TRANSITION OF CARE FROM ACUTE PSYCHIATRIC CARE TO PRIMARY CARE

By

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Abstract

For adults with severe mental illness there are serious issues with poor transitions of care. There are many types of transitions that patients experience that can negatively affect continuity of care. These transitions can also compound a patient's illness. The focus within the limits of this project is on care setting transitions from acute to primary care. The point of discharge from acute psychiatric care to primary care is a critical time in the care continuum, and it should be treated with the utmost importance. The purpose of this integrative review is to examine evidence based practices and processes in order to identify ways to facilitate seamless transitions and continuity of care for mentally ill adults discharged from acute psychiatric care to primary care. Further, to offer recommendations for Family Nurse Practitioners practicing in primary care in Canada. Background information on severe mental illness, care transitions, and a case example are presented along with an overview of primary care. A comprehensive search strategy identified 17 relevant studies. Four key findings underline the importance of confidentiality, linkage between acute and primary care, communication, and therapeutic relationships. The recommendations offered are directed to the FNP in primary care, but are relevant to many healthcare providers. They may also be helpful in other settings, such as acute psychiatric care or community mental health.

Keywords: transition of care, continuity of care, severe mental illness, family, primary care, family nurse practitioner, primary care provider

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Dedication

This project is dedicated to the memory of Stephen and all those who loved him.

"Find a gap between a trigger event and our usual conditioned response to it, and use that pause to collect ourselves and shift our response"

-Sharon Salzburg

Acknowledgement

I would like to acknowledge Linda Van Pelt, Martha MacLeod, and Khaldoun Aldiabat for their contributions to this project.

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CHAPTER 1

Introduction

Individuals with severe mental illness (SMI), such as schizophrenia, bipolar disorder, and major depressive disorder, are among the most vulnerable patients. A complex and unpredictable course of mental illness places this population at increased risk of self-harm (Rose, 2007; Sowers & Rohland, 2004). For many people with SMI, hospitalization for psychiatric care is required at some point in their lives (White, Gutacker, Jacobs, & Mason, 2014).

Care transitions occur at every stage of the healthcare continuum; within both acute and primary care settings and in between care settings (Lattimer, 2011). For individuals with SMI ineffective transitions negatively influence continuity of care, which is an important aspect of managing acute episodes of SMI (Sowers & Rohland, 2004; Viggiano, Pincus & Crystal, 2012). Despite the importance of safe transitions and continuity of care, many Canadian and worldwide health systems are not seamless and provide only incomplete transitions between care settings (Sowers & Rohland; Viggiano et al.).

The point of discharge from acute psychiatric care is considered to be a critical time in the continuum of care. Discharged psychiatric patients who are not well transitioned between care providers and settings are at an increased risk for adverse outcomes (Dixon et al., 2009). The period directly following discharge carries the increased risks of symptom relapse, hospital readmission, homelessness, or suicide (Cleary, Horsfall, & Hunt, 2003; Viggiano et al., 2012). Research supports the argument that a more seamless transition from acute psychiatric care may prevent such outcomes (Price, 2007).

This research project has come from my personal and professional experiences and theoretical studies as a Family Nurse Practitioner (FNP) student in Northern British Columbia. A requirement for completion of the Master of Science in Nursing – Family Nurse Practitioner stream is a practice-based project that provides an integration of current research literature on a critical area of concern to FNPs as primary care providers (PCPs). This project seeks to identify evidence-based practices and processes that help to achieve seamless transitions and continuity of care for mentally ill adults discharged from acute psychiatric care to primary care. Further, to propose solutions that address gaps in care during care transitions for individuals with SMI.

Prior to my studies, I practiced as a registered nurse in an emergency room where it was not uncommon to encounter mentally ill patients. Many patients presented there as a result of service fragmentation and poorly managed care transition. Providing mental healthcare was part of my comprehensive nursing role, but my interest in the area of mental health was heightened following the suicide death of Stephen, a young man who was important to my family. Stephen was a university student in his third year of studies. Often students at this stage of their educational career have had to move away from their family support systems. Stephen, however, still lived with his supportive parents, and he had two older sisters with whom he was well connected. He had a cohesive group of friends and was in a long-term relationship with a young woman.

In the early stages of his illness, personality and behavioral changes resulted in Stephen isolating and disengaging himself from his social connections and eventually alienating himself from his family. Throughout his illness, Stephen's family sought medical advice and endeavored to link him with counseling services. However, Stephen's perception of reality became increasingly distorted and irrational and eventually, detrimental to his health. He was initially admitted to the psychiatric unit of a large urban hospital before being transferred to an acute psychiatric unit in the smaller urban community where his parents resided. Stephen was considered to be an adult although he was dependent on his parents. Despite this dependence, privacy and confidentiality laws restricted his parents from involvement in his care without his consent. As Stephen disengaged from his family, due to his illness, their participation and involvement were circumscribed. They were not considered as resources by Stephen's healthcare providers to provide background information for the history of his presenting illness, nor were they included in the planning of his care, discharge planning or out-patient care and follow-up. His parents' repeated attempts to obtain information about his condition, medications, symptom management, and safety issues, including whether he was safe to drive his car, were met with resistance. The staff of the psychiatric unit, including the psychiatrist, held that Stephen was an adult. They cited patient confidentiality policy, which deemed that unless the patient provides consent, sharing of information with others, including family, is a breach of policy. On the day of Stephen's discharge from the acute care unit, he called for his parents to take him home; they had no prior knowledge that he was to be discharged and had not been offered any opinion or diagnosis of Stephen's condition, which troubled them. Upon discharge, Stephen's parents had questions and apprehensions about his extremely despondent and apathetic behavior, monotone voice, diminished facial expressions, and abnormal facial movements. Stephen was uncertain about his medication schedule and told his parents he was to take more than was indicated on the prescription. His parents made multiple telephone calls in search of answers to help them care for their son, including a pharmacist, a community mental health service, the acute care psychiatric unit from where he was discharged, their family physician (Stephen's primary care provider), and a neighbor who had a child with SMI. Appealing to these resources was futile. Aside from the pharmacist, who did provide helpful information regarding Stephen's medication, no one was willing or able to give them any information that would help them care for their son. The office of the primary care provider claimed that they had no knowledge of Stephen's discharge and were uncertain who was to manage Stephen's care, as a discharge summary with the plan for who would manage his care and follow up had not yet been received. The format and process of disseminating discharge summaries between acute care and primary care practitioners in Stephen's case is not clear. However, one common practice is a report dictated by the most responsible acute care provider, which is then transcribed and faxed to the primary care provider.

Two days after discharge from the acute care psychiatric unit Stephen left unnoticed from his home and committed suicide. A piece of paper with incomplete information that included an appointment with a local Early Psychosis Intervention program for the following day was found in his pocket. His parents had no prior knowledge of this appointment. Fourteen days after Stephen's death, the discharge summary, the primary document communicating his care plan following discharge from the psychiatric unit, arrived at the primary care provider's office.

In retrospect, Stephen's parents questioned if there was any consideration, in his discharge planning, of his capacity to independently keep this appointment. In addition, they questioned why they could not have been informed about concerning symptoms, side effects of medications, and problems that might be encountered during the post-discharge period, including the risk of suicide.

Following Stephen's death, I began to reflect on my experience as an emergency room nurse and the cases involving individuals with SMI, who were there as a result of poor care transitions. I then began my inquiry into the matter of mental illness and healthcare. I sought relevant literature, I developed a heightened interest in media reports relating to mental healthcare and mental illness, and I engaged in conversations about mental health. I was compelled to gain a better understanding of this area of healthcare: I needed to know, was Stephen's case unique? I was confounded with the concept of confidentiality in Stephen's case: he was suffering from paranoia and psychosis, discharged to the care of his parents, his primary caregivers, yet they were not considered relevant in his care transition. Furthermore, the delay and lack of communication between specialty care services and the primary care provider was concerning.

I had to ask, if Stephen's case were not unique, what factors would contribute to untoward outcomes for adult children in these situations? What types of changes or improvements could minimize the risk of such a tragedy happening to others?

In order to deal with these challenges we have to recognize the problems. Approximately half of all discharged psychiatric patients' transition successfully to outpatient care services in the community, including primary care practices (Dixon et al., 2009). Despite longstanding efforts in the organization and delivery of healthcare to improve mental health outcomes in Canada, challenges remain (Mental Health Commission of Canada [MHCC], 2012). Until recently, Canada was the only Group of Eight (G8) country without a national strategy for mental health. This was due largely to the allocation of healthcare delivery across Canada, where provincial and territorial governments have most of the responsibility for providing health and other social services. Consequently, the responsibility for mental healthcare falls under the authority of the individual provinces and health authorities responsible for the management, planning, and delivery of healthcare services within their geographic areas, resulting in challenges aligning a comprehensive strategy.

In general, healthcare for individuals with SMI in Canada tends to be nominal, ragmented, and episodic (Canadian Alliance on Mental Illness and Mental Health [CAMIMH], 006). Individuals continue to suffer unnecessary ill health and mortality from mental illness CAMIMH). Changing trends in healthcare delivery have resulted in a movement from hospital are towards community care and programs (Delany, 2006; Milliken, 2007). Inpatient psychiatric ospitals were once the primary location for psychiatric care, but the acute inpatient stay is now limited to crisis stabilization and safety, with a focus on rapid discharge; therefore, the hospital now plays a more limited role within a community-based system of care (Sharfstein, 2009). With hese changes the burden of care has shifted, with families becoming the primary caregivers Ward-Griffin, Schofield, Vos, & Coatsworth-Puspoky, 2005). Due to this, issues with confidentiality may arise. Families acting as caregivers for their adult family member may face everal challenges in obtaining basic information about the care of their ill adult family member Mood Disorders Association of British Columbia, 2008).

With this transition from acute care to community-based care, psychiatric care is now being provided in the primary care setting, such as family practice offices (Russell et al., 2003). Between 30 and 60% of patients in primary care practices show signs of either a psychiatric or psychological disorder (Service & Digout, 2003). Primary care providers, such as nurse practitioners, play an extensive role in delivering mental healthcare in most communities in Canada (Kates et al., 1997). Largely, primary care providers assume ongoing responsibility for providing a patient's care. They serve as the entry point for patients' medical and healthcare needs, and are charged with coordinating the use of the entire healthcare system to benefit the patient (Aggarwal & Hutchison, 2012). Patients with SMI and their families seek general medical care, advocacy, and support from the primary care provider (Lester, Tritter, & Sorohan, 2005; Russell et al., 2003). This component of care adds substantially to a primary care provider's workload because of the chronic and complex nature of severe mental illness (Lester et al.).

The introduction of this paper has identified the importance of this topic as it is exemplified by the events surrounding a young adult's care transitions during an acute psychiatric admission and discharge. The intention of the research and overall purpose of the paper follows.

Research Question and Aim

This project will methodically and critically review evidence to answer the research question: What are evidence based practices and processes that help to achieve seamless transitions and continuity of care for mentally ill adults discharged from acute psychiatric care to primary care? A critical analysis and synthesis of the findings will be the basis of practice based recommendations for Family Nurse Practitioners in primary care in Canada, in an effort to improve transitions of care for adults discharged from acute psychiatric care. The practice based recommendations will also be useful to other healthcare providers in both acute and primary care settings. While policy and systems level change is important it is beyond the focus, scope and limited size of this paper.

This chapter has highlighted the significance of a complex and unpredictable illness course for individuals with SMI. Chapter Two provides an overview of concepts and background information on severe mental illness and care transitions. Chapter Three offers an overview of the methods for this project, including the search strategy and selection of relevant literature for analysis. An analysis of themed findings is presented in Chapter Four. A discussion of practices and processes that help achieve seamless transitions and continuity of care is presented in

Chapter Five. The paper concludes with a summary, conclusion, and recommendations focusing on the practice level of FNP care and implications for future research.

CHAPTER 2

Background

The diagnosis of SMI comes with extraordinary health, healthcare, societal, and financial burdens. In order to appreciate the magnitude of SMI, and the significance of safe transitions of care for this population, relevant concepts and contextual considerations will be presented.

Severe Mental Illness

Neurobiological explanations for mental illness include a myriad of causes, including genetic, environmental, congenital and developmental, and many that remain unknown (Kaas, Lee, & Peitzman, 2003). The term severe mental illness, SMI, is an umbrella term used to describe mental diseases that are disabling and persistent (Gold, Kilbern, & Valenstein, 2008). Severe, serious, and/or persistent mental illness are terms used interchangeably to describe disorders such as schizophrenia, schizoaffective, bipolar disorder (BD), major depressive disorders (MDD), obsessive compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder (BPD) (Kilbourne, Keyser, & Pincus, 2010; National Alliance on Mental Illness [NAMI], 2014). A detailed description of the definitions of the disorders listed and other key terms and concepts in this paper are located in the glossary. For the purposes of this paper SMI will refer to these disorders.

Individuals with these disorders can exhibit challenging symptoms requiring considerable amounts of care and support (Vella & Pai, 2013). They are likely to have concomitant medical problems and suffer excess morbidity and mortality, compared with the general population (Kaufman, McDonell, Cristofalo, & Ries, 2012). They die at an average of 25 years earlier than the general population, which also reflects an increased occurrence of suicide among them (Farley et al., 2013; Knapik & Graor, 2013). The consequences of these disorders not only adversely affect the individual with the illness and their families, but also negatively impact the economy as a whole.

The health problems and burdens of SMI are prevalent throughout the developed world. The estimates of the incidence of mental illnesses in communities are similar everywhere with one in five people experiencing a significant mental illness at some point throughout life (Milliken, 2007). For many, the illness will begin in youth or young adulthood. The disabilities can be prolonged and the effects can last a lifetime (Milliken). Persons with SMI suffer more from chronic physical illnesses, such as diabetes mellitus, cardiovascular disease, obstructive pulmonary disease, and obesity, compared to the general population (Knapik & Graor, 2013). The severity of the illnesses tends to be greater than that experienced by the general population (Knapik & Graor). People with SMI are more prone to infections and injuries and frequently take risks in their lifestyles, such as smoking and substance abuse (Farley et al., 2013; Knapik & Graor). For younger adults, the personal negative impact is related to educational achievement, occupational or career opportunities, and successes. Severe mental illness also impacts the formation and nature of personal relationships where the effect extends throughout an individual's life (Public Health Agency of Canada [PHAC], 2012).

In 2001, the World Health Organization (WHO) described mental disorders as having an impact on the quality of life of individuals, their families, and society. The economic burden on the Canadian economy is described in terms of productivity losses and healthcare costs. In 1996/97, the Public Health Agency of Canada (2012) estimated the cost to the Canadian healthcare system to be $14.4 billion. The WHO reported that in 1990 mental disorders accounted for ten percent of the world’s total disabilities. By the year 2000 the number was 12%, by 2020 it is projected to have increased to 15%.

An equally important and unsettling burden of SMI is the misunderstanding associated with mental illness, which results in discrimination and stigma (Kirby, 2008). As a result, individuals with SMI often do not receive the care they require (WHO, 2014). Stigma and discrimination result in lower research funding for mental health and poorer and less organized clinical services than for other areas of healthcare (Abbey et al., 2011). In Canada, mental health services are underfunded in relation to their prevalence and the economic burden of illness they inflict (Kirby & Keon, 2006; Picard, 2012). The burden of mental illness is extensive, complex, and on the rise. This burden places an increased demand on healthcare organizations.

Within healthcare systems there is increasing concern about the adverse human and financial outcomes of fragmented and poorly coordinated care. This concern is heightened by quality care indicators that reveal poor patient transitions, repeat hospitalizations, and preventable emergency room visits (Trachtenberg & Ryvicker, 2011). In Canada, the rates of readmission for mental illness are high, relative to those for most other diseases (Canadian Institute for Health Information [CIHI], 2014). Readmission rates for mental illness within one year of discharge are 37% compared to 27% for other types of illnesses (Madi, Zhao, & Li, 2007). Post-discharge suicides tend to cluster in the first few weeks after discharge (CIHI).

Transitions of Care

Every patient admitted to acute care has already experienced one transition and unless admission results in death, the patient will eventually experience a second transition to another setting (Russell, Doggett, Dawada, & Wells, 2013).

“Transition of care” refers to the delivery of services designed to ensure healthcare continuity. It refers to the movement of patients between healthcare settings or providers, or between different levels of care within the same location (National Transitions of Care Coalition

[NTOCC], 2008). Adverse outcomes and discontinuity of care during care transitions occur from nearly every type of healthcare setting, and especially when patients leave acute care to receive care in another setting, such as primary care (The Joint Commission, 2014).

The scope of this paper focuses on transitions of care between acute and primary care as poorly managed transitions of care can pose serious problems, jeopardizing continuity of care, increasing the risk of hospital readmission, and symptom exacerbation or deleterious outcomes (Puschner et al., 2011; Sowers & Rohland, 2004; Steffen, Kösters, Becker, & Puschner, 2009). When coordinating the care of patients with SMI, care providers must acknowledge that transition to the community may be more difficult for these patients than for many others (Gomez, 2008).

To date, research on care transitions has largely been focused on the general medical patient population and only a small number have specifically focused on the mentally ill (Viggiano et al., 2012). However, many factors have been identified as contributing to ineffective care transitions, and these barriers explain why care transitions do not always go smoothly.

Barriers to Transitions of Care

Among the common barriers to effective care transitions are the challenges with information sharing and communication between healthcare providers and care settings. This is largely due to inadequate systems for delivering information reliably between providers (Chong, Aslani, & Chen, 2013). Universal electronic health information systems with connectivity across settings, such as hospital, clinic, or office, are lacking or nonexistent in many cases (Coleman & Berenson, 2004). There is also concern about the suboptimal quality and timeliness of discharge summaries and about the system for delivering this information reliably between care settings or providers (Russell et al., 2013). Likewise, healthcare services often function in isolation, widening the communication gap and narrowing the likelihood of assigning responsibility when problems arise (Coleman & Berenson).

Finally, ambiguity surrounding the role of primary care providers (PCPs), such as FNPs and general practitioners, in post-discharge care often impedes effective care transitions (Russell et al., 2013). When discharge planning is done well it is considered a dynamic, comprehensive, and collaborative process initiated at the time of admission to determine the patient's plans of care and the support that the patient and his or her family may require after discharge (Alghzawi, 2012). For discharge from acute care settings to go well, patients would have an accountable primary care provider during all points of care transition, since patients and healthcare systems tend to rely on primary care providers to coordinate patient care between care settings (NTOCC, 2008; Russell et al.). Unfortunately, the range of services frequently required for the patient with SMI often exceed the coordination capacity of the primary care provider, adding to the challenges of achieving successful care transitions (Pauzé, Gagné, &Pautler, 2005).

The Family in Care Transitions

The context of family in care transitions is based on the assumption that families want to play a supportive role in the care and treatment of their ill relative. It is important to recognize that not all individuals with severe mental illness have families that play a positive role, or any role in in their care. Some individuals do not have families that are involved with their well-being on a day to day basis.

For the purposes of this paper, the term *family* will refer not only to biological relatives but to all people identified by individuals with SMI as important to their recovery or treatment, such as spouses, friends, romantic partners, and room-mates (Solomon, 2012). Research has shown that family involvement in the care of individuals of SMI is effective in reducing morbidity and mortality (Kaas et al., 2003; Macfarlane, 2011). Families are typically a major source of support for people with SMI and often provide housing, assistance with activities of daily living, and financial support (Macfarlane). Families provide crisis intervention and advocate on behalf of their ill relatives, helping them to navigate the mental health system (Macfarlane). They monitor symptoms and encourage treatment and medication compliance (Macfarlane). Thirty-five to 60% of individuals with SMI are living with or receiving care from families (Ward-Griffin, Schofield, Vos, & Coatsworthy-Puspoky, 2005). In Canada, approximately 50% of adults with schizophrenia live with their families (Ward-Griffin et al.).

Caring for a relative with SMI can be a life altering experience that few people are prepared for (Rowe, 2012). With a shift from acute care to community-based care, more responsibility for psychosocial care has been placed on family caregivers (Rowe). Families are faced with multiple issues in caring for a relative with SMI. Personal, interpersonal, and systemic challenges faced by families include lack of acknowledgement of their caregiving roles, stigma of mental illness, and poor relations with the mental health, legal, and welfare systems (Ward-Griffin et al., 2005). Barriers to providing care to an adult family member with SMI stem from poor engagement and communication with healthcare providers, and families' own abilities to cope (Rowe). Poor engagement and communication are commonly related to matters involving privacy and confidentiality.

Privacy and Confidentiality in Care Transitions

The rights to privacy and confidentiality are fundamental values and rights for all members of society, including individuals with mental illness and persons with SMI who have been involuntarily hospitalized (O'Reilly, Chaimowitz, Brunet, Looper, & Beck, 2010). Federal and provincial laws protect an individual's right to privacy and confidentiality of personal and health information through acts such as BC's Freedom of Information and Protection of Privacy Act (CRNBC, 2010). Provincial laws that govern the care and treatment of people with mental illness are covered under the Mental Health Act (Butler & Phillips, 2013).

Healthcare providers working in mental healthcare are bound by law and professional codes of conduct to a duty of confidentiality to their patients (Royal College of Psychiatrists, 2014). If a healthcare provider breaches confidentiality they can face disciplinary measures, including being sued or dismissed (Royal College of Psychiatrists).

Privacy and confidentiality of patient health information take on unique meaning in mental healthcare because of matters such as stigma associated with mental health illness, or issues of family dynamics (Bernstein, 2014). Severe mental illness can alter an individual's level of understanding, reasoning, and judgment. Consequently, issues such as informed consent may become more problematic with seriously mentally ill patients (Amer, 2013). Therefore, balancing patients' rights and families seeking information becomes a challenge for healthcare providers (Bernstein).

At times of crisis relationships can be strained and healthcare providers may get a false sense of the true family dynamic (Royal College of Psychiatrists, 2014). Misconceptions about the family can impede information sharing with them, or considering them as a resource in care. This is compounded if the patient does not consent to information sharing with family members. Healthcare providers involved in a patient's care have a duty to follow professional codes of practice and law regarding confidentiality (Royal College of Psychiatrists). When patients entrust their care and personal health information to a healthcare provider, they expect that it will be kept confidential (CRNBC, 2010). In a similar vein of expectations, patients expect their information to be used in a consistent way among all of their care providers, in order to safeguard continuity of their care in a complex healthcare system (Hogg, Rowan, Russell, Geneau, & Muldoon, 2008).

The Canadian Nurses Association (CNA, 2001) considers an individual's right to privacy as paramount and advises that healthcare organizations implement policies to ensure privacy protection. The boundaries of confidentiality are not absolute and there are situations in which confidentiality may be justifiably breached (O'Reilly et al., 2010). Such situations may necessitate a modification of policy in order to protect the patient or others (Tino, 2009). The CNA recommends the use of decision-making pathways and processes when ethical issues related to privacy arise. Healthcare providers have a responsibility to be familiar with the laws that govern their practice, as well as the policies within the organization where they practice (CRNBC, 2010).

Despite the evidence that inclusion of family in treatment and recovery of adults with SMI improves their outcomes, confidentiality concerns and misconceptions by healthcare providers pose major barriers for families to be actively involved in their care (Wilkinson & McAndrew, 2008). Misconceptions and lack of clarity regarding what information can and should be shared with family places healthcare providers in difficult situations when using their discretionary judgment. A lack of knowledge or confidence on how to address differing needs and rights of patients and families around information sharing creates ethical conflicts for healthcare providers when deciding to disclose certain information when working with families (Wilkinson & McAndrew). It is important to balance and consider confidentiality on a case-by-case basis. Family may often be the only constant resource available to an individual with SMI

(Finke, 2004) and barriers created by the complexities in managing confidentiality issues can impede or thwart effective care transitions and continuity of care for such individuals.

Effective Care Transitions

Effective care transitions occur when the individual is able to experience separate healthcare events as connected, coordinated, and appropriate for their needs and preferences across care providers, levels of care, and locations. Safe and seamless care transitions depend on collaboration across healthcare services (Coleman & Berenson, 2004). Attributes of effective transitions include coordination and continuity of comprehensive plans of care carried out by well-trained practitioners who have current information about the patient's treatment goals, preferences, and clinical status.

Education of patient and family, as well as dialogue among care providers, is important to ensure appropriate resources and services are available in the most appropriate care setting (Cesta, 2012; NTOCC, 2008). Transitional and discharge planning safeguard the same smooth movement of the patient through the care continuum (Cesta). The discharge process from acute care to community care should be considered in the context of the pre-admission, admission, treatment, discharge, and post-discharge continuum (Russell et al., 2013). The focus of discharge from acute care is on the movement of the patient from the acute care setting to an alternate level of care (Cesta). This process involves an assessment of the patient's needs following discharge and confirmation that necessary services are organized to facilitate continued care for the patient (Cesta). For optimal continuity of care, there is orderly and uninterrupted movement of patients among the diverse divisions of services along the continuum of care (Adair et al., 2005; WHO, 2008).

Predictability and continuity of care are considered important for individuals suffering from SMI because the illness is long term and associated with poor social functioning (Crawford, de Jonge, Freeman, & Weaver, 2004; Lester, et al., 2005; Solbjor, Rise, Westerlund, & Steinsbekk, 2013). As such, longitudinal care provided by primary care providers is an important consideration in the care of patients with severe mental illness.

Family Nurse Practitioners and Primary Care

Primary care focuses on health promotion, illness and injury prevention, diagnosis and treatment of illness (Health Canada, 2012). Further, primary care allows for patients to receive care for new and ongoing needs and health problems; primary care is person-focused and coordinates and integrates care provided by other healthcare providers (Aggarwal & Hutchison, 2012). The Family Nurse Practitioner plays an important role in primary care, which is the first point of entry to the healthcare system in Canada (CNA, 2009). In addition to primary care services, FNPs work with individuals, communities, and diverse populations enacting the principles of primary healthcare, such as accessibility to healthcare and community participation (CNA).

Family Nurse Practitioners are healthcare providers who have achieved advanced nursing practice education and skills at the graduate level of education (College of Registered Nurses of British Columbia [CRNBC], 2014). Family Nurse Practitioners provide healthcare from a holistic nursing perspective, in which they independently diagnose and treat acute and chronic illnesses. Family Nurse Practitioners practice within a regulated scope of practice (CRNBC, 2014), and provide primary care services including health assessments, ordering and interpreting diagnostic tests, diagnosis of disease and conditions, and prescribing medications and treatments. (British Columbia Ministry of Health, 2012; CRNBC). It is through an integrated approach that

FNPs bring the nursing focus of teaching, counseling, and support to the medical diagnostic and treatment care they provide (CNA, 2009; CRNBC). In Canada, the regulation and scope of practice for FNPs varies between the territories and provinces, owing to jurisdictional variations among them (Donald et al., 2008). Family Nurse Practitioners work in a variety of community settings, practice in both rural and urban communities, and provide healthcare services to individuals and families of all ages (British Columbia Nurse Practitioners Association [BCNPA], 2014). Nurse practitioners were introduced to improve client health outcomes by increasing accessibility to healthcare services, expanding clients' healthcare options, and filling gaps that exist in healthcare delivery (Wong & Farrally, 2013). As healthcare providers in primary care settings, FNPs have a broad range of patients within their practice and will encounter individuals with severe mental illness and their families. Family Nurse Practitioners practicing in primary care are responsible for the longitudinal care of their patients and will be involved in the delivery of their care.

Admission and discharge privileges vary among jurisdictions across Canada, notwithstanding the FNP may be responsible for coordinating a patient's admission to acute care and transition back to primary care (British Columbia Ministry of Health, 2012). As primary care providers, FNPs may be the first point of access for patients with SMI and are in a position to identify the need for a higher level of care. Further, Family Nurse Practitioners, as primary care providers, may be responsible for the care of patients with SMI following discharge from an acute psychiatric hospitalization. As such, Family Nurse Practitioners can play an integral role in safeguarding effective care transitions for individuals with severe mental illness.

In summary, this chapter has identified and described the complex and unpredictable nature of SMI that places these individuals at increased risk for harm. Poorly managed care transitions and discontinuity of care for adults upon discharge from an acute psychiatric admission have been identified as detrimental. Although the importance of maintaining continuity from transition points in mental healthcare has been well documented, there is a limited amount of research on interventions to address this problem (Viggiano et al., 2012). A case example and relevant background information establish the context for this project as it relates to adults discharged from acute psychiatric care. Despite efforts aimed at improvement in mental health outcomes, challenges remain for individuals with SMI whose healthcare tends to be fragmented and hindered by under funding for mental health services (British Columbia Medical Association [BCMA], 2009). The period of transition between acute care and primary care is important for safe and seamless continuity of care, and the FNP, as a primary care provider, is an integral part of the transition of care process.

The following chapter will describe the search methods for an integrative review of the literature that will examine practices and processes to achieve seamless transition and continuity of care for adults discharged from acute psychiatric care to primary care.

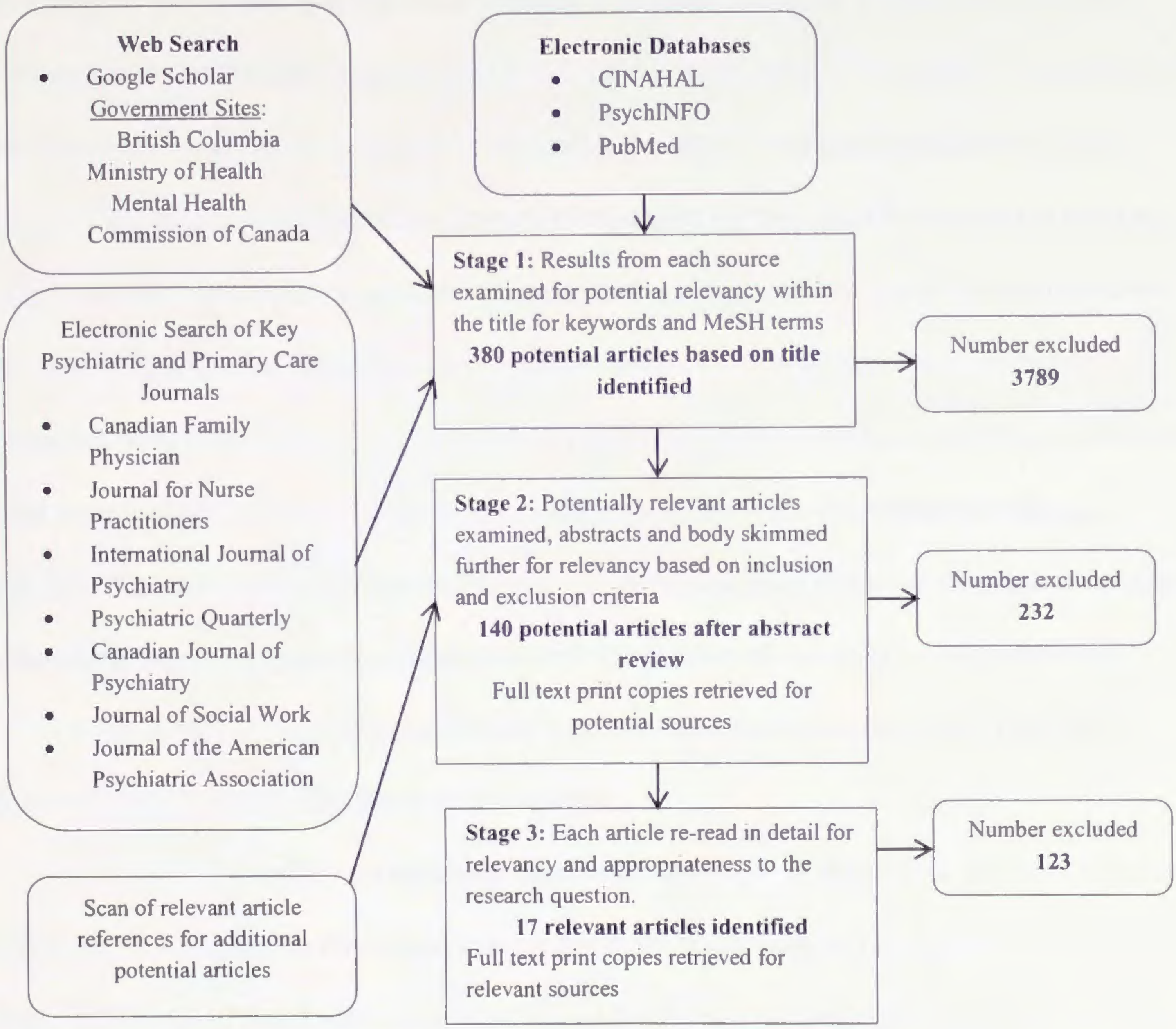
CHAPTER 3

Methods

The purpose of this project is to obtain a more comprehensive understanding of current practices and processes around care transitions for individuals with SMI. Further, to investigate practice improvements that may be made to achieve seamless transitions of care through examination of the literature. The methodological strategy of an integrative literature review has been used because the approach allows for a broad spectrum of research methods that can be applied toward improvements in clinical practice and evidence informed practice initiatives (Whittemore & Knafl, 2005). To obtain diverse and extensive literature the search incorporated electronic databases, electronic journal searching, web searching, reference lists, and guidelines (Whittemore & Knafl). A fundamental component of a credible integrative review is a well-defined search strategy (Whittemore & Knafl), and to this end, the search strategy for this paper will now be outlined.

Figure one outlines the three stages involved in the search strategy, and the filtering of literature for critical analysis. A detailed description of each stage is provided.

Figure 1: *Search Strategy* (adopted from Fehr, 2013)



Stage One: Searching Electronic Databases

Stage one of the literature search was completed using multiple resources. The search terms were obtained through key terms and concepts derived from the research question and topic for this study. The keywords used were: mental disorder, primary healthcare, patient transfer, care transition, psychiatric units, confidentiality, and family. A search through the electronic databases identified the medical subject heading (MeSH) terms needed, including: mentally ill, psychiatric patient, nurse practitioner, family nurse practitioner, continuum of care, continuity of patient care, transfer discharge, psychiatric hospitals, confidentiality and privacy, and privileged communication. The electronic databases searched were CINAHL, PsychINFO, and PubMed. To retrieve only the most relevant and recent literature, articles were limited to those written in the English language and published between January 2002 and October 2014. A time frame of five to ten years is usually placed on the age of works to be included (Cronin, Ryan, & Coughlan, 2008). This time frame was expanded by two years to capture the most up-to-date research without missing older, relevant studies. For the initial search of the databases, age range was limited to those between 19 and 44 to more accurately represent the adult population with SMI, and to exclude literature pertaining to older adults or adolescents. After the initial search, it was noted that there was lack of consistency across the databases for age selection. Therefore, the age range was broadened to 18 years and older for subsequent searches. Appendix II depicts the searches conducted, and the number of results obtained from each.

After pertinent combinations of the terms were searched using Boolean Logic, the duplicates found between databases were removed.

Electronic journals were manually explored to add rigor to the search. Journals searched were the Canadian Family Physician, Journal for Nurse Practitioners, Psychiatric Quarterly, Canadian Journal of Psychiatry, Journal of Social Work, and Journal of the American Psychiatric Nurses Association. These journals were selected to obtain a comprehensive examination of multidisciplinary research in healthcare. The terms used to search within these journals were: discharge planning, continuity of care, psychiatric patient, primary healthcare and primary care, transition of care, family, and confidentiality.

Google Scholar web search engine was also explored to confirm search terms and key terms used, such as planning, transition of care, continuity of care, and continuum of care, and the combination of those terms with psychiatric acute care, psychiatric hospitals, transitions, care transitions, patient transfer and primary healthcare, confidentiality, and family. From this search two articles were retrieved, one of which was used for the background and context for this paper and the other for the purposes of review. The terms mental illness and mental health were used for searching government websites, such as British Columbia Ministry of Health and Mental Health Commission of Canada and a nongovernment organization website, the Canadian Psychiatric Association.

The titles of the articles produced from the database, electronic journals, and internet sources were scanned, and each article was examined for potential relevancy within the title, based on keywords and MeSH terms. If the papers did not contain the appropriate terms or relevant subject, they were eliminated. The scan of article titles produced from the databases, journals, and internet sources resulted in the elimination of 3789 articles at this stage, leaving the remaining 380 articles for further sorting.

Stage Two: Screening Abstracts and Hand Searching

Stage two of the search strategy involved filtering the retrieved articles from the databases by reviewing the abstracts and skimming the body of the articles. In addition, the reference lists of the applicable articles were scanned for seminal articles and additional literature sources to ensure data saturation. The screening process used in stages one and two was also applied to the articles located from the reference lists. To eliminate and further refine the results the inclusion and exclusion criteria, as shown in Table 1, were applied at this stage. Articles were included if they were in English, relevant to adults (18 years of age and older) with mental illness, relevant to care transitions and all other terms listed in Table 1 under inclusion criteria. Articles that discussed transitions that were made because of age, such as transitioning from pediatric and adolescent care to adult, were excluded. Two hundred and thirty articles were eliminated in this stage and 140 were amassed for the final review.

Table 1: *Inclusion and Exclusion Criteria*

Inclusion	Exclusion
English language published between 2002-2014	Published prior to 2002
Adult population aged 18 +	Discharge from long term facility
Severe mental illness	Study population samples limited to children
Articles addressing: transitions of care, discharge, discharge planning, acute psychiatric care to community or primary care/primary healthcare, patient confidentiality, family, primary care/ primary healthcare, nurse practitioners	Adolescents (<18) or elderly with exclusively organic mental disorders (dementia or Alzheimer's disease) Published in a language other than English

Stage Three: Extensive Review for Importance and Relevance

The 140 potentially relevant articles identified in stage two were examined for relevance. The abstracts were re-read and whole papers were read in some detail to assess the quality of the evidence and relevance to the research question. The textbook by LoBiondo-Wood, Haber, Cameron, & Singh (2013), the article by Cronin et al. (2008), and the guidelines, illustrated in Appendix E and Appendix F, were utilized to guide the critical appraisal process. This process resulted in the elimination of 123 articles, and the selection of a final number of 17 pertinent articles. Appendix B presents the level of evidence for each article, which is defined in Appendix A. The final 17 articles were thoroughly read and were used to analyze practices and processes that may achieve seamless transitions and continuity of care for mentally ill adults discharged from acute psychiatric care to primary care.

All searches were conducted between 2013 and 2014. An analysis and summary of the findings from the selected articles follow

CHAPTER 4

Findings

This integrative literature review seeks to examine evidence-based practices and processes that help to achieve seamless transitions of care for adults with SMI discharged from acute psychiatric care to primary care. From the analysis of the key articles four major themes were identified: confidentiality, communication, linkages between acute and primary care, and therapeutic relationships. Barriers to care transitions that were identified in the background of this paper are reflected in the major themes from the literature review, however, therapeutic relationships emerged as a new theme in the findings. These themes organize the presentation of findings and guide the discussion. Due to the scope and size of this project the findings from the selected articles are examined within the context of the Family Nurse Practitioner practicing in primary care, and relevance to adults discharged from acute psychiatric care to primary care. The need for changes to healthcare systems and policies surfaced in the literature. These findings will be discussed briefly because of their importance, however, the system and policy level is outside the scope of this project.

Confidentiality

Confidentiality concerns and misconceptions regarding family involvement by healthcare professionals serve as barriers to effective care transitions and continuity of care (Solomon, 2012). Healthcare professionals vary in their understanding and practice regarding confidentiality and its application with family (Mood Disorders Association of British Columbia, 2008). As previously explored, families are playing an increasing role in providing care for an adult family member with SMI. However, the literature identified that care providers are not adequately recognizing and involving families in the patient's care. Continuity of care for patients with SMI may be negatively affected by this lack of recognition. Five studies identified problems associated with privacy and confidentiality policies, laws, or practice and offer recommendations for improvements. An analysis of these studies follows. Although four of the five studies are not specific to Canada, the findings are applicable within the Canadian context as issues privacy and confidentiality are well documented throughout the broader literature within Canada, and internationally.

A descriptive exploratory study from Philadelphia (Solomon, Molinaro, Mannion, & Cantwell, 2012) involved two components. The first part of the study involved assessing care providers' and administrators' knowledge of confidentially and information sharing with families of people with SMI. The second part of the study was the development of a pilot training program and evaluation, which was based on the findings of the first part of the study.

The first part of the study was a survey composed of a nine-item measure of beliefs and knowledge about families. Two of the questions on the survey were directly related to confidentiality and information sharing with families. The results showed that 40 - 42% of the care providers and administrators surveyed believed that they could not direct families to support resources or listen to information from them about their family member with SMI. These results were troubling as families may have significant information necessary for the care or safety of the patient. Based on these findings, the authors developed the training program as the second part of this study.

Twenty-four case managers participated in the training program that was designed to provide information on confidentiality policies and legislation related to information sharing with families. The program discussed family confidentiality policies within the agency and ten scenarios were created for comment and discussion. A pre-test was administered prior to this discussion. The same test was used following the training to evaluate the program's success.

It was found that the training program initially improved case manager understanding and knowledge, however, re-testing one year later, with the same test used in the pre and post-test, identified that participants had not retained the information. Recommendations included additional education for healthcare providers in matters of privacy and confidentiality, and improved processes for monitoring the effectiveness of training. The authors identified that education alone does not contribute to improvements in communication between families, patients, and care providers. They acknowledged that one reason staff had poor knowledge retention was due to the fact that staff disagreed with the information provided. The authors suggested that miscommunication, insufficient discussions, or lack of trusting relationships between staff and managers may have weakened the effectiveness of training. They acknowledged that more research was needed in this area. An important point raised by the authors was that one time education is not enough to sustain a change in practice. Continuing education and established processes to determine whether the knowledge is translated into practice is important for the involvement of families in the treatment and recovery of family members with severe mental illness.

The study participants were from a wide variety of work and educational backgrounds, increasing the generalizability of the results. Further, the authors piloted the survey in an effort to identify redundant survey questions. The authors did identify that more research is needed to understand why staff disagreed with the training regarding information sharing. This may be a critical aspect to enhancing communication between care providers and families. However, in the survey administered in the first part of the study, the authors mentioned that some survey questions addressed care providers' attitudes towards families of people with SMI. For example, if poor parenting caused mental illness. The authors did not include the results of the survey regarding care providers' attitudes towards families and these results may hold valuable information regarding why care providers are reluctant to share information with families. Increased communication between care providers and families, as well as improving information sharing, may contribute to a more seamless transition of care for people with SMI.

A qualitative study from the UK (Gray, Robinson, Seddon, & Roberts, 2008) used reflexive storytelling and semi-structured interviews ($N = 65$) with staff members, including primary care providers, managers, senior leaders, service developers, social workers, and general practitioners in mental health, to examine confidentiality misconceptions that created barriers for families to obtain information about their family member with SMI. The interviews identified that participants were uncertain about information they could share with families. They also indicated that many of the participants did not take the families' rights to basic information into account to help them care for their mentally ill family member. The study found that healthcare providers reported frequently using confidentiality as a justification to withhold information from a patient's family to avoid intermediating and negotiating confidentiality barriers and information sharing with families. In this study, ambiguity around policy and families' role in patient care led to the identification of a need for care provider training on confidentiality and family, including family rights and assessment of the family and their needs to support the individual with SMI. The authors identified that primary care providers were vital in identifying and assessing families in order to meet their needs for relevant information, and to address feelings of isolation, guilt, stigma, and failure. In examples of good practice, primary care providers acted as intermediaries between patients and families, promoting better understanding and information sharing. This study found that primary care providers need to identify the family as a part of the patient's care. The authors found that examples of good practice included: the provision of information sharing about medications and side effects; advanced care planning when the patient was well, so they can specify their preferences for treatment and information sharing; directing families to support groups, which promoted peer support and coping strategies; and assessing families and raising awareness about families.

The study represented care providers from various settings, in both rural and urban communities. However, the authors did not identify how many of the 65 participants were sampled from each setting. The authors identified that within the semi-structured interviews, they attempted to ensure ample opportunities for respondents to identify key issues and topics, as well as discuss their concerns. This was done to allow participants to tell their stories, both good and bad, and reflect on the impact for families and patients with SMI. The authors did not identify their potential biases or influences within the questions and how this may have been addressed. They also did not identify if they had encountered any need to change the research design to eliminate potential biases. They did provide sound suggestions for further research based on their findings. Overall, this study offers important findings to promote collaboration between families and healthcare providers that will foster a more seamless transition of care. Of particular importance in this study is the finding that primary care providers should perform an assessment of the family's needs.

The Canadian Parliament Senate Standing Committee on Social Affairs, Science, and Technology (2006) inquired into the issues of privacy and confidentiality in their report on transforming mental health and mental illness and addiction services in Canada. The report contained personal accounts from patients and families living with mental illness in Canada.

These accounts were collected via online submissions and public hearings in each province and territory. However, the number of accounts specific to privacy and confidentiality were not clearly stated in the report. The data suggested that families did not need information about the confidential discussions between healthcare providers and their loved ones, however, they needed to know such things as the diagnosis, care plan, medications, and safety issues so that they could continue to provide the best support. The Committee concluded that healthcare providers did not try hard enough to obtain consent from patients for sharing information with family. Further, they identified that overly strict adherence to privacy policies can be detrimental to a seamless transition and continuity of care. The Committee was not convinced that existing laws pertaining to the right to privacy for people with SMI are ineffective. Instead the committee recommended that a transformation of the mental healthcare system is needed

The opinions presented in this report may be critical to creating seamless transition of care from acute to primary care. The recommendation that healthcare professionals place greater emphasis on obtaining consent from patients for information sharing with families is important to enhancing care for patients with SMI. The report supported information sharing with families, but there were conflicting opinions from some members of the mental healthcare community. For example, a coordinator from a mental health program in Vancouver, BC believed that adults with SMI should be treated completely independent of the family, despite their involvement. The fact that there are still key members of the mental healthcare community that do not recognize families in the care of patients with SMI is consistent with other literature that suggests that there are inconsistencies in care providers' knowledge and understanding in this area. This may be critical to understanding how to best address misconceptions in an effort to create seamless transitions of care.

The final two studies related to confidentiality utilized the grounded theory approach to explore the perspectives of families and care providers related to information sharing. A notable strength of this method is the systematic and rigorous process used in obtaining rich data and diverse perspectives.

The first, a well-designed study from Australia involved semi-structured interviews of family members (*N* = 27) caring for an adult son or daughter with SMI. The study's purpose was to report on the problems families experience as a result of patient confidentiality (Wynaden & Orb, 2005). The findings were consistent with those in other literature. They indicated that, in spite of guidelines recommending family involvement in all aspects of the treatment process, confusion around confidentiality issues impede collaboration between healthcare providers, families, and patients. The study found that when uncertainty occurred, healthcare providers usually chose to withhold all information about the ill family member. Wynaden & Orb reported that a close examination of confidentially issues was required to better promote families in the support of the patient in order to create seamless transitions of care. The authors concluded that increased collaboration between families, patients, and healthcare providers will further the expansion of community mental healthcare. This finding may be an important factor in attempting to create seamless transitions of care from acute psychiatric care to community care and improve patient outcomes.

The authors identified that the main theme from the interviews was "being excluded because of patient confidentiality" (p. 168). The theme was reflected in the example narratives from the families and met the purpose of the study, which was to identify problems families encounter on a regular basis due to confidentiality. The authors reported that 11 of the 27 participants were called back to clarify and expand on data obtained during their initial interview, an indicator of a thorough approach. The authors did not offer information on their own potential biases. However, they did explain that they used open-ended questions that became more focused throughout the interview.

The narratives from families in this study underlined the importance of family involvement and identified gaps in care transitions. For example, one narrative described how the family care giver was unaware of the plans for discharge of their family member with SMI. This negatively affected the patient's continuity of care. Along with other narratives in the study, this experience aligns with the case example of Stephen. The experiences in the study further support the idea that family involvement may be critical to safeguarding transitions of care.

The second study (Chen, 2008), from the USA, explored how community mental healthcare providers share information with their patients' families. As part of a larger research project, 24 case managers were interviewed about practices and strategies used to facilitate collaboration with families. Results indicated that case managers would accept patient related information from families to promote stabilization of the patient, rather than help families provide care. The managers had trouble balancing adherence to confidentiality guidelines and the patients' best interests, which became more complex when patients would not consent to the inclusion of their family. Chen explored that within western society individualism is highly valued and information is a personal possession. The author further explored that confidentiality laws in the US promote this possessiveness of information. Chen recommended that it would be helpful to enhance confidentiality laws to improve the exchange of pertinent patient information.

Chen's (2008) study method was clear and thoroughly explained, including a description of how study participants were selected. Although no exclusion criteria was listed, detailed information was given regarding the participants selected including age, race, gender, field of study/work, and years of experience. Chen did not identify personal biases that may have skewed the results, however, clear descriptions of interview methods and question examples were included. The analysis of the data was completed by individuals from Australia, Taiwan, and the USA from a variety of backgrounds, enhancing the validity of the data. The article had an in-depth description of the analysis process and Chen actively reflected on assumptions during the analysis in an effort to address potential biases.

Chen's findings are similar to other studies that have identified that some healthcare providers are not willing to share information with families to help them provide care for their family member with SMI. The author's recommendations of enhanced regulations for healthcare providers to incorporate the release of information, as well as the receipt of information, may be an important aspect in creating seamless transitions of care for people with SMI.

Linkages between Acute Care and Primary Care

The role of acute psychiatric care is now primarily centered on crisis stabilization and rapid discharge (Sharfstein, 2009). Hospitals now play a more limited role within a community-based system of care (Sharfstein). The need for connection between primary care and acute care becomes integral in the patient's transitions between these services.

Linking with primary care is the subject of the following five studies, four from the USA and one from Canada. Each of the articles focused on linking patients with SMI to either new or existing primary care providers following discharge from acute psychiatric care.

The Canadian quantitative study by Dewa, Tugg, Stergiopoulos, Ghavam-Rassoul, and deRuiter (2012) examined the characteristics of patients with SMI without a regular primary care provider, prior to admission to acute psychiatric care. Patients were surveyed during their inpatient hospitalization and again after receiving care by a primary care provider after discharge from an acute psychiatric unit. Data from participants (*N* = 112) from a 33-bed psychiatric inpatient unit and a crisis services center, in a hospital in Toronto, were obtained using several different instruments. The SF-36 Health instrument measured physical and mental health status, and the Alcohol Use Disorders Identification (AUDIT) and CAGE- AID instrument were used to identify drug and alcohol use problems. A logistic regression analysis was used to identify factors associated with continuity of care between discharge and a primary care visit. The authors found that symptoms associated with SMI, such as poorer insight, mistrust of healthcare providers, and difficulties with memory and executive functions were barriers to continuity of care after discharge. They further identified that patients admitted to acute care psychiatric wards without a primary care provider tended to be younger and in better physical health. This suggested that they may have had less opportunity to become familiar with the healthcare system. Dewa et al. identified that the lack of availability of primary care providers and the overwhelming waitlists were a predictor of continuity of care. However, they concluded by acknowledging that removing barriers to healthcare system access is not a guarantee that patients will utilize the resources, rather that the illness-related symptoms and the vulnerability of patients with SMI must be addressed.

The authors set clear goals, utilized appropriate methodology, had clear inclusion and exclusion criteria, there was an in-depth description of the analysis, and there was a clear presentation of the findings and a list of the study's limitations, including a relatively modest sample size. The results of their findings did highlight some predictors of follow up with primary care providers; however, the most important finding of this study, that illness related symptoms were a barrier to accessing primary care, was minimally discussed. The authors made no suggestions on how to manage this, nor did they offer recommendations for research in this area.

The study suggested in settings where primary care is the first point of access, illness related symptoms interrupting continuity of care is particularly problematic. This may be a crucial area to explore in attempting to create seamless transition of care from an acute care admission to primary care.

In a small pilot study, Batscha, McDevitt, Weiden, and Dancy (2011) explored the feasibility of using an Advanced Practice Nurse (APN) to link patients with SMI to their first appointment post discharge. Patients (*n* = 15), aged 19 to 53, referred by the inpatient treatment team, were interviewed to determine barriers to attendance at the first appointment. The results showed that facilitated interventions, such as appointment reminders, and the APN meeting the patient at their first appointment after discharge were practical approaches to linking the transition from acute care to outpatient care. In this study, patients identified four relevant areas they felt were important to discuss with outpatient clinicians: medications, problems or symptoms associated with hospitalization, patient-provider relationships issues, and treatment preferences. The intervention of meeting the patient prior to discharge showed no effect on attendance. It is noteworthy that the three patients with no previous experience with the clinic were the least likely to attend the first appointment ($p = 0.024$). In addition, age, gender, race, were not associated with attendance to the first outpatient appointment. A lack of experience with the outpatient clinic was found to be an important factor in attending the first outpatient appointment.

The authors acknowledged that this study is limited due to its small sample size, however, they suggested that it is feasible to conduct inexpensive interventions to help narrow the gap between discharge from an inpatient unit to the first outpatient appointment. One intervention the authors suggested is physically accompanying patients to the clinic in an effort to overcome unfamiliarity with the environment.

Due to the limited size of the study, it is difficult to determine whether the interventions used in the study were positive predictors of attending a first outpatient appointment. The conclusion about the lack of experience with the outpatient clinic seems to be prematurely drawn, despite a high predictive value assigned to it, as two of the three patients who did not attend their first follow up appointment were re-hospitalized prior to their appointment. Despite this, the conclusions presented within the study may be valid and require more research to identify whether or not interventions, such as accompanying patients to outpatient appointments, could increase attendance at first appointment post discharge, helping to facilitate seamless transition of care. It is important to note, that the use of an advanced practice nurse to link patients to outpatient clinics may not be cost effective or feasible in the current Canadian system.

The mixed-methods study from the USA of Griswold et al. (2008) was the follow-up of a preliminary study from 2005. The 2008 study involved a randomized controlled trial (RCT) to investigate the effectiveness of care managers in connecting patients ($N = 175$) to primary care after a psychiatric crisis, and a qualitative inquiry to gain patients' insights about access to psychiatric or primary care. The researchers hypothesized that, in contrast to care provided at a psychiatric emergency department, case management would result in higher rates of connection to primary care. They were of the opinion that patients emerging from a psychiatric crisis face unique challenges connecting with a primary care provider and require more than simply the name or location of a provider. Furthermore, they suggested that the point of discharge is an opportune time to initiate linkages between medical and psychiatric services, safeguarding continuity of care in both (Griswold et al., 2005).

Participants seeking care in the psychiatric emergency department were randomly assigned to an intervention group with care managers or a control group. The physical health problems were comparable in both groups. Semi-structured interviews from 28 participants in each group were conducted at baseline and again one year later (*N* = 112) to assess participants' healthcare experiences. Qualitative and quantitative data were analyzed separately. The qualitative data was entered into NVivo 2.0 for management and analysis and examined by a multidisciplinary team of five researchers trained in qualitative analysis; trustworthiness of the analysis was strengthened by the diversity of team members, one of whom was a nurse practitioner.

Griswold et al.'s (2008) study showed that care managers and case based interventions had a positive influence on attendance at primary care following a psychiatric crisis. Such interventions included assistance with scheduling and attending appointments, navigating travel mode and routes to appointments, and reinforcement of information provided by the primary care provider. However, the qualifications of the care managers were not made clear. This study identified that established connections with a primary care provider offering collaborative and continuous care are important; patients acknowledged the importance of good communication and sensitivity and respect between themselves and their healthcare providers. They also acknowledged personal challenges in obtaining or accepting care. The qualitative analysis supports quantitative findings, that care management is effective for helping patients access primary care after a psychiatric crisis.

The study described patients' negative care experiences that stemmed from issues as a result of a lack of health insurance. This would not be applicable in Canada's publicly funded healthcare system. This was a well done comprehensive study that employed the rigorous research method of the RCT to determine the relationship between the interventions carried out by a care manager and their outcomes. The research design elicited real-life contextual understandings adding insight from patients, and is useful in identifying helpful strategies for safe transitions and continuity of care following a psychiatric crisis. It is important to note that these results are applicable within the Canadian context, where primary care is often the main point of access for people with SMI.

El-Mallakh et al. (2004) reported that the most important predictor in early re-hospitalization following discharge from a primary psychiatric facility is failing to attend the first outpatient appointment. In this retrospective study of psychiatric inpatient records ($N = 81$) from an acute psychiatric unit in the USA, the authors identified that there may be additional factors associated with aftercare compliance for individuals with SMI. They found that ongoing care with an outpatient clinic was a major influence in avoiding an acute psychiatric admission. In this study, system responsiveness was partially controlled by ensuring that, prior to discharge, patients had a follow-up appointment within two weeks of discharge. El-Mallakh et al. noted that the type of service area of the follow up appointment played no factor in compliance and that patients without insurance were the least likely to attend the follow-up appointment. The authors did note that involvement with an outpatient clinic prior to hospitalization was a positive predictor to keeping the outpatient appointment. They observed that this may be related to established therapeutic relationships. The study concluded that follow-up rates remained suboptimal, even with secured appointments prior to discharge, and that further research is needed to explore community variables.

The finding of this study, that patients without insurance were least likely to attend follow-up appointments, would not be applicable to Canada's publicly funded system. Even though the rates of follow-up in this study remained sub-optimal, despite the trialed intervention, other important findings, such as involvement with an outpatient clinic prior to hospitalization, may be useful in attempting improve care transition following discharge from acute psychiatric care. The authors attributed the follow-up success to established therapeutic relationships. If therapeutic relationships have an effect on linking a patient from acute care to primary care, other interventions centered on therapeutic relationships may be beneficial to help create a seamless transition of care.

Communication

Challenges with information sharing and communication between healthcare professionals and care settings are common barriers to effective care transitions (Chong et al., 2013). Poor communication and incomplete transmission of patient information are factors that contribute to ineffective care transitions (Naylor & Keating, 2008). Further, a lack of communication between acute care and primary care is a significant factor that is correlated to poor care transitions (Brimmer, 2012). Along with this, the literature identified that barriers to providing care to an adult family member with SMI are further complicated by poor communication between healthcare providers and families (Rowe, 2012).

Five of the studies selected addressed matters of communication and information transfer that are barriers to effective care transitions. Further, they provide recommendations for improvement. Two of the studies were not specific to the mental healthcare system, but they investigated issues of care transition between acute and primary care in general; these considerations are relevant to the purpose of this paper.

A systematic review of relevant literature ($N = 73$) by researchers Kripalani et al. (2007) was carried out to describe the prevalence of poor communication and information transfer at hospital discharge in order to identify interventions to improve the process. The studies encompassed a wide range of geographical settings. This review was based on the concern that, upon hospital discharge, delayed or inaccurate communication between hospital-based care providers and primary care providers adversely affected continuity of care. Two types of studies were reviewed: observational studies ($n = 55$) that investigated communication and information transfer at discharge, and controlled studies ($n = 18$) that evaluated the efficacy of improvement interventions. Results showed that delays and omissions in communication were consistent across the studies and reflected the majority of medical practices in the USA. The findings showed that only 3% of primary care providers reported being involved in the discharge discussions, and 17 to 20 % of primary care providers reported consistent notification of discharges. The availability of a discharge summary at the first post discharge visit was low (12%-34%), with modest improvements at four weeks (51%-77%). Discharge summaries were identified as the most common means of communication between inpatient and outpatient providers, but it was identified that they often lacked important information. The study recommended standardized formats that capture the most pertinent information to improve the quality of summaries. Further, interventions such as computer-generated discharge summaries, standardized discharge forms, and using patients as couriers would improve the delivery time of discharge information. The authors suggested that a combined approach of technology and paper based solutions may help to overcome delays in communication.

Despite the fact the review was not specific to mental health services, the results are convincing and relevant to this project based on the view that deficits in communication are common findings of healthcare providers. The review was based upon practices within the USA. This is applicable within the Canadian context where care is provided within the primary care setting and care is transferred to specialists when appropriate, for example admission to acute psychiatric facility. Many issues with communication, as described in the review, were parallel to those in the case example of Stephen. The observational studies selected for the review had a vast date range from 1970-2005. The older studies may not have accurately reflected the current issues of information transfer as healthcare practices and processes have advanced significantly over the years. Overall, the review was well done and presented many key findings and interventions that may be important in creating seamless transition of care for patients with SMI.

The qualitative research of Johnson et al. (2012) included focus group interviews with clinical teams involved with care transitions in six countries, the USA, Poland, Sweden, Italy, Spain, and the Netherlands. The purpose of the study was to demonstrate how process mapping can be utilized to improve transitions from acute to primary care by identifying barriers and facilitators of care. The research was based on the assumption that safe patient transitions depend on effective communication and effective care coordination. The study design allowed participants to refine and reflect on their experiences in real time, limiting recall error. The results were comparable across all sites and the geographical areas studied increases the generalizability of the findings.

Several notable facilitators to communication surfaced during the mapping processes. These included effective communication between care providers regarding preferred method of contact, utilization of families as resources, and full integration of electronic resources across care sites. The authors concluded that the findings from the six sites confirmed that there was a breakdown in communication between hospital physicians and primary care providers. Further, they highlighted some opportunities for improved communication and co-ordination of patient transitions. They identified that process mapping was an important approach in understanding the clinical process in the transition of patients from acute care to primary care providers.

The results of the study showed that process mapping was an effective method to identifying barriers and facilitators in care transitions. Although the study was performed within the USA and six European countries and practices may differ from Canada, the use of process mapping was effective across all sites. This suggests that the technique could be applied in Canada. Facilitators that were identified across the sites, including using families as resources, could be applied to mental health services. Utilizing families as resources to facilitate transitions from acute to primary care resonates with findings from other literature, as explored under confidentiality in this project. One limitation to the study was that it did not include a description of how the data was analyzed.

An Australian qualitative study by Wood et al. (2009) sought to develop and test a standardized communication strategy for improving communication between acute care and community practitioners. One 86 bed private hospital and one not-for-profit mental health hospital were the focus of the study. The study investigated incongruent discharge and communication practices between acute care and community practitioners. A plan-do-study-act (PDSA) cycle, conducted in three stages, was used to develop a standardized discharge process and outcome assessment strategies. The researchers used written surveys to obtain community practitioners' opinions on discharge and documentation processes; telephone surveys were used to measure patient satisfaction regarding discharge. The results showed that standardized clinical handover strategies improved the rates of primary care provider and patient satisfaction. In addition, a notable improvement occurred with the number of discharge summaries faxed to the primary care provider within 48 hours of discharge, and an increase in patient follow-up calls 7-

14 days post discharge. The authors identified that a coordinated approach focusing on community-based care is critical in mental healthcare. They concluded that this study demonstrated that standardized clinical handover strategies can be beneficial in facilitating communication.

Results from private care facilities may not be applicable to Canada's publicly funded and not-for-profit health delivery system because of variances in care delivery models and resources. However, the findings from this study are relevant to identifying improvements in the transition of care for mental health patients to primary care in the Canadian context. This is due to the fact that, within Canadian mental healthcare, there is a transition from care under psychiatrists in acute hospitalizations to primary care providers in the community. In addition, the case example of Stephen highlights that, in the Canadian context, there were issues in the discharge process and a lack of timely information handover to a primary care physician. Wood et al.'s (2009) study presented many important intervention suggestions, including ensuring discharge summaries are faxed to primary care providers within 48-72 hours of discharge, which may be helpful in attempting to create a seamless transition of care for patients with SMI.

The New Zealand quantitative study undertaken by Cleary, Freeman, Hunt, & Walter, (2005) was a well-designed study used to obtain baseline data on the extent of family involvement in the support of a person with SMI. They wanted to examine patient and family perspectives on discharge planning and community care, and to identify information and resources they considered important. The basis of this study was that the shift away from acute hospital care results in greater responsibility on the patients' families. At the time of this research, the authors had noted that few studies existed on family involvement or the differing perceptions of patients and families regarding information and resource needs. The length of acute care admissions had decreased while the level of patient acuity had increased, resulting in greater demands on available resources. Face-to-face interviews of inpatients ($n = 207$) and outpatients ($n = 200$), and surveys of identified families ($n = 50$) of inpatients ($n = 26$) and outpatients ($n = 24$) were conducted and analyzed using the Statistical Package for Social Sciences (SPSS) V 10. The family response rates to the surveys were low, but this was accounted for by the researchers. The results showed that a better understanding of the expectations of patients and families was needed to identify information and resources both groups considered important. Communication challenges between patients and their families were found to be barriers to the provision of adequate information to both. The researchers found that both patients and families wanted clearly communicated individually tailored information that included what to do when patient was unwell, medications and their side effects, and information on available resources. In contrast, families placed greater emphasis on attending discharge planning sessions, meeting case managers before discharge, and receiving written information about discharge arrangements and care plans. The authors concluded that responding to the information needs of both patients and families has the potential to improve the quality of the outcomes of mental health services.

Other studies under this section were more focused on communication between acute care and primary care in the discharge transition process. However, Cleary et al. (2005) highlighted what information families and patients deemed important in the discharge process. This study presented important findings regarding information needs for both patients and families. The results of the study provided beneficial insight into incorporating families into the care of patients with SMI in an effort to create seamless transitions of care. The findings of the study align with the literature, discussed under confidentiality in this project, that families need information about resources, medications and side effects, and discharge plans for patients. The study had limited response rates from families, in comparison to the patient response rates. The study relied on patients to identify family involved in their care. It is important to note that patients may not have recognized families as involved in their care, despite active family involvement. Therefore, the families identified were those who were considered by the patient as involved in their care, and not reflective of the families who may have been actively involved in a patient's care, but whose role was not acknowledged by the patient. This is an important dynamic to consider in the care of patients with SMI.

The study by Rose, Gerson, and Carbo (2007) reported on the results of a transitional care intervention conducted in a large urban medical center in the USA. The goal of the interventions in the study was to address the discontinuity of care in existing programs in an effort to meet immediate post discharge needs of severely mentally ill persons. The interventions were based on the transitional care intervention model (TCM) of care developed and tested in previous successful clinical trials and then refined and applied to high-risk patient groups. This model has been successful in reducing hospital lengths of stay, and in preventing re-hospitalizations. The study participants ($N = 4$) were African American. Of note, the African American population was not specifically targeted for the study, but the inpatient unit where the research took place served a mostly African American population. A Patient Assessment and Intervention Form tracked interventions and goals for each nurse-client and family interaction. The authors reviewed the nurse's notes with the nurse weekly during the study, and critiqued them for biases and unsubstantiated conclusions in order to provide credibility to the findings.

Poor communication among healthcare providers, particularly in the area of family support, was identified as an obstacle to seamless transition from acute care to outpatient care.

The authors identified four categories as critical targets of interventions in a TCM. They included caregiver concerns and caregiver health status impeding illness management, lack of structure and involvement in daily activities, structural and functional factors affecting adherence, and presence of symptoms at discharge. Recommendations for improvement were not offered, but the development of strong therapeutic relationships were identified as facilitators of successful care transitions, and will be discussed under the following section in this paper.

Rose et al.'s (2007) study sample was small and limited to patients from a single facility. In addition, all the participants within the study were African-American, whose experiences may not be directly transferable to other populations or settings. A major strength of this study was its emphasis on an intervention targeting continuity of care. Similar to the results of the study by El-Mallakh et al. (2004), the positive results of intervention were thought to be related to the establishment of strong therapeutic relationships between care providers and patients. Further, this study also focused on communication with families in their intervention and incorporated them into the care of the patient with SMI. The recognition of family in the care of patients with SMI has been an important finding throughout the literature. In an effort to create seamless transitions of care, interventions such as TCM, and a focus on families, may be crucial to creating a seamless transition of care.

Therapeutic Relationships

The aforementioned study by Rose et al. (2007) identified a correlation between strong therapeutic relationships and effective care transitions. In addition, two qualitative studies, one from the UK and one from Finland, and one mixed method study identified therapeutic relationships as important in effective care transitions and continuity of care. These studies are applicable to the Canadian context of mental healthcare because they take place in countries which are identified as peers to Canada under the OECD (Organization for Economic Cooperation and Development). In view of the significant burden of SMI in most OECD countries, and the variations in financing, healthcare delivery, and outcomes among them, there is potential for cross-country learning and sharing of best practices between OECD members. Most OECD countries are struggling to provide appropriate care for individuals with SMI in the community; however, there is potential for learning best practices among OECD peers (OECD, 2013). Health Canada (2014) advises that it is important to examine where progress has been made in Canada, and around the world, in order to make advancements in patient care and health outcomes.

The first UK study by Nolan, Bradley, and Brimblecombe (2011) sought to ascertain how individuals experienced discharge from acute care services, in order to understand how to improve inpatient care. Semi-structured interviews were completed with patients pre-discharge ($n = 26$) and post-discharge ($n = 18$), and analyzed descriptively and themes were identified from the transcribed interviews. Current literature and consultations with staff from four acute psychiatric wards were utilized to develop the interviews for the data collection. The results showed, that upon discharge from acute care, immediate concerns of patients revolved around social integration such as housing, employment, and establishing and sustaining interpersonal relationships. The authors identified that loneliness, lack of daily structure, and insufficient information regarding available community services are the primary concern of discharged patients. They found that the support and relationships established with other patients and staff were highly valued and the void from the loss of these peer relationships can be detrimental to patients' well-being. They concluded that transition from acute care to home needs to place greater emphasis on helping patients with SMI cope with everyday life. Further, the study emphasized the importance of making the inpatient experience equally about focusing on life following discharge as addressing the reasons for admission.

The study had several limitations that the authors did not note. The sample size was relatively small considering that the study took place over a nine month period. The description of the analysis of the data and how themes were identified was minimal for qualitative research. In addition, the ward staff were actively involved in the study design, interview design and content, and the selection of the participants. There was no discussion as to how potential biases, that may have influenced the study design or selection of participants, were addressed. This may be significant as staff involved in the study may have had close therapeutic relationships with the study participants, which may have skewed the results of the research. Despite the shortcomings in this study, there were several important findings. In an effort to improve the quality of care for patients following discharge, the study suggested that a greater emphasis during an acute care admission needs to be placed on addressing the patients' situation following discharge. For patients with SMI, the effect of losing established therapeutic relationships with staff and patient peers was identified as detrimental. Tailoring discharge planning to address this may be an important consideration in creating seamless transitions from acute to primary care.

A large longitudinal study by Jones et al. (2009) examined continuity of care in mental health services to identify points of care where continuity may be threatened. Transitional experiences, as described in the study, included transition at discharge, transition between care provider teams, and transition to new care providers during reassignment of staff. The perspectives of patients and their families were obtained through theoretical and purposive sampling selected from the larger study to capture the experiences and views of a sub sample of patients (*n* = 31) and their families (*n* = 14). In these populations, care transitions and continuity of care had been problematic. These problems with transition had been identified in the quantitative survey as multiple referrals to care providers, changes in healthcare providers or changes in care needs. Five key themes emerged from the semi-structured interviews of groups, relational discontinuity, depersonalized transitions, invisibility and crisis, communicative gaps, and social vulnerability.

Transitions between care providers were identified as source of stress for patients and their families. Jones et al. (2009) acknowledged that both patients and families identified the importance of the relationship with a care provider. The authors found that although most of the participants had experienced a change in care provider at some point, this transition never became easier for the patients and families. From the survey, the authors identified that positive care transitions occurred when care providers placed a stronger emphasis on personalizing the transition between care providers, and incorporated the transition into the daily life of the patient. They underlined that this personalization plays a key role in well-managed transitions. They emphasized that care providers who suddenly left without sufficient warning undermined any positive experiences that had been established with the mental health services.

As illustrated in the study, care for patients with SMI can continue for years and within that time frame changes in care providers will most likely occur. Incorporating the change in care provider into a patient's life is one way to potentially mitigate the potential negative effect this can have on a patient's life. However, it is inevitable that some changes may need to occur suddenly without warning for the patient. The authors suggested that more research is needed on how to cope with these transitions. Research into managing transitions may be a key element in understanding how to solidify therapeutic relationships for patients with SMI and create seamless transition of care from acute to primary care.

Another important point raised in the study is that services were more centered on crisis situations. Both patients and families reported feeling that services were lacking for those who were not an immediate danger to themselves or others. Patients and families identified that preventive care was lacking and this was a source of frustration. These feelings of frustration with the services may negatively affect the therapeutic relationships established with the care provider and program. This is minimally explored in the study and more research is needed in this area to gain a better understanding of the effect of therapeutic relationships on positive care transitions.

Factors contributing to continuity of care for patients discharged from the acute setting were identified in a qualitative phenomenographic study by Hautla-Jylha, Nikkonen, and Jylha (2005) in Finland. At the time of this study, the authors were of the opinion that no research had been carried out to measure continuity of care in psychiatric services. The purpose of this study was to describe and analyze the participants' perceptions of factors improving continuity of care. The data was collected through interviews of patients (*n* = 5) attending outpatient care in inpatient adult psychiatric wards, ward staff (*n* = 13) and administrative staff (*n* = 5) in the hospital, and staff (*n* = 5) of the outpatient mental health service were studied. Through six phases of analysis, seven categories describing factors improving continuity of care were identified:

> (1) Adherence to a good cooperative relationship; (2) adherence to the care environment; (3) flexibility in tailoring care; (4) active maintenance of contacts in care; (5) constant possibility to contact the ward; (6) up-to-date patient data; and (7) active cooperation between outpatient services and other collaborators achieved through active flexible cooperation between inpatient ward and outpatient services personnel (p.38).

In this study, it was identified that active and flexible cooperation between inpatient wards and outpatient services can improve the continuity of care. In addition, continuity of the care environment was found to improve patients' feelings of security, thereby improving commitment to their care. The authors emphasized the importance of adherence to a good care relationship. Further, the authors underlined the importance of patients being able to contact the ward and 'drop in' without a referral as another factor in improving their commitment to care. The authors concluded adherence to a good cooperative relationship is the foundation for patients' commitment to their care as patients, with good cooperative relationships with staff, are more inclined to seek help when needed.

It is important to note that the study had a small patient sample and no inclusion or exclusion criteria for patients were discussed. The study's participants were mainly staff and the background of the staff was diverse in order to have a broad representation of perspectives. The rationale for the number or type of staff and patients in the study was not discussed.

Hautla-Jylha et al. (2005) noted that a patient's ability to walk in to the inpatient ward for assessment of their mental health status was key for patients with SMI. The authors found that patients had established relationships with the staff members and trusted their assessment of their mental health. The ability to walk into the patient ward for assessment may not be applicable in the current Canadian system, as care is provided for patients with SMI with a different care delivery model. However, a healthcare delivery model where patients are able to walk in to the ward for assessment may be an important consideration in attempting to create seamless transitions of care for patients with SMI in Canada.

The 17 articles analyzed here were selected following a thorough investigation of the literature applicable to a seamless transition and continuity of care of adults with severe mental illness discharged from acute care to primary care. These articles were then reviewed and critically appraised. From the analysis, four themes have emerged as important to seamless transitions of care for individuals with severe mental illness: confidentiality, linkages between acute care and primary care, communication, and therapeutic relationships. Research presented is from a broad range of contexts and it provides important evidence for this paper. Many of the recommendations identified in the literature are feasible within primary care settings. The following section will provide a synthesis of the findings in these articles, as well as recommendations for practice, education, and research for FNP practice in the Canadian context.

CHAPTER 5

Discussion and Conclusion

The aim of this project is to identify evidence based practices and processes, at the level of the FNP practicing in primary care, that help to create seamless transitions and continuity of care for mentally ill adults discharged from acute psychiatric care to primary care. Further, to offer recommendations for practice for Family Nurse Practitioners practicing in primary care in Canada. From this analysis four major themes emerged: confidentiality, linkages between acute and primary care, communication, and therapeutic relationships. It is evident throughout the findings that many of these themes are inter-related. The literature identified that issues surrounding privacy and confidentiality can be major barriers in effective communication; this in turn can affect a patient's transition from acute to primary care. Furthermore, a common thread throughout the literature was that establishing positive therapeutic relationships may impact seamless transitions and continuity of care. The discussion will include the application of these findings and their relevance to clinical practice, and will conclude with key recommendations for practice, education, and research.

Confidentiality

Information sharing between patients, families, and mental healthcare providers has been shown to improve patient outcomes. Although many treatment guidelines recommend family involvement in all aspects of the treatment process, patient confidentiality issues hinder this involvement (Gray et al., 2008; Wynaden & Orb, 2005; Solomon et al., 2012).

The background of this paper identified effective care transitions for individuals with SMI, including the involvement of family. The wider literature related to privacy of personal health information supports the findings from the review, which indicated that many treatment guidelines recommend family involvement in all aspects of the treatment process. However, a lack of clarity in confidentiality policies poses a barrier to family collaboration (Marshall & Solomon, 2004). A common theme in the literature identified that healthcare providers defaulted to withholding information from family when confusion around confidentially surfaced. In addition to this, Solomon et al. (2012) found that healthcare providers would potentially ignore pertinent information sharing from families regarding the patient's well-being.

All of the articles identified that confusion surrounding confidentiality laws, disrupted seamless transition of care. The Canadian Senate (2006) identified that families do not want information about confidential discussions between healthcare providers and patients; however, families need information regarding diagnosis, medications, care plan, and safety issues. In the case of Stephen, his family's chief concerns were centered on the practical side of understanding his condition including plans of care, side effects of medications, management of symptoms, and problems that might be encountered post discharge, including the risk of self-harm. The primary care provider needs to do an assessment of the family to identify their needs for relevant information and provide that information as able, so that the family can care for their family member (Gray et al., 2008). Without such information, family members are unable to support treatment goals and promote the recovery process (Marshall, & Solomon, 2004). Primary care providers are ideally situated to identify the family members who are central to the life of patients and to approach the issue of consent with patients and their families. This review identifies good practice as one that considers family as an integral support for the individual with SMI. Healthcare providers have the opportunity to act as intermediaries between patients and families by negotiating confidentiality barriers and information sharing. This includes discussion with the patient and the family regarding advanced directives or plans for care related to acute episodes and acute care mental health admissions (Gray et al.).

Findings from the wider body of literature support the need for advance directives early on in the care of individuals with SMI (Noble & Douglas, 2004). As noted in the background of this paper, symptoms of SMI can impair capacity to make reasonable decisions about the release of personal health information. Advanced care planning while the patient is stable and has the capacity to consent, will address these situations. Advance care planning in mental health is an emerging and key concept to help guide a patient's care during times of acute illness (Mood Disorders Association of British Columbia, 2008). By incorporating this concept into the care of patients with mental illness, it empowers the individual and allows for them to have a voice in their care and during times of acute illness.

It is important to consider the occasions where there is no prior opportunity to establish an advanced care plan, such as the primary onset of illness or initial encounter, as in Stephen's case. However, the evidence shows that basic information regarding diagnosis, care plan, medications and their side effects, symptom management, and safety issues are essential for families to provide appropriate care and assist with safe transition (Canadian Parliament Senate Standing Committee on Social Affairs, Science and Technology, 2006). This will promote the involvement of families who may have important information related to the history of the presenting illness, and may be involved in caring for the patient (O'Reilly et al., 2010).

Healthcare providers have a responsibility to be familiar with the laws that govern their practice, as well as the policies within their particular organizations (CRNBC, 2010). These articles show a need for responsive confidentiality policies and for healthcare professionals receive education on the application of patient confidentiality to clinical practice (Chen, 2008;

Solomon et al., 2012; Wynaden & Orb, 2005). Solomon et al. further emphasized that education cannot be an isolated event; instead it must be a continuous process that aligns with an effective way to monitor the translation into practice. The Canadian Senate (2006) highlighted that key members of mental healthcare had differing views on the involvement of family in the care of patients with SMI. As identified in the analysis of Solomon et al. an important consideration of implementing education is to understand why healthcare professionals are reluctant to involve families, as biases and misunderstandings may hinder progress in this area. Chen explored how changing laws regarding privacy and confidentially may be required to address the confusion around information sharing between healthcare providers, patients, and families. However, The Canadian Senate reported that enhancing the laws may not be the answer; instead, transformation of the Canadian mental health system as a whole is needed. Consideration of both findings may be required to overcome barriers of information sharing between patients, families, and healthcare providers.

Linkages between Acute Care and Primary Care

The literature recognized that the period of transition from acute to primary care is a high-risk time for individuals with SMI. It emphasized that continuity of care is crucial, and identified successful connection to primary care as an important factor in the comprehensive care of an individual with severe mental illness. Patients with SMI suffer excess morbidity and mortality, and compared with the general population, they are more likely to have concomitant medical problems, such as diabetes and hypertension (Kaufman, McDonnell, Cristofalo, & Ries, 2012). Furthermore, changing trends in healthcare delivery have resulted in a movement from hospital care towards community care, with the majority of psychiatric care now being provided in the primary care setting (Russell et al., 2003). The discharge process from acute care should be considered in the context of the pre-admission, admission, treatment, discharge, and post-discharge continuum (Russell et al., 2013). Continuity of care is crucial during transition from hospital to community. The transition between acute and primary care allows for an opportunity to initiate relationships between healthcare providers, and therefore bridge the gap in the continuum of care (Griwsold et al., 2008).

Patients requiring follow-up care face a unique set of challenges in connecting to primary care. Often the discharging provider simply gives the patient the name of a primary care provider or clinic. This is not helpful for a patient emerging from a psychiatric crisis when further support is needed (Griswold et al., 2005; Griswold et al., 2008). The literature identified several suggestions to help link patients to primary care providers following discharge from an acute psychiatric admission. Batscha et al. (2011) suggested that physically accompanying patients to their initial primary care provider appointment may be a way to ensure follow-up and assist in transition. However, this intervention could be costly and put great demands on already limited resources. The literature also identified pre-arranged appointments prior to discharge as an effective method to ensuring a smooth transition between acute and primary care (El-Mallakh et al., 2004; Griswold et al., 2008).

El-Mallakh et al. noted an emphasis on ensuring patients are connected with the primary care clinic prior to hospitalization. They identified that if patients do not have a usual source of care prior to an acute psychiatric admission, they remain at risk for discontinuity of care following discharge. In situations where patients have no primary care provider prior to acute psychiatric admission, connecting patients with a primary care provider during hospitalization has the potential to create continuity of care. Involvement with the primary care provider prior to, or during, admission to acute psychiatric care was noted in several studies to be positively correlated with established therapeutic relationships. Dewa et al. (2012) noted that reducing barriers to accessing primary care, such as waitlists, were important to facilitate transition from acute care to primary care. However, they emphasized addressing these barriers may not improve the transition and that the vulnerability and illness related symptoms of patients with SMI need to be addressed in order to create a seamless transition of care.

Patients are more likely to attend their appointments when accompanied by a case manager or an advanced practice nurse (Batscha et al., 2011; Griswold, et al., 2008). Conversely, the increased pressure to manage costs in healthcare needs to be a consideration when determining an appropriate care provider to help patients navigate the mental healthcare system (Cleary et al., 2005). The most appropriate and cost effective care provider should be appointed to helping patients navigate the system. However, it is noteworthy that a primary care provider, or advanced practice nurse, may not be the most cost effective care provider. Mental health workers or care aides may be more cost effective in this role, however, more research is needed in this area.

Another important consideration in addressing demands on the healthcare system is recognizing families. The broader literature identified that families are major sources of support for people with SMI, and often provide housing, assistance with activities of daily living, finances, and ongoing support (Macfarlane, 2011). In this context, families who are willing to be actively involved in patients' care should be acknowledged and their support and assistance appropriately utilized. Therefore, when addressing the issue of linking acute to primary care, consideration of sharing information with family needs to be a priority.

There were inconsistencies in the literature around post discharge follow-up. Wood et al. (2009) identified follow-up calls from primary care providers within 7-14 days post discharge were acceptable. El-Mallakh et al. (2004) aimed for appointments within two weeks of discharge. The wider literature states that the first week of discharge has a heightened risk of suicide (Canadian Mental Health Association [CMHA], 2013). Upon reviewing the literature it is clear that there is no consistent standard of care when discharge follow-up needs to occur. Stephen's suicide occurred within a week of discharge. After his death, it was discovered that an appointment with outpatient services was scheduled within the first week of his discharge. Despite the seemingly appropriate time frame of the first appointment for follow-up, no evident plan was in place to ensure his attendance at this appointment.

In addition to advanced care planning for acute psychiatric admissions, discharge planning should be initiated at the time of admission to determine the patient's plans of care and the support that the patient and his or her family may require after discharge, including connection with primary care post discharge to facilitate transition (Alghzawi, 2012). Current literature indicates that healthcare services often function in isolation, widening the communication gap and narrowing the likelihood of assigning responsibility when problems arise (Coleman & Berensen, 2004). Therefore, primary care providers, such as Family Nurse Practitioners, need to collaborate with acute care providers to establish expectations of each service in the discharge plan and follow-up. Families also need to be active partners in the discharge process. These approaches to family involvement and linking the patient to primary care providers prior to discharge are key in facilitating seamless transition to primary care. However, without effective communication between acute and primary care, endeavors to link newly discharged patients to primary care will be compromised.

Communication

Effective care transitions are fraught with challenges in information sharing and communication between healthcare providers and care settings, owing largely to inadequate systems for reliably delivering information between providers (Chong et al., 2013). The important finding of Kripalani et al. (2007) was that direct communication between acute and primary care providers occurs infrequently. Primary care providers identified that patient discharge summaries were the most common means of communication between inpatient and outpatient providers. Kripalani et al. noted that the availability of a discharge summary at the first post discharge visit was low and it often lacked important information. The case example of Stephen also reflects a troubling delay and a lack of communication between specialty care services and the primary care provider. Such a lapse in communication fails to meet patients' expectation that their information will be used in a consistent way among all of their care providers (Hogg et al., 2008).

The literature identified clarification of primary care providers' contact information and preferences for mode of contact to be an important and practical strategy to improve communication (Johnson et al., 2012). Progressive strategies, such as computer-generated summaries, integrated across care sites can facilitate more timely transfer of relevant patient information to primary care providers. Further, it will make discharge summaries more readily available during follow-up care (Johnson et al.; Kripalani et al., 2007). Wood et al. (2009) did not focus on specific modes of information transmission, rather they emphasized the importance of a standardized clinical handover process. Until there is full integration of such strategies, using patients as couriers of their own discharge summary had been proposed (Kripalani et al.). However, as Dewa et al. (2012) identified, the vulnerability and illness related symptoms of SMI make this a less desirable alternative. This is exemplified in the case example of Stephen, who was not able to manage his own care, and it highlights the importance of identifying family as an integral source of support.

One important finding from the literature was Johnson et al.'s (2012) use of process mapping to identify the clinical procedures involved in the transition of patients from acute to primary care. By utilizing process maps, care providers were able to examine clinical processes and identify gaps in care and communication.

Another area of concern was the lack of communication between families, patients, and care providers. Cleary et al. (2005) identified that patients and families have different information needs. Both patients and families wanted personalized information regarding medications and side effects, symptom management, and access to resources. However, families placed a greater focus on discharge care planning. More care is being provided in a community care context, and families are the main source of support for individuals with SMI. (MacFarlane, 2011; Russell et al. 2003). Within this context, it is important for primary care providers to address communication needs with both patients and families in an effort to improve the outcomes in primary care mental health services (Cleary et al.). Issues surrounding privacy and confidentiality must be addressed in order to implement these strategies to improve communication.

Therapeutic Relationships

The literature identified that therapeutic relationships are important to continuity of care (El-Mallakh et al., 2004 & Jones et al., 2009). These continuing relationships between care providers and their patients and families, along with personalized care management, may be beneficial for seamless care transitions (Batscha, et al., 2011; Jones et al.; Nolan et al., 2011;

Rose, et al., 2007). Transition to the community may be more difficult for patients with SMI and care transitions are found to be more successful when care providers are supportive (Gomez, 2008).

Nolan et al. (2011) explained that therapeutic relationships are important not only between care providers and patients, but also with patients and their peers. They explored that transition from acute care to outpatient care needs to place a greater emphasis on coping with everyday life and establishing and sustaining relationships. In Stephens's case, he had disengaged from all his social contacts and alienated himself from his family. It appears that social reconnection was not a consideration in Stephen's discharge planning. Nolan et al. identified a risk to patients' well-being can occur when therapeutic relationships established with staff and peers are lost following discharge.

Jones et al. (2009) identified that patients experienced periods of transition through multiple care providers. They found that if transitions between care providers were not personalized for the patient, it could undermine any positive experiences with the mental health services. In the context of Family Nurse Practitioners, providing primary care, this is an important consideration when working with patients with SMI. For example, it is important to prepare patients with SMI for any changes in care providers well in advance, regardless of how brief this may be. Hautala-Jylha et al. (2005) further added that good cooperative relationships with patients will improve their commitment to their care as patients are more willing to seek care with a provider they trust. Another important finding from Hautala-Jylha et al. was that in a system where patients are able to return to the inpatient ward for assessment of their mental health status, patients had increased commitment to their care. The authors noted that patients had established relationships with the staff on the ward and trusted their assessment of their mental health status. In the current Canadian mental health system, this may not be feasible. However, in consideration of the Canadian Senate's (2006) suggestion of a transformation of the mental health system, it may be reasonable to consider adapting Canada's mental health system to incorporate this concept. A transformation of the mental healthcare system would be an arduous undertaking and would require considerable time and effort. However, these findings are promising in enhancing care for patients with SMI, and Canada could benefit from considering the literature, and looking to other countries successes to determine where improvements in our system can be made (Health Canada 2014).

Another key finding from Jones et al. (2009) was that patients experienced frustration that services were more focused on crisis stabilization, rather than on preventative management. This frustration with services and healthcare providers was shown to have a negative impact on established therapeutic relationships. The PHAC (2010) reported that health services that are more focused on prevention, rather than reactive management, need to be a priority and are necessary for the sustainability of the healthcare system. This finding further supports the idea that a change within Canada's mental healthcare system is needed.

These findings are congruent with literature that assigns prime importance to the therapeutic partnership and the perceived helpfulness of the primary care provider (Mitchell & Selmes, 2007). Findings from the literature are further supported by the wider research literature, indicating that the development and maintenance of a therapeutic relationship in a nonthreatening environment is critical to achieving optimal clinical outcomes (Storfjell et al., 2008). It is clear that positive therapeutic relationships are key to the success of transitions of care for the severely mentally ill population.

Conclusion

This integrative review sought to answer the research question: what are evidence-based practices and processes that help to achieve seamless transitions and continuity of care for mentally ill adults discharged from acute psychiatric care to primary care? The findings derived from the review identified several important practices and processes, at the level of the FNP practicing in primary care, in the facilitation of seamless transition of care. In summary, these concern the following.

Early identification of patients with SMI in the primary care setting and assessment of families on an individual basis can assist to determine needs specific to the patient and their family. Advanced care planning with the patient to determine their directives during times of acute illness may improve transitions between acute and primary care and lessen confusion during crisis (Gray et al., 2008; Jones et al., 2009).

The value of understanding family role in care transitions, appropriate information sharing with the family, and the importance of the inclusion of family were common findings from the literature (Canada Parliament Senate Standing Committee on Social Affairs, Science and Technology report, 2006; Chen, 2008; Gray et al., 2008; Wynaden & Orb, 2005; Solomon et al., 2012). Continuing education for healthcare providers on the appropriate application of confidentiality to clinical practice and establishing standardized process for information sharing between healthcare providers can facilitate seamless transitions of care (Gray et al.; Johnson et al., 2012; Kripalani et al., 2007; Solomon et al.). Further, a raised awareness of families in the care of individuals with SMI, as well as an emphasis on the importance of therapeutic relationships, may improve patients' transitions from acute to primary care (Batscha et al., 2011; Cleary et al., 2005; Gray et al.; Rose et al., 2007).

When used in isolation these approaches may have a limited effect on creating the goal of seamless care transitions. However, when used in conjunction with one another these approaches can narrow the gaps in care and create seamless transitions of care. Linking patients from acute care to primary care involves a collaborative approach among acute care, primary care, and family in the discharge planning process (Cleary et al., 2005).

Recommendations

The purpose of this project was to examine current literature with the goal of obtaining a more comprehensive understanding of current practices and processes in care transitions for patients with SMI. Further, to investigate interventions that could possibly achieve seamless transitions and continuity of care for severely mentally ill adults discharged from acute psychiatric care to primary care. As part of this review, the four themes that were identified, confidentiality, linkages between acute care and primary care, communication, and therapeutic relationships, were further synthesized and linked to practice and the wider body of literature. Recommendations for practice, research, and education were identified. The institution of these recommended practices has the potential to improve health outcomes of individuals with severe mental illness, and in this way, to create momentum for the continuation of education and research initiatives for improvement in care transitions for this population.

While it is outside the scope of this project, it is important to recognize that Family Nurse Practitioners must be prepared to advocate for influencing changes at the local, provincial, and national levels to contribute to improving transition of care processes for adult patients with SMI. Family Nurse Practitioners can work at the local, provincial, and national levels to address healthcare system issues that affect transitions of care for SMI patients. This project has focused on offering recommendations for FNPs to improve care transitions for patients with SMI from a practice perspective, however, a participation in advocating for change at the policy and systems level is imperative in order to promote effective changes that contribute to seamless transitions of and continuity of care for adults with SMI.

Recommendations for Practice

These recommendations are intended for the FNP practicing in primary care in Canada, but may also be relevant to other healthcare providers, both in Canada and elsewhere. Some of the recommendations may also be helpful for the acute psychiatric care setting, or community mental health programs.

Table 2: *Recommendations for Practice*

Recommendation	Action
1. Perform an assessment of the patient and their family to determine their level of involvement in care	• Perform an annual assessment of the family or with any changes in the family situation or dynamics • Be knowledgeable and understanding of confidentiality laws and provide appropriate information to families and direct them to resources • When applicable, involve families in discharge planning • Act as an intermediary between patients and families • Individualize information for the family
2. FNPs as PCPs should actively negotiate, document and update clear and detailed advanced directives as part of living care planning with the patient and family	• Assess the patient's capacity to negotiate an advanced care plan • Make advance care planning and information sharing with families a priority of care • Implement anticipatory planning for patients with SMI by promoting healthcare provider acceptance and embed practices which facilitate advanced care plans as part of routine care. • Share care plans with acute care • Refer to Appendix A: Components of an Advanced Care Plan

Table 2: *Recommendations for Practice*

Recommendation	Action
3. FNPs as PCPs should ensure that they have a current understanding of relevant confidentiality, laws and policies as they relate to psychiatric care	• Attend psychiatric care related education sessions and conferences as part of continuing education requirements for healthcare providers • Network with other healthcare providers knowledgeable in psychiatric care • Become familiar with the confidentiality laws and policies within jurisdiction of practice. • Subscribe to relevant literature and websites to stay current in confidentiality laws • Refer to the Mental Health Act specific to jurisdiction of practice. For example in British Columbia: http://www.bclaws.ca/civix/document/id/complete/statreg/96288_01 • Refer to The Canadian Mental Health Association: http://www.cmha.ca/
4. FNPs in PC should work to establish partnerships between acute care and primary care to outline expectations of responsibility for performing specific roles associated with care transitions, and to allow involvement of all essential care providers in discharge planning meetings	• In coordination with relevant stakeholders meet with members of the psychiatric acute care team to identify mutually agreed upon responsibilities and processes for performing specific roles associated with care transitions • Contribute essential information from primary care in the communication tool used for patient management in the acute care setting • Be actively involved in quality improvement activities within healthcare systems at the local, provincial, and national levels. • Be actively involved in creating policies regarding care transitions
5. Start collaborative discharge planning upon admission to acute care	• Identify a date and/or time of discharge as early as possible • Identify whether the patient has simple or complex discharge planning needs • Identify what these needs are and how they will be met • Work collaboratively to plan care, including both acute and primary care providers, agree who is responsible for specific actions and the process and timing of discharge • Consider the social context of pre-admission and established interpersonal relationships in the discharge process, communicate this with acute care

Table 2: *Recommendations for Practice*

Recommendation	Action
6. Acute care and primary care providers or support staff to ensure the patient is scheduled for follow-up appointments with primary care prior to discharge	• Acute psychiatric care or primary care support staff or care providers to schedule a telephone contact with patient within 24-48 hours of discharge • Acute psychiatric care or primary care support staff or care providers to schedule a face-to-face appointment within five days of discharge • Actively negotiate and collaborate with acute care to create consistent process for arranging follow appointments.
7. Establish formal processes to ensure primary care provider contact information is regularly updated and available to acute care providers	• Designate support staff to regularly update PCP contact information and preference for mode of contact, such as cell phone, pager or office number as part of office routine • Establish a process to regularly distribute accurate contact information to all agencies and care providers
8. Establish consistent processes, in collaboration with the greater system, collaborator and care team members to ensure that essential patient information is transmitted/received during care transitions.	• Acute psychiatric and primary care to collaboratively establish a formal process for exchanging patient information, such as discharge summaries • Create a reference document clearly outlining the content process of sending and receiving patient information during care transitions. • Acute and/or acute care provider to collaboratively ensure that discharge summary information is available to the PCP 24 hours prior to patient telephone contact or face-to-face appointment post-discharge. • Orientate new staff to the documents/process to safeguard continuity of care • Ensure essential patient information is reviewed regularly and acted upon, including requesting clarification when information is missing or unclear
9. Utilize and maximize existing electronic systems, and/or paper patient records, ensuring all patient information is complete and kept up-to-date	• Ensure both paper and/or electronic records are completed in a timely fashion • Adopt a positive attitude towards the use of existing or emerging electronic medical systems • Become a champion in the use of existing and emerging technology that supports timely and comprehensive transfer of patient information • Advocate for and be actively involved within healthcare jurisdiction in working towards interoperable healthcare records systems

Table 2: *Recommendations for Practice*

Recommendation	Action
10. Establish and strengthen collaborative partnerships with patients and establish a sense of affiliation between PCP and patient	• Use a tailored responsive approach to care • Consider the individual's social context in care provision • Prepare patient for any changes in care providers, i.e. PCP vacation • Keep the lines of communication open by creating an atmosphere where the patient feels free to express themselves honestly • Listen to the patient and instill optimism in treatment
11. Facilitate therapeutic relationship connection between acute care and primary care	• Courtesy visits during an acute psychiatric admission to preserve established therapeutic relationships, advocate on the patient's behalf, and help coordinate care and supports for the patient

Recommendations for Education

Family Nurse Practitioners and healthcare providers, in general, have a responsibility to maintain continuing education to remain current in their knowledge and skills for practice. As healthcare professionals, FNPS are obligated to remain current in advances and trends in healthcare delivery. Primary care providers need to subscribe to journals relevant to the care of patients with SMI and ensure all practice guidelines are current. Further, primary care providers need to seek educational opportunities when unclear about best practice recommendations.

Knowledge about privacy and confidentiality laws and the appropriate application of patient confidentiality to clinical practice is an important aspect of providing patient care. Additional education regarding these issues need to be included in the program of study for Family Nurse Practitioners and all healthcare providers. In addition, primary care providers must perform an annual review of laws surrounding privacy and confidentiality and seek educational opportunities when available.

It has been made clear that poor communication is a common problem in seamless care transitions, partly because of a lack of understanding of the role of the family. In raising awareness of the integral role of family through education, there is potential to improve the outcomes of patients with severe mental illness. The core curriculum for healthcare professionals, as well as continuing education, needs to include education on working with families, especially in the context of mental health. This may include education on assessment and involvement of families in care. In addition, education needs to include how to act as an intermediary between patients and families. This may be important when negotiating advanced care planning.

Recommendations for Research

The literature search for this project identified that there is a limited amount of available research specific to transition of care for individuals with severe mental illness. Transitional care models (TCM), designed to support early discharge and prevent hospitalizations, have been used successfully with other high-risk populations. Two of the studies included in this integrative review examined the applicability and feasibility of a TCM, adapting the interventions for recently hospitalized SMI persons and their families. The results were promising. This indicates that continued research efforts are warranted to assess and modify care transition interventions that are specific to patients with SMI. This finding agrees with the views of Viggiano et al., (2012) who stated that, in spite of the well-recognized importance of maintaining continuity of care from transition points for individuals with SMI, there is a limited amount of research to address this problem.

Research in Canada on the use of process mapping in mental healthcare may be beneficial to identifying facilitators and barriers to effective care transitions. Johnson et al. (2012) found promising results in other counties, and utilizing this method across the varying Canadian healthcare jurisdictions may highlight potential process improvements.

More research is needed to study situations where families, patients, and care providers conflict over confidentiality issues, and to examine strategies for effective and inclusive information sharing. Moreover, research on patients' perspectives with regard to information sharing between healthcare providers and their families is needed to strengthen the adequacy of confidentiality policies and information sharing practices. Finally, comparative studies are needed to identify the optimal time frame and method of initial follow-up appointments post discharge from an acute psychiatric admission.

Limitations

Like many other research projects, this one is not without its limitations. The first is that many research papers were not specific to FNP practice, although the majority of studies were largely relevant to FNP practice. There was potential bias in this project. The author has a personal connection to the case of Stephen and his family, as well as relevant background and experiences associated with mental healthcare. Despite taking steps to avoid bias, this connection may have skewed the interpretation of the literature and conclusions. The recommendations of this project are focused on actions FNPs can take at the practice level, however, it is important that FNPs contribute to policy and systems changes at the local, provincial, and national level to improve care transitions for adult patients with SMI. Finally, FNP practice in primary care varies across Canada and this must be considered in the application and recommendations of this project.

Conclusion

Individuals with severe mental illness are among the most vulnerable patients and the point of discharge from acute care is a critical time in the continuity of their care. This period directly following discharge carries the increased risks of symptom relapse, hospital readmission, homelessness, or suicide. A more seamless transition from acute psychiatric care may prevent such outcomes. In general, healthcare for individuals with SMI in Canada tends to be nominal, fragmented, and episodic. This integrative project examined evidence-based practices and processes in order to identify ways to facilitate seamless transitions and continuity of care for mentally ill adults discharged from acute psychiatric care to primary care. Further, to offer recommendations for Family Nurse Practitioners practicing in primary care in Canada. Background information on SMI and care transitions, including a case example, have been presented. After a comprehensive search of the literature was done, 17 studies were selected for review and the evidence in each has been critically appraised to identify its strengths and its relevance to Canadian healthcare. Four key findings from this integrative review are the importance of confidentiality, linkage between acute and primary care, communication, and therapeutic relationships and their relevance to seamless transition of care. The recommendations offered are directed to the FNP practicing in primary care in Canada, but they may be relevant to any healthcare providers practicing primary care. Some of the recommendations may also be helpful in other settings, such as acute psychiatric care, or community mental healthcare. Recommendations for further research are based on gaps identified in the literature. Recommendations for education address the need for primary care providers to be well-informed on the appropriate application of patient confidentiality to clinical practice, to seek education to clarify any misconceptions, and to be knowledgeable about current practices and guidelines involving family. In conclusion, this project shows that FNPs practicing in primary care have the capacity to improve transitions for adults discharged from acute psychiatric care to primary care. This adds to the current literature regarding transitions of care for individuals with SMI, by focusing on the role of the Family Nurse Practitioner in these transitions, in order to improve them and to ensure continuity of care. This is particularly important in light of the fact that many Canadian healthcare systems are not seamless and provide only incomplete or ineffective transitions between services.

Glossary of Terms

Advanced Care Planning (ACP): provides patients with the ability to make their decisions known about how they would like to be treated if they lose capacity (Cartwright, Montgomery, Rhee, Zwar, & Banbury, 2014)

Acute Care: hospital-based acute care is a key component of the continuum of healthcare services in Canada. It provides necessary treatment for severe episodes of illness for a short period of time. The goal is to discharge patients as soon as they are healthy and stable (CIHI, 2014)

Bipolar Disorder (BD): a major psychiatric disorder characterized by intense variations of mood and energy (Musenga, Saracino, Sani, & Raggi, 2009). Episodes of depression, characterized by low mood, low energy, inability to experience pleasure in activities usually found enjoyable, and apathy, alternate with episodes of intense nervous excitation, hyperactivity, elation of mood or irritability, and grandiose ideas. These variations in mood and energy affect thinking and judgment, and in extreme cases, persons with BD experience delusions and hallucinations, impairing many aspects of their life such as work, and relationships. Hospitalization, is often required during these episodes. (Musenga et al.)

Boolean Operator: in a literature search, the word that defines the relationships between words or groups of words; for example, “AND,” “OR”, “NOT”, or “NEAR” (LoBiondo-Wood et al., 2013)

Borderline Personality Disorder (BPD): a SMI characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior (Mental Health Canada, nd). Family, work life, long-term planning, and the individual's sense of self-identity are often disrupted as a result of the pervasive characteristics of the disorder (Mental Health Canada).This disorder is less well known than schizophrenia or BD, but is more common, affecting two percent of adults, mostly young women (Mental Health Canada). With BPD there is a high rate of self-harm without suicide intent, as well as a significant rate of suicide attempts, and completed suicide in severe cases. Individuals with BPD often need extensive mental health services, and account for 20 percent of psychiatric hospitalizations (Mental Health Canada)

Care Aide: Aka Health care aide. Provide personal assistance or support services for elderly, disabled, acute, or chronically ill people. They provide both short term assistance and ongoing support. (Alberta Government: Alberta Learning Information Services, 2014)

Collaborative Care: occurs when multiple health providers from different professions provide comprehensive services by working with people, their families, care providers, and communities to deliver the highest care across settings. Practice includes both clinical and non-clinical health-related work, such as diagnosis, treatment, surveillance, health communications, management, and support services (WHO, 2010)

Community Care: is delivered in community clinics, private homes, residential or long-term care homes, or retirement communities (CIHI, 2014)

Confidentiality: is a type of informational privacy in which one individual or organization agrees to safeguard information about another individual or organization (CRNBC, 2010)

Continuity of Care: uninterrupted, coordinated care/service across programs, practitioners, organizations, and levels of care/service over time (CIHI, 2009)

Continuum of Care: is a concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care (Evashwick, 1989)

Discharge Planning: is a process that aims to improve the coordination of services after discharge from hospital by considering the patient's needs in the community. It seeks to bridge the gap between hospital and the place to which the patient is discharged, reduce length of stay in hospital, and minimize unplanned readmission to hospital (Katikireddi & Cloud, 2009)

Evidence-Based Practice: the conscious, explicit, and judicious use of the current best evidence in the care of patients and the delivery of healthcare services (LoBiondo-Wood et al., 2013)

Family/Families: in matters of caregiving, family is recognized to be those people identified by the person receiving care or in need of care as providing familial support, whether or not there is biologic relationship (CNA, 2008)

Freedom of Information and Protection of Privacy Act (FOIPPA): contain privacy protection measures that public healthcare organizations, such as hospitals, health authorities, and the health ministries are subject to. It prevents the unauthorized collection, use, or disclosure of personal information by public bodies and it requires that reasonable safeguards be in place to protect personal information (British Columbia Medical Association, 2009)

Major Depressive Disorder (MDD): a complex disabling condition characterized by physical, emotional, and cognitive changes (Catena-Dell`Osso, Marazziti, Rotella, & Bellantuono, 2012). Symptoms can include irritability, anxiety, hostility, with dangerous impulsive behavior, and potentially lethal acts of self-harm (Smith & Blackwood, 2004). For individuals with MDD, all aspects of their life can be affected, such as family, personal relationships, work, and general health. This mental disorder represents a major cause of morbidity worldwide, and is currently considered the fourth-leading cause of disease burden (Catena-Dell`Osso et al.)

Mental Health Act: all Canadian provinces and territories have legislation to treat and protect people with SMI and to protect the public. The Mental Health Act provides people with mental disorders the treatment and care they need when they are not willing to accept it (British Columbia Ministry of Health, 2005)

Mental Health Worker: Aka community support worker. Help people deal with personal and social problems by teaching related skills and providing information and support (Alberta Government: Alberta Learning Information Services, 2014).

Obsessive Compulsive Disorder (OCD): another form of anxiety disorder. The individual who suffers from severe OCD experiences obsessions and compulsions for more than an hour each day; repetitive thoughts, and behaviors are senseless, distressing, and extremely difficult to overcome in a way that interferes with his or her life (Mental Health Canada, nd; NAMI, 2014). It affects more than two percent of the population, and is two to three times more common than schizophrenia, and BD (NAMI; Mental Health Canada)

Panic Disorder: falls under the umbrella of anxiety disorders; a condition that fills peoples' lives with overwhelming worry and fear (Mental Health Canada, nd). Anxiety disorders are chronic, relentless, and can become severe if not treated (Mental health Canada). Panic disorders are characteristic of feelings of terror that strike suddenly and repeatedly with no warning (Mental Health Canada). The unpredictable nature of panic disorder causes the individual to agonize over when and where the next one will strike, often precipitating intense anxiety between episodes.

Plan-Do-Study-Act Cycle: a structured trial of process change by developing a plan to test the change, carrying out the test, an analysis of the results of the trial and determining what modifications should be made to the test next steps based on the analysis (Luther, Hammersley, & Chekairi 2014)

Post-Traumatic Stress Disorder (PTSD): an anxiety disorder characterized by flashbacks, constant frightening thoughts, and memories, anger or irritability in response to a traumatic experience in which physical harm occurred or was threatened (such as rape, child abuse, war or natural disaster) (PHAC, 2012). It can occur at any age, and is often accompanied by depression, substance abuse, or one or more other anxiety disorders (Mental Health Canada, nd)

Primary Care: refers to the first contact with the healthcare system. In Canada, the primary division of labor is organized mainly around family physicians, general practitioners and nurse practitioners (Bourgeault & Mulvale, 2006)

Primary Healthcare: refers to an approach to health and a spectrum of services beyond the traditional healthcare system. It includes all services that play a part in health, such as income, housing, education, and environment. The five principles usually associated with the primary healthcare approach are: accessibility, health equity, community participation, and intersectoral approaches to health (Muldoon, Hogg, & Levitt, 2006)

Privacy: is the right of individuals to determine how, when, and to whom and for what purposes any personal information will be divulged (CRNBC, 2010)

Schizoaffective Disorder: a disorder in which an individual has symptoms of both major depression or BD and schizophrenia. It is a combination of schizophrenia symptoms (hallucinations, delusions) and mood disorder symptoms (mania or depression) (CMHA, 2013).

Schizophrenia: a complex, chronic disorder with a diverse presentation of symptoms such as delusions, hallucinations, conceptual disorganization, paranoia, agitation, and hostility. Other symptoms include blunted affect and emotional and social withdrawal. The course of schizophrenia is often characterized by acute psychotic episodes, often requiring hospitalization. These disturbances have a pervasive impact on many areas of life functioning and quality of life (Abioda, Morakinyo, & Ibrahim, 2012).

Seamless Care: is a smooth and safe transition of a patient between care settings (Spehar et al., 2005)

Suicide: the act of deliberately killing oneself and is the greatest cause of violent death around the world; it is among the top three leading causes of death in young people aged 15-34 years worldwide (WHO, 2009; WHO, 2014). Serious mental illness is the significant factor that predisposes people to suicide (McAuliffe, & Perry, 2007). For individuals with severe and enduring mental health problems, as many as 43 percent of suicides occur within three months of discharge, with a heightened risk period in the first five days following discharge (Harkavy-Friedman et al., 1999)

Transitions of care: connotes the scenario of a patient leaving one care setting (i.e. hospital, nursing facility, assisted living facility, primary care physician care, home care, or specialist care) and moving to another setting or to the patient's home. The transition frequently involves multiple persons, including the patient, family, or other caregiver(s), nurse(s), social worker(s), case manager(s), pharmacist(s), and other providers (NTOCC, 2008)

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Appendix A

The following table of evidence uses Levels I-VII to identify the type and strength of each research article. Evidence provided by qualitative studies is ranked lower in the hierarchy of evidence, however, these methods are the most effective in attempting to answer clinical and research questions when little is known or a new perspective is needed (LoBiondo-Wood et al., 2013).

Table 3: *Levels of Evidence*

Level	Evidence
I	Systematic review or meta-analysis of randomized controlled trials (RCT); Evidence informed clinical practice guidelines based on systematic reviews
II	A well designed RCT
III	A controlled trial without randomization (quasi-experimental study)
IV	Single non-experimental studies – case control, correlational, cohort studies
V	Systematic reviews of descriptive and qualitative studies
VI	Single descriptive or qualitative study
VII	Opinions of authorities and/or reports of expert committees

Appendix B

Table 4: *Table of Evidence*

Author	Design	Study Aim	Sample	Level of Evidence
Batscha et al. (2011)	Quantitative	To explore the feasibility of using an Advanced Practice Nurse (APN) to link patients with SMI to their first appointment post discharge	15 patients with a diagnosis of SMI	III
Chen (2008)	Qualitative	To explore how community mental healthcare providers share information with their patients' families	24 community case managers	VI
Cleary et al. (2005)	Quantitative	To obtain baseline data on the extent of family involvement in the care of a family member with SMI	407 (207 inpatients and 200 patients in the community) and 50 family members	IV
Dewa et al. (2011)	Quantitative	To examine the characteristics of patients with SMI who do not have a primary care provider	112 individuals with SMI	IV
El-Mallakh et al. (2004)	Quantitative	To determine predictors of not attending follow-up after discharge	81 patients with SMI	IV
Gray et al. (2008)	Qualitative	To explore the challenge of confidentiality issues from the perspectives of professionals and implications for professional practice and training	65 staff: managers, senior leaders, GPs, primary care staff, advocacy groups and social workers	VI

Appendix B

Table 4: *Table of Evidence*

Author	Design	Study Aim	Sample	Level of Evidence
Griswold et al. (2008)	Mixed-method	To test the hypothesis that, in contrast to usual care, case management will result in higher rates of connection to primary care	175 patients without a primary care provider	II
Hautala-Jylha et al. (2005)	Qualitative	To describe and analyze perceptions of factors for improving continuity of care for individuals with SMI	15 patients with SMI; inpatient and outpatient personnel (13); administrative staff (5)	VI
Johnson et al. (2012)	Qualitative	To demonstrate how process mapping can be utilized to improve transition from acute care to primary care	Clinical teams involved with care transitions in six countries	VI
Jones et al. (2009)	Mixed-method	To capture the experiences and views of patients and families focusing on the meanings associated with problematic care	Patients (n = 31) families (n =14)	III
Kripalani et al. (2007)	Systematic review	To characterize the prevalence of deficits in communication and information transfer at hospital discharge and to identify interventions for improvements	73 articles for review	I

Appendix B

Table 4: *Table of Evidence*

Author	Design	Study Aim	Sample	Level of Evidence
Nolan et al. (2011)	Qualitative	To ascertain how individuals experience discharge from acute care services in order to understand how to improve inpatient care	44 patients with SMI	VI
Rose et al. (2007)	Qualitative	To address the lack of continuity of care in existing programs to meet the immediate post discharge needs of individuals with SMI	4 patients with SMI	VI
The Standing Senate Committee on Social Affairs, Science and Technology (2006)	Report	To transform mental health, mental illness and addiction services in Canada	Over 2000 personal accounts from across Canada	VII
Solomon et al., (2012)	Qualitative	To gain knowledge of confidentiality issues related to families	640 participants (care provider staff, administrators and students	VI
Wood et al. (2009)	Quantitative	To develop and test a standardized communication strategy for improving communication between acute care and community practitioners	150 participants from one 86 bed private and one not-for-profit mental hospitals	III
Wynaden & Orb (2005)	Qualitative	To report on the problems that families experience as a result confidentiality	27 family members	VI

Appendix C

Table 5: *Stage One Search Results*

Search Terms	**Data Bases**	**N**
Mental Disorder **OR** Psychiatric Patient **AND** Primary Healthcare **OR** Nurse Practitioners	CINAHAL with full text	88
	PubMed	n/a
	PsychINFO	248
Mental Disorder **OR** Psychiatric Patient **AND** Transfer Discharge **OR** Patient Discharge	CINAHAL with full text	27
	PubMed	478
	PsychINFO	55
Mental Disorder **OR** Psychiatric Patient **AND** Care Transition **OR** Patient Transfer **OR** Continuum of Care **OR** Continuity of Patient Care	CINAHAL with full text	25
	PubMed	285
	PsychINFO	38
Mental Disorder **OR** Psychiatric Patient **AND** Privacy and Confidentiality	CINAHAL with full text	157
	PubMed	n/a
	PsychINFO	3
Mental Disorder **OR** Psychiatric Patient **AND** Family	CINAHAL with full text	23
	PubMed	392
	PsychINFO	71
Psychiatric Units **OR** Psychiatric Hospitals **AND** Care Transition **OR** Patient Transfer **OR** Continuum of Care **OR** Continuity of Patient Care	CINAHAL with full text	25
	PubMed	15
	PsychINFO	6
Psychiatric Units **OR** Psychiatric Hospitals **AND** Primary Healthcare **OR** Nurse Practitioners **OR** Family Nurse Practitioner	CINAHAL with full text	3
	PubMed	29
	PsychINFO	0
Psychiatric Units **OR** Psychiatric Hospitals **AND** Transfer Discharge **OR** Patient Discharge	CINAHAL with full text	70
	PubMed	114
	PsychINFO	0
Psychiatric Units **OR** Psychiatric Hospitals **AND** Privacy and Confidentiality	CINAHAL with full text	0
	PubMed	8
	PsychINFO	9

Appendix C

Table 5: *Stage One Search Results*

Search Terms	**Data Bases**	**N**
Psychiatric Units **OR** Psychiatric Hospitals **AND** Family	CINAHAL with full text	58
	PubMed	53
	PsychINFO	80
Care Transition **OR** Patient Transfer **OR** Continuum of Care **OR** Continuity of Patient Care **AND** Primary Healthcare **OR** Nurse Practitioners **OR** Family Nurse Practitioner	CINAHAL with full text	32
	PubMed	285
	PsychINFO	52
Care Transition **OR** Patient Transfer **OR** Continuum of Care **OR** Continuity of Patient Care **AND** Transfer Discharge **OR** Patient Discharge	CINAHAL with full text	179
	PubMed	173
	PsychINFO	22
Care Transition **OR** Patient Transfer **OR** Continuum of Care **OR** Continuity of Patient Care **AND** Privacy and Confidentiality	CINAHAL with full text	1
	PubMed	9
	PsychINFO	2
Care Transition **OR** Patient Transfer **OR** Continuum of Care **OR** Continuity of Patient Care **AND** Family	CINAHAL with full text	123
	PubMed	144
	PsychINFO	30
Primary Healthcare **OR** Nurse Practitioners **OR** Family Nurse Practitioner **AND** Transfer Discharge **OR** Patient Discharge	CINAHAL with full text	18
	PubMed	10
	PsychINFO	0
Primary Healthcare **OR** Nurse Practitioners **OR** Family Nurse Practitioner **AND** Family	CINAHAL with full text	220
	PubMed	n/a
	PsychINFO	4
Transfer Discharge **OR** Patient Discharge **AND** Privacy and Confidentiality	CINAHAL with full text	3
	PubMed	29
	PsychINFO	0
Psychiatric Units **OR** Psychiatric Hospitals **AND** Transfer Discharge **OR** Patient Discharge	CINAHAL with full text	1
	PubMed	10
	PsychINFO	0

Appendix C

Table 5: *Stage One Search Results*

Search Terms	**Data Bases**	**N**
Transfer Discharge **OR** Patient Discharge **AND** Family	CINAHAL with full text	43
	PubMed	157
	PsychINFO	5
Privacy and Confidentiality **AND** Family	CINAHAL with full text	157
	PubMed	n/a
	PsychINFO	5
Totals	CINAHAL with full text	1305
	PubMed	2366
	PsychINFO	661
Totals after duplicates removed	CINAHAL with full text	897
	PubMed	1837
	PsychINFO	403
Electronic Database Results		
DATA BASES TOTAL		4074
Total after duplicates removed		3200
Total kept after reading title		380
Total kept from abstracts		140
Total kept after in depth reading		17

Appendix D

Table 6: *Journals Searched*

Terms	Canadian Journal of Psychiatry	Journal for Nurse Practitioners	International Journal of Psychiatry	Psychiatry Quarterly	Canadian Family Physician	Journal of Social Work	Journal of American Psychiatric Nurses Association
Continuity of Care	6	n/a	0	3	n/a	n/a	10
Discharge Planning	1	n/a	3	0	n/a	n/a	40
Transition of Care	0	n/a	0	0	n/a	n/a	75
Primary Healthcare	4	n/a	n/a	8	n/a	n/a	269
Primary Care	51	n/a	29	8	n/a	n/a	131
Psychiatric Patient	42	n/a	44	28	0	62	408
Family	286	n/a	49	79	n/a	n/a	18
Privacy and Confidentiality	1	n/a	1	2	44	442	1
Psychiatric Unit **OR** Psychiatric Hospital	45	n/a	n/a	5	n/a	4	59
Nurse Practitioner or Family Nurse Practitioner	0	n/a	n/a	37	13	0	93
Mental Illness **AND** Continuity of Care	n/a	13	n/a	n/a	n/a AND	1	n/a
Mental Illness **AND** Discharge Planning	n/a	7	n/a	n/a	n/a = 38	1	n/a
Mental Illness **AND** Transition of Care	n/a	25	n/a	n/a	0	0	n/a
Mental Illness **AND** Primary Healthcare	n/a	115	n/a	n/a	1	0	n/a

Appendix D

Table 6: *Journals Searched*

Terms	Canadian Journal of Psychiatry	Journal for Nurse Practitioners	International Journal of Psychiatry	Psychiatry Quarterly	Canadian Family Physician	Journal of Social Work	Journal of American Psychiatric Nurses Association
Mental Illness **AND** Primary Care	n/a	119	n/a	n/a	1	0	n/a
Mental Illness **AND** Psychiatric Patient	n/a	67	n/a	n/a	0	2	n/a
Mental Illness **AND** Psychiatric Unit **OR** Psychiatric Hospital	n/a	51	n/a	n/a	0	4	n/a
Mental Illness **AND** Nurse Practitioner or Family Nurse Practitioner	n/a	152	n/a	n/a	0	0	n/a
Mental Illness **AND** Privacy Confidentiality	n/a	16	n/a	n/a	1	17	n/a
Mental Illness **AND** Family	n/a	147	n/a	n/a	8	97	n/a
Number taken based on title	18	42	33	16	9	11	50
Number taken after reading titles	5	2	1	7	4	1	1

n/a: Results that produced numbers greater than 500

Appendix E

Table 7: *Guidelines for Critiquing a Qualitative Research Study*

Elements	**Questions**
Elements influencing reliability and validity of the research	
Writing style	Is the report well written – concise, grammatically correct, avoids the use of jargon? Is it well laid out and organized?
Author	Do the researcher's qualifications position indicate a degree of knowledge in this field?
Report title	Is the report title clear, accurate and unambiguous?
Abstract	Does the abstract offer a clear overview of the study, including the research problem, sample, methodology, findings and recommendations?
Elements influencing rigor of the research	
Statement of the phenomenon of interest	Is the phenomenon to be studied clearly identified? Are the phenomenon of interest and the research questions consistent?
Purpose significance of the study	Is the purpose of the study clearly identified?
Literature review	Has a literature review been undertaken? Does it meet the philosophical underpinnings of the study? Does the review of the literature fulfill the objectives?
Theoretical framework	Has the conceptual or theoretical framework been identified? Is the framework adequately described? Is the framework appropriate?
Method and philosophical underpinnings	Has the philosophical approach been identified? Why was this approach chosen? Have the philosophical underpinnings been of the approach bee explained?
Sample	Is the sampling method and sample size identified? Is the sampling method appropriate? Were the participants suitable for informing research?
Ethical considerations	Were the participants fully informed about the nature of the research Was the autonomy confidentiality of the participants guaranteed
Data collection data analysis	Are the data collection strategies described? Are the strategies used to analyze the data described? Did the researchers follow the steps of data analysis methods identified? Was data saturation achieved?
Rigor	Does the researcher discuss how rigor was assured? Were credibility, dependability, transferability and goodness discussed?
Findings discussion	Are the findings presented appropriately? Has the report been placed in the context of what was already known about of the phenomenon? Has the original purpose of the study been adequately addressed?
Conclusion implications and recommendations	Are the importance and implications of the findings identified? Are the recommendations made to suggest how the research findings can be developed?
References	Were all the books, journals and other media alluded to in the study accurately referenced?

Adapted from Ryan, Coughlan, & Cronin, 2007

Appendix F

Table 8: *Guidelines for Critiquing a Quantitative Research Study*

Elements	**Questions**
Elements influencing reliability and validity of the research	
Writing style	Is the report well written – concise, grammatically correct, avoids the use of jargon? Is it well laid out and organized?
Author	Do the researcher's qualifications/position indicate a degree of knowledge in this field?
Report title	Is the report title clear, accurate and unambiguous?
Abstract	Does the abstract offer a clear overview of the study, including the research problem, sample, methodology, findings and recommendations?
Elements influencing rigor of the research	
Purpose/research problem	Is the purpose of the study/research problem clearly identified?
Logical consistency	Does the research report follow the steps of the research process in a logical manner? Do these steps naturally flow and are the links clear?
Literature review	Is the review logically organized? Does it offer a balanced critical analysis of the literature? Is the majority of the literature of recent origin? Is it mainly from primary sources and of empirical nature?
Theoretical framework	Has the conceptual or theoretical framework been identified? Is the framework adequately described? Is the framework appropriate?
Aims/objectives/research question/hypotheses	Have aims and objectives, a research question or hypothesis been identified? If so are they clearly stated? Do they reflect the information presented in the literature review?
Sample	Has the target population been clearly identified? How were the samples collected? Was it a probability or non-probability sample? Is it of adequate size? Are the inclusion/exclusion criteria clearly identified?
Ethical considerations	Were the participants fully informed about the nature of the research? Was the autonomy/confidentiality of the participants guaranteed? Were the participants protected from harm? Was ethical permission granted for the study?
Operational definitions	Are all the terms, theories and concepts mentioned in the study clearly defined?
Methodology	Is the research design clearly identified? Has the data gathering instrument been described? Is the instrument appropriate? How was it developed? Were reliability and validity testing undertaken and the results discussed? Was a pilot study undertaken?
Data collection/data analysis	What type of data and statistical analysis was undertaken? Was it appropriate? How many of the sample participated? Significance of the findings?
Discussion	Are the findings linked back to the literature review? If a hypothesis was identified was it supported? Were the strengths and limitations of the study including generalizability discussed? Was a recommendation for further research made?
References	Were all the books, journals and other media alluded to in the study accurately referenced?

Adapted from Coughlan, Cronin, & Ryan, 2007

Appendix G

Table 9: *Components of an Advanced Care Plan*

Component	**Information Required**
Date and Support Team	• List the date of the care plan and the people named in the agreement and their contact information • The date is important because this agreement should be frequently reviewed, as the information may have changed
Purpose	• Describe the purpose of the agreement, which is to provide a clear set of guidelines for actions to be taken by members of the patient's support system if the patient exhibits symptoms of their illness
Symptoms	• This section lists the symptoms that the patient would like others to notice and respond to, and describes the most helpful way to respond
Communication	• Clarify what can and cannot be shared: begin with the assumption that information will be shared and move the conversation towards clarifying what specifically can and cannot be talked about • Record how the patient would like to deal with issues of confidentiality
Plan of Action	• Record the actions that the patient requests others to take in the event of acute illness
Cancellation	• Describe the manner in which the agreement can be cancelled • It is important that the process of cancellation requires a period of time and a sequence of steps: during acute illness the patient might attempt to cancel this agreement. Therefore, the plan needs to clearly outline the process of cancellation of it
Periodic review	• Describe the manner in which the agreement will be reviewed (at least annually, as well as after each time the agreement is used) • During the review, a copy of the agreement should be given to everyone named on it, and each person should be clear about his or her role
Signatures and Date	• Signature of the patient and primary care provider • Signatures of the patient's designated support system

Adapted from Mood Disorders Association of British Columbia, (2008)