vogel, 2018). Decentralization results in different executions of the law and more local collaborations (Nowak et al., 2015), which subsequently can obstruct clarity and continuation of care. Lastly, concerning collaboration, De Vogel (2018) mentions that organizations do not collaborate sufficiently to realize a smooth transition. Many patients do not receive immediate care after discharge (Steffen et al., 2009). Steffen and colleagues emphasize that in the time immediately after discharge from a psychiatric hospital, the rates of medication non-compliance and relapse risks are elevated, and a considerable number of readmissions occur within 6 months after discharge. Although it is known that the three factors previously mentioned negatively influence the continuity of care (De Vogel, 2018), it is still unknown why this process stagnates. Insight into the current situation and its points of improvements is crucial to solve this problem and increase continuity of forensic care.

In the last few years, many initiatives have been developed and policy documents have been written to increase the continuity of forensic care. The report ‘Mind the gap’ (De Vogel et al.,

2019a; De Vogel et al., 2019b) reports the results of these initiatives in the Netherlands and offers concrete suggestions and recommendations for follow-up research. Main conclusions from this report are that 86% of professionals in the forensic mental health care regularly or always experience problems concerning the continuity of care. Furthermore, literature shows that continuity of care in forensic field is unchartered territory and research is limited (Davoren et al., 2013; Hammett et al., 2015; Teixeira et al, 2015; De Vogel et al., 2019a). Concrete changes in the forensic field are limited and most programs only have a local or regional scope and have not been investigated for effectivity. The report (De Vogel et al., 2019a; De Vogel et al., 2019b) stresses to formulate the treatment process of a patient as soon as possible, including both the intermediate steps and the end goal: discharge planning. Given the limited knowledge and guidelines about discharge planning, the necessity of a guideline for discharge planning became apparent from this report. This guideline can be divided into three elements that comprise discharge planning 1) the organisation of care and organizational collaboration, 2) the knowledge and skills necessary in follow-up organisations and 3) the discharge criteria. The discharge criteria comprise all criteria the patient needs to meet to be discharged from a facility. After discharge, the patient preferably continues his care in a facility with a lower level of security. This guideline for discharge planning is necessary since it is expected to significantly increase the continuity of care when used as intended.

Objectives

The objective of this study is to explore the criteria for discharge to gain more insight into this topic and eventually compose a guideline for discharge. This involves all criteria that are considered when making an informed decision about discharging a patient. When these criteria are specific and measurable, the process of discharge is expected to start earlier and run smoother from a professional viewpoint. Furthermore, from a patient viewpoint, when a patient knows what is expected of him, this can in turn increase compliance and clarity. Essentially a clearer and more specific view on the criteria on a patient level is desired: what is exactly needed of patients with each step of lowered security? Known criteria for discharge from literature are among others described in The Dangerousness Understanding, Recovery and Urgency Manual quartet (DUNDRUM quartet). This handbook describes structured professional judgement instruments, the DUNDRUM-3 program completion items describe the extent in which patients in a forensic secured hospital have engaged successfully in treatments under seven pillars of care or domains relevant to reducing and managing risk of

harm. These domains are: 1) physical health, 2) mental health, 3) drugs and alcohol problems, 4) problem behaviours, 5) self-care and activities of daily living, 6) education, occupation, and creativity, 7) family and social networks: friendship and intimacy (Davoren et al., 2013). Concerning mental health, known criteria that need to be further investigated are stability, self-insight, therapy adherence and devotion to discharge planning (Davoren et al., 2013; Hammett et al., 2015; Teixeira et al, 2015). Furthermore, criteria related to problem behaviour are offence behaviour, risk factors and bad adjustment skills (Davoren et al., 2013).

Though these criteria are a good base to start from, more information and clarity is necessary, and the question rises what other criteria can be identified. This study is a first step into realising these criteria for discharge and will assess which factors within the domains mental health and problem behaviour, influence the discharge of patients within the forensic care, according to forensic mental health professionals. It is expected that these domains are of importance during the entire pathway of care. Furthermore, what differences in criteria or relevance of criteria can be distinguished in facilities with different security levels? This study will result in a list of factors relevant for discharge planning for the mentioned domains. Future research can specify these factors to concrete criteria.

Design and method of analysis

Design and setting

This study employs an explorative qualitative research design to collect input to formulate discharge criteria in the domains problem behaviour and mental health. This study is part of a larger study about discharge planning, which further explores the discharge criteria within all domains and explores the topics organization and collaboration of care and knowledge and skills of forensic facilities. The project group of this study exists of a project leader, project implementers, representatives of various forensic facilities and rehabilitation in the Netherlands (such as clinicians and patient coordinators) and external advisors. Furthermore, four students participated in the project group. In-depth semi structured interviews about discharge planning were conducted by the project implementer and four students. This type of interviewing focusses on specific themes, however cover them in a conversational style. This is especially suitable to gain insight in the motivations behind people's choices and behaviour, their attitudes and beliefs and their impact of specific policies and events (Adams, 2015), which is accordance with the aim of this study.

Participants

The target group of the entire research project are mental health professionals, clinicians, patients, people working in management positions and people concerned with collaboration of forensic care. In this study, solely clinicians and other mental health professionals in the forensic care were included. This decision was made, since it was thought clinicians (health psychologists) have an interesting view, but also a big influence in discharge planning. Furthermore, other professionals, e.g., socio-therapists and social psychiatric nurses, were thought to have a good outlook on the pathway of discharge and the quality of this process from their perspective. Inclusion criteria for participants were that they worked within the forensic field in the Netherlands, worked with the patients themselves and that they had an active role in discharge planning. Both participants working in outpatient and inpatient services were considered, since both perspectives needed to be considered. Participants who did not work with the patients directly, such as managers in a forensic facility, were excluded from this study. Recruitment of participants was done through purposive sampling and snowball sampling. The research group created a list of possible participants suitable for interviewing, this list was made by active brainstorming within the project group. This list did not only contain mental health professionals and clinicians, but also people working in management were included to be further analysed by members of the project group, concerning collaboration and organization of care. Furthermore, some members of the project group were added to this list. Snowball sampling further completed this list of participants: when participants took part in the study, they were asked if the person knew possible participants suitable to be interviewed for the study. Four participants were recruited through purposive sampling and one through snowball sampling. Possible participants were contacted by the researchers via phone or email and were asked to participate in an interview about discharge planning. When phone or email information was not available, it was requested by the secretaries of the corresponding organization the participant worked at. Clinicians and mental health professionals who participated in the study worked at various forensic mental health facilities in the Netherlands, for example Transfore and Fivoor Kijvelanden. Four clinicians and one mental health care professional (socio-therapist) were interviewed (n=5). All participants worked in in-patient facilities, since complications with discharge planning happen more often within an in-patient setting. These in-patients facilities were mainly related to (the highest) security level four (e.g., Forensic Psychiatric Centre) and one lower level, level three (e.g., Forensic Psychiatric Centre). Three

of those were male, two were female. The level of education of all participants were a bachelor's degree (one) or a master's and/or doctorate degree (four).

Materials and procedure

Participants were interviewed by following a semi structured interview guide which contained a mix of both open-ended and closed questions. This guide consisted of five main topics: 1) collaboration and organization, 2) coordination, 3) discharge criteria, 4) patient's environment and 5) skills of follow-up organizations. The answers from section three (discharge criteria) were used in this study to answer the research questions, the remaining topics did not concern the current study but were analysed by a member of the project group for further research. Section three consisted of eight main questions and was about the participants' experiences and attitudes concerning the current criteria used for discharge planning and the process of using these criteria in practice. The abbreviated interview scheme concerning solely section three can be found in the Appendix. First, questions were asked about the pathway of care and competences of patients for admittance. Then questions were asked about other criteria for discharge and which problem behaviour of the patient is acceptable for discharge. Subsequently, questions were asked about discharge planning in practice. The interview ends with citing the domains of criteria known in the literature and asking to what extent the participant agrees with them. Table 1 gives an overview of the main topics including example questions.

Table 1. *Overview of interview topics*

Main topics	Example questions
Visualising pathway and conditions for admittance	What is needed when patients are admitted in your facility and where do they come from?
Criteria for discharge	What other criteria does the patient have to meet to be discharged?
Discharge planning	Does every patient have a plan for discharge?
Margin of criteria	What amount of problem behaviour is acceptable for discharge?

The interviews were conducted through video-calling using communication platform Microsoft Teams, given the COVID-19 restrictions and social distancing measurements at the

time of interviewing. At the beginning of the interview, all participants were asked to give a verbal informed consent (IC) of a recording at the beginning of the interview. The IC entailed that the interview data would be stored on secured organisational cloud and that the data would be anonymously analysed, used solely for research purposes. The participants on the list were divided among members of the project group for interviewing and transcribing. Researchers continued interviewing till all participants on the list were interviewed and no new participants were brought forward. Approximately 15 interviews were conducted, each interview took on average 60 minutes. Interviews with participants who did not meet the in- and exclusion criteria for this study, were excluded (eight interviews). Furthermore, not all interviews contained valuable information about discharge criteria, they were also excluded for this study (two interviews). Reasons for this, were for example because the part concerning the discharge criteria was insufficiently questioned because of the limited available time.

Analysis

The audio of the interviews were recorded and fully verbally transcribed and subsequently used for systematic thematic analysis using ATLAS.ti software (version 8). Thematic analysis is a method for qualitative research that searches for themes or patterns within the data (Braun & Clarke, 2006). An inductive analysis was conducted, which started with reading the transcripts to get familiarized with the data. Then interesting fragments of two transcripts were open coded, open coding is a process of coding by discovering ideas or concepts within the data (Glaser & Strauss, 2000). Two researchers open coded one interview, the codes were then discussed together till consensus of the open codes was reached. Subsequently these codes were put into initial themes, which resulted in the first draft of the coding scheme. Then the remaining three transcripts were open coded and put into themes, following the initial coding scheme. The coding process was iterative, meaning that the coding scheme was revised multiple times in the coding process until coding new transcripts did not result in new codes. Codes (based on the fragments) were grouped together based on the emerging themes and subthemes. Then all interviews were coded using the final draft of the coding scheme and comparisons were made between the data. This resulted in the final version of the coding scheme. This coding scheme consists of seven codes (categories), a description of this code and an example, which can be found in Table 2.

Results

Clinicians and professionals provided input for discharge criteria in the forensic mental health care. The identified factors (main codes), the found variations within these factors (subcodes) and their accompanying definitions are provided in Table 2.

Table 2. *Coding scheme*

Main- and subcodes	**Definition of code**	**# Par.**[a]
Risk assessment		5
Risk management plan	Plan concerning risk factors is available, this plan is used by patient and clinician.	5
Leave	Patient has practiced with and went on leave, and can cope with this freedom.	4
Recognition problem behaviour		5
Insight into problems	Patient shows insight into his own problems.	5
Following modules	Patient followed e-Mental health modules related to his problem behaviour.	1
Offence analysis	Patient has insight into the offense analysis.	4
Motivation patient		4
Collaboration treatment	Patient is able and motivated to collaborate with all professionals involved within treatment.	4
Unacceptable behaviour		3
Aggression	Patient limits his aggressive behaviour fitting to his (follow-up)residence and the corresponding level of security.	3
Self-reliance and skills		3
Social skills	Patient practices enough social skills and can apply these skills.	1
Coping skills	Patient uses suitable coping strategies when necessary	1
Independence	Patient can independently go through life and his treatment process	3
Treatment adherence		2
Medication adherence	Patient takes medication independently and according to the agreements	2
Alert plan	Plan concerning crisis situations is available, this plan is used by patient and/or the patient's social network/professionals	2
Substance use		2
Abstinence	Patient shows negative urine checks (UC) and goes through the circles of change. The patient is at the phase fitting to his (follow-up)residence and the	1

	corresponding level of protection, which must be at least the phase of preparation.	
Relevance offence behaviour	Amount of, in which is assessed by clinicians that substance use is a risk factor for the offence behaviour of the patient.	1

[a]*the number of participants that mentioned a code.*

Risk assessment

This main code refers to the risk assessment done by the clinician. It was mentioned by all participants, both participants related to protection level thee and four mentioned this as one of the most important criteria, since the safety of society always must be taken into consideration firstly. Some participants even mentioned this factor is the basis of all the other factors, which highlights its importance. Participants mentioned that the risks need to be clear and carefully weighed. In the literature this was mentioned as 'risk factors', part of the risk assessment is to identify the patient's risk factors (Davoren et al., 2013). A used method to weigh all factors and come to a final judgement of the risk, is a ***risk management plan***. This plan needs to present for discharge and recognised by patient and clinician. One participant mentioned that all clinical variables (including recognition problem behaviour, unacceptable behaviour, substance use, self-reliance and skills, treatment adherence and motivation patient) and historical variables (facts about previous offences), are considered when weighing all risks. Furthermore, a clinical view was mentioned as an important tool in this process. This clinical view was also called 'forensic thinking' by one participant, in which the participant explained that forensic experience is necessary to be able to understand and weigh all risks. The participant mentioned that risk assessment can not be done in a purely systematic manner, although validated diagnostic instruments are used in this process, such as the HKT-R, a risk assessment tool used in forensic clinical practice (Bogaerts et al., 2018). Participant 3 and 1 explained this:

> *'' The treatment goals usually have the risks hidden in them. These (treatment goals) are formulated based on the risk analysis that we made. When you think that progress has been made and the patient does not need the care that we offer, it is time for discharge.''*
>
> *'' Part of the risk assessment are the historical variables that predict relapse. During the treatment, the clinical part is of importance. All these factors need to be looked at*

> *with a clinical view. The HKT [risk assessment tool] will say: fill it in, a total score will appear and that is it. But you always need to be able to look broadly, with risk assessment we have a consensus conversation with everyone involved, the end result is a clinical final judgement.''*

When the risk management plan has been formulated, this can be put into action by ***leave***. A patient needs to demonstrate he can adequately deal with this given freedom before discharge is possible, the first step in this process can be supervised leave. Leave was mentioned by Participant 1: *''They need to have experienced leave.''* and Participant 3: *''Can someone go outside for leave? (listing criteria for discharge)''*.

Recognition of problem behaviour

This main code refers to the recognition of patients of their past and current behaviour and realising their responsibility for these behaviours. All participants mentioned this factor, both participants related to highest level of protection (level four) and the level below (level three). To start treatment and to work towards discharge, the patient must gain ***insight into his problems*** and into their behaviour. This factor 'self-insight' was previously found in the literature, it refers to whether the patient acknowledges its own problems (Davoren et al., 2013). This starts with an ***offence analysis***; participants indicated a patient needs to recognise and admit their offence. However, one participant mentioned that recognition of offence can not always be fulfilled, for example by patients with low cognitive abilities or severe autism. It seems that all the found factors mentioned by the participants cannot always be fulfilled by every patient, exceptions are always present. Lastly, participants indicated that the offence analysis must lead to patients being able to identify their risk factors. This factor was previously mentioned as 'risk factors' in the literature and relates to the clinician being able to identify the patient's risk factors. However, the patient also needs to recognize its own risk factors. Only if the patient can look from a victim's perspective to their offence, the criterion is fulfilled. Participant 1 explains this factor as followed:

> *''An important factor is the offence analysis, that patients know their risk factors. Recognition of their offence is also a part of this, that is very important. People need to look from the victim's perspective to the situation. This means recognition of their offence, that is recognition of their own behaviour. They need to assess how the offence was perceived by the victim.''*

Another way for the patient to gain insight into his problems, is by ***following an e-Mental Health module*** **(EMH)** about this topic. Participants indicated that modules are used in the treatment process and chosen dependent on the problem(behaviour) of the patient. The patient needs to have finished the modules related to their problems before discharge is possible. Other forms of treatment besides EMH were not mentioned.

> *''They need to do the EMH-module for recognition (of offence). But when there are problems of addiction, they need to have done the EMH-module for addiction. A schizophrenic boy has to have done a psycho-education module. You need to do have a certain base.''*

Motivation patient

This main code refers to the ***motivation*** of the patient in his treatment process. Four participants who were interviewed referred to the amount of internal motivation to achieve their treatment goals and to actively participate in this process. It was found to be an important factor in discharge planning. When the clinician notices a lack of active treatment participation, discharge is not possible. Actively participating in the treatment process refers to the amount of ***collaboration*** in the treatment: the patient needs to be able to collaborate with all professionals involved within treatment. Participant 4 explained this as followed:

> *''It is always nice when someone enters who is motivated, who wants to get somewhere. This is not always achievable in practice when dealing with forced admission, there is always a certain tension. Someone doesn't want certain things but has to. But someone has to have a certain intention to get ahead. It is not pleasant to have a forced admission, but you arrived at this stage for a reason. You have to have a certain willingness to work on this. And someone needs to want to collaborate in this.''*

Unacceptable behaviour

This criterion refers to the type of behaviour that crosses boundaries, participants mentioned this can be a considerable amount of ***aggression*** shown in the clinic. Multiple participants from inpatient clinics with the highest security level (four) mentioned this as an important factor. It is unknown how this factor can be measured, and which frequency and intensity of aggression is sufficient for discharge. Aggressiveness is explained by Participant 3: *''I think the protection of society is the most important factor, so during moments that*

someone shows offence behaviour or aggression, the possibilities for discharge are only to a different clinic, but not outside the clinic.''.

Self-reliance and skills

This main code refers to the number of skills the patient has (acquired) according to the clinician, to become self-reliant and ***independent,*** it was mentioned by three participants. One participant mentioned that two skills the patient is expected to manage, are ***social skills*** and ***coping skills***. It is unknown how these factors can be measured and what is expected of the patient. Participant 3 mentioned this criterion:

> *'What we do during treatment, is focussing on the clinical part: coping skills, social skills, …. When you break ground in this part, you can protect the historical variables that are fixed and cannot be changed.''*

Treatment adherence

Treatment adherence refers to the independence of the patient to adherence to their treatment, two participants mentioned this factor. This factor was also previously found in the literature and relates to the same concept (Davoren et al., 2013). It can refer to the patient's adherence to ***medication*****.** Looking at the answers of the participants, it can be concluded that the further the patient is in his treatment process, the more it is expected that the patient takes his medication according to the agreements. The criterion 'stability' was also mentioned in the literature (Davoren et al., 2013). This criterion does not entirely fit to this factor, but can relate to the stability of symptoms, in which medication can take a part in. Participant 5 explains medication adherence:

> *''I think when it comes to mental health, the importance is that someone is stable, someone is adherent to medication. …. When you say, in a year we want you to be at the RIBW and the patient himself also wants that, what is needed for that? I need to be adherent to medication, not too much drug use. So, I think the sooner you start with discharge planning, the more concrete the goals become within the domains you just mentioned.''*

Furthermore, the active use of an ***alert plan*** is related to this. Participants mentioned that this plan needs to be present for discharge and contains information about what to do in crises or when the patient is at risk. This also related to some extent to 'stability': the better the patient follows this plan, the sooner the patient can intervene, therefore the patient is more stable over time. The patient is expected to adhere to this alert plan. Participant 5 mentioned this: *''We*

always demand that, … [deleted because of privacy reasons], the previous team made an alert plan and crisis plan.''. Furthermore, participant 1 elaborated on this: *''Measurable criteria are the delict analysis, alert plan, and risk management plan. This needs to be present for discharge.''*.

Substance use

This main code refers to use of alcohol and drugs, two participants mentioned this factor. Substance use can be a criterion in the clinic, participants indicated that a criterion for discharge is ***abstinence***. This is regularly monitored by urine checks (UC). Participants indicated that when substance use is a treatment goal, the patient then must go through the circles of behavioural change, the phase that is necessary for discharge is dependant on their residence. These circles of behavioural change are thought to be based on the transtheoretical model by Prochaska & DiClemente (1983). For example, at the forensic psychiatric clinic, they need to be at the phase 'willingness to change', this is explained below by Participant 1.

> *''When it is a treatment goal (abstinence), you will also look at the circles of behavioural change. Where are they, and we try to start this process of change. At the same time, they need to have taken a few steps, they need to be willing to change. Halfway through the circle, that should be enough for discharge to an FPA, this willingness needs to be there.''*

However, the ***relevance to their offence behaviour*** always needs to be considered, substance use is not always included as a treatment goal. When the patient's substance use is not seen as a risk factor and not in clear connection to the patient's offence, this factor becomes less important. In the literature, 'offence behaviour' was seen as a separate criterion, it should therefore always be weighed in what extent the substance use is or could be part of their offence behaviour (Davoren et al., 2013). This relevance to the offence behaviour is explained by Participant 3:

> *''When someone uses alcohol and is has nothing to do with their offence, we will scratch behind our ears*[1]*, but it is not necessarily a reason to prevent discharge. When someone does things that are financially not so smart, but it did not play a role in the reason he was here, then this is stupid, and he will be in financial troubles, but it not a reason to prevent discharge.''*

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[1] *Dutch expression, meaning: 'carefully considering an unexpected or worrisome development'.*

Discussion

The objective of this study was to lay the groundwork for discharge criteria in the domains mental health and problem behaviour of forensic psychiatric patients. Seven factors were identified, the factors related to the domain mental health are *self-reliance and skills* and *treatment adherence*. These factors relate to the previously mentioned criteria known from literature. The factors related to the domain problem behaviour, are *unacceptable behaviour* and *substance use*. Substance use also relates to the domain 'alcohol and drugs' known in the literature; this study indicates that the importance of substance use is dependent on its relevance to the patient's offence behaviour. Lastly, the factors *motivation, risk assessment* and *recognition of problem behaviour* are both related to mental health and problem behaviour. This study highlights the importance of the risk assessment, since it was mentioned as the most important factor by all participants. Recognition of problem behaviour was previously mentioned in the literature. The factors motivation, skills and unacceptable behaviour were, although of importance, not found in the previous literature. Looking at all factors, a clear borderline was found regarding the measurability of the criteria. Some factors, such as leave, risk management plan, following modules and alert plan are measurable and need to be present for discharge. However other factors, such as motivation, unacceptable behaviour and risk assessment, contain a level of subjectivity and cannot be purely measured in a systematic manner. The found factors give a clear direction for future research, which is necessary to develop these factors into measurable criteria.

An important finding that arose from the interviews, is the importance of risk assessment. Forensic risk assessment refers to the attempt to predict the likelihood of future offending to identify individuals in needs of intervention (Brown & Singh, 2014). Modern structured approaches to risk assessment have been found to accurately predict recidivism and are widely accepted (Chaimowitz et al., 2020; Venner et al., 2020), most professionals use some form of structured approach (Singh et al., 2014; Blanchard et al., 2016). However, recent research showed that the use validated test instruments and third-party information can be improved and that a multi-method risk assessment approach is not common practice in forensic psychiatric evaluations (De Clercq & Van der Laenen, 2019). Furthermore, the past has shown that missteps have been made when it comes to risk assessment , in the Netherlands, the case of Michael P. gained broad media attention when he committed a major crime during his placement in a psychiatric institution with a low level of security

(Onderzoeksraad voor Veiligheid, 2019). This raised questions about the quality of the previous risk assessments, which led to a case report with concrete learning lessons: the risk assessment was not (adequately) done and risk assessment tools were not used (Onderzoeksraad voor Veiligheid, 2019). Safety and sharing relevant information with other professionals, is currently not common practice (Van Vliet, 2019). This conclusion is alarming, given the importance that was given to the risk assessment by all participants. This criterion then needs to be given more attention and this highlights the importance of specification of the risk assessment into measurable criteria.

Furthermore, another important finding from this study was that criteria can not be measured in a purely systematic manner, exceptions were present for almost all criteria, including risk assessment. Criteria also need to be looked at with a clinical view. In the previously mentioned report about Michael P., this was called ‘’the permanent dilemma between trust that is needed for a good therapeutic alliance and professional suspicion that is necessary to recognise risk signals’’ (Onderzoeksraad voor Veiligheid, 2019, pp. 6). This clinical view or professional suspicion is also known as forensic vigilance (in Dutch: forensische scherpte), which is an important topic within the forensic care. It is seen as a core competence that can be trained. The exact definition of forensic vigilance is unclear, though the term is vague and cannot be put in clear systematic conditions, it is widely used in the Netherlands. Various forensic organizations offer courses and learning pathways for their employees to increase forensic vigilance (Alberts & Homburg, 2018; ggzecademy, n.d.; Inspectie Justitie en Veiligheid, 2018). Recent research showed that the closest definition is ‘’being able to recognize even subtle signs of impending danger/possible escalation” (Clercx et al., 2020, p. 6). and “daring to be assertive” (Clercx et al., 2020, p. 11). Future research in this field includes testing a newly constructed 15-item instrument for measuring forensic vigilance and explore its relationship with personal and professional characteristics (Clercx et al., 2020). This might result in more clarity in the role forensic vigilance plays in the assessment of the to-be-developed criteria. What aspect of the criteria can be measured systematically and what aspect can only be measured by using forensic vigilance? Subsequently, what is needed of professionals when using forensic vigilance?

Lastly, an important finding from this study was that not all factors were relevant for each patient, especially when they were not directly related to the patient’s offence and their corresponding risk behaviour. This was for example the case with substance abuse,

dependency on alcohol of drugs was not seen as a criterion when it does not pose a risk to their initial offence (e.g., sexual offence or fraud). However, disagreement exist about whether this is the case, Kraanen and colleagues argue that there is a clear association between substance abuse and criminal behaviour, therefore substance abuse in offenders should be assessed and, if present, be treated (Kraanen, Scholing & Emmelkamp, 2011). Furthermore, addressing the substance disorders can result in recovery from the mental illness and reduces the likelihood of offending (Ogloff et al., 2015). Most in-patient clinics demand monitored abstinence as a condition for discharge as a means of reducing and managing risk. Negative urine checks (UC) were mentioned by multiple participants of this study as criterion for discharge. The question rises whether addressing substance use is sufficient or that treatment is necessary in all cases. Moreover, is demanding abstinence a way for forensic patients to adequately cope with their substance use? Pickard and Fazel (2013) mention that careful planning in collaboration with the patient for maintaining abstinence when leave or discharge is granted, is essential. They stress that substance use monitoring should be seen as an offer instead of a threat, only then the autonomy of the patient is considered, which could essentially decrease relapse rates (Pickard and Fazel, 2013).

Strengths and limitations

A limitation of this study is the small number of respondents, a total of five participants were recruited. An increase in participants would have increased the representativeness of the population. This would also increase the variation across the different levels of security and the variation of participants related to in-patient and out-patient facilities. More variation would have resulted in clearer and more specified factors. Another limitation of this study were the limited possibilities for in-depth questing, which meant some factors could not be fully elaborated or specified. The reason for this, was the broad explorative objective of the bigger study this study is part of, which resulted in a broad interview scheme. Therefore, the possibilities to conduct in-depth interviews about the criteria within the two domains were limited. This was for example the case with the factor self reliance and skills: social and coping skills were identified but could not be further explained or specified. Lastly, a limitation of this study is the unknown inter-rater reliability. Although a member of the research group open coded one interview, the coding process was not continued into the development of a coding scheme. This meant the codes could not be

compared and subsequently analysed for inter-rater reliability, which means that codes could differ between researchers.

A strength of this study is the broad variety of respondents, despite the low number of respondents. This resulted in broader exploration of the topic. Participants were recruited from various forensic mental health care facilities, from various places within the Netherlands. Furthermore, two types of participants were recruited (clinicians and mental health professionals). This is favourable in explorative research, which aims to gather preliminary information to help define problems and suggest hypotheses (Babbie, 2007). The broader the exploration, the more information can be gathered. Furthermore, the representativeness of the population becomes less important in explorative research since it is a starting point for future research. Another strength of this study, is the style of open interviewing. Although an interview guide was used and questions were decided in advance, the style of interviewing was semi-structured. This meant that participants could bring in new topics, this flexibility caused a broader exploration of the topics to gain insight into practice (Holloway, 2005). Lastly, a strength of this study was the inductive approach of the research. An inductive approach can result in discovering new ideas or concepts within the data (Glaser & Strauss, 2000), which means new criteria could be identified. Given the explorative nature of this research, this resulted in a broad exploration of possible criteria.

Conclusion and recommendations for future use

This study is a first step to lay the groundwork for criteria for discharge concerning the domains mental health and problem behaviour. Seven factors were identified, the factors related to the domain mental health are self-reliance and skills and treatment adherence. The factors related to the domain problem behaviour, are unacceptable behaviour and substance use. The factors motivation, risk assessment and recognition of problem behaviour are both related to mental health and problem behaviour. Some new factors were identified, and some factors were previously mentioned in the literature. Risk assessment was mentioned as one of the most important factors, although the preferred multi-method risk assessment is not yet common practice. Furthermore, although some factors could be systematically measured, some factors were found to be more subjective. This subjectiveness was mentioned as forensic vigilance, which is an important skill to assess risks in practice and plays a role in the measurement of the criteria. It is however still unclear what role forensic vigilance plays in the measurement of the criteria. Lastly, some criteria were found of less importance when

they were not in direct relation to the offence and risk behaviour of the patient, for example substance use. It was stressed that abstinence and substance use monitoring should be an offer, rather then a threat, to increase patient autonomy. All found factors serve as input for future research into the development of the criteria.

Future research should further specify these factor into measurable criteria. The question rises what is needed of the patient for discharge, this should be measurable when possible. Besides the necessity of further research to obtain measurable criteria, further research can also identify the variations of the criteria within each security level. Although the criteria are relevant for all security levels, the exact measurements can differ. This is for example the case for the found factor ‘substance use’, it was mentioned that the patient goes through the circles of behavioural change. The phase of behavioural change the patient needs to be in for discharge, can differ across the facilities and their corresponding security level. Furthermore, it is expected the criteria for the patient’s skills can differ across the security levels, the lower the level of security, the more is expected of the patient. Future research could also focus on what role forensic vigilance plays in the measurement of the criteria. It was found not all criteria could be measured systematically, future research could focus on what part of the criteria can and cannot be measured systematically. This can then be linked to the future research in this field, regarding the personal and professional characteristics of professionals working in the forensic care. This might gain more insight into how the more subjective part of the criteria can be effectively measured.

Concluding, this study identified factors for discharge in the domains mental health and problem behaviour. Although useful factors were identified, these factors serve as a foundation for future research to identify measurable criteria for discharge.

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Appendix: interview guide

Interview guide, abbreviated solely concerning discharge criteria.

Introduction

Good morning/afternoon, welcome and thank you for taking the time to call us. I am (name), I am (occupation) / study (the study) and am in my final year. I do my research at Transfore and will contribute to an ongoing research concerning discharge planning. Before I ask you some questions, I want to ask for your consent for recording the conversation. I would appreciate it, when I start the recording, you give your consent one more time, so it is an informed consent. (Start recording and ask again.) During this interview I will discuss different themes related to discharge planning, namely: collaboration and organisation, coordination, environment of patient and discharge criteria. First I will ask you some general questions.

1. What does discharge planning mean to you? (Explanation of our definition of discharge planning, describing context and research and describing similarities in both definitions).
2. Do you have any experience with discharge planning?
3. What does discharge planning look like when it goes well? What would it look like in a perfect world?
4. Why is discharge planning applied or not applied?
5. What would possible results be of discharge planning?

Discharge criteria

1. What are the most important conditions for a smooth discharge planning?
2. On what basis is the decision made to let a patient transition to a different form of care?
3. What is needed when patients are admitted in your facility? Where do they come from (visualising pathway)?
    a. What is needed of the patient? What are his/her competences? When a patient is not competent in a specific criterion, what do you organise to intercept this and how is this done?
    b. What is needed of the follow-up facility?

4. What other criteria does the patient have to meet for transition/discharge?
5. Which problem behaviour of the patient is a barrier for transition/discharge and which problem behaviour is not? What amount of problem behaviour is sufficient for transitioning?
6. Which criteria are applied for the decision of transition/discharge?
    a. What do you think of these criteria? Are these clear enough?
    b. How are these criteria used in practice?
7. Does every patient have a transition/discharge plan?
    a. Which patients have these, and which do not?
    b. Which barriers are there?
    c. What is the most important reason making a transition/discharge plan does not always happen?
8. Known criteria for transition and discharge, fall under the following domains according to the literature: offense behaviour, physical health, mental health, drugs and alcohol related problems, problem behaviour and family, social and occupation.
    a. How do you see this? Which domains are most important?
    b. Which criteria are there in the domains of mental health and problem behaviour on transition? What do you think of these criteria and what can be improved?

Concluding

1. Which factors need to be a part of the shaping of discharge planning?
2. What needs to be in the manual?
3. Do you know more persons we can approach to interview about discharge planning?