What is the Lived Experience of Being Discharged From a Psychiatric Inpatient Stay?

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Abstract

Psychiatric patients encounter many difficulties post-discharge reflected by quantitative data such as high suicide rates within the first 3 months. However, little is known about *why* discharge is so difficult. This article aimed to understand the lived experience of being discharged from a psychiatric unit. Eight participants were interviewed to explore their experiences of discharge. Interpretative phenomenological analysis was used to analyse data. Four superordinate themes emerged: *leaving hospital; the outside world; the journey to health;* and *self-identity*/*beliefs*. Clinical implications and suggestions for further research are discussed.

Keywords

Interpretative phenomenological analysis (IPA)

Mental health and illness

Lived experience

Inpatient

Discharge planning

Suicide

Introduction

The immediate post-discharge phase is critical for psychiatric inpatients, possibly because of stressors associated with re-entry to the community following intensive inpatient treatment (Gerson and Rose 2012). Following discharge, patients are at high risk of self-harm and suicide, with many incidents occurring in the first 2 weeks (Gunnell et al. 2008). Statistics from the National Confidential Inquiry (NCI 2011) in England (1997–2008) reported that the maximum risk period is during the transition from the ward to the community. Post-discharge risk is elevated for those with previous history of suicide attempts, substance misuse, unemployment, living alone and homelessness (Gunnell et al. 2008; Meehan et al﻿. 2006).

[**AQ1**](http://eproofing.springer.com/journals/mainpage.php?token=NsyJq7SmtLnj7BgT9z27cwc9Z4ILpzvehAzNI7Aomt0)

Limited community social networks (often comprising of only staff or other patients (Forrester-Jones et al. 2012), loneliness and difficulties attending appointments because of lack of transport (Beebe 2010) have been cited as reasons why the post-discharge period is so difficult. Strategies that bridge the gap between discharge and community care are needed (Dixon et al. 2009).

The Department of Health (DH 2003) provides recommendations for discharge from hospital. Discharge Planning (DP: NCI 2006) aims to ease the transition between psychiatric hospital and the community by improving the co-ordination of services. The aim being to reduce length of admission, readmission rates and costs (Sheppard et al. 2010; Steffen et al. 2009). However, there is limited research exploring whether these recommendations are routinely implemented and it is argued they have had limited success (Walker and Eagles 2002).

Existing research into psychiatric discharge has typically used quantitative methods to examine rates of suicide (e.g. Meehan et al. 2006), or has explored the effectiveness of discharge interventions (e.g. Puschner et al. 2011). Research has however not thus far addressed patients’ experience of the *process* of discharge, findings which might be useful in the design of service provision. A method particularly suited to understanding the ‘lived experience’ of an individual is interpretative phenomenological analysis (IPA; Smith et al. 2009), which seeks to understand the participant’s view of the world.

Method

Aims

This study aims to explore what it is like for people being discharged from a psychiatric hospital stay. It is hoped that this might aid our understanding of why being discharged from hospital can be so difficult and for some, lead to increased risk of suicide.

Participants

Participants were recruited through three community mental health teams (CMHTs), an assertive outreach team (AOT) and a service user consultancy and support team (CAST; although these members were supported through a CMHT at point of discharge). Participant demographic data are presented in Table 1. Eight individuals were recruited, aged 26–65 years. Time since discharge (to interview) ranged between 6 and 29 months, with a mean time of 20 months. Data on diagnosis was collected although selection for participation was based on experience as an inpatient and not diagnosis. No information was gathered on differences in experience dependent on diagnosis or the team supporting individuals on discharge as the focus was on lived experience. Crisis resolution/home treatment (CRHT) was available, but no information was gathered on who used this service.

| **Table 1**  Demographic information | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Gender** | **Age** | **Ethic origin** | **Time in hospital** | **Diagnosis** | **Employment** |
| Female | 65 | White British | Almost 1 year | Adjustment disorder/anxiety | Nursery sister |
| Female | 58 | White British | 12 weeks | Borderline personality disorder | Support worker |
| Female | 42 | White British | 6 weeks | Borderline personality disorder | Office worker |
| Female | 41 | White British | 3 weeks | Paranoid Schizophrenia | NatWest Bank |
| Male | 26 | White British | 2 weeks | Depression/Personality Disorder | Factory worker |
| Female | 48 | White Irish | 5 days | Depression | HMRC |
| Male | 46 | White British | Data missing | Paranoid Schizophrenia | NA |
| Male | 45 | White British | 5 weeks | Paranoid Schizophrenia | Grounds maintenance |

Inclusion criteria were: age (18 years plus); discharged from psychiatric hospital within the last 6 to 36 months; judged by care coordinators to be well enough to participate; English as a first language. No incentive for participation was provided, but travel costs were reimbursed.

Procedure

Participants were recruited through the NHS and therefore ethics approval was obtained from the Isle of Wight, Portsmouth and South East Hampshire research ethics committee. Qualitative data were obtained through semi-structured interviews lasting 35–80 min. Participants were asked to discuss their experience of being discharged from hospital, the support they received, what they found helpful and unhelpful about the process, and following multiple discharges, if there were differences between them.

Analysis

The data were analysed using procedures outlined by Smith et al. (2009) and Smith (2011). Themes were developed from the interview dialogue, not from a pre-existing theoretical position. Each interview was transcribed and analysed individually, identifying emerging themes, and using these to establish connections between themes to form subordinate themes.

Once all interviews were analysed individually, patterns were established across all cases. Themes that ‘clustered’ together emerged as superordinate themes. Continual reflection and re-examination of transcripts ensured themes were embedded in the original text. Different levels of recurrence were identified (Table 2), however, ‘richness’ of accounts was also considered.

| **Table 2**  Master table of themes | | |
| --- | --- | --- |
| **Superordinate** | **Subtheme** | **Frequencya** |
| Leaving hospital | Meaning of discharge  Emotions on discharge  Experience of returning home  Discharge as impersonal  Discharge as collaborative  Support on discharge  Discharge as a process  Graded support | General  Typical  General  Variant  Typical  Variant  General  Typical  Typical |
| Returning to the outside world | Adapting to life outside  The real world is scary  Return to old life  Process of adapting as gradual  Coping with life outside  Feelings  Regaining independence | General  General  Typical  Variant  Variant  Typical  Typical  General |
| The journey to health | Health on a continuum  Role of medication  Recovery as fragile  There is no magic wand!  Recovery as a journey  Readiness to change  Change as a challenge  Feelings about the future  The journey continues | General  Variant  Variant  Variant  Variant  Typical  Typical  Variant  Typical  Variant |
| Self-beliefs/ Identity | Understanding/attitudes to mental illness  Sense of self with mental illness  Feeling Valued  Being different  Asking for/Accepting help as difficult  Staff genuineness  Building relationships as  important  Support as a privilege  Importance of support  Support needed  Self & others | General  Typical  Typical  General  Typical  Typical  Variant  Typical  Typical  General  Variant  Typical |

Validity and Reflexivity

Credibility checks in line with guidelines for good practice were utilised throughout the process of data collection and analysis (Smith 2003, 2011; Yardley 2000). Yardley’s (2000) principles for assessing the quality of qualitative research were followed. Additionally, measuring recurrence across cases enhances the validity of findings (Smith et al. 2009) and is a criteria Smith (2011) uses to measure “good” quality IPA research. This study measured several levels of recurrence.

Qualitative researchers emphasise the importance of reflexivity in qualitative research, which is the process of examining one’s effect as a researcher in the research process (Elliott et al. 1999; Stiles 1999; Yardley 2000). Although they may be firmly committed to honouring the data, no researchers are without bias. Therefore, values, beliefs and assumptions were acknowledged at the outset of the study and were ‘bracketed’ during analysis (Elliott et al. 1999).

Following each interview, the researcher reflected on her emotional responses and tentative ideas that emerged from the interview. These were noted in the reflective journal.

Results

A large amount of rich thematic material was developed, but for the purposes of this article the focus is on that which has most clinical utility.

Four superordinate themes emerged from the analysis: (1) *Leaving hospital*; (2) *The return to the outside world*; (3) *The journey to health*, and (4*) Self-beliefs*/*identity*. The structure, and frequency, for each superordinate theme and their subordinate themes are represented in Table 2. Support for these superordinate themes is demonstrated in transcripts from all participants.

Leaving Hospital

Discharge was viewed as a process. This theme highlights participants’ experiences of what leaving hospital was like for them.

There was a shared experience regarding the meaning of discharge. Participants’ viewed this as something that happened when you no longer needed hospital but did not mean you were ‘cured’: “discharge to me is when you’re, they feel, everyone feels you’re well enough to leave hospital, but that doesn’t mean that you’re better. It just means you’re well enough not to be there” (Marie). Marie’s change of words here possibly implies she is unsure as to who decides whether you are well enough for discharge .

Participants described feeling a mixture of emotions ranging from joy and relief, to anxiety and fear that they could not cope. Sally experienced different emotions about her discharge, which changed from before leaving: “absolute joy going home, erm, thinking things are going to be different. You know, I’m going to make a huge effort, it’s going to be all different from now on” (Sally), almost as though it will be easy if she just tries hard enough. To actually being home:

The first time I was discharged it was awful, I felt so alone. Because my husband was gone off to work, my children were gone off to school and college, I was alone in the house every day. And I was totally lost. (Sally).

This description gives the impression of people leaving her and Sally not knowing what to do with herself, perhaps due to having lost the role she had before admission. The very word ‘discharge’ often led participants to experience negative thoughts and feelings: “I was panicking and thinking “I don’t want to go, I’m not ready! I don’t wanna go, I don’t wanna go!” because it was safe!” (Gill). Gill’s repetition here comes across as almost childlike in her desire to stay somewhere safe.

Participants reported feeling all of these emotions in one discharge, but they also seemed to differ across discharges (where they experienced multiple), possibly depending on the circumstances. Some spoke about discharge as something that was ‘done to them,’ where they were told about decisions rather than it being a collaborative process. There was a sense of being powerless; that it did not matter how they felt: “it was going to happen” (Gwen).

Emotions also differed across discharges. The act of putting the key in the door for some was anxiety provoking: “It was almost like going into (pause), letting yourself into somebody else’s house, almost. It, it didn’t feel like I was letting myself home” (Gill).

Two people described returning home alone:

Everything was just the way it was and for example, I had a take away before I went into hospital and that was still on the bed, yeah and then I thought it was poison…… that put me off food again. (Mina).

For Mina, this resurfaced paranoid beliefs and she felt unable to cope and resorted to throwing all of her sheets away. She spoke about having only a “small piece of cheese” in her fridge and feeling “disheartened.” For others, this was not perceived as a problem: “It was fine yeah, you know my room was such a mess when I got home it was like a bomb site” but it was “home sweet home” (Dan).

Discharge was viewed as a process rather than a discrete event. For some, discharge began weeks before they left hospital, gradually building up to it with day release, visits home and continued with community support.

I had, had a series of phased discharges home I think it was type thing, I had a series of erm (pause) nights home, so I’d go home for a day and night and then go back and then I’d go home for two nights, then I went home for 3 nights, then I went home for a few nights before the day of the discharge and things. So it was gradually built up (Gill).

This appears to be in line with DP guidelines (DH 2003) that state discharge should be a collaborative process beginning from admission. However, participants had mixed experiences in relation to their involvement.

Participants’ had mixed experiences in relation to their involvement in their discharge plan. Some spoke about a collaborative approach where they felt involved in decisions about their treatment and felt they left hospital when they were ready. Gill was informed by her key nurse: “if it (discharge plan) needs to be adapted at any time then that can be changed. So if it needed to be lengthened or shortened you could do it” and she felt that things were moving at a pace that she was in control of, which she found helpful:

(it) felt like I was partially in control helped. Because I wasn’t being told, you are ready to go, we think we need to talk about a discharge you know let’s do, we’ll do it this way. So it was all part of, I was part, I felt I was part of the whole thing. So I wasn’t just being told.

Gill laughed at her thought that she was partially in control of the process. One interpretation of this might be that, having said it, she wondered if it was presumptuous to think such a thing. It possibly indicates some doubt that she was able to have such an input within the system and that her view was powerful enough to change things.

At other times, participants were told they were leaving, with little preparation: “I saw the doctor and I was basically told I was being discharged that day. It wasn’t like ‘how do you feel about being discharged?’” (Mark). Despite not feeling ready to be discharged, it seems Mark did not feel he was qualified to be involved in decisions about his care: “I just thought to myself, who was I to argue with the doctor you know?” Mark said he was readmitted to hospital a few weeks later.

There were shared experiences that support upon discharge varied, with little consistency, with some receiving no support: “no, none whatsoever. There was erm, (pause) they, no, no they…. Erm, no I, I had no home treatment, I had, nothing except a prescription” (Marie). This description gives an impression of support being a piece of paper: thin and delicate, easily broken but all she had to rely on.

The return to the outside world

Participants spoke about their experiences of the community after having been in hospital. They shared a mixture of feelings, reported that adapting took time, and many found it difficult to accept the support they needed.

For some, being discharged felt like being introduced to the world for the very first time. Having adapted to life in hospital, they now had to ‘re-learn’ how to live in the community. This for many was a scary prospect and they described having to “fend for themselves” (Gwen) and “face life” (Gary). Words such as ‘fend’ perhaps give the impression of fighting for survival in the world they had experienced difficulties living in. Gary described what it felt like to be part of the real world again: “Stepping through your front door and into the big bad world and erm, for me it felt, there wasn’t any safety net you know?” Stepping into the “big bad world” gives an image of their homes being separate from this scary outside world, where if they stayed inside, they wouldn’t have to face it. It highlights just how difficult the transition from living in a small, confined space into the wide expanse of ‘the community’ could be. Merely walking out the front door was a challenge. One interpretation might be that patients had become institutionalised and therefore were questioning whether they could be independent again. It almost gives the feeling of being introduced to the world for the very first time.

Participants spoke of how alone they felt at times:

It’s 4 o’clock in the morning and all your family’s asleep, you’re on your own, you’re depressed, you may be suicidal, my first thought is I could do something now and no one could stop me (Marie).

This feeling seemed to occur particularly when there was no support and in the first few days post-discharge when there was pressure, both from themselves and family, for life to return to normal. Participants’ adopted different ways of coping. Sally described feeling alone and unable to cope during the first few days, which resulted in her drinking or attempting suicide, which impacted on her view of herself: “absolutely hated myself with a vengeance, really *really* hated myself” and “when I drank to cope with life there was such shame in that, oh it was absolute, I couldn’t handle the shame at all.” The repetition of words and use of “absolute” gives real emphasis to her feelings, it gives the impression of it being all encompassing.

t would be no surprise then that participants might seek ways to avoid their feelings: “I don’t recall allowing myself to sit very much” (Gill). Mina spoke of using medication to help block the thoughts and voices she was hearing: “to forget about what was going on in my head and just to block it out and go to sleep.” This seems to be a way for Mina to not only avoid her distress but gain some relief from it, possibly hoping that when she woke it would feel easier.

This feeling seemed to occur particularly when there was no support and in the first few days post-discharge when there was pressure, both from themselves and family, for life to return to ‘normal.’ It seems for many, life did not return to ‘normal’: “er, I was quite a high achiever getting all those bonuses all the time……so erm I’ve tried to get that thing back in my life again and try and go for different jobs and never found it.” Mina’s words give the impression of searching for something, possibly searching for her old life and the desire to recapture her successes at work. It seems work was something Mina valued and took pride in, for example once she found out she had lost her job, she stated that she no longer wanted to be discharged.

For some, the process of adapting to life outside was slow and one that continues. Gary spoke about “the gradual exposure to the um community,” which sounds similar to phobia work. In a similar thread, Sally stated the support helped “ease” her back into “normal” life. It sounds as though returning to normal living was something that needed to be handled delicately.

The journey to health

This theme related to participant’s experiences of recovery, which they perceived to be part of the discharge process. This theme related to people’s experiences of recovery, what they found challenging and what helped. Health and illness were not viewed as dichotomous states but on a continuum: “meeting new people who were, um, slightly more ill than myself” (Gary).

Some participants spoke of the role of medication in their recovery. For some, it helped them manage their symptoms:

The medication is one area that is another safety net, for many years I was on several different types of depo injection, which erm didn’t help at all. Again I was anti-psychotics like Amisulpride, Olazapine, but the one I’ve been on currently for about 4–5 years now is Clozaril and it’s a miracle what it’s done in my life (Gary).

For others, it did not help them address their difficulties.

Everyone wants the easy option and the drugs are the easy, they blank things but they’re not a long-term solution. I, I mean I’m not against drugs in the short-term, *very* short-term to get you over extreme anxiety or something like that maybe when you’re in hospital but they need to start taking you off them gradually as you come out. That would have helped as well, if they’d just didn’t stick you on this medication and keep you drugged up like that. I mean I wouldn’t have been able to go back to work if they kept me on that Olanzapine (Sally).

Models of change (Prochaska and DiClemente 1982, 1983) discuss stages people take before embarking on changing something. Participants discussed recovering from mental illness in similar terms, beginning with pre-contemplation: “erm, in the past I blamed everyone for my troubles other than, mm I shouldn’t blame me as such but I took no responsibility at all for any change, I expected other people to do it for me” (Sally). Participants recognised that there was no magic wand and at some point they realised that they had to take responsibility for their recovery: “you’ve got to do a lot yourself erm, it’s got to come from you really. You’ve got to want to get better, it’s got to come from you.” (Gwen).

Sally’s use of the word “blank” appears to imply that medication helps to make problems invisible. Her words here suggest that medication is not only an easy option for the patient in order to forget their difficulties, but also for the staff. It also seems to dehumanise the patient; to “stick” something and “keep you drugged up” almost gives the impression of something that is done *to* the person, so they don’t have to do anything else with you. Sally seems to imply here that medication is a short-term solution and that something else is needed for people to recover. For some, medication was not the solution: “I know doctors rely very heavily on, on meds but, I believe there’s a lot of people like me where they don’t make a huge difference you know” (Marie).

This came with challenges and it was acknowledged that change was difficult. For some, it seemed that mental illness was something that they needed to fight and battle with to overcome: “to me, you have to, (sighs) I don’t know if fight is the right word, but you have to think right, I’m gonna take this on and I’m gonna win when you’re thinking about the illness.” (Marie). To “take it on” implies that it is something tough and mean to overcome. The need to remain positive in order for it not to get the better of you was highlighted. Gary’s use of words here gives the image of defeating and gaining control over the illness: “to see if um I can conquer these feelings you know, about apprehension, about stepping out” (Gary).

People worried about returning to hospital, almost as though their mental illness was something that was always lurking in the background: “maybe I, maybe that erm, I the hospital hasn’t seen the last of me you know?” (Dan). It seemed that being well was something precious: “the best gift I could ever have is being well and being stable for a long time” (Gary).

Many felt that their journey to recovery continued: “I still feel as if I’m withdrawn a lot now but erm, it’s getting a little bit easier for me to talk now” (Gwen) but they were hopeful: “that’s what I am now you know instead of attending a therapist I am my own one” (Sally).

Self-belief/ identity

The theme of self-belief and identity emerged as an over-arching theme incorporating issues relating to their identity as having a mental illness. This theme underlies the other superordinate themes throughout their journey.

The notion of normality emerged frequently throughout the transcripts, regarding how participants’ felt, what they perceived as normal and other people’s expectations: “certainly if you’ve children or teenagers, erm, they just want life to be back to normal. And they treat you as normal” (Sally). What was ‘normal’ was questioned and changed throughout their journey. The sense of not being a normal person is highlighted in Sally’s description of being on medication: “you don’t care about anything, er, going around like a zombie, you can’t feel anything, you’re totally out of it” (Sally). We tend to view zombie’s as dead, unfeeling, non-human creatures; therefore Sally’s use of it here is quite poignant.

Participants felt that mental illness could not be fully appreciated unless a person had experienced it. Gwen stressed how different it was: “cos that’s natural isn’t it you have your off days then, but when you’re depressed it’s er, it’s a bit more of a deal and that it’s a bigger thing really.”

Other people’s lack of understanding has been cited as one of the reasons for stigma around mental illness (Jorm 2000). Participants spoke about being judged and labelled due to having a mental illness:

It was with er, my workplace, as soon as they found out I was schizophrenic, they dropped me like a ton of bricks. Erm, my manager got scared of me, she was scared that I might follow her, which I’d never done before (Mina).

Mina’s use of words here gives a sense of rejection. The “ton of bricks” gives the sense of weight, as though she is a burden for others. Mina described how she had to be careful what she said within her community due to stigma. She reported their assumption that “you don’t know what you’re talking about” because you have a mental illness, therefore in their eyes, she counted for nothing. Mina coped with this by telling people she had depression as this was less stigmatising than revealing she had schizophrenia.

However, those with a mental illness have also made judgements about others. Gary spoke about being fearful in the community he lived in:

Just walking down the street is a challenge you know because you know, you tend to find, especially in the area that I live XX you tend to find a lot of people there are on the corners drinking, there’s a lot of people around that area that are either using or have been using psychiatric services. There’s a few erm, houses along the street I live that are dry house for alcoholics and drug addicts so the area is quite a um, colourful mix of people.

Gary’s use of ‘colourful’ implies a range of people from all cultures and different walks of life. However, given that he seems to be making the assumption that they are people to be wary of, ‘colourful’ could possibly mean that they are intimidating.

Mental illness resulted in some people questioning their identity and their roles:

I’d been questioning what sort of wife was I, what sort of mother am I, what sort of grandmother am I, I keep questioning myself cos I say my self-esteem is so low. I can’t understand why people would want to be with me at the moment. (Gwen).

It seems that Gwen is questioning who she is as a person and whether she can fulfil her roles as well as she used to. Participants questioned whether they were ‘mad’, believing there was something wrong with them. They assumed an identity of being ‘ill’: “I’m thinking ‘no I can’t I’m ill!’” (Sally), but at the same time rejecting it: “what am I doing here? I’m not (whispers) really ill” (Gill). The language used also helped to reinforce this: “now that I’m *out*, ‘out’ sounds as if I’m mad” (Gwen).

Not feeling valued was a shared experience. Participants described times when their calls to services were not returned, or they felt as though they were a drain on services. Receiving support from someone genuine, who had time for them was highly valued:

Oh it was absolutely amazing, it was such an appreciated feeling…. and it felt like somebody was there for you, that you weren’t alone, neglected and just, abandoned, by everybody (Mina).

Their accounts highlighted how important it was to have even one significant person to support them, family or staff, but that it took time for them to build relationships with staff. Sally highlighted that for some people, receiving short-term therapy would not be beneficial: “This idea 12 weeks (of therapy), it’s, I don’t think you can build up a relationship with people over that period of time.” She voiced how this trust enabled her to discuss feeling suicidal without fear of being readmitted.

Changes in staff were difficult to cope with, almost like bereavement: “I had to say goodbye to (name) and be introduced to somebody else. And each time it was, it got, each time it got more difficult really, I was losing my circle of support” (Gill).

Some support was time limited: “The emergency number I had, I knew that was only good for like, till the end of the week” (Marie). Whilst services may have no choice but to have time restrictions, the fact that the number was ‘good’ for a limited time gives the impression that there is a best before date, where patients must be ‘well’ before this time, otherwise they run out of support.

Participants viewed support and treatment as a privilege, stating that they felt “lucky,” did not deserve help and experienced difficulties asking for help, sometimes reaching crisis point before contacting services:

I used to let myself get really ill and then access the services and it used to frustrate (care coordinator) a lot, she used to say you know (laughs) ‘just pick the phone up, you don’t have to wait until you needed admission into hospital before you access the services’ but I used to think no, no I’m not unwell enough yet! (Mark).

Staff needed to repeatedly encourage participants to call them, make it part of their treatment, or to contact them rather than relying on participants to call. Gill would create ways for staff to call her: “I sent them a text so the phone call came from them, which then made it easier to talk to them.” The very act of someone else calling her, made it easier for Gill to accept the support she needed.

Discussion

This study aimed to gain insight into the lived experience of being discharged from psychiatric hospital. Four superordinate themes are highlighted which together, encapsulate the experience of discharge: *leaving hospital; the return to the outside world; the journey to health*, and *self-belief*/*identity*. These themes are intrinsically linked. For example, it is impossible to separate an individual’s experience of discharge from their self-beliefs; furthermore, whilst a ‘successful’ discharge was not the focus of this study, the themes that have emerged go some way to helping us make sense of what contributes to discharge being a success in the eyes of the patient. The study highlighted many common themes between participants’ accounts. These included; perceiving discharge as a process, readiness to change, the difficulties with adapting to the community, the importance of support on discharge and the impact of having a mental illness on perceived attitudes of others and on their self-beliefs. Individual differences were apparent in their emotions and perceptions of their journey through hospital and discharge to the community. The reasons for these differences were not explored in this study but may be linked to stages of change, personality, environment and past experiences. Of note, no thematic patterns between diagnoses were identified during analysis.

IPA involves a double hermeneutic whereby the researcher is attempting to make sense of the participant’s account, who is also trying to make sense of their own experience (Smith et al. 2009). This requires interpretation by the researcher. Therefore, the researcher chose themes which stood out most in helping to understand the individual’s lived experience. It is acknowledged that there are other themes that could be presented. The themes highlighted here reflect the journey of the discharge experience undertaken by participants, beginning with their hospital experience and continuing with the point of leaving hospital, their adaptation to the community and their journey to recovery. Throughout, this journey is underpinned by the impact of their experiences on their self-beliefs with a mental illness, how they were treated by others and the support they received from services, staff and family.

Despite the implementation of DP and CRHT teams, many patients still do not receive the support they feel they need post-discharge (Gerson and Rose 2012). The amount of support people receive varies (Mind 2011), and patients find it difficult to cope when support stops abruptly (Larivière et al. 2010). Participants in this study spoke of similar experiences, with amount, type and length of support varying greatly. They also felt that linked care between inpatient and community would have eased anxiety, reporting how helpful they found it when this occurred.

The NCI (2006) recommended that patients at high risk of suicide post-discharge should have ways of contacting services if they are in crisis. However, participants reported not feeling able to ask for help for various reasons, for example believing they did not deserve help, an issue that other patients have reported elsewhere (Mind 2011), despite the risk of suicide being particularly high for the first 3 months (Meehan et al. 2006). Services might need to be more proactive about contacting patients during high risk periods (e.g. during transition times and up to 3 months post-discharge).

Participants spoke about the importance of having someone there to talk to, or visit in the immediate days post-discharge, particularly in relation to keeping them safe. Studies suggest that this contact can help prevent crisis and admissions (Fallon 2003). In the current study some participants found delays in such contact difficult to cope with.

For some participants, discharge from CRHT could be just as difficult as being discharged from hospital and evoked feelings of being alone (e.g. Sally). Others received input until they felt ready for discharge (e.g. Gill, Gwen). This might indicate that involvement of CRHT is inconsistent, or that there are discrepancies between the views of the patient and the CRHT regarding their needs. Reports suggest that this phase should be handled sensitively and gradually as rapid discharge and referrals to other services can instigate return to crisis (Bridgett et al. 2006). Participants in this study echoed the need for services to withdraw gradually.

This study supports findings from previous research where patients have viewed their experience of services as a journey (Fallon 2003) and that recovery from mental health is a dynamic process (Pitt et al. 2007). Further, that discharge is not a discrete concept, but one that involves overcoming milestones along the way.

This study also raises issues that do not appear to have received as much attention in the literature. These relate to the detailed descriptions of difficulties in adapting to life outside hospital. Participants seemed to experience hospital and the community as two separate worlds and highlighted the difficulties of re-entering the ‘real world’ which had become scary and unfamiliar. Expectations of returning to ‘normal’ and struggling to identify what this meant were mentioned. Additionally, the need for therapy such as dialectical behaviour therapy (DBT; Linehan 1993) to address the underlying issues contributing to admission was highlighted as a factor needed to help prevent readmission.

Limitations of Research

Whilst this study had an appropriate sample size for a qualitative design, care must be taken in generalising the findings. Given the selection criteria, only patients who were deemed well enough to participate were given information regarding the study. Patients who were not sufficiently well might have a different experience.

Individuals recounted their experiences as they remembered them, which represent a snapshot in time and it is acknowledged that their memories might have changed or faded since the experience. Provision of care within the NHS is changing and might vary across the country. Therefore, it is acknowledged that experiences might differ.

It might have been useful to have asked explicitly about differential team support on discharge to identify differences, and implications for experience and readmission. However, review of the data indicated that variability of experience *within* teams was more apparent than between.

Implications for Future Research

The reasons for individual differences were not explored in this study. Further research examining these factors could provide useful information. For example, whether experience of discharge differs depending on diagnosis, length of admission, whether admission is voluntary and other potentially significant factors such as stigma (Read and Law 1999). Additionally, research is needed to explore the relationship between the themes identified in this study and suicide, readmission and self-harm post-discharge to highlight possible risks. This information could be used to inform quantitative measures examining satisfaction on discharge.

Clinical Implications

This research supports the idea that ‘successful’ discharge is a *process*, rather than a discrete event, and is dependent upon all of the factors raised in the superordinate themes coming together. Factors that seemed particularly pertinent include confidence (and readiness) in accessing available, collaborative support, and feeling respected and valued by teams.

As patients value their relationship with staff, having someone familiar to talk to might help alleviate crisis and prevent admission. Psychological therapy (in particular DBT), was identified as helpful in teaching skills to prevent readmission, in line with other findings (Fallon 2003), thus this should be offered in acute services wherever possible.

Participants spoke about how difficult it was to ask for help and tended to contact services once they had reached crisis point. Services could usefully be proactive in contacting patients who have recently been discharged to prevent further crises. Establishing links between inpatient and community teams has been shown to reduce readmissions and improve appointment attendance, (Dixon et al. 2009) and so similar models might be worth implementing.

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Compliance with Ethical Standards

*Conflict of interest*

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References

Beebe, L. H. (2010). What community living problems do persons with schizophrenia report during periods of stability? *Perspectives in Psychiatric Care, 46*(1), 48–55.

Bridgett, P., Flowers, P., Ford, K., Hoult, J., Lakhani, N., & McGlynn, P. (2006). *Crisis resolution and home treatment. A practical guide*. London: The Sainsbury Centre for Mental Health.

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

Dixon, L., Goldberg, R., Iannone, V., Lucksted, A., Brown, C., Kreyenbuhl, J., Fang, L., & Potts, W. (2009). Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalisation. *Psychiatric Services, 60*(4), 451–458.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*(3), 215–229. doi: 10.1348/014466599162782 .

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.

Forrester-Jones, R., Carpenter, J., Coolen-Schrijner, P., Cambridge, P., Tate, A., Hallam, A., Beecham, J., Knapp, M., & Wooff, D. (2012). Good friends are hard to find? The social networks of people with mental illness 12 years after deinstitutionalisation. *Journal of Mental Health, 21*(1), 4–14.

Gerson, L. D., & Rose, L. E. (2012). Needs of persons with serious mental illness following discharge from inpatient treatment: Patient and family views. *Archives of Psychiatric Nursing, 26*(4), 261–271.

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*.

Jorm, A. F. (2000). Mental health literacy. *The British Journal of Psychiatry, 177*(5), 396–401. doi: 10.1192/bjp.177.5.396 .

Larivière, N., Desrosiers, J., Tousignant, M., & Boyer, R. (2010). Revisiting the psychiatric day hospital experience 6 months after discharge: How was the transition and what have clients retained? *Psychiatric Quarterly, 81*(2), 81–96.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of Borderline Personality Disorder*. New York: The Guildford Press.

Meehan, J., Kapur, N., Hunt, I., Turnbull, P., Robinson, J., Bickley, H., Parsons, R., Flynn, S., Burns, J., Amos, T., Shaw, J., & Appleby, L. (2006). Suicide in mental health in-patients and within 3 months of discharge. *British Journal of Psychiatry, 188*, 129–134.

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

National Confidential Inquiry. (2006). *Avoidable deaths. Five year report of the national confidential inquiry into suicide and homicide by people with mental illness*. Manchester: The University of Manchester.

National Confidential Inquiry. (2011). *The national confidential inquiry into suicide and homicide by people with mental illness*. Annual report. Manchester: The University of Manchester.

Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: A user-led project. *Psychiatric Bulletin, 31*, 55–60.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*, 276–288.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390–395.

Puschner, B., Steffen, S., Völker, K. A., Spitzer, C., Gaebel, W., Janssen, B., Klein, H. E., Spiessl, H., Steinert, T., Grempler, J., Muche, R., & Becker, T. (2011). Needs-oriented discharge planning for high utilisers of psychiatric services: Multicentre randomised controlled trial. *Epidemiology and Psychiatric Sciences, 20*, 181–192.

Read, J., & Law, A. (1999). The relationship of causal beliefs and contact with users of mental health services to attitudes to the’mentally ill’. *International Journal of Psychiatry, 45*, 216–229.

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. New York: Wiley.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenlogical analysis. *Health Psychology Review, 5*(1), 9–27.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis. Theory, method and research*. New York: Sage Publications Ltd.

Steffen, S., Kösters, M., Becker, T., & Puschner, B. (2009). Discharge planning in mental health care: a systematic review of the recent literature. *Acta Psychiatrica Scandinavica, 120*(1), 1–9.

Stiles, W. B. (1999). Evaluating qualitative research. *Evidence Based Mental Health, 2*(4), 99–101. doi: 10.1136/ebmh.2.4.99 .

Walker, S. A., & Eagles, J. M. (2002). Discharging psychiatric patients from hospital. *Psychiatric Bulletin, 26*(7), 241–242.

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