

# Post discharge network coordination in Zurich

<b>Submission date</b>	<b>Recruitment status</b>	<input type="checkbox"/> Prospectively registered
21/10/2011	No longer recruiting	<input type="checkbox"/> Protocol
<b>Registration date</b>	<b>Overall study status</b>	<input type="checkbox"/> Statistical analysis plan
25/04/2012	Completed	<input checked="" type="checkbox"/> Results
<b>Last Edited</b>	<b>Condition category</b>	<input type="checkbox"/> Individual participant data
08/09/2016	Mental and Behavioural Disorders	

## Plain English summary of protocol

### Background and study aims

Poorly planned discharge hinders a smooth transition between inpatient and outpatient mental health care, as well as a smooth transition from inpatient care to everyday life. The aim of the Post-Discharge Network Coordination Program (PDNC-P) is to ease the transition between inpatient and outpatient care by coordinating a social support network that reduces negative relationships, promotes positive relationships, and help patients integrate back into society. This study aims to test PDNC-P's effect on the frequency and duration of re-hospitalization, psychiatric symptoms, social support, quality of life, and independence in daily functioning.

### Who can participate?

Adult psychiatric inpatients aged between 18 and 64

### What does the study involve?

Patients are randomly allocated into two groups: the treatment group and the control group. The treatment group participates in the PDNC-P upon discharge. The PDNC-P assigns each patient to a social worker. Each patient meets with his/her social worker prior to discharge. The patient collaborates with the social worker and agrees on a close network of social support, a crisis plan, and the terms of program termination. The social worker visits the patient within the first week of discharge to support and monitor the patient's adjustment to outpatient care and everyday life. The social worker and at least two individuals from the social support network meet within the second week of discharge to discuss the patient's personal goals and how the social network can help the patient to cope better with everyday life. A network pilot is chosen to mediate between the patient and the social support network. After the home visit during the first week, the social worker schedules occasional visits based on the patient's progress and needs. The program is designed according to the patient's personal needs and completed once the terms of termination have been reached or after a maximum of three months after discharge from inpatient care. The social support network continues to assist the patient after program termination. The control group receives treatment as usual with no additional social support. Both groups are assessed at discharge, 3 months and 12 months after discharge. Patients' psychological symptoms, independence in everyday life, social support, and quality of life are assessed.

### What are the possible benefits and risks of participating?

Taking part in this study could give the patient the benefit of an easier transition from inpatient

to outpatient care due to linkage with social and outpatient psychiatric services. We consider the risk for the patients as insignificant.

When is the study starting and how long is it expected to run for?

September 2011 to March 2015

Who is funding the study?

Department of Health - Zurich (Switzerland)

Who is the main contact?

Dr Agnes Von Wyl

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## Contact information

### Type(s)

Scientific

### Contact name

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## Additional identifiers

### Protocol serial number

N/A

## Study information

### Scientific Title

Zurich Program for Sustainable Development of Mental Health Services - elements of integrated care: post-discharge network coordination

### Study objectives

Does the Post-Discharge Network Coordination Program (PDNC-P) have a clinical and statistical significant impact on the frequency and duration of patient re-hospitalization?

### Hypothesis:

The treatment group will have fewer occurrences of re-hospitalization and shorter duration of re-hospitalization than the control group

**Additional Hypotheses:**

1. The treatment group will show a higher level of independence in daily functioning than the control group
2. The treatment group will have more social support than the control group
3. The treatment group will show a larger decrease in psychiatric symptoms than the control group
4. The treatment group will show a larger increase in quality of life than the control group
5. Gender will not have an effect on outcome factors

**Ethics approval required**

Old ethics approval format

**Ethics approval(s)**

Ethics Committee of the Canton of Zurich [Kantonale Ethikkommission Zürich], Switzerland, 18/08/2011, ref: EK: 2011-0175/3

**Study design**

Randomized controlled trial

**Primary study design**

Interventional

**Study type(s)**

Treatment

**Health condition(s) or problem(s) studied**

Mental and behavioural disorders

**Interventions**

Zurich University of Applied Sciences [Zürcher Hochschule für Angewandte Wissenschaften (ZHAW)] and Institute of Psychiatry (IPW) collaborated and developed PDNC-P. The program aims to ease the transition between inpatient and outpatient care by coordinating a social support network that reduces negative relationships, promotes positive relationships, and help patients integrate back into society.

Subjects are split into two groups: treatment group and control group. The treatment group participates in Post-Discharge Network Coordination Programme (PDNC-P). The control group receives treatment as usual with no additional social support. Further outcome variables include: social support, change in psychiatric symptoms, quality of life, and independence in daily functioning.

The program assigns each patient to a social worker. Each patient meets with his/her social worker prior to discharge. The patient collaborates with the social worker and agrees upon a close network of social support, a crisis plan, and the terms of program termination. The social worker visits the patient within the first week of discharge to support and monitor the patients adjustment to outpatient care and daily life. The social worker and at least two individuals from the social support network meet within the second week of discharge to discuss the patients personal goals and how the social network can help the patient better cope and adjust to daily life. A network pilot is chosen to mediate between the patient and the social support network. After the home visit during the first week, the social worker schedules occasional visits based on

the patients progress and needs. The program is tailored according to the patients personal needs. The program is terminated once the terms of termination are reached or after a maximum of three months after discharge from inpatient care. The social support network will continue to aid the patient after program termination.

## **Intervention Type**

Behavioural

## **Primary outcome(s)**

Frequency and duration of re-hospitalization:

1. IPW database
2. Client Socio-Demographic and Service Receipt Inventory-European Version (CSSRI-EU)

## **Key secondary outcome(s)**

Independence in Daily Functioning:

1. Social and Occupational Assessment Scale (SOFAS) and Global Assessment of Functioning (GAF) Scale
2. German adaptation of the Client Sociodemographic and Service Receipt Inventory (CSSRI-EU)

Social Support:

1. Fragebogen zur Sozialen Unterstützung (F-SozU K-14)

Change in Psychiatric Symptoms:

1. Health of the Nation Outcome Scales (HoNOS)
2. Clinical Global Impression Scale (CGI)
3. Outcome Questionnaire (OQ®-45)

Quality of life

1. Manchester Short Assessment of Quality of Life (MANSA)
2. Recovery Assessment Scale (RAS)
3. Internalized Stigma of Mental Illness Inventory (ISMI)
4. Morisky-Score

## **Completion date**

01/03/2015

## **Eligibility**

### **Key inclusion criteria**

1. The subject must have at least one inpatient stay within the past three years
2. The subject must have a Global Assessment of Functioning (GAF) score of 60 or lower
3. The subject must have the ability to make informed decisions
4. The subject must be between the age 18 and 64 years old

### **Participant type(s)**

Patient

### **Healthy volunteers allowed**

No

### **Age group**

Adult

**Lower age limit**

18 years

**Sex**

All

**Key exclusion criteria**

1. The subject cannot participate if he/she cannot sufficiently communicate in German (lack of adequate German speaking skills can make it difficult for the patient to provide usable data through questionnaires and interviews)
2. The patient cannot participate if he/she is already being supported by a case manager
3. The patient cannot participate if he/she already lives in any form of supportive housing [ Betreutes Woken]

**Date of first enrolment**

01/09/2011

**Date of final enrolment**

01/03/2015

## Locations

**Countries of recruitment**

Switzerland

**Study participating centre**

**Zurich University of Applied Sciences**

Zurich

Switzerland

8032

## Sponsor information

**Organisation**

Zurich University of Applied Sciences (Switzerland)

**ROR**

<https://ror.org/05pmsvm27>

## Funder(s)

**Funder type**

Government

**Funder Name**

Zurich Department of Health (Switzerland)

## Results and Publications

### Individual participant data (IPD) sharing plan

#### IPD sharing plan summary

Not provided at time of registration

#### Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
<a href="#">Results article</a>	results	01/12/2016		Yes	No
<a href="#">Participant information sheet</a>	Participant information sheet	11/11/2025	11/11/2025	No	Yes
<a href="#">Study website</a>	Study website	11/11/2025	11/11/2025	No	Yes