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Inpatient psychiatry

August 2026

The scope of this current awareness bulletin is inpatient psychiatric care and patient discharge. The bulletin focuses on administration and organisation of inpatient psychiatry rather than psychiatric treatment itself. UK/Europe/North America/Australia/NZ limits.

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References

Andreassen M., et al. (2026) 'Coordination of Hospital Discharge for Older People with Dementia: Insights from Politicians and Local Government Officials.' *BMC Geriatrics 26*(1) (pagination), Date of Publication: 19 May 2026.
BACKGROUND: After hospital care, older people with dementia often require further health and social care services. Hospital discharge is a complex process in which such support is planned and coordinated. This typically requires collaboration between professionals with different responsibilities representing various authorities to ensure integrated care. In Sweden, the decentralised organisation of health and social care services may lead to variation in discharge procedures and in how collaboration across care providers and authorities is organised. Politicians and civil servants play a central role in shaping discharge practices and in organising collaboration and coordination of services within regions and municipalities. However, their perspectives remain relatively underrepresented in previous research on hospital discharges for older people with dementia.
METHOD(S): Maximum variation strategy was used to recruit four politicians and eleven local government officials. Semi-structured interviews were conducted and analysed using reflexive thematic analysis.
RESULT(S): Our findings suggest that the discharge process from inpatient hospital care is governed by formal agreements outlining responsibilities between care providers. This process involves both a physical relocation and an administrative handover of responsibilities. Strategic workforce planning is essential to ensure sustained staff competence, and particular attention must be given to safeguarding the individual's representation throughout the discharge process.

CONCLUSION(S): Politicians and local government officials highlight the need for clearly defined procedures and guidelines, governed by formal agreements between care providers and care authorities. The findings problematize frequent staff turnover, which undermines the development of a stable organizational culture in relation to hospital discharges. Furthermore, there is a need for experienced professionals committed to working with people with dementia, applying a person-centred approach throughout discharges.

Apajalahti H., et al. (2026) **'Care Needs of Adult Patients in Psychiatric Inpatient Settings Based on the Fundamentals of Care Framework: An Integrative Review.'** ***Archives of Psychiatric Nursing 62*****, 152133.**
Psychiatric inpatient units, designed for short stays, should support advanced person-centered care for individuals with acute mental disorders. The threshold for psychiatric hospital admission has risen, and patients present with increasingly complex care needs. Accurately identifying these needs is critical for individualized care planning and determining appropriate care levels. However, research on adult care needs in psychiatric inpatient settings remains limited. This integrative review aimed to identify, describe, and synthesize the care needs of adult psychiatric inpatients reported in the literature, using the Fundamentals of Care Framework. A systematic search of three electronic databases was conducted in January 2025. Methodological quality was assessed with the revised Mixed Methods Appraisal Tool (MMAT), and findings were narratively synthesized according to the review's objectives. Thirty-seven studies published between 1977 and 2024 were included. The core care needs centered on safety, emotional well-being, and being involved and informed. Notably, nurses and patients expressed differing views on psychosocial needs. Despite heterogeneity in existing research, findings suggest promising benefits for nursing practice. The divergence between nurses' and patients' perspectives underscores the need for holistic, collaborative care planning. Furthermore, the strong emphasis on safety among nursing staff reflects a risk-oriented culture that may overshadow other essential aspects of care. Further research is warranted to deepen understanding and inform evidence-based practices for adult psychiatric inpatients.

Berge J., et al. (2026) **'Psychiatric Inpatient Bed Capacity and Suicide Mortality in Sweden: A Nationwide Ecological Study.'** ***The Lancet Regional Health - Europe 66*****(pagination), Article Number: 101675. Date of Publication: 01 Jul 2026.**
Background: Suicide is a leading cause of premature mortality worldwide, but the impact of system-level mental health resources remains unclear despite the central role of psychiatric inpatient care and declining bed capacity. Prior research has yielded inconsistent findings with limited control for confounding. We aimed to estimate the effect of psychiatric inpatient bed availability on suicide mortality in a universal, publicly dominated mental health-care system.
Method(s): We conducted a nationwide ecological study using data from 20 Swedish counties between 2015 and 2024. Suicide mortality was obtained from the Cause of Death Register. Psychiatric inpatient bed availability and county-level healthcare budget allocation were extracted from Swedish Municipalities and Regions. Pooled cross-sectional quasi-Poisson regression models, fixed effects models, and Bayesian hybrid mixed-models were used to estimate effects between and within

counties. The primary effect estimate was the percentage change in suicide mortality associated with a 10-bed increase per 100,000 inhabitants.
Finding(s): Psychiatric bed capacity declined nationwide from approximately 30.6 beds per 100,000 inhabitants in 2015 to 24.2 in 2024. The overall between-county effect was estimated to 0.892 (95% CI: 0.827-0.961). In the primary analysis of within-county effects, each 10-bed increase per 100,000 inhabitants was associated with a 7.6% reduction in suicide mortality (rate ratio 0.924, 95% CI: 0.881-0.969; p = 0.001). In the Bayesian within-between decomposition models, only the within-county effect of psychiatric bed capacity was fully within the credible intervals (95% credible interval 0.852-0.994).
Interpretation(s): Greater psychiatric bed availability was associated with lower suicide rates, highlighting the inverse association of inpatient care availability and suicide mortality in a high-income country. Extrapolating to Sweden's population of 10.6 million in 2024, a return to the psychiatric bed capacity of 2015 would correspond to approximately 83 fewer suicides annually, assuming that the association is causal. Safeguarding timely access to inpatient psychiatric care may be an important component of national suicide-prevention strategies.
Funding(s): USVE grants.

Browne B., et al. (2026) 'Identifying the Determinants of Hospital Readmission in Dementia Patients - A Retrospective Cohort Study using Electronic Healthcare Records in England.' *PloS One 21*(7), e0351331.
BACKGROUND: People living with dementia are at an increased risk of multiple hospital admissions due to acute illness, underlying vulnerability, progression of behavioural symptoms of dementia, or breakdown of care provision. Reducing readmission rates is a key clinical priority. This study used linked electronic health records from general practice and hospitals in England, to investigate the determinants associated with hospital readmissions and estimate the mortality risk of older adults with dementia within one year of hospital readmission.
METHOD(S): A retrospective cohort study using Clinical Practice Research Datalink and linked data. Patients were included if they were > 65y, diagnosed with dementia, and had a recorded acute general hospital admission. Outcome variables were readmission to hospital within 180 days of discharge, and in the readmitted group, mortality within one year of readmission. Demographics, long term conditions, polypharmacy, antipsychotic medication, medication review, post-discharge primary care appointments, and living in residential care were examined as determinants using stepwise logistic regression for readmission, and Cox regression for survival models.
RESULT(S): 30,527 patients were included, median age 84y (62.7% female), with 12,351 (40.5%) readmitted within 180 days of discharge. Being male, having multiple long-term conditions, having a medication review or attending a primary care appointment post-discharge were positively associated with readmissions, while Alzheimer's type dementia, having 'Other' ethnicity, and living in residential care were negatively associated. We found a significant effect on mortality risk of age, sex, type of dementia, having two or more long-term conditions, body mass index, antipsychotic medication, polypharmacy, and living in residential care.
CONCLUSION(S): The findings of this cohort study suggest that biological, psychological, and social factors interact to influence hospital readmissions in older

adults with dementia. Multiple long-term conditions emerged as the strongest determining factor for readmission, while age was important in survival. Future research should assess psychosocial factors such as social support, caregiver burden, and mental well-being. These findings have important implications for strengthening community-based healthcare for adults with dementia, to reduce hospital readmission.

Elgendy H.E., et al. (2026) 'Predictors of Psychiatric Emergency Department Visits within Twelve Months Post-Inpatient Psychiatric Discharge in Alberta, Canada.' *PloS One 21*(7), e0351753.
BACKGROUND: Psychiatric emergency department (ED) visits following discharge from inpatient psychiatric care remain a significant challenge for mental health systems and may reflect gaps in continuity of care and community support. While sociodemographic and clinical predictors of recurrent ED utilization have been widely studied, the role of inpatient satisfaction and transitional care interventions in predicting post-discharge psychiatric ED visits remains less clear.
OBJECTIVE(S): This study aimed to examine predictors of psychiatric ED visits within 12 months following discharge from acute psychiatric inpatient units, with particular focus on inpatient satisfaction, prior ED utilization, intervention exposure, sociodemographic characteristics, and clinical factors.
METHOD(S): This observational cohort analysis used data from participants recruited through a pragmatic stepped-wedge transitional care study in Alberta, Canada. A multivariable logistic regression model was conducted to identify predictors of psychiatric ED visits within 12 months post-discharge. Predictor variables included intervention group [treatment as usual (TAU), supportive text messaging (SMS), and supportive text messaging combined with peer support (SMS + PS)], prior ED visits within 6 months before index admission, inpatient satisfaction, sociodemographic variables, and clinical characteristics.
RESULT(S): The study included 1,070 participants. Prior psychiatric ED visits within 6 months preceding the index admission emerged as the strongest predictor of post-discharge psychiatric ED utilization. Unemployment and housing instability were also significantly associated with increased likelihood of ED visits within 12 months following discharge. In contrast, inpatient satisfaction, intervention group, gender, ethnicity, relationship status, resilience, wellbeing, depression, and anxiety measures were not independently associated with post-discharge psychiatric ED visits.
CONCLUSION(S): Psychiatric ED visits following discharge were primarily associated with prior ED utilization and socioeconomic factors, particularly unemployment and housing instability. Although inpatient satisfaction represents an important component of patient-centered psychiatric care, it was not independently associated with subsequent psychiatric ED visits in this cohort. These findings highlight the importance of addressing structural and social determinants alongside transitional care planning to reduce recurrent psychiatric ED utilization.

Goossens C., et al. (2026) **'Rules and Limit-Setting in Adolescent Inpatient Psychiatric Wards: A Systematic Narrative Review.'** ***Journal of Child and Adolescent Psychiatric Nursing : Official Publication of the Association of Child and Adolescent Psychiatric Nurses, Inc 39*****(3), e70063.**
BACKGROUND: Inpatient psychiatric wards are a crucial, albeit unique, part of the paediatric mental healthcare system. By their nature they exert greater control over their patients' daily lives, by means of rules and restrictions on behaviour, than do other types of health services. As such, it is essential to have a clear and comprehensive understanding of what rules and structures are reasonable to impose in these settings. Limited literature exists on this topic, particularly relating to adolescent inpatient mental health settings.
OBJECTIVE(S): This paper reports a systematic narrative review of existing knowledge on structures of rules on adolescent inpatient psychiatric wards. DATA SOURCES: A search of databases (PsycINFO, Medline, and Embase) identified 31 papers meeting inclusion criteria.
CONCLUSION(S): Data extraction and analysis of included papers revealed six themes: descriptions of rules and behaviour structures, the flexibility of rules, the rationale for rules, patient autonomy and involvement in the development of rules, and outcomes of rule structures. IMPLICATIONS FOR PRACTICE: Implications for practice include a recommendation for adolescent inpatient wards and their governing policies and procedures to take these elements into account when devising ward rules and structures. We hope the findings of this review will improve consistency of care in adolescent inpatient settings, reduce arbitrariness of behaviour restrictions, and enable future research to evaluate the impact of rules on mental health outcomes.

Halstead S., et al. (2026) **'Comparative Incidence Rates of Physical Multimorbidity in a Psychiatric Inpatient Population among People with and without Severe Mental Illness: A Retrospective Cohort Study.'** ***Australian and New Zealand Journal of Psychiatry 60*****(6), 562–574.**
Objective: While people experiencing severe mental illness have a greater prevalence of physical multimorbidity, data on incidence are largely limited to the onset of specific physical conditions. We assessed whether people with severe mental illness have increased incidence rates of physical multimorbidity compared to people with other psychiatric conditions.
Method(s): This retrospective observational cohort study reported on a longitudinal psychiatric inpatient sample (2010-2024) in a metropolitan service in Brisbane, Australia. Within a subgroup of individuals with no pre-existing physical conditions, we compared individuals with and without a history of severe mental illness (schizophrenia-spectrum or bipolar disorder). With a denominator of person-years, we calculated the incidence of different thresholds of physical multimorbidity using adjusted Fine-Gray subdistribution hazard ratios.
Result(s): Among the 3310 individuals with severe mental illness, 298 developed physical multimorbidity (two chronic physical conditions) across 21893 person-years, compared to 52 among the 2850 individuals and 18,112 person-years in the comparison group. When adjusted for clinical and demographic covariates, people with severe mental illness had an increased risk of developing one (subdistribution hazard ratio = 3.36; 95% confidence interval = 2.79, 4.03), two (subdistribution

hazard ratio = 4.06; 95% confidence interval = 3.02, 5.46), three (subdistribution hazard ratio = 5.36; 95% confidence interval = 3.35, 8.59), and four (subdistribution hazard ratio = 4.84; 95% confidence interval = 2.49, 9.40) chronic physical conditions. Except for malignancy and genitourinary disease, people with severe mental illness had increased incidence of chronic physical conditions in all other organ systems.
Conclusion(s): People with severe mental illness experienced greater incidence rates of multimorbidity at various thresholds, with a majority of organ systems affected. This highlights the need for holistic prevention and intervention strategies to curb the accumulation of physical multimorbidity.

Hamill R., and Kelly, B. D. (2026) 'Rates of Restrictive Practices in Acute Adult Inpatient Psychiatry Units in Ireland.' *Irish Journal of Psychological Medicine 43*(2), 199–204.
Objectives: This paper examines rates of physical restraint and seclusion under the Mental Health Act 2001 in acute adult psychiatry inpatient facilities (approved centres) in Ireland.
Method(s): Analysis of rates of physical restraint and seclusion in acute adult approved centres in Ireland in 2023, based on data made publicly available by the Mental Health Commission, Health Research Board, and Central Statistics Office.
Result(s): Rates of physical restraint vary 16-fold between approved centres, ranging from 116 episodes of physical restraint per 100,000 population per year to 7 per 100,000 population, with a national rate of 39 per 100,000 population. Among the six approved centres with the highest rates of physical restraint, five are in Dublin (i.e. urban). Among approved centres that use seclusion, rates vary 19-fold, ranging from 38 episodes of seclusion per 100,000 population to 2 per 100,000 population, with a national rate of 15 per 100,000 population.
Conclusion(s): There are within-country variations in rates of physical restraint and seclusion in Ireland, but these are of a lesser magnitude than between-country variations. Overall, Ireland's rates of restrictive practices are lower than those in other jurisdictions, consistent with Ireland's low rate of involuntary admission. Future research could usefully focus on the relationship between restrictive practices and urbanicity, among other themes.

Ishida K., et al. (2026) 'Sex Difference in Risk and Protective Factors of State Psychiatric Hospital Readmissions among Non-Forensic Psychiatric Patients in the United States in 2020-2023: Discrete-Time Hazard Models Applied to the National Mental Health Client-Level Data.' *Administration and Policy in Mental Health 53*(3), 240–250.
Researchers and policymakers use hospital readmission rates as measures of health care quality and cost. This study used the Mental Health Client-Level Data (MH-CLD) to document hospital readmission rates and determinants of readmission for female and male patients discharged from state psychiatric hospitals across 36

U.S. states and Puerto Rico between 2020 and 2023. The results show that the readmission rate was significantly higher among males than among females at 30 days (7.8% vs. 7.1%) and throughout the 26-week post-discharge observation period. Based on discrete-time hazard models applied to discharge-week panel data constructed from discharge data from 110,353 unique patients, the most important common risk factors for both sexes were being Hispanic, a diagnosis of schizophrenia or other psychotic disorders or bipolar disorder, co-occurring substance use problems, and having a serious mental illness (SMI). However, a diagnosis of depressive disorders increased the likelihood of re-hospitalization only among males and a diagnosis of bipolar disorder increased the likelihood of re-hospitalization more substantially for males than females. Being married was a common protective factor for both sexes, but its effect was significantly greater for males. Other significant sex differences included Black male patients having a higher likelihood of readmission than their White counterparts, but this was not observed among Black female patients. Involuntary admission had opposite effects by sex: it increased the likelihood of readmission for females but decreased it for males. Consideration of the types and length of treatment at hospitals and post-discharge care may provide insight into these sex differences.

Modini M., and Large, M. (2026) **'Understanding the Suicide Rate Post-Discharge from a Psychiatric Hospital: Time for a Rethink.'** ***Australasian Psychiatry 34*(3), 227–230.**
Objective: Research has repeatedly failed to account for the high suicide rate post-discharge from a psychiatric hospital. It is apparent that research in this field largely focuses on simple categorical variables and fails to consider inpatient experiences of their admission and treatment.
Conclusion(s): Empirically investigating how the treatment experience itself can contribute to post-discharge adverse outcomes is required. Failure to broaden our investigation into causes of post-discharge suicide will hamper our efforts in addressing this devastating issue.

Mullen A., et al. (2026) **'Lived Experience Workforce Perspectives about the Consumers' Experiences of Safewards in Acute Inpatient Mental Health Units: A Qualitative Exploratory Study.'** ***International Journal of Mental Health Nursing 35*(4), e70301.**
The Safewards model and its ten interventions have been effective in reducing restrictive practices and preventing conflict within acute inpatient mental health units. However, few studies in the current literature explore the consumers' experiences of Safewards. This exploration also needs to consider the views of Mental Health Nurses and the Lived Experience Workforce, who are both important stakeholders in the application of Safewards and how it impacts on consumers' experiences. Despite this, the views of Mental Health Nurses and the Lived Experience Workforce about consumers' experiences of Safewards are limited. This qualitative study explored the views of Lived Experience Workforce leaders about consumers' experiences of Safewards, and Mental Health Nurses' responses to these experiences in acute inpatient mental health units in Australia. Six Lived Experience Workforce leaders participated in individual interviews. Data were analysed using thematic analysis, revealing four themes: (1) consolidating Safewards through understanding consumers' experiences, (2) consumers as leaders in Safewards, (3) acknowledging the realities of acute inpatient mental health units and (4) practice foundations

underpinning Safewards. Results highlighted the positive impact of improved consumer involvement in Safewards. Additionally, mechanisms to develop strategic partnerships between Lived Experience Workforce leaders and mental health nurses warrant further investigation. This study highlighted the restrictive nature of acute inpatient mental health units and the need to acknowledge the impact this has on consumers. Further embedding of foundational approaches, such as trauma-informed and recovery-oriented practice within Safewards, is also required to align with consumers' expectations. Greater recognition of consumers' experiences and their agency within the model, and consideration of other Safewards interventions, is also needed. This is required to increase safety, reduce harms associated with restrictive practice, and enhance Safewards effectiveness.

Plever S., et al. (2026) 'Interventions for Smoking Cessation in Inpatient Psychiatry Settings.' *The Cochrane Database of Systematic Reviews 7*, CD015934.
RATIONALE: Tobacco smoking is a leading preventable cause of premature morbidity and mortality in people living with severe mental illness. Smoking rates are disproportionately high and abstinence rates low in people with severe mental illness, despite their reported interest in quitting being comparable to that of the general population. Inpatient psychiatry settings have been identified as opportune places to promote and support tobacco cessation amongst people with severe mental illness who smoke, particularly since many hospitals have implemented smoke-free policies. Evidence is needed to guide policy and practice for tobacco cessation interventions within inpatient psychiatry settings.
OBJECTIVE(S): To assess the effects of smoking cessation interventions on tobacco smoking in adults receiving inpatient psychiatry treatment.
SEARCH METHOD(S): We searched the following bibliographical databases and clinical trial registers from inception until 10 February 2026: Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, Embase (Elsevier), PubMed, PsycINFO (EBSCOhost), CINAHL Complete (EBSCOhost), ProQuest Dissertations and Theses Global, ClinicalTrials.gov, World Health Organization International Clinical Trials Registry Platform (WHO ICTRP). We also handsearched the annual meeting abstracts for the Society for Research on Nicotine and Tobacco (SRNT) and screened reference lists of eligible studies. ELIGIBILITY CRITERIA: We included randomised controlled trials (RCTs) and cluster-RCTs that assessed interventions for tobacco cessation amongst people of 18 years and older who were inpatients in psychiatry settings. Interventions had to be initiated in the psychiatry inpatient setting and aimed at supporting smoking cessation.
OUTCOME(S): Our critical outcome was smoking abstinence at six months (biochemically verified) and our important outcomes included serious adverse events. RISK OF BIAS: We used the Cochrane risk of bias tool (RoB 2) to assess the outcomes of our review. SYNTHESIS METHODS: We synthesised results using meta-analysis where appropriate, calculating risk ratios using the inverse-variance random-effects model. Where this was not possible, we synthesised results following Synthesis Without Meta-analysis (SWiM) guidelines. We used GRADE to assess our level of certainty in the evidence for our two key outcomes. INCLUDED STUDIES: We included 10 studies that involved 2262 people in total. Three trials were conducted in the USA, two in Australia, two in Taiwan, two in Iran, and one in Israel.

The studies took place in emergency or acute and long-stay psychiatric settings. In most studies, the participants had a mix of diagnoses (e.g. mood disorders, anxiety disorders, schizophrenia), and three studies involved only participants with schizophrenia or schizophrenia-type disorders. Five studies tested smoking cessation counselling plus nicotine replacement therapy with post-discharge follow-up support versus usual care; one study tested a group behavioural programme for smoking reduction versus waitlist control; and four studies tested pharmacotherapy interventions including smoking medications (bupropion versus placebo, cytisine versus nicotine replacement therapy) and nicotine replacement therapy (different types and doses). SYNTHESIS OF RESULTS: We found low-certainty evidence of increased smoking abstinence from interventions that provided counselling with nicotine replacement therapy and post-discharge support, compared to usual care, when measured six months after the start of the intervention or hospital discharge (RR 1.81, 95% CI 1.33 to 2.47; P < 0.001, I2 = 0%; 5 studies, 1611 participants; low-certainty evidence). Across studies, serious adverse events (SAEs) were low. We pooled four studies reporting deaths at 6 to 18 months after the start of the intervention or hospital discharge. We found that the intervention of smoking cessation counselling plus nicotine replacement therapy with post-discharge support may result in a slight reduction in deaths compared to usual care, but the results are very uncertain due to low event numbers (22), considerable imprecision, and some concerns about risk of bias (RR 0.81, 95% CI 0.34 to 1.96; P = 0.50, I2 = 0%; 4 studies, 1431 participants; very low certainty evidence). AUTHORS' CONCLUSION(S): People receiving inpatient psychiatry treatment may be more likely to have successfully stopped smoking six months after the inpatient intervention when offered smoking cessation counselling plus nicotine replacement therapy with continued post-discharge support, compared with usual care, but the certainty of the evidence is low. There was insufficient evidence to determine the effectiveness of other smoking cessation interventions initiated in the psychiatry inpatient setting. More randomised controlled trials, especially those evaluating pharmacological interventions, are needed to strengthen conclusions about treatment effects. FUNDING: This Cochrane review had no dedicated funding. REGISTRATION: Protocol (2024) DOI: 10.1002/14651858.CD015934.

Rickett M., et al. (2026) 'Duration of Care in Early Intervention in Psychosis Services: A Multi-Perspective Qualitative Study.' *Early Intervention in Psychiatry 20*(7) (pagination), Article Number: e70199. Date of Publication: 01 Jul 2026.
Introduction: Early Intervention in Psychosis (EIP) services in England are commissioned to provide up to 3 years' support to people experiencing first episode psychosis, but the optimal duration remains debated. This qualitative study aimed to explore how decisions about EIP duration are made and experienced by multiple stakeholders.
Method(s): Qualitative longitudinal study comprising semi-structured interviews with EIP Service Users (SUs), carers, EIP practitioners, GPs, and mental health service commissioners; follow-up interviews with SUs 6-11 months later. Data were collected between September 2022 and September 2024 and informed by information power. Data were thematically analysed by a multidisciplinary team. Patient and carer involvement and engagement were integral to the study.

Result(s): The 3-year time limit of contact with EIP teams was thought to work well when SUs felt supported and ready for discharge, but constrained shared decision making when they did not. Some participants described early discharge before 3 years, either as a negotiated decision based on wellness and readiness to move on or as a consequence of poor engagement. Others reported extended care beyond 3 years in response to individual needs or delays in transfer to Community Mental Health Teams (CMHTs). This flexibility in duration varied across teams and trusts. Well-managed, relational care was viewed as key to effective discharge.
Conclusion(s): Flexible, person-centred episodes of care and collaborative discharge planning, supported by effective coordination between EIP, primary care, and CMHTs, are essential to sustaining relational practice and ensuring smoother transitions.

Senthil S., et al. (2026) **'Prevalence and Factors Associated with Restraints in Mental Health in-Patient Wards.'** ***BJPsych Bulletin 50*(3), 237–242.**
Aims and method Restraints in mental health in-patient settings can negatively affect recovery. This study aimed to examine the prevalence and associated factors of restraint use. A retrospective cohort study was conducted in a rural NHS mental health trust in the UK, covering all adult in-patients from July 2020 to July 2021. Results The prevalence of restraint was 34%. Factors associated with restraint included age 18-25 or >=65 years, female gender, disability, long-term sickness benefits, detention under the Mental Health Act, frequent admissions and a diagnosis of depressive or severe mental illness. Statistically significant associations were found for age >=65 years (odds ratio 3.920), Section 2 detention (odds ratio 5.72), more than ten previous admissions (odds ratio 5.672) and depressive disorders (odds ratio 3.478). Clinical implications Restraint use remains common and is linked to identifiable risk factors. These findings support the need for targeted interventions to reduce restraint, particularly for high-risk patient groups.

Stanciu C.N., et al. (2026) **'Substance use Referrals among Inpatients with Serious Mental Illness: Clinical Characteristics and Real-World Evaluation of the New Hampshire Hospital Screening and Referral Algorithm.'** ***Primary Care Companion for CNS Disorders 28*(2) (pagination), Article Number: 25m04110. Date of Publication: 2026.**
Objective: To evaluate the performance of the New Hampshire Hospital Screening and Referral Algorithm (NHHSRA) and describe the characteristics of inpatients aged 18-65 years, with serious mental illness (SMI) referred for substance use disorder (SUD) interventions.
Method(s): Two questions were evaluated: (1) the accuracy and utility of the NHHSRA in identifying patients appropriate for addiction-focused interventions and (2) associations between referral status and patient characteristics. Receiver operating characteristic (ROC) curve analysis evaluated diagnostic performance of the NHHSRA, with sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), precision, and F1 score assessed. Logistic regressions assessed associations between patient characteristics and referral outcomes. The reference standard ("need for SUD intervention") was defined as the addiction psychiatrist's clinical assessment following direct patient evaluation. The patients assessed in this study were admitted to New Hampshire Hospital between January

2023 and February 2025.
Result(s): The cohort (n = 927) was predominantly male (66.7%), with a mean age of 36.5 years. Opioid use disorder (OUD) was the most prevalent primary SUD (37.9%), followed by alcohol (23.9%), cannabis (15.1%), and methamphetamine (13.7%). The NHHSRA demonstrated excellent performance-sensitivity: 96.6%, specificity: 93.6%, PPV: 98.5%, NPV: 86%, and F1 score: 97.5%. ROC analysis yielded an AUC of 0.82, indicating strong discriminative ability. Logistic regressions identified higher odds of a positive NHHSRA screen among patients with OUD and lower odds among those with cannabis use disorder, after adjusting for age, sex, and psychiatric diagnosis.
Conclusion(s): The NHHSRA is an accurate, objective tool that enhances identification of SUD intervention needs among inpatients with SMI. By addressing limitations of subjective clinical judgment and patient self-report, its implementation may improve access to addiction services and optimize treatment delivery. Patient characteristics associated with referrals inform targeted strategies for integrated care in this population.

Torales J., et al. (2026) **'ChatGPT-4 in Psychiatric Discharge Summaries: Toward a More Comprehensible and Emotionally Sensitive Clinical Communication.'** ***The International Journal of Social Psychiatry 72*****(4), 931–943.**
BACKGROUND: Psychiatric discharge summaries are vital for ensuring continuity of care, yet they are often written in technical language that can be difficult for patients to understand and may cause emotional distress or reinforce stigma. With increasing patient access to medical records, there is a pressing need to develop communication tools that are both comprehensible and emotionally safe. AIM: This study aimed to evaluate the diagnostic fidelity, linguistic clarity, emotional sensitivity, treatment comprehension, and readability of psychiatric discharge summaries rewritten by ChatGPT-4 based on real clinical cases.
METHOD(S): This was the first study in South America to examine the use of a generative language model for rewriting psychiatric discharge summaries. A mixed-methods, observational cross-sectional design was applied. Twenty-five anonymized clinical cases were rewritten using ChatGPT-4. Three psychiatrists independently assessed each AI-generated summary across four dimensions: diagnostic fidelity, clarity of language, perceived emotional risk, and understanding of treatment. Readability was evaluated using the Fernandez-Huerta Index and the INFLESZ Scale. A thematic analysis of evaluators' written comments was also conducted.
RESULT(S): Summaries generated by ChatGPT-4 were rated positively, particularly for clarity and treatment explanation. Significant improvements in readability were observed across all diagnostic groups ($p < .001$), with mean values surpassing recommended thresholds for general comprehension. However, five summaries remained below those thresholds, and some diagnostic inaccuracies were noted (e.g. omissions in bipolar disorder). Evaluators also highlighted emotionally charged or stigmatizing language in a few cases.
CONCLUSION(S): ChatGPT-4 can enhance the accessibility and emotional appropriateness of psychiatric discharge communication, supporting more patient-centered care. Nevertheless, professional oversight remains critical to ensure clinical accuracy and contextual sensitivity. Future research should include patient feedback, assess long-term outcomes, and explore hybrid human-AI collaboration models.

Wu J., et al. (2026) **'Hospitalization Costs Associated with 30-Day Unplanned Readmissions and Potentially Preventable Readmissions in US Older Patients with Alzheimer's Disease and Related Dementias.'** ***BMC Health Services Research 26*****(1) (pagination), Date of Publication: 21 Ar 2026.**

BACKGROUND: Older patients with Alzheimer's disease and related dementias (ADRD) face high rates of unplanned hospital readmissions, many of which may be avoidable through better care coordination and post-discharge support. This study aims to examine the costs associated with 30-day unplanned readmissions and potentially preventable readmissions (PPRs) among US older patients with ADRD.
METHOD(S): This study utilized the 2022 Nationwide Readmission Database to identify index admissions, 30-day unplanned readmissions, and PPRs in patients >= 65 years with ADRD, following the criteria established by the Centers for Medicare & Medicaid. Cost outcomes were assessed at the patient and event levels, including annual total hospitalization costs, 30-day unplanned readmission costs, and PPR costs.
RESULT(S): Among older patients with ADRD (n = 743,855), 20.6% experienced at least one 30-day unplanned readmission. Patients with a 30-day unplanned readmission incurred significantly higher average total hospitalization costs per patient than those without ($67,566, [95% confidence interval (CI): $67,219-$67,914] vs. $27,239 [95% CI: $27,147 - $27,333], p < 0.001), translating to 117% higher adjusted total costs. Among readmitted patients, 50.6% experienced at least one PPR. Patients with a PPR incurred higher readmission costs than those without ($32,802 [95% CI: $32,490 - $33,113] vs. $24,525 [95% CI: $24,293 - $24,757], p < 0.001), translating to 25.9% higher adjusted readmission costs. Unplanned readmission costs represented 14.3% of total hospitalization costs, with PPR costs accounting for 75.7% of unplanned readmission costs. The highest PPR cost category was associated with infections ($780 million), followed by chronic conditions ($251 million).
CONCLUSION(S): Unplanned readmissions and PPRs imposed a substantial financial burden on payers and healthcare systems caring for older patients with ADRD. Targeted efforts to improve care transitions and better manage infections and chronic conditions are critical for reducing PPRs and associated costs in this vulnerable population.

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