What is the lived experience of being discharged from a psychiatric inpatient stay?

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Background

- The immediate post-discharge phase is critical for psychiatric patients, particularly for long-term adaptation to the community (Bruffaerts, Sabbe, & Demyttenaere, 2004).
- They are at risk of homelessness (Forchuk, Russell, Kingston-Macclure, Turner, & Dill, 2006), stigma (Farina et al., 1991) violence (Steadman et al., 1998) & re-hospitalisation (Irmiter, McCarthy, Barry, Soliman & Blow, 2007) post-discharge.
- Suicide & self-harm rates post-discharge are high, with many incidents occurring within the first 2 weeks (Gunnell et al., 2008).
- However, most research is quantitative. Therefore, little is known about why discharge is so difficult.

Background

- Discharge Planning (DP) aims to ease the transition between hospital & home by improving the coordination of services (Sheppard et al., 2010).
- Department of Health (2003) recommends:
  - a "whole systems approach"
  - the patient & carer as experts
  - DP begins prior to admission (if planned)
- Discharge is often unplanned, delayed or without successful links to the community (Boyer, McAlpine, Pottick & Olfson, 2000).
- Interventions at discharge have had limited success (Walker & Eagles, 2002).

Current Study

- Used qualitative methods to explore what discharge is like for patients.
- It was hoped that by increasing understanding of what discharge is like, improvements can be made.

Method

- Utilised Interpretative Phenomenological Analysis (IPA) methods (Smith, Flowers & Larkin, 2009).
- Ethics approval obtained by Southampton University & NHS.
- Participants recruited through 3 Community Mental Health Teams (CMHT), Assertive Outreach (AOT) in Southampton & CAST (service user Consultancy AND Support Team).
- Inclusion criteria: over 18yrs, discharged from psychiatric hospital stay within the last 3 years (but not within 6 months of discharge), able to consent.

Method cont.

- Sample:
  Small samples are the norm when using an idiographic approach.
  8 participants (5 female, 3 male) were interviewed.
  Age range: 26–65, 7 were white, 1 was Asian
  Time since discharge ranged from 6 months to 2.5 years.
- A semi-structured interview schedule was used. Open-ended questions were used to elicit more detailed responses.
- Interviews were recorded & transcribed verbatim.

Analysis

▸ Transcripts were analysed using IPA.

▸ Follows the hermeneutic circle: moving from particular to shared, from description to interpretation.

▸ Therefore, each transcript is analysed entirely before moving on to the next:
  - Immerse in data
  - Initial noting
  - Identify emerging themes
  - Clusters of themes used to establish subordinate themes

▸ Once each interview is analysed in detail, patterns across transcripts are established. Common subordinate themes emerge to form superordinate themes.

▸ Yardley's (2000) principles for quality qualitative research were utilised. In addition, recurrence of themes was noted.

Results

- Five superordinate themes were evident across the interviews:
  - The hospital experience
  - Experience of discharge
  - The outside world
  - The journey to health
  - Self-beliefs/identity.
- Each had several subordinate themes.

Summary of Findings

- Hospital experience highlighted positive & negatives of their stay. Participants found they became "institutionalised."
- Discharge was found to be easier when it was planned, graded, supported by staff & when they felt ready. Emotions on discharge were mixed. DP appeared to vary greatly. Discharge as a process.
- Adapting to the "outside world" was difficult. Emerged as two different worlds, inside hospital & the community. The "big bad world" was frightening. Notion of returning to "normal."
- Many felt they were on a road to recovery, one that continued. Wellness was seen as a continuum. There is no magic wand.
- Sense of self with a mental illness & how others viewed them. Building relationships as important, "lucky" to get support.
- Findings supported in other literature (e.g. Fallon, 2003; Mind, 2011).

Clinical Implications

- Participants spoke about wanting care to be more individualised & less focussed on medication.
- Participants highly valued staff who were genuine & treated them as important.
- They highlighted how difficult it was to ask for help, often needing encouragement from staff or for staff to contact them. Therefore CMHTs may need to be more proactive in contacting people at risk.
- Changes in staff could be traumatic, therefore consistency (where ever possible) was recommended.

Limitations

▸ IPA acknowledges that interpretations are tentative, subjective and can be dependent on the context, therefore may not be generalisable.

▸ IPA recommends using a homogenous sample. The participants varied in age, gender & ethnicity. However, all shared the experience of hospitalisation due to mental illness.

▸ Participants may be seen as more motivated, or confident in sharing their experiences. We obviously can not interview those who have committed suicide, who may be deemed to have the worst experiences. However, the interviews revealed both shared & different experiences, both positive & negative.

▸ Interviews are a snap shot in time. Given the changes in NHS & how time can alter our views, these views may vary & experiences may change as services change.

Further Research

- The reasons for individual differences were not explored in this study, but may be linked to stages of change, personality, environment and past experiences. Further research examining these factors might provide useful information regarding their relationship.

- Further research needs to explore the relationship between the themes identified in this study and suicide, readmission and self-harm post-discharge in order to highlight possible risks. This information could be used to inform quantitative measures examining satisfaction on discharge.

- Further guidance regarding how to cost-effectively implement DP guidelines is needed.

- Research to establish the frequency of use of DP interventions in order to highlight whether the experiences here are the norm.

- Further research exploring the experiences of discharge among BME groups.

▸ Thank you, any questions?

References

▸ Boyer, C. A., McAlpine, D. D., Pottick, K. J., & Olfson, M. (2000). Identifying risk factors and key strategies in linkage to outpatient psychiatric care. *American Journal of Psychiatry, 157*, 1592-1598.

▸ Bruffaerts, R., Sabbe, M., & Demyttenaere, K. (2004). Effects of patient and health-system characteristics on community tenure of discharged patients. *Psychiatric Services, 55*, 685-690.

▸ Department of Health. (2003). *Discharge from hospital: pathway, process and practice*. (30473). Department of Health.

▸ Fallon, P. (2003). Travelling through the system: the lived experience of people with borderline personality disorder in contact with psychiatric services. *Journal of Psychiatric and Mental Health Nursing, 10*(4), 393-401. doi: 10.1046/j.1365-2850.2003.00617.x

▸ Farina, A., Fisher, J. D., & Fischer, E. H. (1991). Societal factors in the problems faced by deinstitutionalized psychaitric patients. In P. J. Fink & A. Tasman (Eds.), *Stigma and mental illness* (pp. 167-184): American Psychiatric Press, Inc.

▸ Forchuk, C., Russell, G., Kingston-Macclure, S., Turner, K., & Dill, S. (2006). From psychiatric ward to the streets and shelters. *Journal of Psychiatric and Mental Health Nursing, 13*, 301-308.

▸ Gunnell, D., Hawton, K., Ho, D., Evans, J., O'Connor, S., Potokar, J., Donovan, J., & Kapur, N. (2008). Hospital admissions for self harm after discharge from psychiatric inpatient care: cohort study. *British Medical Journal*.

References

▸ Irmiter, C., McCarthy, J. F., Barry, K. L., Soliman, S., & Blow, F. C. (2007). Reinstitutionalization following psychiatric discharge among VA patients with serious mental illness: A national longitudinal study. *Psychiatric Quarterly, 78*, 279–286.

▸ Mind. (2011). Listening to experience: An independent inquiry into acute and crisis mental healthcare: Mind.

▸ Sheppard, S., McClaran, J., Phillips, C. O., Lannin, L. A., Clemson, L. M., McCluskey, A., Cameron, I. D., & Barras, S. L. (2010). *Discharge planning from hospital to home (Review)*: The Cochrane Collaboration. John Wiley & Sons, Ltd.

▸ Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., Roth, L. H., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the   same neighborhoods. *Archives of General Psychiatry, 55*(5),   393–   401. doi: 10.1001/archpsyc.55.5.393.

▸ Walker, S. A., & Eagles, J. M. (2002). Discharging psychiatric patients from hospital. *Psychiatric Bulletin, 26*(7), 241–242. doi: 10.1192/pb.26.7.241

▸ Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215–228. doi: 10.1080/08870440008400302