‘Don’t They Call It Seamless Care?’:
A Study of Acute Psychiatric Discharge
'DON'T THEY CALL IT SEAMLESS CARE?': A STUDY OF ACUTE PSYCHIATRIC DISCHARGE

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Scottish Executive Social Research
2002
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ACKNOWLEDGEMENTS

Our thanks must go firstly to those who as respondents provided the information on which this report is based. This includes in particular the users and carers who were willing to share their experiences of the discharge process and their subsequent months outwith hospital. We also acknowledge the professional staff at both strategic and operational levels who either enabled our access to the research sites or participated in the key informant or key worker interviews. Key workers were also involved in the completion of the Camberwell Assessment of Need and we thank them for their patience with our persistent phone calls. We are grateful also to the consultant psychiatrists who took time to respond to the postal questionnaire.

A number of people were involved in the data collection for this study. Clare Armstrong played a major role during the first phase of the study and was instrumental in compiling the interim report on this phase. The second phase of the study involved extensive periods of interviewing at the research sites. Locating respondents and their addresses was often challenging, and our thanks are offered for their initiative and imagination over an extended period to Steven Beattie, to Ann MacInnes and to Isla Laing. Interviews in the Western Isles were achieved, against considerable odds, through the tenacity of Carol Ann Huson and Alison Cropper, while Patricia van der Velde completed interviews in the north east.

Research embracing the boundaries of health and social care often uncovers the unease which hovers around differing research traditions. We would like to thank the members of the Advisory Committee for this project who have sat amongst these dilemmas.
SUMMARY

INTRODUCTION

Hospital discharge needs to negotiate administrative boundaries in a way which ensures the delivery of seamless care. The boundary between hospital and community is particularly prone to breakdown in communication and appears resistant to change. Of particular importance is a commitment to communication both within the hospital and between hospital and community, and to the mechanisms for achieving this communication. Three particular issues have been targeted by past guidance: a multi-disciplinary approach, discharge planning to start soon after admission, and involvement of users and carers. Guidelines from the Scottish Intercollegiate Guidelines Network (SIGN) in 1996 highlighted information essential to a minimum dataset at discharge.

The study reported here is based on fieldwork undertaken throughout Scotland between 1998 (Phase 1) and 1999-2000 (Phase 2). The focus of the study has been the experience of acute psychiatric discharge, and the perspectives of a range of stakeholders have been explored. The study sought to identify what happens during the process of discharge from an acute psychiatric bed, and what impact the process has on those discharged, both within the initial six weeks and during the subsequent six months. The specific objectives set for the study were to examine:

♦ the impact of screening and admissions procedures on discharge
♦ the quality of assessment and discharge planning
♦ the impact of decision-making by both staff and patients on the quality of discharge planning
♦ the extent to which inter-agency and multi-professional relationships impact on the discharge process
♦ the support available to individuals on discharge from acute care.

DATA COLLECTION

♦ Phase 1 of the study comprised interviews with 89 key informants across Health Boards, local authorities, and NHS Trusts and wards in order to profile the policy and practice for acute psychiatric discharge that was current across Scotland.

♦ Phase 2 of the study sought to explore the outcomes for individuals of the discharge process. A sample of users was drawn across eight Health Boards chosen to reflect the national distribution of discharged patients. Inclusion factors were age 16-65 and an in-patient in an acute psychiatric bed for at least 7 days and less than 6 months. Exclusion factors were dementia or a primary diagnosis of substance misuse. Respondents were interviewed in their own homes six weeks and six months after the initial discharge. The Camberwell Assessment of Need (CAN) was also completed with the individual and with the keyworker.
Interviews were completed with 173 individuals at the six week stage (Time 1) and with 128 of these six months later (Time 2). The response rate from the 377 people approached at Time 1 was 46%, not dissimilar to other studies in the psychiatric field using a comparable approach.

Interviews were completed with 58 informal carers, and with 27 keyworkers who had been involved with a respondent throughout the study period.

A questionnaire was circulated to all members of the Royal College of Psychiatrists in Scotland seeking their awareness and views on discharge policies and protocols. A response rate in the order of 65% (n=152) was achieved.

SAMPLE GROUP

The profile of individuals discharged included slightly more women than men (98 women / 75 men), over half in hospital for less than four weeks, and with the majority admitted on an informal but emergency basis. Over three quarters of the sample had at least one previous admission. Only a handful of the sample were on the Care Programme Approach (CPA).

Just over a third of the sample of discharged individuals (61) had a diagnosis of a psychotic illness; just under two-thirds (112) had a non-psychotic diagnosis. Much of the analysis distinguishes between these two groups in order to ascertain whether the nature of the diagnosis has an impact on outcome.

Carers were most often partners (approximately half of cases), followed by parents (one quarter). The majority lived at the same address and had been in the support role for the duration of the illness.

KEY FINDINGS

Discharge policy at Trust and ward levels

There was little focus on local policy development for acute psychiatric discharge; it was more likely for there to be generic discharge statements, with specific psychiatric policies focusing on CPA or long-stay patients. At the Trust and ward level a variety of generic and specific admission and discharge policies (Trust) and protocols (ward) were produced.

Fifty-nine per cent of consultant psychiatrists were aware of an existing acute discharge policy.

The effectiveness of discharge policies is dependent on the cumulation of a number of components: the admission process, discharge planning, interagency and multi-disciplinary relationships, the discharge event itself, and community support available post discharge.
The examination of outcomes is, therefore, more complex than simply mapping a set of outcome variables against specific models of discharge.

Key informants reported that individuals would be screened on admission by the named nurse to identify issues requiring the involvement of other agencies. Determination of a specific diagnosis was not necessarily regarded as a priority at this stage. Almost a third of users reported accommodation problems that they wished to be addressed; less than half of these had been resolved by the six-month follow-up. A range of unresolved difficulties relating to finances and welfare benefits was also cited.

Considerable variation in the discharge planning process was reported. Less than half the users and carers interviewed felt they had had some involvement in the decision to discharge; where carers were involved in the decision it was often on their own initiative. The notice given for discharge varied considerably. One in five users considered they had been given insufficient notice.

The majority of the sample had spent time on day or overnight pass, although there appeared to be little scrutiny of individuals’ experiences while on pass. The principle of pass was welcomed; however, weekends were commonly used for pass, and this was not necessarily in accordance with individual needs.

Communication and co-ordination of discharges amongst professionals

Arrangements for communication between professionals, within and across different agencies, was varied, including alignment of hospital and community based social workers, liaison through community mental health teams, and jointly funded care manager posts.

Arrangements for liaison with general practitioners (GPs) were similarly varied. All wards completed a brief discharge summary followed by a more detailed discharge letter. These were distributed in a variety of ways; there were also a number of formal and less formal links with GP practices or primary care.

Keyworkers reported positively on interaction across the hospital - community interface. A variety of mechanisms to facilitate communication were cited, including the use of fax, video link and e-mail. A number of local policies and practices which inhibited professional contact, for example on open cases and on visiting, were also highlighted.

Consultant psychiatrists cited major difficulties in involving community services in discharge. Over half of those responding to a postal survey described problems with social work, primarily the speed of response. A quarter reported problems accessing community psychiatric nursing (CPN) services. Only 7 service users in the study were at some point on CPA; only just over half of the responding consultants considered that CPA benefited their patients.
Arrangements for transport, provision of medication, emergency contact arrangements and final notification to community services were not always clearly communicated to other staff, users and carers.

The large majority of users organised their own transport on discharge and this was the preference of key informants and some users. A number of users, however, reported both practical and emotional difficulties in negotiating transport facilities.

The majority of users were on some form of medication following discharge; one third of those already taking medication on admission had had it changed. There was evident scope for improving both the quantity and quality of information relating to medication. The use of leaflets written in accessible language was commended. Normal practice was to supply 7 days medication on discharge; a small number of users detailed difficulties which they had experienced in accessing medication.

A variety of strategies for crisis contact were reported by users; more consistent provision was sought.

The average number of needs identified on the Camberwell Assessment of Need at Time 1 was 4.6 for the psychotic group (n=61) and 6.4 for the non-psychotic group (n=112). Unmet needs were recorded as 1.6 and 2.9 respectively. By Time 2, total needs had reduced to 3.8 and 5.3 for the two groups; unmet needs to 1.4 and 2.8.

Needs that were commonly identified amongst those with both psychotic and non-psychotic diagnoses included daytime activities, company, benefits advice, information and safety of the individual. The non-psychotic group additionally cited psychological distress, while support for psychotic symptoms featured amongst the top five needs identified by the psychotic group at Time 1.

An overall readmission rate of 27% was experienced amongst those interviewed on two occasions. A higher proportion of those whose unmet needs increased between the Time 1 and Time 2 interviews had been readmitted.

There were no significant differences between those readmitted and those not in terms of age, gender, number of previous admissions, number of community supports, having a CPN, or the level of satisfaction with the discharge process.

The support of informal carers was important to those service users who were interviewed, 90% referring to some form of supportive relationship. Of the carers interviewed, 85% reported daily contact.

Formal support services in the community included the CPN service, social work, out-patient services, day services, and voluntary sector support workers. Those with higher levels of need (CAN) tended to be in receipt of higher levels of community support. Those in the psychotic group received higher levels of support than the non-psychotic group. Amongst the latter, those with more than one admission tended to have a higher number of formal...
supports. The pattern of support was much more stable in terms of on-going contact for the psychotic group than the non-psychotic group.

Key informants reported that all those psychotic and non-psychotic patients are followed up through an out-patients appointment within four to six weeks after their discharge. This was not the case, however, for the user sample: approximately a quarter of the psychotic group and a third of the non-psychotic group did not have a follow-up appointment. The lack of a follow-up appointment did not appear to impact on readmission for either group.

CPN support was most likely amongst those with a psychotic diagnosis and for others who had had two or more admissions or were aged over 45. Users were particularly appreciative of CPNs who were readily available and responsive. Contact with social work was less than with CPNs but similar patterns were present: more contact with the psychotic group and with those with multiple admissions.

Almost half the user sample was not involved in any formal day activity. Just over one in 10 at Time 1 were employed, while 4 in 10 were attending some form of day services. Day service attendance had declined by Time 2.

There was a significant relationship between the level of satisfaction with discharge procedures and both the number of community supports and the involvement of family carers. Specific problems with community support services were highlighted: lack of co-ordination between hospital and community in terms of out-patient appointments, lack of contact from the CPN service and from day services. Changes in personnel could be unsettling for individuals. Transport and travelling distance could inhibit attendance at day services.

One in four users (25%) stated that they had had little support during the discharge process while a similar proportion (29%) had had a mixed experience. Fewer than half of the respondents were therefore able to express unqualified approval.

Implications for policy and practice

Professional co-ordination and communication of the discharge process is lacking. A discharge co-ordinator should be identified to carry lead responsibility for all acute discharges within a designated area. This designated person would be responsible for screening all individuals on admission and identifying the smaller number for whom specific interventions around discharge are required. Wards from which individuals are discharged would be contacted on a daily basis. This would allow identification of new admissions who required to be screened and of individuals who were being discharged that day and for whom liaison requirements had been identified. The discharge co-ordinator would be responsible for creating continuity and co-ordination between hospital and community rather than the current disjuncture. The role of discharge co-ordinator would be specified as part of the wider workload of a specific individual; this individual would most likely be either a CPN or social worker with dedicated time built in on a daily basis.
♦ The response time of social workers and CPNs to requests for involvement in the discharge process requires urgent consideration.

♦ Individuals discharged from acute psychiatric in-patient care should be a priority for the receipt of services from community mental health teams.

♦ The screening and assessment of individuals on the ward by a discharge co-ordinator would contribute to the development of an integrated care pathway for those individuals identified as requiring a range of inputs in order to sustain community placement. The discharge co-ordinator could be involved during pass arrangements, acting as a link between the community and the hospital. A thorough investigation of the extent and depth of screening is needed, along with an assessment of how ward staff deal with any difficulties that are identified.

♦ There needs to be ready access to information for individuals on a range of practical issues, including medication, diagnoses, benefits, transport and community based resources. The designated discharge co-ordinator could provide access to this information for users and carers.

♦ The role of discharge co-ordinator should embrace a ‘hands-on’ practice dimension which facilitates immediate practical intervention as needed at the point of discharge. This could include, for example, arranging to fix household items, accessing basic domestic requirements and sorting out transport, housing or benefit issues.

♦ Some examination is required of the potential for reduction in readmissions through more effective discharge planning. There also requires to be a recognition of those individuals discharged from long-stay beds for whom periods of acute admission may be required.

♦ Working across different groups involved in discharge needs to embrace informal carers and to recognise both their need for information and consultation and the pivotal role which they often play in the discharge process.

♦ National level policy on the six-week benefits rule can lead to artificial constraints on the length of hospital stay and the prospect of premature discharge. This policy needs to be re-examined in light of readmissions and vital support for patients discharged prematurely.

♦ A more systematic approach is required to the provision of day support, training and employment opportunities within the community, including the removal of disincentives within the benefits system to employment.
CHAPTER ONE: INTRODUCTION

The focus of this report is on acute discharge from psychiatric beds. It seeks to identify the processes that are in place and the impact that these have on the individuals discharged, both in the shorter term and in the course of the ensuing six months. It seeks in particular to locate the somewhat elusive concept of discharge planning, and to clarify the extent to which claims made for the discharge process more generally remain valid within the context of discharge from acute psychiatric beds.

This opening chapter will sketch the policy background within which current discharge planning and practice operates, and will examine to what extent common understandings about the discharge process are supported by the evidence base. This will allow some judgement in turn on the closeness of fit between policy directive and system implementation. The specification of the study design will also be outlined.

POLICY CONTEXT

People experiencing mental health problems require a range of health and social care responses. One of the major challenges for acute discharge is to ensure that administrative boundaries do not detract from the seamless delivery of care. Multi-disciplinary working to plan health and social care programmes is necessary prior to discharge, while service response requires to be integrated and community care to be co-ordinated from a multi-disciplinary base. Moreover, local authorities have a duty under Section 8 of the Mental Health (Scotland) Act 1984 to provide support and after-care services to individuals who are, or have been, suffering from mental illness.

Ryan (1994:33) suggests that ‘although discharge planning is often referred to, it is rarely defined’. The importance, for example, of a multi-disciplinary approach to assessment, the need to set the discharge process in train as early as possible, the desirability of a discharge co-ordinator function, are all features whose merits are commonly asserted. Policy guidance has sought to respond to a number of these concerns. In June 1988, The Scottish Office issued a Circular on the Discharge of Patients from Mental Illness and Mental Handicap Hospitals, stressing the need for ‘close co-operation and good working practices’ to be maintained between hospital based workers and those in the community to ensure ‘the smoothest possible transition from hospital care to the community’. The following year, a Department of Health Circular (1989a) highlighted three areas considered generic to effective discharge planning: a multi-disciplinary approach, discharge planning to be started soon after admission, and involvement of patients and carers. At the same time, the Royal College of Psychiatrists (1989) produced its own Guidelines for Good Practice in Discharge.

A brief, generic guide to good practice in hospital discharge was issued by The Scottish Office, following the deliberations of a working group in 1993, while in 1994 a generic Hospital Discharge Workbook was produced (Department of Health, 1994). This sought to highlight practical issues for implementation by each of the key players in the discharge process.
In 1996, the Scottish Intercollegiate Guidelines Network (SIGN) developed ‘The Immediate Discharge Document’, its suggestions for a minimum dataset for the hospital / community interface. This document would provide the information necessary prior to the final discharge summary. The key requirements for such a dataset were regarded as ‘brevity, uniformity and versatility’ and the proposed template comprised 21 main fields.

The importance of compliance with the SIGN guidelines was one of the features of discharge management highlighted by the Accounts Commission (1999) in their review of acute admissions and discharges. The Accounts Commission stressed in particular the need to ensure adequate arrangements for district and practice nurses to receive information on an appropriate timescale. It also sought to ensure the provision to patients of comprehensive written information at discharge, and detailed the elements for joint discharge agreements and protocols essential to inter-agency working. A particular feature identified by the Commission was the need to monitor discharge delays, with few Trusts recording ‘same day’ delays caused, for example, by the need for transport or prescribed medication. Only a minority of healthcare Trusts monitored the quality of discharge, and the Accounts Commission suggested that Trusts should review their discharge policies to ensure that they:

♦ clearly stated the underlying principles
♦ set agreed timescales for action
♦ specified how the quality and efficiency of discharge planning would be monitored and maintained. (1999:25)

Significantly, it came to light in the course of this study that The Scottish Office issued a letter in April 1999 to Trust Chief Executives from the Chief Nursing Officer specifying a minimum data set and standards for the provision of information to all patients on discharge. The requirement was for these standards to be in place across all clinical settings by the end of 1999. Awareness of this requirement amongst the respondents to this study appeared to be minimal.

Planning and provision for individuals with mental health problems has benefited in the last three years from the higher profile accorded by the publication of the Framework for Mental Health Services in Scotland issued in 1997 (Scottish Office, 1997). The main purpose of the Framework has been to assist in the process of developing comprehensive community mental health services in Scotland; for many, however, the need for such services may be triggered at the point of hospital discharge.

It is important to note that the Framework does not specifically address the issue of acute discharge policies, although it does focus on the need for comprehensive integrated community-based services. Joint planning, joint working and joint resource allocation are advocated in the document, but there is no explicit reference to the need for co-ordinated or jointly developed discharge procedures or policies between relevant agencies. With such an emphasis on joint working, however, there is now more need for such measures in order to ensure there is uniformity between Trusts and community agencies.
STUDY DESIGN

Aims and objectives

Against this background, funding was provided by the Scottish Executive for a two-year study to develop a profile of current discharge policy and practice in Scotland for people with mental illness from acute psychiatric care and to identify factors which inhibit or facilitate effective discharge in terms of patient and/or carer outcomes. The specific objectives set for the study were to examine:

♦ the impact of screening and admissions procedures on discharge
♦ the quality of assessment and discharge planning
♦ the impact of decision-making by both staff and patients on the quality of discharge planning
♦ the extent to which inter-agency and multi-professional relationships impact on the discharge process
♦ the support available to individuals on discharge from acute care.

Methodology

The study comprised two phases:

Phase One Developing a profile of current discharge policy and practice
Phase Two Outcomes of discharge arrangements

The first phase mapped the discharge arrangements at all sites throughout Scotland, including an overview of the strategic policy background against which these were operating in each Health Board and local authority area. Interviews were completed with a range of key informants and a postal questionnaire was distributed to consultant psychiatrists. The second phase explored the detailed operation of these policies through tracking a sample of individuals discharged from eight Health Board areas in Scotland. Tracking involved interviews with people who had been discharged both at six weeks and six months post-discharge, with their informal carers, and with a sample of keyworkers associated with them. Further details of the methodology are provided in Chapter Two.

THE EVIDENCE BASE

A number of key themes recur throughout the discharge literature, both that specific to acute psychiatric discharge and that derived from generic discharge studies. Many studies accord with both Marks (1994) and Lundh and Williams (1997) who have highlighted the apparent intractability of the discharge process to repeated attempts at improvement, the latter in a cross national context. A number of studies highlight the lack of communication and failure of service delivery, in general (Neill and Williams, 1992; Tierney et al, 1994; Davies and Connolly, 1995; Bull and Kane, 1996), and, specifically, for individuals with mental health problems (Cowan, 1991; Walker and Eagles, 1994; Wylie, 1994). The importance of multi-disciplinary
collaboration, linkage between hospital and community, and the establishment of networks are noted. Although a recent review by Taraborrelli et al (1998) examines literature and practice relating to hospital discharge for frail older people in Scotland, many of the key issues raised are pertinent to this study, including the need for adequate notice and a period of preparation, discussion of after-care arrangements and liaison with community-based professionals, effective information sharing between hospital and community, and co-ordination by a skilled 'named nurse'. Likewise, the views expressed in a study of carers’ experiences of hospital discharge procedures for adults with physical and complex disabilities (Heaton et al, 1999) are of relevance, in particular the priority given by carers to the need to be informed and involved in the discharge planning process.

Key themes from relevant studies will be identified in this section; more detailed evidence will be presented in the discussion of data relating to each of the stages of the discharge process.

Managing the process of discharge from an acute hospital has featured over many years as a boundary particularly prone to breakdown, and one that, despite a number of initiatives, is often cited as particularly resistant to change. Durgahee (1996) highlighted the disjuncture between the expressed commitment of staff to discharge planning and the lack of identification of discharge issues in written care plans.

“Discharge planning was rushed and patients were sometimes discharged at short notice to vacate beds for new admissions. Consequently, proper assessment of needs was problematic, because of a combination of staff not assessing discharge needs sooner and a congested system of health-care delivery due to a shortage of beds. As a result, patients were discharged into the community with inadequate assessment and no co-ordination of services to support them.”

(1996:61)

Underpinning much of the discussion is a focus on both the principles and mechanisms of communication, both across different individuals within the hospital and between the hospital and the community (King, 1994; Smith, 1996). Closs (1997) reviewed discharge communications between hospital and community health care staff in order to clarify what is known about effective information exchange across the primary / secondary interface. Six specific dimensions were highlighted:

♦ the timing of the dispatch and arrival of written discharge communication
♦ the relevance and completeness of the content of discharge communications
♦ the format in which discharge information is transmitted (structured or free-form)
♦ the mode of discharge communications (hand-delivery, mail, electronic communication)
♦ the participants in communications (uni- or multi-disciplinary)
♦ the direction of communications, and differing perceptions of the adequacy of communications by hospital and community staff.

These dimensions are useful to explore the literature relating specifically to acute psychiatric discharge.
Communication on discharge is routinely directed towards the General Practitioner (GP). Wylie (1994) sought the views of GPs on this process through a postal questionnaire focusing, in particular, on the frequency with which GPs were informed of the discharge plans for psychiatric patients in advance. Two-thirds of respondents expressed dissatisfaction with the extent to which they were involved, with 43% ‘never’ informed of plans prior to discharge, and 54% ‘never’ consulted over discharge plans. In contrast, 96% of responding GPs considered that pre-discharge discussion would be useful, with the preferred method being through telephone contact with a medical member of the hospital team.

In terms of the content of discharge summaries, Craddock and Craddock (1989; 1990) suggest that what is produced rarely meets the requirements of the GP or of the hospital psychiatrist. Following an audit of 100 summaries, they concluded that a number of important areas were overlooked, including prognosis, personality, mental state at discharge, management advice, and information given to patients and relatives. In Grampian, Walker and Eagles (1994) asked GPs to prioritise across 24 potential information items; the top 8 featured were diagnosis, discharge treatment, mental state examination at discharge, date of discharge, advice regarding management, in-patient treatment, prognosis, and information given to the patient.

There may be different preferences as to the format in which information is presented. Craddock and Craddock (1989) suggested that psychiatrists preferred a longer, standardised format, whereas GPs were looking for a shorter, focused summary. Walker and Eagles (1994) used the information they had obtained from GPs on desired content to produce a new semi-structured format for the discharge summary. This comprised a single A4 sheet including the GPs’ ‘top ten’ items. Their review also sought responses to what Closs (1997) terms the mode of discharge communication. At that time the policy was for patients to hand-deliver their letter to the GP, a system commended by 70% of the GPs. Asked for their preferred mechanism, 38% requested both hand-delivery and telephone, 17% postal delivery, 12% postal and hand-delivery, 15% hand-delivery, 7% telephone only, 5% telephone and postal, and 2% a combination of all 3. Seventy-one per cent of GPs considered that it would be useful for a ward receptionist to telephone to arrange a GP appointment prior to discharge. Implementation of this strategy is discussed below (Naji et al, 1999).

Closs (1997) noted that the use of fax was relatively uncommon in the UK as a mode of discharge communication. Carey and Hall (1999) reported on the use of fax to send immediate discharge letters for individuals discharged from the Crichton Royal, Dumfries. Views of GPs were sought and they endorsed the use of structured letters, hand-written at discharge and sent to the GP by fax.

Reflecting on the dimension of who is involved in the discharge process, Cowan (1991) examined the extent of multi-disciplinary working in the context of the publication by the Royal College of Psychiatrists in 1989 of the Guidelines for Good Medical Practice in Discharge and Aftercare Procedures. Consultant psychiatrists in the West Midlands were asked which of six professional groups had been assigned to and which were actually present at ward reviews and at the meeting immediately prior to discharge. Results indicated that there were considerable shortfalls to the goal of multidisciplinarity: 68% of discharge meetings had fewer than five of the six groups represented and 29% had fewer than four. The study by Durgahee (1996) also
highlighted a general lack of clarity as to the responsibilities and procedures for various professionals within the discharge process, with a specific need to strengthen the communication and information flow to community psychiatric nurses (CPNs). CPNs identified the need for long-term planning around discharge, a continuous and two-way information flow between ward and community, earlier notice of referrals, and a follow-up policy.

As part of their study of the quality of patients’ care in acute psychiatric wards, the Sainsbury Centre for Mental Health (1998) detailed patients’ experiences around discharge. They highlighted the ad hoc nature of much of the discussion and procedure, with only 34% of patients in their study having any formal or separate meeting prior to discharge.

“Most patients had no idea they were about to be discharged until a few days before they left, and had little involvement in the discussions about their future.”
(1998:33)

Where formal discharge meetings were held, those consistently attending were only the patient and the consultant psychiatrist. CPNs attended under half of meetings and social workers less than a third, while informal carers and relatives were often not invited, and were present at only a third of the formal meetings. The Sainsbury (1998) study emphasises the need for discharge planning to include consideration of any factors, including social factors, that might contribute to a relapse or crisis (see also Moore, 1998). Research from the USA reported by Olfson et al (1998) suggests that establishing communication between the individual patient and the future outpatient clinician prior to discharge led to higher compliance with the outpatient referral and improved control of clinical symptoms.

The review by Closs concludes that:

“a brief but comprehensive, highly structured, uni- or multi-disciplinary discharge summary should be dispatched to all relevant community staff either before or on the day of discharge. Where patients are frail or elderly and needing immediate support, information should be sent by the most rapid means possible.”  (1997:189)

Specifically for the psychiatric field, Naji et al (1999) report the development of a novel discharge protocol and detail its application in a randomised controlled trial of 343 psychiatric patients. The key feature for the experimental group was telephone contact by the responsible doctor with the GP practice prior to discharge, arranging an appointment for the patient within one week of discharge and preferably discussing the patient with the GP. A copy of the initial discharge summary was given to the patient to hand over to the GP; a copy was also posted out on the day of discharge. The control group were asked to make contact with their GP within one week of discharge and were given the summary for delivery. A range of outcome measures were used for comparison of the two groups. After one month, patients in the experimental group had had more GP consultations relating to mental health and a lower number of hospital out-patient appointments. There was no difference in mental health status, readmission, speed of contact with primary care, continuation of medication or number of GP appointments. Over half of GPs and slightly less than half of psychiatrists preferred the new protocol. The main reservations of
the psychiatrists related to the practical difficulty of getting hold of GPs on the telephone and that contact in routine cases was unnecessary.

The effectiveness of the dedicated discharge co-ordinator model for use in general medical wards was examined by Houghton et al (1996). The introduction of the co-ordinator improved the discharge planning process, and reduced patient problems and their perceived need for healthcare services. There was no impact on the provision of community services or on the appropriateness or efficiency of bed use.

Definitions of discharge

In examining the discharge process, both the immediate event and the longer-term context have been addressed. Thus, discharge was largely defined in terms of the end of an in-patient episode, with the possibility of continuing support in the community. Respondents within the study described it in these terms, but also added that it was not just a matter of continuing support in the community but the possibility of readmission to community services, which they defined as CPN services, day hospitals or social work services. One respondent added to this definition by including admission to the Care Programme Approach (CPA).

A further point highlighted by one of the key informants was that, although at present discharge is defined as discharge from a hospital bed, as a result of potential changes in the configuration of services for the acutely ill, people may not be admitted to hospital in future, accessing alternative community-based facilities or arrangements. Too rigid a reference to the notion of an ‘in-patient stay’ should therefore be avoided.

Structure of the report

The detail of how the study was carried out and the numbers achieved in the various samples is outlined in Chapter Two. The characteristics of local discharge policies and protocols are explored in Chapter Three highlighting, in particular, key components of decision-making and discharge planning, and the strategies for communication and co-ordination amongst professionals. The wider context of admission and of associated factors such as accommodation and finance are explored in Chapter Four, while core elements of the discharge event itself are discussed in Chapter Five, including transport, medication, and arrangements for emergency contact. In Chapter Six the focus is on the supports available within the community post-discharge, exploring the extent to which these match with the specific areas of need identified for each individual. Chapter Seven concludes with a discussion of the implications of the study for policy and practice. Throughout the report a number of examples highlighting good practice are cited.
SUMMARY

1. This study sought to identify what happens during the process of discharge from an acute psychiatric bed, and what impact the process has on those discharged, both within the initial six weeks and during the subsequent six months.

2. Hospital discharge needs to negotiate administrative boundaries in a way which ensures the delivery of seamless care. Three particular issues have been targeted by past guidance: a multi-disciplinary approach, discharge planning to start soon after admission, and involvement of users and carers. SIGN guidelines in 1996 highlighted information essential to a minimum dataset at discharge.

3. The boundary between hospital and community is particularly prone to breakdown in communication and appears resistant to change. Of particular importance is a commitment to communication both within the hospital and between hospital and community, and to the mechanisms for achieving this communication.
CHAPTER TWO: METHODS AND SAMPLES

As outlined above (see page 9), the study comprised two distinct phases, designed to offer a comprehensive understanding of the patterns of discharge throughout Scotland and to reveal any significant relationships between features of the discharge process and outcomes for the individual.

PHASE ONE MAPPING POLICY AND PRACTICE ACROSS SCOTLAND

A sample for Phase 1 of the study was selected to provide data to develop a profile of current discharge policy and practice for acute psychiatric discharge across Scotland. Key informants were identified at the Health Boards, local authorities, NHS Trusts and wards and invited to take part in a semi-structured telephone interview. The key informants were asked to provide appropriate documentation pertaining to acute psychiatric discharge, ranging from mental health strategies and mental health framework documents at Health Board and local authority level to discharge documentation used at ward level. Time constraints precluded systematic analysis of this documentation but it was used to provide the research team with context for each site.

Table 2.1 details the areas and sites approached for interviews with key informants. All the local authorities (32) and 13 Health Board areas were included in the sample. At the Trust level all the appropriate Trusts within the Health Board areas were included. At the hospital sites where there was more than one ward, only one contact was made. The total number of potential interviews was therefore 98.

Table 2.1 Sites for key informants for Phase 1

<table>
<thead>
<tr>
<th>Health Board Area</th>
<th>Health Board</th>
<th>NHS Trusts</th>
<th>Hospital unit</th>
<th>Local Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll and Clyde</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Borders</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fife</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Grampian</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Highland</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Lothian</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Tayside</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Western Isles</td>
<td>1</td>
<td>1(^1)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Orkney(^2)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Shetland(^2)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>20</td>
<td>33</td>
<td>32</td>
</tr>
</tbody>
</table>

\(^1\) The Western Isles was not an NHS Trust therefore two key informants from the health unit were contacted
\(^2\) The health boards were not included as there were no psychiatric beds
The key informants were identified in different ways. For the local authorities the directors of the social work departments were contacted asking them to nominate an appropriate individual. For the Health Boards the research sought the individuals with a remit for strategic planning in relation to acute psychiatric discharge. This was usually within a wider planning remit. For the Trusts the clinical service managers (or equivalent) were contacted and asked to nominate the appropriate individuals for the Trust and the ward interviews. The response rate for Phase 1 was high (Table 2.2), with only one local authority, 3 Trusts and 5 wards being unable to take part in the interviews, giving an overall response rate of 91% (n=89). The high response rate can be attributed to the importance placed on the research by the participants.

### Table 2.2 Response rate for key informants

<table>
<thead>
<tr>
<th></th>
<th>Number contacted</th>
<th>Response rate (n)</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Boards</td>
<td>13</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Trusts</td>
<td>20</td>
<td>17</td>
<td>85</td>
</tr>
<tr>
<td>Wards</td>
<td>33</td>
<td>28</td>
<td>84</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>32</td>
<td>31</td>
<td>97</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>89</td>
<td>91</td>
</tr>
</tbody>
</table>

Three different semi-structured interview schedules were developed for the telephone interviews (see Annex Three). The same schedule was used for Trust and ward informants, with dedicated schedules for the Health Boards and local authorities.

In order to protect the identity of the key informants, individuals’ names and positions have not been used. Health Board areas, local authorities and Trusts have been named where appropriate.

### PHASE TWO OUTCOMES OF INDIVIDUAL DISCHARGE ARRANGEMENTS

#### User views on acute psychiatric discharge

**Sample specification**

A sample of individuals discharged from acute psychiatric in-patient services was selected to be interviewed 6 weeks after discharge and again at 6 months. The design of the study included a case distribution model (see Annex One) which was representative of annual discharges in the eight Health Board areas included in the study. Health Board areas were chosen to reflect a random sample of discharged patients from across Scotland, Health Boards having been stratified on a rural/urban typology.

The criteria for inclusion in the sample were that people were aged 16-65, and had been an in-patient on an identified acute psychiatric unit for at least 7 days and less than 6 months. Some cases were excluded on the basis of diagnosis: dementia or primary diagnosis of substance misuse or where the admission was for detoxification purposes only.
Selection procedure

Ethical approval was obtained from the Multi-Centre Research Ethics Committee for Scotland and the local research ethics committees for the eight Health Board areas.

Cases were sampled from SMR4 returns, information collected for the Information and Statistics Division (ISD) on hospital discharges, giving 100 percent coverage for Scotland. The SMR4 data gave all the details necessary to assess for inclusion in the study sample, including demographic information. Although the hospital discharge data was chosen as the most appropriate sampling tool available, it is important to acknowledge that the accuracy of the data, particularly for diagnosis, has been questioned (Alderson 1988: 253). This potential inaccuracy is, however, endemic to any study based on routine returns.

The ISD data gave an indication of the number of discharges over a specified period. A period was identified for each Health Board area which it was hoped would achieve more than the target number of discharges in order to use the replacement sampling technique outlined at Annex One. Once this time period had been set, contact was made with each acute unit to enlist their help in informing potential subjects that the study was taking place in that area and that they might be contacted at a later date and invited to take part in the study. Ward staff were asked to distribute an information leaflet to all patients discharged over the specified period (see Annex Three), and to inform the researcher if any patient expressed a firm refusal to take part in the study at this stage.

All consultant psychiatrists working in acute psychiatry in the study areas were informed of the study and were asked if they had any objections to their patients being included in the study. One team of clinicians (Borders Community Health Services NHS Trust) asked to be informed as to who was in the sample prior to making contact with the individuals. This request was adhered to.

Where an individual included in the sample was identified as having community support, the researcher contacted the community based worker (referred to as community support worker throughout this report) to ask if they had any concerns about the researcher contacting that individual. To aid this process, information sheets were sent to the managers or team leaders of all the community teams in the study areas and they were asked to distribute them to the team members. Teams varied in composition according to their degree of specialisation and whether they were multi-professional and/or multi-agency. It became apparent that this process was not always being carried out in time for the researcher making contact with the team. The researcher therefore started to contact team leaders by telephone to discuss the study and the implications for the community support workers. One community team in the Greater Glasgow area invited the researcher to make a short presentation to the team seminar series. This greatly aided the process of contacting the community teams and, had time permitted, it would have been pursued with all the teams involved. The responses from the community teams were variable but generally positive. Keyworkers tended to be protective of their clients and sought to make the decision whether an individual would be interested in taking part in the study. The researcher had to make it clear that the decision to participate in the study lay with the individual who had
been discharged rather than the keyworker and that contacting the keyworker was a courtesy rather than a request for permission.

If an individual did not have any community support, direct contact was made by letter asking if they were interested in taking part in the study. An interviewer then called at their house at a pre-arranged time to see if they were willing to participate. If they were, the interview usually went ahead on that day. In all cases, if the individual was not in, another attempt was made to contact them before categorising them as non-responders. All individuals gave written consent to taking part in the study before the interview took place. Interviews took place in individuals’ own homes unless they requested otherwise.

**Interview procedure**

The first interview (Time 1) consisted of two parts. A study-specific semi-structured interview aimed to explore the discharge arrangements for each individual and their living situation, professional contacts and support networks (see Annex Three). The Camberwell Assessment of Need (CAN) was also completed, selected on the basis of comprehensiveness and comparability with other studies. The CAN, developed by PRiSM at the Institute of Psychiatry, has both clinical and research versions and allows for needs to be assessed both by the individual service user and by a keyworker (Phelan et al, 1995; Slade et al, 1999). Use of the CAN in this study allowed need and unmet need to be assessed over time and to identify any links with patterns of discharge. The CAN was also completed with the identified keyworker at both time points, allowing the user and staff assessments to be compared, as achieved in other studies (Slade et al, 1996; Slade et al, 1998).

The follow-up interview (Time 2) also consisted of two parts, a study specific semi-structured interview (see Annex Three) and completion of the CAN.

Of particular concern for this study was the identification of features which could serve as outcome measures. Discharge studies often resort to readmission rates as a proxy outcome measure; their use, however, has to be treated with caution, with planned admission often a positive rather than negative feature. Other potential measures include respondents’ accounts of satisfaction with the discharge process and reduction in the level of unmet need.

Looking to related studies, for their comparative study of discharge protocols Naji et al. (1999) select as outcome measures readmission within 6 months, mental health status, the speed and frequency of contact with services, and appropriate continuation of medication. Outcome measures selected for an evaluation of the impact of GP input on discharge planning for frail older people (McInnes et al., 1999) included community service referral, accommodation changes, length of stay, readmission rate, length of time to first readmission, and patient satisfaction with discharge arrangements. Similarly, a study in the US of the effectiveness of an advanced nurse-centred discharge planning and home follow-up intervention for older people at risk (Naylor et al., 1999) took for its outcome measures the number of readmissions and the time to first readmission, acute carer visits after discharge, costs, functional status, depression, and patient satisfaction. For the evaluation by Houghton et al. (1996) of the impact of introducing a discharge co-ordinator, the chosen outcome measures were readmission rates, duration of stay,
appropriateness of days of care, patients’ health and satisfaction, problems after discharge, and receipt of service.

A study by Gantt et al. (1999) sought to predict factors which might compromise the discharge process. Consecutive psychiatric admissions were evaluated for the quality of available support resources in three domains, housing, daily activity and psychiatric treatment, using the Mount Sinai Discharge Planning Inventory. Optimal discharge plans were compared with the actual, recording areas where there was a shortfall (impediment). A significant association was found between impediments at discharge for housing and psychiatric treatment services and return to hospital within 90 days. An evaluation of the effectiveness of two in-patient units attached to community mental health centres (Boardman et al., 1999) employed standard measures of a range of clinical and social outcomes, examination of changes in need according to the CAN, and comparison of patient satisfaction.

The outcome measures specified in the current study included those focusing on professional and user perspectives on met and unmet need as recorded on the CAN, the service receipt measures relating to service contact following discharge, and the measures of satisfaction, both summary and across a range of domains, reported by users and by carers.

Response rates

A full discussion of the response rates can be found in Annex One. Table 2.3 details the response rates for both stages of the user sample. These were not dissimilar to other studies of individuals with long-standing mental health problems (Thornicroft et al., 1998). In total 173 individuals were recruited to take part in the study, and 128 of these were followed up 6 months later. In the presentation below, responses will be distinguished, where appropriate, for two groups, those with a psychotic diagnosis and those with a non-psychotic diagnosis.

<table>
<thead>
<tr>
<th>Health Board area</th>
<th>Target</th>
<th>Population</th>
<th>Time 1 number</th>
<th>Time 1 %</th>
<th>Time 2 number</th>
<th>Time 2 % T1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forth Valley</td>
<td>20</td>
<td>17</td>
<td>14</td>
<td>82</td>
<td>9</td>
<td>64</td>
</tr>
<tr>
<td>Fife</td>
<td>27</td>
<td>24</td>
<td>13</td>
<td>54</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Tayside</td>
<td>55</td>
<td>49</td>
<td>13</td>
<td>26</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>51</td>
<td>67</td>
<td>36</td>
<td>54</td>
<td>28</td>
<td>78</td>
</tr>
<tr>
<td>Borders</td>
<td>13</td>
<td>18</td>
<td>6</td>
<td>33</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>100</td>
<td>156</td>
<td>63</td>
<td>41</td>
<td>49</td>
<td>78</td>
</tr>
<tr>
<td>Highland</td>
<td>18</td>
<td>28</td>
<td>16</td>
<td>57</td>
<td>10</td>
<td>63</td>
</tr>
<tr>
<td>Western Isles</td>
<td>15</td>
<td>18</td>
<td>12</td>
<td>67</td>
<td>8</td>
<td>68</td>
</tr>
<tr>
<td>Total</td>
<td>299</td>
<td>377</td>
<td>173</td>
<td>46</td>
<td>128</td>
<td>74</td>
</tr>
</tbody>
</table>

Carer views on acute psychiatric discharge

Informal carers were identified during both interviews with the user. Only when permission was granted by the user were carers contacted and invited to take part in the study. The carer interview (see Annex Three) aimed to ascertain how the carer felt about the services the
individual had received and how they as a carer had been supported. Carer interviews were completed in 58 cases. There were only 27 individuals who did not identify a carer during the interview process. For the remaining cases, the researchers felt on 7 occasions that it was not appropriate to approach the carer for interview, mostly because of difficult relations between the individual and carer at that time. In 15 cases the user refused permission for the research team to approach the carer and in 21 cases the carer declined to take part. One user consented to the researcher contacting the carer and this interview was completed; however the user then declined to take part himself. For this reason there are only 57 cases with both carer and user interviews.

Community support worker views on acute discharge

When a statutory keyworker (CPN or Social Worker) had been involved in the user’s care over the whole study period, they were invited to take part in a telephone interview looking at aspects of discharge and inter-agency collaboration (see Annex Three). All keyworkers (27) who fitted this criterion agreed to take part in the telephone interview. Twenty-five CPNs and 2 social workers were involved, 9 from Greater Glasgow, 5 from Ayrshire and Arran, 4 from Highland, 2 each from Borders, Fife, Forth Valley and Western Isles and one from Tayside.

The interviews with users and carers were conducted by the research team and by 6 sessional interviewers, all of whom had experience with qualitative research interviewing and/or mental health care. All the telephone interviews with keyworkers were completed by the research team.

Consultant psychiatrist views on acute psychiatric discharge

All members of the Royal College of Psychiatrists in Scotland were circulated with a questionnaire (see Annex Three). Those without consultant responsibility for discharging acute general psychiatric in-patients were asked to opt out and return the questionnaire uncompleted. Those with such responsibility were asked to detail their post and complete the questionnaire. There is no reliable method of identifying the specific responsibilities of individual consultants in Scotland. The Royal College's 1998 census shows that there were 152 adult general psychiatrists in Scotland. This figure has been used as the denominator for the purpose of calculating the response rate, providing a response rate of 65% for the 98 completed questionnaires received.

Questions were developed to clarify consultants’ awareness of existing discharge policies in their own setting and their usefulness, the numbers of acute patients discharged on a weekly basis, their ability to involve community support in the discharge process and their use of the Care Programme Approach.

Data analysis

The analysis was carried out using SPSS and NUD*IST software packages. For quantitative data, significance was measured using the chi-square test. A range of variables were routinely deployed, including diagnosis, gender, length of stay and Health Board area. A framework for analysis of the qualitative data from the key informant, user and carer and keyworker interviews.
was developed as described by Ritchie and Spencer (1994). This allowed for the identification of emergent themes relevant to the context of the study.

METHODOLOGICAL ISSUES

Although all key informants in Phase One were asked by letter to send the appropriate documentation concerning acute psychiatric discharge from their area, few documents were received, despite telephone prompting; moreover some of those received did not concern discharge. For this reason definitive conclusions cannot be drawn about the quality of the policies, protocols and processes relating to discharge. The difficulty in accessing documentation does raise issues about the accessibility of Trust policies and ward procedures/protocols more generally, and whether staff adhere to them.

The study asked users and carers in Phase Two to focus on a particular part of the experience of being in hospital, namely discharge. Although discharge arrangements can have an impact on other aspects of the hospital stay, for many users the discharge was not an event that was important to them. Often users wanted to talk about other aspects of the hospital stay, for instance incidents which had taken place on the ward. Whilst not wanting to diminish the importance of these events, the research team had to extract the relevant information carefully.

The Camberwell Assessment of Need (CAN), whilst a well developed and established tool (Ericson et al., 1997; Heinze et al., 1997), does pose a number of difficulties for studies of this type. The CAN does not take account of services that have been offered and then refused by the user. In completing the assessment, people appear to have unmet need when on exploration the user had been offered access to some services and refused them. There is also a value judgement as to when ‘met need’ may become classified as no need. Moreover, Wiersma et al. (1998) reported a 21% divergence between user and investigator assessment of unmet need status.

SAMPLE CHARACTERISTICS

Sample of service users

The sample for the study had a number of components. The main group in the sample were the mental health service users and the characteristics of this group are described below and detailed in Table A2.1 in Annex Two.

♦ The sample comprised 75 men and 98 women (43% : 57%).

♦ The average age was 40 years, with the age range being 17 to 65. Using ISD age categories (<25, 25-44, 45+) there was no significant difference in age by gender.

♦ Seventy-six individuals (44%) had been diagnosed with a depressive disorder, 33 (19%) with a psychotic disorder, 22 (13%) with bi-polar disorder and 19 (11%) with personality disorder. There was a small number of other diagnoses. Eighteen individuals had a secondary
diagnosis of substance misuse. Aggregated into two diagnostic groups, 35% of the sample (61) had psychotic disorders (psychosis, bi-polar disorder, schizo-affective disorder and puerperal psychosis) and 65% (112) non-psychotic disorders (depressive disorder, anxiety disorder, substance misuse, adjustment disorder, post-traumatic stress disorder, somatoform disorder, behaviour disorder, eating disorder, unspecified disorder).

♦ Of the 61 with a psychotic diagnosis, 35 (57%) were male and 26 (43%) female. Of the 112 with a non-psychotic diagnosis, 40 (36%) were male and 72 (64%) were female. This gender difference between the two diagnostic groups is significant.  

♦ The average length of stay in an acute psychiatric unit was 35.8 days, with the range being 7-185 days. Over half of the sample were in-patients for 4 weeks or less (55%), with a further 28% having an in-patient stay of over one month and less than 2 months. The remainder (17%) were in-patients for over 2 months. There was no significant difference in length of stay by gender.

♦ The majority of the admissions were on an emergency and informal basis (72%) with 16% being arranged admissions and 10% formal emergency admissions. Three individuals were under Section 18 of the Mental Health (Scotland) Act and on leave of absence from hospital. Admission status did not vary by gender.

♦ Over three quarters of the sample had at least one prior admission to an acute psychiatric unit (76%). There was no significant difference in the number of admissions according to gender.

♦ Five individuals were on the Care Programme Approach (CPA) at Time 1, one in Greater Glasgow, and 4 in Highland. The Time 2 interviews included 4 individuals on CPA, one each in Greater Glasgow, Forth Valley, Highland and Western Isles.

♦ In the 6 week period between being identified for the study and the initial interview taking place, 26 individuals had been re-admitted, with 12 in hospital at the time of interview. A further 26 had been re-admitted on at least one occasion by the 6 month stage. This gives an overall readmission rate within 6 months of 27%. There was no significant variation in readmission by gender.

♦ Seven individuals left the hospital of their own accord against medical advice.

♦ Thirty-one individuals were in employment at the time of admission to hospital.

♦ Few users had no community support throughout the study period. Over half the sample had one or 2 supports at Time 1, almost a quarter had 3, and small numbers had more than 3. The levels of community support across the sample had lowered by Time 2. Levels of support did not vary by gender.

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3 chi-square = 7.55, 1df, p<.05
The most common community support was an out-patient appointment, followed by a CPN, and then day services. Fewer users had contact with social work and voluntary sector support workers. At Time 2 the proportion of users in contact with support services was similar.

There was no difference in the key characteristics of the sample at the follow-up stage.

Comparative national data on discharges from mental illness hospitals and psychiatric units of individuals with a stay of between one week and six months was available from ISD for the year ending 31 March 1998. The following comparative features can be highlighted.

- The gender breakdown for the 22,140 discharges was 48% male, 52% female.
- Twenty-nine per cent of admissions were first-time admissions.
- Eleven per cent of admissions were formal admissions.
- The breakdown in terms of length of stay was 61% between one and four weeks, 21% between one and two months, and 18% over two months.

This provides confirmation (Table 2.4) that the sample can be regarded as indicative of the national picture.

### Table 2.4  Comparison of study sample to national characteristics

<table>
<thead>
<tr>
<th></th>
<th>Study sample %</th>
<th>Scotland, 1997-98 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>43.4</td>
<td>48.5</td>
</tr>
<tr>
<td>female</td>
<td>56.6</td>
<td>51.5</td>
</tr>
<tr>
<td>First-time admissions</td>
<td>23.8</td>
<td>29.0</td>
</tr>
<tr>
<td>Formal admissions</td>
<td>10.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Length of stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4 weeks</td>
<td>54.4</td>
<td>60.6</td>
</tr>
<tr>
<td>1-2 months</td>
<td>28.3</td>
<td>21.4</td>
</tr>
<tr>
<td>&gt; 2 months</td>
<td>17.3</td>
<td>18.0</td>
</tr>
</tbody>
</table>

### Readmission

As detailed above, during the initial six week period after discharge, 15% of those who were interviewed had been readmitted to hospital. There was no significant difference between the two groups, readmitted and not, on the following factors:

- gender
- age
- Health Board area
- employment status
- the length of notice given prior to discharge
- whether individuals were at the same address
- whether individuals were happy with their accommodation
- the level of family involvement
- when individuals first saw their GP after discharge
♦ whether individuals had a psychotic diagnosis
♦ the number of community supports.

There were significant differences between the two groups in terms of:

- satisfaction with the notice of discharge\(^4\)
- broad diagnostic group (six categories)\(^5\)
- use of “pass”\(^6\)

A further 26 people were readmitted in the ensuing six month period. These readmissions are discussed further in Chapter Six.

**Sample of carers**

Fifty-eight carers of discharged individuals were recruited to take part in the study. Table A2.2 in Annex Two provides full details of the characteristics of this group.

♦ The gender split was 41% male and 59% female.
♦ Most commonly the carer was the spouse or partner of the user (48%), followed by parent (26%), with 7% of carers being a friend of the user.
♦ The majority lived at the same address (69%), but a sizeable minority did not (31%).
♦ Almost all of the carers had been in the caring role for the length of illness (90%).
♦ The majority of carers had been in that role for more than 2 years (76%), with only a quarter being in this role for less than 2 years.
♦ All carers reported ‘keeping an eye on’ the user and almost all ‘keeping the user company’ (85%) (Parker and Lawton, 1994). Few carers, as would be expected in a mental health sample, were involved in physical caring tasks (11%).

**Needs identified on the Camberwell Assessment of Need**

As detailed above, the CAN was completed at each time period, recording both the individual user’s assessment of their needs and the assessment of the keyworker. Table 2.5 details the levels of need which were identified for the sample at Time 1.

---

\(^4\) chi-square = 4.01, 1df, p<.05
\(^5\) chi-square = 13.25, 5df, p<.02
\(^6\) chi-square = 6.22, 1df, p<.02
Table 2.5  Needs identified on the Camberwell Assessment of Need, Time 1

<table>
<thead>
<tr>
<th></th>
<th>Psychotic group (n=61)</th>
<th>Non-psychotic group (n=112)</th>
<th>Total (n=173)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total needs identified in each domain</td>
<td>Total unmet needs identified in each domain</td>
<td>Total needs identified in each domain</td>
</tr>
<tr>
<td></td>
<td>number</td>
<td>%</td>
<td>number</td>
</tr>
<tr>
<td>Accommodation</td>
<td>9</td>
<td>15</td>
<td>3</td>
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<tr>
<td>Food</td>
<td>19</td>
<td>31</td>
<td>5</td>
</tr>
<tr>
<td>Looking after the home</td>
<td>14</td>
<td>23</td>
<td>3</td>
</tr>
<tr>
<td>Self care</td>
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<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Daytime activities</td>
<td>31</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>Physical health</td>
<td>14</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Psychotic symptoms</td>
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<td>38</td>
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<tr>
<td>Information</td>
<td>21</td>
<td>34</td>
<td>12</td>
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<td>Psychological distress</td>
<td>27</td>
<td>44</td>
<td>10</td>
</tr>
<tr>
<td>Safety to self</td>
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<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Safety to others</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
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<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Drugs</td>
<td>5</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Company</td>
<td>23</td>
<td>38</td>
<td>12</td>
</tr>
<tr>
<td>Intimate relationships</td>
<td>6</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Sexual expression</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
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<td>16</td>
<td>7</td>
</tr>
<tr>
<td>Education</td>
<td>10</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>Telephone</td>
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<td>5</td>
<td>1</td>
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<td>21</td>
<td>4</td>
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<tr>
<td>Money</td>
<td>14</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>Benefits</td>
<td>15</td>
<td>25</td>
<td>11</td>
</tr>
</tbody>
</table>
SUMMARY

♦ Phase 1 of the study comprised interviews with 89 key informants across Health Boards, local authorities, and NHS Trusts and wards in order to profile the policy and practice for acute psychiatric discharge that was current across Scotland.

♦ Phase 2 of the study sought to explore the outcomes for individuals of the discharge process. A sample of users was drawn across eight Health Boards chosen to reflect the national distribution of discharged patients. Inclusion factors were age 16-65 and an in-patient in an acute psychiatric bed for at least 7 days and less than 6 months. Exclusion factors were dementia or a primary diagnosis of substance misuse. Respondents were interviewed in their own homes six weeks and six months after the initial discharge. The Camberwell Assessment of Need (CAN) was also completed with the individual and with the keyworker.

♦ Interviews were completed with 173 individuals at the six week stage and with 128 of these individuals some six months later. The response rate from the 377 people approached at Time 1 was therefore 46%, not dissimilar to other studies in the psychiatric field using a comparable approach.

♦ Interviews were completed with 58 informal carers, and with 27 keyworkers who had been involved with a patient respondent throughout the study period.

♦ A questionnaire was circulated to all members of the Royal College of Psychiatrists in Scotland (estimated n = 152) seeking their awareness and views on discharge policies and protocols. A response rate of 65% (98) was achieved.

♦ The profile of individuals discharged includes slightly more women than men, over half in hospital for less than four weeks, and with the majority admitted on an informal but emergency basis. Over three quarters of the sample had at least one previous admission. Only a handful of the sample were on CPA.

♦ Carers were most often partners (approximately half of cases), followed by parents (one quarter). The majority lived at the same address and had been in the support role for the duration of the illness.
CHAPTER THREE: DISCHARGE POLICIES AND PROTOCOLS

The effectiveness of discharge policies is influenced by a number of factors other than simply the final process of discharge. These include the admission process, discharge planning, inter-agency and multi-disciplinary relationships, the discharge event, and support available post discharge. This chapter explores the discharge policies and protocols that were operating across the various agencies (Health Boards, Trusts, wards and local authorities) at the date when discharge policies were mapped. Firstly the extent to which there has been development of discharge policies at strategic level by Health Boards and local authorities – and the extent to which this activity has been joint – is explored. Secondly the operational activity at Trust and ward level is detailed, setting out the extent to which particular procedures and protocols have been specified. Subsequently the extent to which the experience of discharge as detailed by both key agency informants and users and carers was found to accord with these requirements is explored. This focuses in particular on planning and decision-making in respect of discharge, including the use of ‘pass’ for day or overnight stays away from the hospital, and on the profile of interprofessional communication. The Chapter concludes with details of the features central to a well-specified discharge protocol.

LOCAL POLICY DEVELOPMENT

The extent to which health and social care agencies had addressed the issue of acute psychiatric discharge and taken strategic measures locally to develop, implement and operationalise any policies was explored in the key informant interviews. There appeared to have been limited strategic activity at the local level specifically in relation to acute discharge for individuals with mental health problems, either in terms of policy directives or guidelines for good practice, although discharge for other user groups had often been discussed in some detail. In Ayrshire and Arran, Borders, Lothian and Greater Glasgow Health Board areas, there were several examples of joint working around discharge policies for all care groups, and there had been a number of joint working groups on discharge for the long-stay patient group in most other Boards.

At the strategic level, local authority and Health Board respondents were asked whether there were policies for discharge in place, and, if so, whether these were generic across a range of care groups or specific to acute psychiatric discharge. Table 3.1 specifies by local authority area the nature of this strategic activity (as at the mapping in 1998) and the extent to which it was joint with the relevant Health Board. In six local authority areas there were joint policies both for generic discharge and specifically for acute discharge. A further 11 councils had a policy specific to acute discharge, while ten relied on a generic discharge policy. The respondent from East Lothian highlighted that a generic policy inevitably required modification for the particular situation: ‘everyone from every specialty says “this doesn’t fit me”’. In four local authority areas there had been no development of jointly agreed written discharge policies, although one (Renfrewshire) spoke of ‘a convention rather than written’. The existence of a specific rather than generic policy may not in practice, however, signify major difference. There was specific reference to patients detained under the Mental Health Act in the psychiatric policies, but otherwise they differed little from the generic policies.
Table 3.1: Joint discharge policies in operation (1999)

<table>
<thead>
<tr>
<th>Joint general and acute psychiatric discharge</th>
<th>Joint general only</th>
<th>Joint acute psychiatric discharge only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll and Bute Council</td>
<td>Aberdeen Council</td>
<td></td>
</tr>
<tr>
<td>Dundee City Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>East Dunbartonshire Council</td>
<td>Clackmannan Council</td>
</tr>
<tr>
<td>Glasgow City Council</td>
<td>East Lothian Council</td>
<td>Dumfries and Galloway Council</td>
</tr>
<tr>
<td>North Ayrshire Council</td>
<td>Inverclyde Council</td>
<td>Edinburgh City Council</td>
</tr>
<tr>
<td>North Lanarkshire Council</td>
<td>Midlothian Council</td>
<td>Falkirk Council</td>
</tr>
<tr>
<td>West Lothian Council</td>
<td>Moray Council</td>
<td>Highland Council</td>
</tr>
<tr>
<td>Western Isles Council</td>
<td></td>
<td>Orkney Islands Council (CPA)</td>
</tr>
<tr>
<td>Perth and Kinross Council</td>
<td></td>
<td></td>
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<tr>
<td>Shetland Islands Council</td>
<td>South Lanarkshire Council</td>
<td></td>
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<tr>
<td>South Ayrshire Council</td>
<td>Stirling Council</td>
<td></td>
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<tr>
<td>Scottish Borders Council</td>
<td></td>
<td></td>
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<tr>
<td>West Dunbartonshire Council</td>
<td></td>
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</tr>
</tbody>
</table>

NB – there were no jointly agreed discharge policies in Aberdeen City, Angus, Fife or Renfrewshire; no interview was completed in East Renfrewshire

Why has acute psychiatric discharge not featured in policy development to any great extent, given that the user group often has complex health and social care needs and is often vulnerable in the community? Policies such as CPA and care management are available to address these issues. However, it is clear from the research that individuals who require these services have not always received them due to breakdowns in communication between hospital and community services. Even though not all individuals fit the criteria for these two models of care, patients do require initial support and follow-up in order to be discharged effectively into the community.

Despite the lack of specific policy directives, acute psychiatric discharge was characterised by all Health Board respondents as being of equal importance to the discharge of other groups. Not all, however, were able to provide any evidence of this, and when questioned further admitted there were fewer issues arising from acute discharge as bed blockages were not such a problem, and finding community placements was not usually required as most people retained their own homes.

Nonetheless, an important minority did identify particular problems associated with the issue. Fife and Dumfries and Galloway Health Boards, for example, raised the issue of a lack of appropriate accommodation for people with acute mental health problems and felt that this sometimes delayed discharge. Highland identified problems specific to their rural location.
problems sometimes as to whether discharge could actually take place due to delays with, or lack of, transport and community services. Ayrshire and Arran said it had become more of an issue in recent years and would continue to gain importance as a result of the Framework for Mental Health Services. Forth Valley considered discharge was of particular importance as it represented an important component of all community-based services. In effect, they felt if discharge was not adequately planned, it would be difficult to know what other services, for example community mental health teams (CMHTs) and resource centres, were required. Lanarkshire admitted that little attention had been paid to acute discharge as the focus had been on retraction of long-stay beds and the discharge of long-stay patients. However it was felt that as this programme came to an end, more attention would be paid to acute discharge, considered a growing issue with an apparently increased number of cases and intensity of problems.

No target rates for discharge were set in any Board areas except Greater Glasgow. Here they were set largely on a historical basis, but also taking into account the availability of new services which were thought to increase throughput. All other Boards worked with the number of occupied bed days, which served as an indicator of the rate of discharge and could be used to identify high and low points within the service. Tayside Health Board had specifically used this as a measure to monitor the effectiveness of a new drug treatment for psychosis. Officials expected the drug to impact on the length of stay and therefore reduce occupied bed days. In contrast to Tayside’s view of the ability to use this as an effective measure, Ayrshire and Arran felt the number of occupied bed days was not particularly useful but did show the extent to which beds were under pressure. Fife used activity episodes to monitor admission and discharge of acute cases.

**DISCHARGE POLICIES AND PROTOCOLS AT TRUST AND WARD LEVEL**

Against this strategic background, the extent to which admission and discharge policies had been developed at both Trust and ward levels was examined. It has been argued that without such policies, good practice cannot be developed (Durghhee, 1996), and, as indicated by the Audit Commission (1991), it is important that ward-based staff are involved in developing locally based protocols, which they will find easier to adhere to than Trust-wide policies. The Commission also highlighted the importance of using written communication to ensure all information is recorded and passed on to other professionals involved in an individual’s care. Tierney (1994) discussed the use of systematic procedures for planning discharge as an effective way of ensuring the transition between in-patient and community care; there was, therefore, a particular intent to determine the extent to which admission and discharge checklists and care plans were developed. An appropriate distinction between policy and protocol is that the former describes statements, procedures or standards produced at Trust level by some form of working party; the latter refers to statements, standards or procedures developed locally at the ward level, either independently or as an adaptation of Trust wide policy.

**Trust discharge policies**

A variety of generic and specific discharge policies and protocols were forwarded by Trusts and wards and others were reported in the course of the key informant interviews. Table 3.2 provides
a detailed summary of the existence across the 20 relevant Trusts of policies, protocols and checklists at the reporting of the mapping exercise in 1999. (It should be noted that the configuration and names of a number of Trusts have subsequently changed.) This information has been aggregated from the interviews with respondents in 17 of the 20 Trusts and in 28 wards (Table 2.2) and from the range of documentation submitted by various Trusts.

Table 3.2 indicates that at Trust level discharge policies specific to acute psychiatry were in the minority, cited by only 4 Trusts. In a further 8 Trusts, a general discharge policy existed for implementation across all sites. Responses for the remaining 4 Trusts were unable to specify either a generic or specific discharge policy. In all but 2 Trusts an admission policy was in operation, in 15 cases specific to acute psychiatry.

These figures can be compared with a survey of UK Trusts cited by the Mental Health Reference Group (2000). Of the third who responded, one half reported using a discharge protocol, while over a quarter said they had one under development. In one in 7 Trusts, there was no discharge protocol in use or under development. Nearly two-thirds of those responding used a discharge checklist and nearly a third a discharge rating scale.
### Table 3.2: Acute psychiatric admission and discharge policies, protocols and checklists (1999)

<table>
<thead>
<tr>
<th>NHS Trusts and Wards</th>
<th>Policy</th>
<th></th>
<th>Protocols</th>
<th></th>
<th>Checklists</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>a</td>
<td>d</td>
<td>dg</td>
<td>a</td>
<td>d</td>
</tr>
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<td>Ward A</td>
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<td>Ward B</td>
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<tr>
<td>2. Argyll and Bute</td>
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<td>Ward A*</td>
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<tr>
<td>16. Angus</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Ward A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Dundee</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Ward A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Perth and Kinross</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Ward A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. East &amp; Midlothian Ward A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>20. Western Isles Ward A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

*d* = discharge, *a* = admission, *dg* = general discharge policy  
* = Interviews not carried out
Central Scotland Healthcare Trust had one of the clearest discharge policy documents, specifying as its objective ‘to provide guidelines for all disciplines to improve understanding among all parties involved in admission, discharge and aftercare arrangements’. With a general principle that ‘discharge planning should be a priority from the day of admission’, the detail of discharge planning is specified. This policy embraces features common to the majority of the more comprehensive policies: assessment in respect of physical, mental and social functioning and the development of a structured discharge plan; written referral to community-based services at the earliest opportunity; regular and full involvement of patients and relatives/carers in discharge decision making including a minimum of 2 days and preferred 5 days notice of discharge; co-ordination of the discharge arrangements by the named nurse/key worker, including completion of a discharge checklist; patients and relatives informed of the arrangements for medication, continuing treatment and post discharge services, and the provision, prior to discharge, of sufficient medication for a minimum of 7 days.

In addition the detail of effective systems to be in place for communication and liaison between hospital and community is laid down.

- The named nurse/key worker to contact the GP practice by phone on the day of discharge.
- Patients should be provided with clear written information in everyday language on their discharge from hospital (name of key worker in the community and any follow up arrangements).
- Medical Records should be notified immediately of any patients who are discharged and live outwith the health Board area to enable the health Board of Residence to be informed.
- Discharge prescription and brief discharge summary should be sent to the GP within 72 hours of discharge,
- A copy of Form 9/10, for a patient on Section 18 of the Mental Health (Scotland) Act or Section 58 of the Criminal Procedures (Scotland) Act (DATE?) should be sent to the patient’s GP when the patient leaves hospital on Leave of Absence to stay in the community.
- The GP is notified of the death of a patient within 24 hours of death occurring (if still on GP list).
- A comprehensive discharge summary should be sent to the GP within 14 days following patient discharge.

A number of the elements highlighted by this policy are discussed in greater detail below, including the notice for discharge, collaboration with other professionals, and the involvement of the user and carer in the decision-making process.

Ward protocols and checklists

Protocols at ward level tended to be shorter than Trust discharge policies and provided more of a guide to the admission and discharge process than those at Trust level; checklists were most often of a ‘tick-box’ format. It should be appreciated however that as locally developed proformas there will inevitably be overlap and similarities between the organising categories of
policy, protocol and checklist. From Table 3.2 it can be seen that discharge protocols were in place for 12 of 31 wards (compared with admission protocols for 26 of these wards), with specific discharge checklists for 20 of the wards. Table 3.2 also indicates that 11 wards featured discharge checklists but not protocols; for 3 wards there were discharge protocols but no checklists. In a number of Trusts, including Edinburgh and Perth and Kinross, specific requirements relating to the discharge process had been transformed into standards, for example ‘the clinical pharmacist will be advised of the intended date of discharge within one working day of the decision’.

The most comprehensive discharge protocols covered the following issues:

**Pre-discharge**

- arrange discharge meeting
- ensure patient has been informed of discharge plans
- ensure support services are in place
- ensure discharge medication is ordered
- inform next of kin
- prepare patient for discharge

**Discharge**

- clarify instructions for taking medication to patient and/or carer
- return valuables
- record date on admission form
- send all nursing documentation to relevant others e.g. day hospital
- ensure discharge letter is sent to GP and inform GP, CPN if necessary
- discharge letter completed and sent to GP within 7 days.

The protocol relating to discharge procedures in Borders, for example, included the following specifications.

- There should be multidisciplinary medical and nursing evidence that the patient is ‘fit’ for discharge.
- Patients, family and carers should be involved at each stage of the patient’s care and especially in the discharge planning.
- Effective discharge arrangements must involve agreed management protocols and the use of staff such as liaison and specialist nurses to provide continuity of care across the complex web of individuals and agencies.
- When the date and specific services have been decided, it is up to the named nurse to coordinate the discharge plan.
- It is vital that correct local procedures are followed and that accurate documentation of all patients’ needs is clear and concise.
A number of Trusts specified the procedure to be followed if individuals left hospital prior to professional approval. For example, at Western Isles Health Unit,

‘all the relevant agencies involved will be alerted within 12 hours of the patient’s self discharge from hospital… The named nurse in collaboration with the Consultant Psychiatrist and any other member of the multi-disciplinary team will assess the patient’s degree of risk and arrange, where appropriate, a multi-agency meeting to discuss how the patient’s well being can be monitored in the community.’

Checklists provided in the main a mechanism for a ready visual recording of the extent to which key discharge tasks had been completed. Of particular note was the practice in East and Midlothian NHS Trust where the Discharge Integrated Care Pathway had replaced the traditional discharge checklist.

‘The Discharge ICP was devised by the multidisciplinary Trust Discharge Care Planning Group for introduction on a Trust-wide basis. It is intended as a replacement for the existing Discharge Checklist. The ICP is useful as an aide memoire and, as a record of the implementation of the Lothian Health/Social Work Discharge Planning Standards, will help facilitate the required clinical audit process for patients with identified complex health and social needs.’

Specified within the pathway document were the time periods within which specific actions were to be completed, with any variance from these times to be recorded. A related Admission Integrated Care Pathway focused on the activities to be accomplished during the first three days of admission.

**Consultant perspective**

Information was sought in the consultant questionnaire on the extent to which discharge policies were an active influence on practice generally across Scotland. Fifty-nine per cent of the 98 consultants who responded were aware of an existing acute discharge policy, 83% of whom used it. Of the 41% (40) who were unaware of any discharge policy, just over a quarter (27%) said they would like such a policy to be developed. Those consultants who worked within a system that did not have an existing discharge policy for acute in-patients and who considered that it would be helpful to develop such a policy were nonetheless ambivalent as to its potential usefulness. Most judged that a discharge policy would lead to better liaison and communication; a number, however, were concerned about the rigidity imposed by a strict policy and preferred guidelines which allowed some flexibility.

“*Would provide consistency, safety, avoid people falling between service cracks.*”

“*We may be required to develop one (discharge policy) but the dangers are of expanding bureaucracy for limited or no benefit.*”
Many commented upon the potential pressure on their acute beds and were concerned that any procedure which delayed discharge would seriously interfere with their ability to provide a responsive service.

Against this background, the importance of a number of specific features of the discharge process can be explored, highlighting in particular why they should feature in the optimum discharge policy or protocol.

**Notice of discharge**

The length of notice of discharge to be given to users and carers is an issue of debate. If discharge planning is to start on admission and users are to be fully involved in this process then it could be argued that a standard timing for the notice of discharge should not be necessary. The key informants indicated that the notice given to users was dependent upon ward or psychiatrist preferences and was often not laid down in a policy document. There was, therefore, a lack of consistency within Trusts. A number of informants stated that the notice given depended upon the user’s individual circumstances. Where informants indicated that a minimum standard did exist, it varied greatly from between 24 hours to one week. Policies regarded as examples of good practice recommended a minimum of 2 to 5 days notice.

The interviews revealed that, as a result of the lack of policy, wards within the same Trusts gave different responses when asked how much notice patients were given of their discharge. It seemed that pressure on beds, consultant preference, and the patient’s eagerness to leave once informed of a discharge date contributed to the variation in the amount of notice patients were given; this could vary from 24 hours to 3 weeks. On the whole, agency respondents felt that, providing community support was in place for those who required it, notice of discharge was not a problem.

“There’s no set rule. It is enough though. There’s never been any problems with lack of notice.”

The average number of patients that consultants responding to the postal survey reported discharging each week is shown in Table 3.3. Eighty-two per cent of consultants discharged 3 patients or less per week.

<table>
<thead>
<tr>
<th>Mean number of patients discharged by consultants per week</th>
<th>% of consultants (n=98)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>37</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>&gt; 4</td>
<td>7</td>
</tr>
</tbody>
</table>

Consultants reported that the majority of in-patients were given between 4 and 7 day’s notice, with a substantial minority being given 3 days or less. This has significant implications for any
community follow up services and the response time required if social workers and CPNs are to be involved in pre-discharge planning.

Table 3.4 details the notice of discharge as reported by the user sample. About one quarter of the sample had over one week’s notice of discharge and about one quarter had 48 hours to one week. The next largest group is those users who had less than 24 hours notice of discharge. There was no difference according to diagnostic group in the notice of discharge.

Table 3.4 Notice of discharge as reported by users

<table>
<thead>
<tr>
<th>Notice of discharge</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;24 hours</td>
<td>38</td>
<td>22</td>
</tr>
<tr>
<td>24-48 hours</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>&gt;48 hours -1 week</td>
<td>45</td>
<td>26</td>
</tr>
<tr>
<td>&gt;1 week</td>
<td>45</td>
<td>26</td>
</tr>
<tr>
<td>own discharge (AMA)</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>cannot remember</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
</tr>
</tbody>
</table>

Seventy-seven per cent of users were satisfied with the notice of discharge they were given, 21% felt it was insufficient, and 2% reported that they had too much notice. There was no difference in satisfaction with notice of discharge by the two main diagnostic groups, but more people who had been given short notice of discharge were dissatisfied\(^7\) - 42% of those given less than 24 hours notice of discharge were dissatisfied. However, even when the notice of discharge was more than a week, there were 8 users who were not satisfied with this notice.

Discharge planning

Several key informants repeated the common rhetoric that the ideal starting point for discharge planning is on admission, echoing one of the generic standards of the Clinical Standards Board for Scotland (2001): ‘effective discharge planning begins on or shortly after admission and is a continual process. Communication and transfer of information among health care professionals is essential to a seamless process’. Details of the admission process, discussed in Chapter Four, highlighted the need for adequate screening and assessment on admission to draw attention to difficulties other than health that might be a factor in the length of admission. Once these factors have been identified, professional staff have the information necessary to start planning for discharge. Many practitioners, however, saw admission and discharge as two distinct processes. The majority of ward-based key informants held the view that discharge planning was something that started at a particular point, vaguely defined as the point when the user’s mental state began to improve, or when the consultant psychiatrist initiated discharge discussions at the weekly ward meeting:

"the consultant gives a date at the first multi-disciplinary meeting"

\(^7\) chi square = 17.73 df3 p<0.001
Informants at 7 Trusts, however, held a more progressive view towards discharge planning and aimed towards the ideal of discharge planning starting on admission.

"On admission we'll start to complete the discharge documentation. There are questions which address circumstances which might have led to the breakdown such as accommodation and support in the community, so we need to sort them out."

One local authority used an admission checklist comprising 10 questions relating to social care needs, facilitating the referral process from the acute wards. Social workers were informed when an individual in receipt of their care was admitted to an acute psychiatric ward and they continued to monitor that person throughout the in-patient episode. The general attitude, however, seemed to be that admission and discharge are 2 distinct events, with some connections, but not a continual process leading to seamless transition into the community.

The decision to discharge

According to the majority of Trust and ward level informants at Stage 1, the decision to discharge appears largely to be made by the psychiatrists, nursing staff, the patient and, to a lesser extent, family (Table 3.5). Less frequently community agencies were involved. A smaller, but notable, proportion suggested that the decision was made by ward staff or the psychiatrist alone, without user or carer involvement.

Table 3.5 Reported participants in the discharge decision

<table>
<thead>
<tr>
<th>Ward staff</th>
<th>Ward staff and patient</th>
<th>Ward staff, patient and family</th>
<th>Ward staff, patient, family and community agency</th>
<th>Consultant led</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses (n=45)</td>
<td>11</td>
<td>9</td>
<td>11</td>
<td>7</td>
</tr>
</tbody>
</table>

Despite the range of those involved in the decision to discharge, it was reported for all but three wards that the consultant was accountable for the decision to discharge, although several respondents did indicate that the named nurse was accountable for all nursing records. This would include not only the continuous updating of care plans but the completion of any admission or discharge checklists and contacting any relevant agencies in the community.

Communication and co-ordination amongst professionals

Community liaison

Bridging the communication gap between agencies is an important factor in promoting effective discharge, yet difficulties in communication and traditional professional boundaries have often
Interviews with key respondents explored the formality of arrangements for inter-agency and interprofessional collaboration at the operational level. Only two wards had a designated liaison officer, while one Trust was piloting the use of discharge co-ordinators. All these liaison posts were filled by CPNs. The pilot scheme entailed CPNs following up all patients in the community for six weeks once they had been discharged, then either transferring them to the appropriate agency or discharging them totally. This was viewed as an effective service but was expensive as it employed two E grade nurses; there was uncertainty as to whether it would continue beyond the pilot stage.

Other wards who had no formal liaison officer had either developed good working relations with community agencies, such that information was readily available and staff were easy to access, or the development of sectorised CMHTs meant that there was good continuity between in-patient and community services. Ayrshire and Arran Community Healthcare NHS Trust, Fife Healthcare NHS Trust and Moray Health Services Trust had admission wards based on geographical sectorisation with their own CMHTs attached. Other wards within different trusts were sectorised but appeared not to have CMHTs. On occasions, when there were no beds on a particular ward, patients would be admitted to another ward catering for a different geographical area and transferred as soon as possible. Those who had dedicated CMHTs felt patients received better follow up.

“No specific liaison officer. Good communication due to CMHTs. Each ward has a link person who attends team meetings in the community and on the ward. The ward phones the duty social worker on a daily basis to discuss admissions and discharges.”

“CPNs come to the ward. Ward based staff are encouraged to communicate with CPNs and we have aircall pagers which have improved communication because we can get hold of a CPN right away instead of leaving messages that are not picked up quickly.”

Where CPNs and/or social workers were based in the hospital building, or worked in small geographical areas, relationships appeared to be good even if there were no CMHTs or formal liaison strategies.

“Community services are part of the Trust so liaison is in-house. Social work are within the hospital so there are good links. Lots of multi-disciplinary working.”

A small number of respondents appeared to have limited collaboration with community agencies and expressed concern about the gap between the two: ‘no, there is no liaison. There is a gap, there are detached processes.’ On the whole liaison between the services appeared to be good and there was an awareness that this was an important issue which needed to be constantly addressed.

At the time of the fieldwork, Western Isles Health Unit appeared to be the only site to use an inter-agency computer system. The majority of wards did not use any form of computerised system to communicate with other agencies, although some did use databases within their own
area which were not accessible to other agencies. Highland Communities NHS Trust and Ayrshire and Arran Community Healthcare Trust both had a computerised CPA database.

**Collaboration with social work**

Local authority key informants during Phase 1 were asked about the links between the acute ward and community based social workers (Table 3.6). Eleven local authorities with specialist mental health teams based at the psychiatric hospital all had active links with community based social workers. For example, in Edinburgh City Council the hospital team of social workers was linked to acute wards aligned with sectors served by mental health social work teams. For an individual who already had a social worker, the approach in South Ayrshire Council was for the specialist mental health team social worker to inform the community social worker of their admission and discharge. In Aberdeenshire, the CMHT was described as being in a secondary position and they liaised with the hospital-based social work team to look at discharges and admissions.

Five local authorities who provided most of their mental health services through community mental health teams linked directly with the acute ward team on a regular basis. In West Dunbartonshire the social workers in the community mental health teams attended multi-disciplinary team ward rounds. The community mental health officers (MHOs) in Argyll and Bute travelled to the main psychiatric hospital to participate in case reviews with hospital-based social workers. Scottish Borders Council ‘gifted’ five MHOs to Dingleton Hospital; they were hospital based and worked with the multi-disciplinary ward teams which also served a discrete geographical area in the community.

Perth and Kinross Council had jointly funded care managers on the wards who started discharge planning at admission and liaised with area social work teams. East Lothian, East Ayrshire and North Ayrshire Councils each had a hospital social worker who was the link between the hospital and community. In Falkirk, the mental health specialists from the five adult community care teams linked into multi-disciplinary teams at the hospital. Orkney and Shetland Councils had links with social workers at the Royal Cornhill Hospital in Aberdeen who they described as having a critical liaison role. Fife and Dumfries and Galloway Councils had no integrated structure for mental health services; ward staff were the link between the hospital and community.

<table>
<thead>
<tr>
<th>Nature of link</th>
<th>No of authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital mental health team to community social work</td>
<td>11</td>
</tr>
<tr>
<td>Direct link CMHT to hospital ward</td>
<td>7</td>
</tr>
<tr>
<td>Ward to community social work</td>
<td>4</td>
</tr>
<tr>
<td>Hospital social work to community social work</td>
<td>5</td>
</tr>
<tr>
<td>No routine link</td>
<td>4</td>
</tr>
</tbody>
</table>

* no information for one authority

Angus Council indicated that the links between hospital and community were only formal for people on CPA and that in practice, referrals to social work may come from the acute wards just
one day before discharge. The key informant from another area highlighted one aspect of the problem in practice.

“The difference with acute psychiatric discharge is that people are in and out of hospital very quickly and all the good practice in the standards becomes time consuming. When people discharge themselves or refuse help, the best protocols won’t work. Involving people at short notice is difficult.”

An interesting development cited in Orkney was the use of resource transfer monies to fund a mental health resource centre with three beds for people discharged from an acute ward who were not ready to go back to their own homes. However, the nature of the funding precluded 24 hour care, which had been identified as a major gap in the service.

Eighteen local authority key informants stated that social workers were involved in pre-discharge planning. The social workers’ responsibilities for acute psychiatric discharge were outlined in the interviews as a process involving community care assessment, designing a care plan, obtaining funding for the plan, purchasing the care, monitoring the care and conducting regular reviews. In Dumfries and Galloway, for example, the social work department was involved at an early stage prior to discharge, especially in planning the care package for the person with the aim of providing an enabling service. In Highland the role of hospital social worker was to provide continuity of care into the community, to address accommodation and general welfare issues, and to liaise with the key worker in the transfer of care. The key informant from another area reported:

“we are involved in one way or another with everyone who is discharged. We liaise with other agencies like Housing, DSS, child care – we have a pivotal role.”

At an operational level, housing issues were cited as one of the main triggers for referral to social work of people in acute psychiatric wards. Local authority key informants discussed accommodation issues in relation to packages of care for people being discharged from hospital. In Dundee, the interviewee explained that being in a single department had improved working relationships and that a special needs housing allocation committee had been developed to refer people with mental health problems for housing. East Lothian stated that being an integrated department had made a huge difference: ‘we have shifted from supported accommodation to domiciliary care which has been very important’.

There were 11 councils that had informal links between housing and social work, but Scottish Borders, South Lanarkshire, North and East Ayrshire all pointed out that the links were formal for CPA. Six councils with separate housing and social work departments had formal links for people being discharged from acute psychiatric wards. Fife had 3 special needs housing officers; Inverclyde and Orkney had a housing officer link. In Aberdeen a discharge care group had been developed to ensure good planning in relation to housing prior to discharge. Moray council described a joint social work and housing project which was set up for people with multiple readmissions to the acute psychiatric ward who had difficulty in sustaining a tenancy. They were assured a three-month tenancy in the first instance; if the 3 months was successful it was renewed, and if they sustained it for one year they got a permanent tenancy.
Liaison with GPs

The role of the GP in the management of individuals discharged from an acute psychiatric ward is important. Although time and resources precluded a GP survey, information was sought from the key informants on when GPs would be contacted, by whom, and through what means.

All wards appeared to follow the same procedure of completing a brief discharge summary followed by a more detailed discharge letter. In all cases the former was done by a member of the medical team. There were differences in how the discharge summary was relayed to the GP and how early they were notified of the individual’s discharge (Table 3.7). In Western Isles Health Unit, all after-care arrangements and discharge summaries were sent via e-mail to the GPs. Eleven wards indicated that they notified the GP prior to discharge; this was by phone or fax and was the responsibility of the named nurse or the medical team. Dumfries and Galloway Community Health Services exemplified this approach.

“Often ongoing communication. Immediate discharge document is faxed to GP the day they go. A more comprehensive letter is sent by medics later.”

Three wards gave the discharge summary to the patient to give to their GP. The remaining majority of the wards appeared to send the discharge summary on the day of discharge, followed up by the more detailed letter from the medical team. A key informant from one ward was concerned that the patient could present at the GP surgery for a prescription before the discharge summary or letter arrived. The majority of key informants appeared unaware of any time limits for the detailed discharge letter being forwarded to GPs, despite reference in a number of discharge protocols that this should be sent within seven days.

Table 3.7 Communication of discharge summary between ward and GP

<table>
<thead>
<tr>
<th>Method of notification to GP</th>
<th>No of wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge summary sent on day of discharge</td>
<td>13</td>
</tr>
<tr>
<td>Phone or fax notification prior to discharge</td>
<td>11</td>
</tr>
<tr>
<td>Discharge summary given to patient to pass to GP</td>
<td>3</td>
</tr>
<tr>
<td>E-mail</td>
<td>1</td>
</tr>
</tbody>
</table>

In all Trusts the GP would be invited to all discharge planning meetings for people on CPA, although it was reported that they did not usually attend. It was policy that they were always notified prior to the day of discharge.

A more general route for contact with GPs was by way of social work. Nine local authorities that operated either on a locality, sectorised or geographical basis had formal links with GP practices. For example, each CMHT in Dundee was aligned to groups of GP practices in the locality that they covered, giving each practice a named worker from the CMHT. The mental health social work teams at Fife Council were described as being coterminous with the GP practices. The CMHTs serving geographical areas in Highland and Aberdeenshire were aligned with GP practices. Perth and Kinross had four area social work teams aligned to GP practices, with the key informant stating that ‘geographical matching facilitates collaboration’. It was clear
from the discussion with the informants from these local authorities that they considered the formal links within their structure to be effective.

East Lothian, Falkirk and Orkney Councils had a link social worker for GP practices and South Ayrshire Council was trying to establish similar links. Three councils said that they had a lot of informal contact with primary care because they were small, but there were no formal links. The remaining local authority areas had fewer formal links with primary care and stated that contact was on a case by case basis. One key informant from Renfrewshire stated that there was no contact with GPs because of the separation between health and social work.

Keyworker perspectives

A major feature of the interviews with the 27 community-based keyworkers was their account of the contacts they had with ward staff and with other professionals around discharge. Many of these accounts suggested a fair degree of interaction across the hospital/community interface. For example, where CPNs were members of CMHTs, there was often provision for a member of the team to attend the regular ward round within the hospital. This facilitated communication both about those recently admitted, those on pass, and those who were likely to be discharged. The individual attending the ward round would report back to other members of the community team. In addition a psychiatrist would often attend the regular CMHT meeting. Such liaison was routine, for example in Ayrshire and Arran, although only for individuals on the CPA was it practical for the CPN to attend a discharge meeting. In Borders the key informant reported that the multi-disciplinary community team based in the hospital visited the ward on a weekly basis for a three hour meeting with ward-based staff.

A variety of mechanisms to assist communication were described. In Forth Valley, for example, admissions were faxed to the CPN team daily. In the Western Isles a video link is used between the hospital site and the CPN on the southern islands. This link-up, operative for two years, takes place after the ward round and enables the worker to contribute to the discharge discussion. It also allows direct contact between the CPN and the patient. Another worker in the Western Isles reported the move towards a single patient record that could be passed between the hospital and community base. A small number of keyworkers reported the use of e-mail; others indicated that they would very much like to have access to it.

A minority of individuals spoke of protocols or practices which inhibited contact between professionals. One, for example, cited a local protocol whereby individuals were officially discharged from community services when an in-patient; if admission extended beyond a month, then a new referral had to be made at discharge and a discharge meeting attended. This same worker also reported that local protocols precluded him from visiting a service user’s elderly parents, even though he considered it would have been beneficial for the mother to understand more of her son’s illness. In another area, one CPN explained that they did not visit individuals in hospital due to local policy, guidelines detailing that CPNs could not use time to visit clients in hospital.

Keyworkers were asked what they considered to be the most important factors around hospital discharge. Their responses highlighted a number of core considerations:
continuity of care
assessment of needs on discharge
avoiding premature discharge, allowing discharge plans to be put in place
user being reasonably well, with their mental state fairly stable
ensuring user and carer understanding through information sharing
detailing the plans for contact post-discharge
being aware of the date of discharge, and in advance
everyone being involved, knowing what is on offer and what they are doing
review procedures being in place.

In summary, keyworkers highlighted the importance of ensuring that ‘people are in a state ready to be discharged, prepared, and have support in place for going home’. Particular features of good practice cited by individuals included the opportunity for a ‘trial run’, for example of day services and transport, and the need to ensure basic elements such as food and heating were in place for an individual coming home. By way of contrast, one keyworker detailed how the ward appeared to make assumptions as to caseloads and entered tasks on discharge paperwork without her knowledge. Another reported being unaware when individuals were discharged – ‘they often turn up on the CMHT step without notice’. Only in Greater Glasgow was there any reference to pressure on beds precipitating early discharge. In Borders it was reported as unusual for a discharge to take place outwith the assessment and planning process.

User involvement in the discharge decision

The experience of the user should not be omitted from this examination of discharge policy and practice. How much involvement in the discharge decision did the users and carers in the sample report and did they feel their involvement was appropriate? Eighty of the 173 users interviewed (46%) felt they had some control and involvement in the decision to discharge. However, that still leaves 54% who were not involved, or the involvement did not have sufficient impact for it to be brought to the attention of the research team. A similar proportion of carers (47%) reported having some involvement in the discharge decision.

The use of ward meetings (sometimes referred to as review or discharge meetings) did not often feature in the accounts of the users and carers in the sample. Only 5 users reported attending such a meeting. One user described attendance at the meeting, but stated that she "was informed at a meeting that I could go home that day" (192) (authors’ italics). The way this incident was described would suggest that the woman was present at the meeting, but the extent of discussion and her input (she was not happy with the discharge arrangements) to the decision-making was questionable. Similarly, only 10 carers reported attending a ward meeting. The majority of cases with users and carers attending a ward meeting were in Ayrshire and Arran, with a few in Tayside, Greater Glasgow and Borders. It was also evident that a number of carers additionally asked to attend meetings or meet with the ward staff. It is important to think about the perception of meetings by users and carers. They may have attended and taken part in meetings but did not see this as an important or useful part of the discharge process.
For some users the discharge event was quite routine; they had had a number of other admissions, knew what to expect and were not overly concerned by the process. A number of users, however, specifically spoke about particular anxieties or concerns. One user stated he was

"not really prepared for real life... [you] live a charade of normality for 2 months then suddenly leave and are expected to cope. You need to be eased into it a bit more. You need help to sort out what you're doing with your life, like what happens the day after you're discharged. No-one addressed your life, just your illness." (16)

Another user explained how he was "frightened at the prospect of facing reality again" (168). Some of these users had also had an involvement in the discharge process, suggesting that even with such involvement and prior planning some users still experienced anxiety about the transition from hospital to home. It is important for discharge policies to promote the reduction of these anxieties or at least to acknowledge them so that users know that their fears are taken into account by the mental health professionals.

Other types of user involvement in the discharge decision varied greatly. Some users (n=27, 16%) described the admission as planned and knew at the point of admission how long their hospital stay would be. Eight users took the decision to leave the hospital against medical advice (AMA). McGilp et al (1994) demonstrated that a sample of AMA patients in Scotland were more likely to have a history of substance abuse, a finding replicated in the US (Pages et al, 1998). Other service users in the study reported being asked their opinion as to whether they were ready for discharge. Twenty-nine users described how the discharge decision was made jointly between themselves and the psychiatrist:

"we both agreed I was well enough to go home" (238)

"they were waiting for me to be ready”. (16)

Another aspect of discharge arrangements where a joint decision had been made was that users were often given the option of returning to the hospital if they were not coping, or they went home on ‘extended pass’ which turned into discharge if all went well.

Carer involvement was again often at the initiation of the carers themselves, with most of the carers happy with such involvement. A number of carers believed that the psychiatrist would only agree to discharge if the carer was happy for the user to come home. They reported that the discharge decision was made jointly between themselves and the psychiatrist.

Of the carers who reported a lack of involvement in the discharge decision, the majority had wanted such involvement. However, there was a small number who felt the decision should lie with the psychiatrist or with the user themselves. Some of those carers who wanted involvement felt that the professionals put up barriers to such involvement. Four carers reported that they had asked for appointments with the medical staff to discuss the care and discharge arrangements, but they had never been given times, or appointments had not been kept by the staff. Two carers were not able to visit the hospital because of transport difficulties and therefore felt excluded.
from the discharge process. Little attempt appeared to have been made by the ward to address this. Other carers said even a phone call from the staff would have been useful and given them reassurance. One carer, a partner, summed up his opinion of carer involvement in the discharge process:

“it seems that they have all the control and relatives do not have much say in the matter”. (200)

Users also spoke to the research team about their desire to have carers involved in the decision making but this not happening. One user described how his partner had

"tried to involve herself and speak to the doctors about how long I was likely to be in hospital but they were vague and seemed uninterested in talking to her". (381)

Another carer, a friend of the user, believed that the discharge arrangements would have been improved if she had had some involvement.

"I was] not approached at all by ward staff although I visited regularly, may be it would have been helpful if they had discussed it with me as I could have told them about the family and how she was quite isolated at home, because she didn't get any support when she went home”. (11)

The findings indicate that just under half of the users and carers in the sample were satisfied with their involvement in the decision making and felt that their involvement had benefited the situation. The other half of the sample did not have such a positive experience, encountering little motivation from professionals to include them in the discharge process and decision making.

Carer involvement is generally considered to be beneficial to the discharge process. For some users, however, this is not the case. These users prefer to make the decisions about their care themselves and do not want their family, partners or friends involved. Carers may have reasons for wanting the user to return home which could conflict with the user and with professional reasons for discharge. Two users reported that their partners agreed that they were well enough to come home, even when the users themselves did not feel ready, because the (male) partners wanted the user (female) at home. There were also a small number of situations where the carers did not want to have any involvement although the user would have liked it. One user stated that

"I would like more support from my family but it is not there for me, so I don’t have it” (218).

Another woman spoke about how reluctant her husband was to have contact with the services; even though the services had tried to engage him in discussion he was unwilling to do so.
Preparation for discharge

Discharge planning often included a number of home passes before notice of discharge was given. The hope was that the possible negative consequences that could occur from a sudden discharge were addressed in advance. Sixty-five percent of the total sample left the hospital on an arranged basis at some point during their admission, with “pass” arrangements in place in each of the Health Board areas from which the sample was drawn. The use of the term “pass” to indicate time spent away from the hospital ward, most likely at home, has connotations of a secure environment. Users spoke about “being let out” or “being released” on pass. Although pass would seem to be used routinely, little work has been done on the effectiveness of pass and whether outcomes are different because of its use. It was apparent from users that little attention was paid to what happened when on pass or to the setting of goals. Hospital staff tended to assess on an intuitive basis whether the pass had worked or not. The use of pass also seemed to vary by individual practitioner, with no guidelines or rationale for the use of time away from hospital. Although users from all sampled Health Board areas reported the use of pass, key informants from only 4 Trusts reported its use in preparation for discharge. This may reflect the attitude of ward staff to the use of pass - they may see it as a tool to manage their workload rather than to prepare the user for discharge.

Patients were most often given pass at the weekend. This is a time when other community services are not operating or operating at a reduced level. Indeed there was one example where a user in the sample went home on weekend pass and became acutely unwell again because of the isolation experienced over this time. Weekends can heighten feelings of loneliness and isolation; other people may well be spending time within their social networks and if a user does not have much social contact it could be the worst time to be out of hospital.

The majority of the sample had spent time on pass, 86 people staying at home overnight and 27 having day passes. There was no difference in the two main diagnostic groups in the use of pass. Fifty-five people did not have pass although almost half of these would have liked time on pass. The longer the stay the more likely users were to have been on pass. The only area in which the majority did not spend time on pass (7 of 12) was Western Isles. In Highland and Fife half of the sample had time on pass. In all other areas the majority went on pass. The lower numbers in the three areas may be explained by the rural location, particularly in Western Isles where some would have to travel to other islands. There were also differences between areas in the use of day pass and overnight pass. One hospital in particular used day pass much more than others.

A number of people made comments about how they felt pass was beneficial and had helped them prepare for discharge. One man described how he had regular passes over his 11 week stay in hospital, with the length of passes increased until his final pass was for 2 weeks. He commented on how this had ensured a successful discharge. One woman described how she thought pass was a

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8 The term is specific to Scotland and has no similar usage elsewhere in the UK
9 chi-square = 44.73, df8, p<0.001
"really good system as you're frightened to go home at first and it makes you feel like you can take the first step and if it doesn’t work you can go back. The first weekend didn’t work and I came back after a night. I then tried again the following weekend and it was OK." (22)

These comments suggest that hospital can be perceived as a sanctuary for the users. They have a feeling of safety when they know they can return to the ward if they find themselves unable to cope when at home. Other comments illustrate how the users perceived pass to be beneficial:

"it eased you into it" (303)

"[pass] builds up your confidence to make going home for good easier". (97)

Conversely, some people reported problems when being out of hospital on pass. Most of the comments related to being unable to cope whilst on pass and returning to the hospital earlier than expected; although they had experienced problems on pass, most felt that pass was still a positive thing and it could be beneficial. However two people reported problems with services when out on pass. One man was at home over the weekend and the day centre that he usually attended was closed. This meant that he had to spend the weekend by himself at home and he described how he had ‘felt very bad’. The next time he was on pass he spent some time with his sister as the ward staff advised him to occupy himself. One woman described how when she was on pass she started drinking and taking illicit drugs because the ward had not given her the medication which she would normally take to calm her down. She visited her own GP when on pass in an attempt to get the appropriate medication. Another woman reported how she took an overdose when out on pass for the first time. She was not coping and this made her feel like a failure. On subsequent times on pass she spent the time at her friend’s house rather than go home. Fifteen respondents in total reported having problems when out on pass, but only a few recalled ward staff offering advice on coping strategies or discussing whether the individual wanted to go on pass again. In some cases it appeared that when pass was not successful little response was made by the ward staff.

GOOD PRACTICE DISCHARGE POLICIES AND PROTOCOLS

Drawing on the details of discharge policies, protocols and associated checklists provided by key informants, and on the accounts of their own experience recounted by users, it is possible to highlight features which could be considered key elements of such policies and protocols. Although the precise detail afforded to each of these areas may vary between a more strategic policy and a more detailed protocol, the most useful strategy might be to work to a core set of features which should be common across all documents, elaborated as appropriate at operational level.
Discharge policies and protocols that were judged by the researchers to illustrate good practice included the following elements:

- assessment
- referral at an early stage to community services
- notice at an early stage to community services of discharge
- involvement of carers and patients in discharge planning including specific meetings
- accountability of named nurse for co-ordinating discharge
- the use of a discharge checklist
- involvement at an early stage of GPs and CPNs
- no discharge before weekends or public holidays unless arrangements for support are in place
- specified duties for the named nurse and other professionals
- a mechanism and set time in which to send the discharge summary and prescription information to the GP and a more detailed discharge letter
- two to five days notice of discharge
- advice leading to competence in self-medicating
- provision of seven days medication
- detail of follow-up contact post-discharge.

The detail of the discharge protocol operating on one of the wards in Fife Healthcare Trust exemplifies a document complying with the majority of these features and illustrates the level of detail which can be laid down at operational level:

**Pre-Discharge**
- if the patient comes under the remit of the Community Care Act assist in arranging the discharge planning meeting
- ensure the doctor has informed the patient of discharge plans and discuss plans with patient giving them the opportunity to voice any fears and apprehensions they may have
- ensure support services are in place prior to discharge
- if the patient is to attend day hospital confirm they have received referral letter from ward doctor and arrange a pre-discharge visit for the patient to meet staff and finalise arrangements for attendance
- arrange transport if required
- inform next of kin if relevant
- ensure discharge medication is ordered and correct on arrival at ward
- ensure ward doctor has completed discharge letter for GP
- complete referral form for CPN if relevant and include prescription kardex for depot injection completed by ward doctor if depot is to be administered
- prepare patient for discharge in a caring and sensitive manner

**On Discharge**
- clarify instructions for taking medication with the patient and/or relative before handing over medication, discharge slip and GP letter
♦ return any valuables and money from safe keeping in accordance with Fife Healthcare policy
♦ send death/discharge form to finance if applicable
♦ gather and complete all nursing documentation for collection by secretary and send all relevant documentation to day hospital if relevant
♦ record date of discharge on admission form
♦ arrange for bed and locker to be cleaned.

SUMMARY

♦ The research indicates that there appears to have been relatively little focus on local policy development for acute psychiatric discharge; it was more likely for there to be generic discharge statements, with specific psychiatric policies focusing on CPA or long-stay patients. At the Trust and ward level a variety of generic and specific admission and discharge policies (Trust) and protocols (ward) were produced. Fifty-nine per cent of consultant psychiatrists were aware of an existing acute discharge policy.

♦ The examination of discharge outcomes is more complex than simply mapping a set of outcome variables against specific models of discharge. The effectiveness of discharge policies is dependent on the cumulation of a number of components: the admission process, discharge planning, interagency and multi-disciplinary relationships, the discharge event itself, and community support available post discharge.

♦ Considerable variation in the discharge planning process was reported. Less than half the users and carers interviewed felt they had had some involvement in the decision to discharge; where carers were involved it was often on their own initiative. The notice given for discharge varied considerably, and one in five users considered they had been given insufficient notice.

♦ The majority of the sample had spent time on day or overnight pass, although there appeared to be little scrutiny of individuals’ experiences while on pass. The principle of pass was welcomed; the common use of weekends for pass, however, was not necessarily in accordance with individual needs.

♦ A variety of arrangements for communication between professionals within and across different agencies was detailed, ranging from alignment of hospital and community based social workers or liaison through community mental health teams to jointly funded care manager posts.

♦ Arrangements for liaison with GPs were similarly varied. All wards completed a brief discharge summary followed by a more detailed discharge letter. These were distributed in a variety of ways; there were also a number of formal and less formal links with GP practices or primary care.
Keyworkers reported positively on interaction across the hospital – community interface. A variety of mechanisms to facilitate communication were cited, including the use of fax, video link and e-mail. A number of practices which inhibited professional contact were also highlighted.
CHAPTER FOUR: THE EXPERIENCE OF DISCHARGE

Chapter Three has focused on the specifics of discharge policies and protocols and on how the core elements addressed by these procedures were experienced by the users in this study. The discharge experience, however, embraces a broader context which will be addressed in the current chapter. In particular the need to relate discharge to the earlier stage of admission and the role of assessment and diagnosis will be examined.

ADMISSION PROCESS

The study aimed, in Phase 1, to assess the extent to which admission policies had been developed and were in use both at Trust and ward level. Taraborrelli et al. (1998) have argued that for older people admission policies are important for discharge because if good quality assessment is carried out on admission this can promote more effective transfer back into the community. This argument could equally be applied to discharges from acute psychiatric settings. The importance of admission policies and protocols with regard to discharge is to allow the early identification of any social, economic, family or housing problems which could make discharge more difficult. The Hospital Discharge Workbook (DoH, 1994) stresses that the interaction of health and social needs of the patient will have an impact on the length of stay in hospital. For this reason early identification of social needs is vital to assess continuing care requirements. Durgahee (1996) found that psychiatric patients were being discharged without adequate assessment of their health or social needs and consequently lacked co-ordinated services to support them after discharge. The Sainsbury Centre report on acute psychiatric in-patient care (1998) suggests that, because of the high number of readmissions to acute wards within a year,

“it is likely that many of the problems apart from symptoms that may have contributed to breakdowns in the first place – such as housing, finance, social relations, daily occupation or stigma – are not being tackled satisfactorily.”
(Sainsbury Centre, 1998:20)

They drew this conclusion because the data from CAN assessments completed with both patients and staff showed that staff rating of patients’ social needs on admission was lower than patients’ ratings of such needs, and by the end of the in-patient episode staff felt that patients’ social needs had not been addressed.

Fifteen trusts at the mapping stage reported that they worked to a specific admission policy for acute psychiatry. The two policies actually forwarded both provided comprehensive policies which covered emergency and planned admissions:

- preadmission information for planned admissions
- allocation of a named nurse
- initial risk assessment within 15 minutes of arrival
- orientation to ward within 2 hours of arrival
- co-ordination of medical and nursing staff to avoid duplication of information requests to patients and carers and completed within three hours of admission
record of referral to other services within 24 hours of referral

patients under section must be given information and explanation about their rights.

Twenty-six of the ward informants indicated an admission protocol was in place on their ward. While not all wards and Trusts operated an admission policy or protocol, the key informants reported that screening for problems other than health was carried out with all patients. The individual responsible for this was the named nurse who would usually be appointed to the patient within 24 hours of admission. Two wards indicated that named nurses were allocated to patients according to the patient’s problem and the nurse’s specific skills or training. In these wards, for example, there were several nurses who had undertaken courses on eating disorders and patients were therefore allocated accordingly. All informants also stated that if the named nurse was not on duty then the associate nurse within the nursing team would carry out the initial screening process. Although all informants stated that this was policy, one ward informant underlined the discretionary element that may intervene:

“there is one [admission protocol] - it is not often used because of the pressure of work and the way people are admitted”.

It can be argued that ward staff should not be concerned with addressing the social needs of the patient. Their focus should remain with the user’s health needs. Almost all of the key informants on the wards suggested that if social difficulties such as housing and finance were identified then another agency would be contacted. Overwhelmingly this would be a social work department, either within the hospital or the locality. Other agencies that featured in these areas were welfare rights, often with a welfare rights officer dedicated to the ward, and housing departments. One Trust informant described how the housing department, if invited, would come to ward meetings and they had joint action group meetings each month to make sure all agencies were in touch with each other.

Another function of the screening process is that ward staff are made aware of any other community service that the user is in contact with in order to inform them of the admission. This may not be necessary in many cases as the CPN or member of the CMHT may have been involved in the admission process, indeed may have triggered the admission to hospital. Community support staff, however, as detailed in their interviews, are not always informed of admission. It is difficult to assess the impact of poor communication at this level on the user: no users in the sample spoke about a lack of communication between the agencies. The extent to which problems are identified and addressed during the admission process will be explored further in relation to accommodation and finance.

The screening process not only drew attention to longer term problems but also highlighted more immediate problems such as worries about caring for pets while in hospital or the security of property. Once a problem was identified, interviewees proffered several ways in which they were dealt within their ward or Trust. Firstly, it was seen as the named nurse’s responsibility to address the problem. Thirty-eight out of the 45 key informants said they would refer the problem to the social worker, either the patient’s own or the social worker attached to the ward. However 16 of these would only refer to the social worker if there were no family or friends who
could look after the patient’s affairs. The remaining seven said they would refer the problem to the CPN or the police.

The named nurse was also seen as responsible for developing a care plan which in all but three wards was started on admission. Two wards used emergency care plans for patients who were too ill to provide formal information or undergo any type of initial assessment or interview. The use of emergency care plans was seen as a positive aspect of care by those who used them as it made the admission process less stressful for the patient.

**Diagnosis**

A study carried out in Grampian indicated that diagnosis was the most important item for GPs on a discharge summary following a psychiatric admission (Walker and Eagles, 1994). The issue of diagnostic labels being given by professionals to mental health service users has created much debate. This study explored with key informants when a diagnosis was made during an admission and if this was passed on to the user. The data suggest that diagnosis was not seen as a priority by those questioned. It was felt that a diagnosis could be difficult to make, especially on the first admission. Some informants also thought that consultant psychiatrists were disinclined to label users according to a specific illness but preferred to treat them symptomatically.

“I generally deal with patients symptomatically rather than label. The consultant will give a diagnosis if requested by the family. It can help.”

Once a pattern had been established or the illness was clear cut, a diagnosis could be made if necessary. There were no Trust policies on diagnosis, so practice was at the discretion of the individual psychiatrist.

These accounts from respondents have to be treated with some caution, however, not least because of the requirement to provide a diagnosis for the SMR4 returns for ISD. The data collected from these returns for the study sample indicated that a diagnosis had been entered for all users. However, only 75% of the sample reported knowing this diagnosis. There was no difference in being given a diagnosis according to gender, age or diagnostic group (psychotic or non-psychotic). Slightly higher numbers of users were given diagnoses in Borders, Highland, Forth Valley and Western Isles. There was a strong relationship between being given a diagnosis and number of admissions, indicating that those users with longer contact with services were more likely to be given a diagnosis.

There was a difference in user and professional understanding of the diagnosis. Table 4.1 details the diagnosis recorded in medical records and the diagnosis offered to the study by the users. In only 77 of the 173 cases (45%) do the official and user-given diagnoses agree. This has implications for patient access to information and to medical records.

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10 chi-square = 8.61, 1df, p<.01
## Table 4.1  User and professional diagnoses

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S: schizophrenia  
SA: schizoaffective disorder  
B: bi-polar disorder  
D: depressive disorder  
P: puerperal psychosis  
PT: post traumatic stress disorder  
A: anxiety disorder  
AJ: adjustment disorder  
BD: behaviour disorder  
P: puerperal psychosis  
E: eating disorder  
SM: substance misuse  
PD: personality disorder  
U: unspecified disorder  
SY: symptoms only  
DK: don't know  
N: none given
Two main themes emerged from the comments made by users about diagnosis: the importance or not of having a diagnosis, and the understanding of the diagnosis. A large majority of users (over 70 per cent of those offering comments) felt that having a diagnosis was important. Some thought that having a name for their condition would help them in some way. For instance one man said

“if you don’t know what is wrong you’re not able to fight it” (103).

Another woman said that it removed any blame from herself for how she was.

“I felt better when I was given a name and was relieved that it wasn’t my fault, that it was an illness.” (276)

A number of users felt they had had to ask for a diagnosis, that one was not being offered and they had to “press” or “pester” the clinicians for an answer (303, 313). Two users related how they first found out about their diagnosis when they saw it on benefit forms the clinicians had filled in for them. One man described how it was a “shock” for him to see the diagnosis of schizophrenia on the benefit form and he was “taken aback” by it (325).

A number of users expressed their agreement with the diagnosis given by clinicians. Some others, however, did not understand their diagnosis. One woman, for example, said that her diagnosis was bi-polar disorder but that she was “not sure what this means” (163). A small number of users also felt that they did not agree with the diagnosis they had been given.

Only 9 users suggested that having a diagnosis was not important to them and would not help in any particular way - “just a label” (260); “it does not alter my life and it does not help to have a name for the condition” (99).

A small number of users made comments about labelling, an issue that has attracted a lot of attention from the mental health user movement. One young man told how the psychiatrist had informed him that he was unwilling to give a diagnosis as he thought labels were detrimental, a stance with which he was in agreement. Although he knew he had been suffering from something, he felt he was now “normal” (168).

Accommodation

Accommodation is one of the main social factors other than ill health contributing to admissions to acute settings. Accommodation issues are considered sufficiently important to be one of the 12 dimensions of the Health of the Nation Outcome Scale (HoNOS) (Wing et al., 1998; Orrell et al., 1999) and were highlighted in the user consultation carried out by the Clinical Resource Audit Group for the report on outcomes in acute psychiatry (CRAG, 1996).

Just over a quarter of the user sample had been unhappy with their accommodation prior to admission (n=45, 27%). A higher (although not statistically significant) proportion of users with a psychotic diagnosis (31%, n=18) identified accommodation problems that they felt had
contributed to their ill health than those with a non-psychotic diagnosis (24%, n=27). The main problems for both groups included overcrowding, problems with the local area, relationship difficulties either present or previous, or not managing to look after the house. The other problems identified concerned substandard housing, safety and neighbours, with 6 users being roofless or living in homeless accommodation. A further 10 users identified accommodation as a problem on the CAN, but felt that it had not contributed to their ill health and reason for admission. Fifteen users had moved house by the follow-up stage. The follow-up sample included 33 who had identified accommodation problems at Time 1, 12 with a psychotic diagnosis and 21 with a non-psychotic diagnosis. There was no difference between Health Board area and incidence of accommodation problems, save that no problems were identified in the Western Isles.

A larger proportion of users with psychotic diagnosis reported that their accommodation problems had been resolved by the time of the first interview (7 pg: 2 npg\(^{11}\)). By the follow-up interview a further 6 users (non-psychotic group) felt their accommodation problems had been addressed. Thus, less than half of the users who identified accommodation problems had found some resolution by the 6 month stage. There was a sense amongst health and social care professionals that little could be done about accommodation problems as resolution rested with the housing departments who were felt to be slow to act.

The agency most often reported by users as helping with accommodation issues was social work. This is supported by the data on the role of social workers as perceived by the users (see below). No users reported receiving direct help from the ward staff, reflecting the argument that ward staff are not best placed to deal with such problems. Others reported as helping were psychiatrist, community psychiatric nurse, occupational therapist, housing department, psychologist and in one case, the local MP.

A small group of users reported that they would have liked help with their accommodation but had not received it. This was either because they had not asked the ward staff, had not known whom to ask, or did not know help would be available. Although screening is said to take place and the wards report making appropriate referrals, little had been resolved in respect of the accommodation problems in the sample.

**Individual finances**

The financial situation of individuals is another issue that could be expected to feature during the admission screening process. Users in the CRAG consultation identified that mental ill health has an impact on financial security both in the short and long term (CRAG, 1996). A National Schizophrenia Fellowship (Scotland) survey of user and carer experience of hospital discharge (1998) highlighted the lack of attention given to service users' welfare rights. This research explored whether mental health professionals address these concerns to any extent and whether this is borne out by the experience of the users in the sample.

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\(^{11}\) pg refers to the group of individuals with a psychotic illness, npg to those from the group with a non-psychotic diagnosis
Only 44 users remembered being asked about finances by the ward staff. Fourteen (23%) of the users in the psychotic group and 33 users (28%) in the non-psychotic group identified finance as a problem on the CAN assessment. There was no correlation between those being asked about finances and those reporting it as a problem: only 6 people who reported finance as an issue were asked about it on the ward. By the follow-up stage, similar proportions in each group reported finance as a problem on the CAN (pg 24%, npg 26%). Further exploration of the data shows that some users had resolved their financial difficulties over the study period whilst others had developed new ones. In total for both diagnostic groups about 40% of users reported some experience of financial difficulties.

Most of the sample (82%) were not in employment, with many reliant on benefits for their income. Comments about benefits were a common feature in the responses made by users. A small group of users mentioned the social work department in connection with financial problems and some mentioned specific agencies such as the Citizens Advice Bureau (CAB) or advocacy. Some people who had previously been in hospital were familiar with the Department of Social Security (DSS) rule that a patient who is in hospital for 6 weeks has his or her benefits reduced.

"I was not in long enough for my benefits to be stopped so no financial worries.” (15)

"No-one asked about finances but they probably thought I was OK because I was only in for 3 weeks." (94)

In one case it appears the decision to discharge was based on this rather than the state of the person’s health.

"I asked if I could be discharged because of the 6 week problem with benefits. The psychiatrist agreed to this." (152)

One of the key informants from a ward indicated that patients may want to be discharged to preserve benefits. They stated that if users discharged themselves for this reason then some follow-up arrangements were made, but if the user was detainable then compulsory measures under the Mental Health (Scotland) Act 1984 would be used to prevent early discharge for financial reasons.

Other individuals felt that the staff on the ward were aware of their circumstances and did not need to ask if they had any financial concerns. However, others reported financial problems that were not dealt with by nursing staff and the respondents were not aware of where to get help. Some reported having to go to the DSS on the day of discharge to try to get some money as they had no other access to cash. One user asked why social workers do not tell anyone what benefits are available. Another said that she did not know her benefits would be cut and that "luckily I had a bit saved so I could use that” (108). Another explained that they only found out about the social work office in the hospital because another patient informed them.
One woman reported that she had to deal with her financial problems herself when she was an in-patient and she found this difficult when she was ill. She said that the DSS staff were rude in their replies to her queries; she had complained about the service and received an apology and assurance that training would be given to help DSS staff deal with patients.

The CAN assessment covers problems with receiving appropriate benefits. After discharge, 40 users (23%) reported that they did not think they were receiving all the benefits to which they were entitled. Of those who identified this as an unmet need (33), only 11 felt they were getting the right input to start to address this need. The remaining 22 thought that they required a higher level of support from services. At follow-up a similar picture can be seen, with 23% identifying benefits as a need. Twenty-one users reported an unmet need for benefits and 16 thought they were not getting the sufficient level of support to address these problems. As with other financial problems, however, the picture is complicated in that a number of those who identified benefits as a problem at Time 1 reported no difficulties at Time 2, whilst other users had developed problems over the period. It is not possible to determine whether these financial problems resulted from their mental health problems, but it is apparent that financial and benefits issues are subject to change over a short period of time.

CONSULTANT PERSPECTIVE ON COMMUNITY SERVICES

Consultants have a pivotal role in the discharge process. It is most unusual for an in-patient to be discharged without the consultant’s direct involvement. Consultants rely upon an infrastructure of acute admission wards and community resources which vary considerably from area to area. The majority of consultants in adult general psychiatry operate within a sectorised or catchment area system. Individuals living, or registered with general practitioners, in a certain area automatically become the responsibility of one or possibly two consultant psychiatrists. There are still some areas which operate an open referral system, but the vast majority work within a sectorised service. The intention is that this should allow consultants to develop local awareness and close working relationships with general practitioners, social workers, community psychiatric nurses and local voluntary organisations. They should therefore be aware of local resources, statutory and voluntary, which can be accessed at the point of discharge from hospital.

In the postal survey of consultants, respondents were asked whether they had any problems involving social workers, CPNs, voluntary agencies and advocacy workers in the discharge of acute patients. Eighty-six per cent of respondents commented on this question. Fifty-three percent of those responding described problems with the social work department, predominantly noting that their slow response-time precluded their involvement at the time of discharge. Comments included:

“*Involving social services is a nightmare!*”

“*Social work involvement – promises are made re input, but often not followed through.*”
“Impossible to obtain social work input – no staff available in our area team to pick up cases unless on CPA or children at risk (even then you’ll be lucky!).”

Twenty-five per cent of respondents described problems accessing community psychiatric nursing services. The difficulties centred around lack of availability, waiting lists and shortage of staff.

“Insufficient CPN staff to provide rapid response at discharge.”

“In the area where I work there is a shortage of all community staff – it is concerning.”

“CPN allocation meetings only on Tuesdays. Discharges must be geared around this date unless there is existing involvement. Also the CMHT decides who sees which patient.”

“Shortage of CPNs limits discharge options.”

Fourteen per cent of the respondents described having problems accessing both social workers and CPNs while only 25% of the respondents felt that they had no problems with either. Consultants occasionally involved voluntary organisations when discharging acute in-patients, but advocacy workers were almost never involved.

Table 4.2 suggests that, according to consultants, CPNs are involved in a significant percentage of discharges, social workers in relatively few and voluntary agencies in very few. Advocacy workers are almost never involved.

**Table 4.2 Consultant involvement with other professionals**

<table>
<thead>
<tr>
<th>Percentage of discharges involving:</th>
<th>Social workers</th>
<th>CPNs</th>
<th>Advocacy workers</th>
<th>Voluntary organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25%</td>
<td>55</td>
<td>24</td>
<td>98</td>
<td>86</td>
</tr>
<tr>
<td>~50%</td>
<td>29</td>
<td>34</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>&gt;75%</td>
<td>17</td>
<td>43</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

The overall picture from the survey, therefore, is of consultants, predominantly isolated from community teams and social workers, balancing the need to prevent blocking of their beds with providing what they consider to be a reasonable period of notice before discharge. There was a strong impression of professionals working within different time frames, with consultants requiring decisions within days and CPNs and social workers responding within weeks.
THE CARE PROGRAMME APPROACH

The Care Programme Approach was first mooted in the 1989 White Paper, Caring for People (Department of Health, 1989b). Initial guidance was issued in Scotland in 1992 (Scottish Office, 1992); revised guidance in 1996 (Scottish Office, 1996). The CPA seeks to ensure that individuals with enduring mental health problems benefit from co-ordinated and targeted support in the form of a sustainable package of care designed to address their individual needs. Particular attention is given to sustained collaboration between different professionals involved with the individual, with a named individual, the keyworker, playing a pivotal role in co-ordination across different professionals and different agencies.

The model of implementation for the CPA in Scotland has been one of selective targeting, focusing on those with the highest levels of need. This differs from England where health authorities have been required to implement CPA, albeit distinguished into three levels, for all patients in contact with specialist psychiatric services. The discharge event would of course be a critical event for the intervention and activity of the CPA keyworker. In the event, as highlighted in Chapter Two, only a very few users within the initial sample (5) were on CPA.

Consultants were asked in the postal survey whether they believed that their patients, in general, benefited from the Care Programme Approach. Overall 54% of consultants felt the CPA benefited their patients. Those that considered the CPA did benefit their patients highlighted improved co-ordination and multi-disciplinary working with prioritised access to social work and housing. A number noted, in particular, the benefit of involving carers. Others were not so sure of the value of the CPA.

“Does not get us any more social work input or GP contact and meet the same staff you’ve had coffee with upstairs five minutes before the meeting. A complete waste of my time”.

“We use CPA sparingly as it seldom adds benefit to the co-ordinated team approach we already have”.

The number of patients reported by consultants as being on the Care Programme Approach is shown in Table 4.3. It should be noted that the majority of such patients will have long standing severe mental illness and do not necessarily fall within the category of acute discharge. Fifty per cent of consultants had only 3 or fewer patients on CPA.

Table 4.3 Consultant involvement with CPA

<table>
<thead>
<tr>
<th>Number of current patients on CPA</th>
<th>% of consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>1 – 3</td>
<td>29</td>
</tr>
<tr>
<td>4 – 6</td>
<td>18</td>
</tr>
<tr>
<td>7 – 10</td>
<td>10</td>
</tr>
<tr>
<td>11 – 15</td>
<td>8</td>
</tr>
<tr>
<td>16 – 20</td>
<td>8</td>
</tr>
<tr>
<td>21 – 30</td>
<td>4</td>
</tr>
<tr>
<td>31 - 47</td>
<td>2</td>
</tr>
</tbody>
</table>
Whilst the CPA may be of value in preparing for the discharge of individuals with long-term mental illness, this snapshot suggests that consultants perceive its usefulness in the discharge of acute short-term admissions as limited.

SUMMARY

♦ Key informants reported that individuals should be screened on admission by the named nurse to identify issues requiring the involvement of other agencies. Determination of a specific diagnosis was not necessarily regarded as a priority at this stage.

♦ Almost a third of users reported accommodation problems that they wished to have addressed; less than half of these had been resolved by the six-month follow-up. A range of unresolved difficulties relating to finances and welfare benefits were also cited.

♦ Consultant psychiatrists perceived major difficulties in involving community services in discharge. Over half described problems with social work, primarily the speed of response. A quarter reported problems accessing CPN services.

♦ Few service users in the study were on CPA; only just over half of the consultants responding to a general survey considered that CPA benefited their patients.
CHAPTER FIVE: THE DISCHARGE EVENT

On the actual day of discharge, the issues that concern staff and users should be the final preparations for going home: transport, medication, emergency contact arrangements and final notification to community services of the discharge. Further planning activity should not be necessary as this is the stage at which all the planning is brought together and implemented (Department of Health, 1994). The use of discharge checklists should aid this process, their use in other health care settings, as highlighted by Taraborrelli et al. (1998), having improved aspects of the discharge experience. The acute psychiatric discharge checklists available for scrutiny included both elements relating to the immediate discharge and other issues, for example how to return patient records and to update ward in-patient information, relating to ward procedure. This chapter explores the experiences of users and carers around the discharge event.

TRANSPORT

The vast majority of users organised their own transport home from hospital. Only 17 (3pg; 14 npg) out of 173 users had transport provided, in 11 cases by the hospital and 6 by community services. This was generally because of the rural location. Not surprisingly, transport was a particular issue in the Western Isles where 6 of 12 users had transport provided, including 5 who were flown back from Stornoway to the Uists. It is interesting to note, however, that the key informants from Western Isles had stated that relatives should make transport arrangements for discharge.

Good Practice Example A: Rural Access Service, West Stirlingshire

The rural access service was developed by Stirling and District Association for Mental Health and funded by Stirling Council Social Work Department in 1995. It aims to provide a short to medium term service to people living in rural areas experiencing symptoms of mental illness. The service is designed to minimise the effects of such experiences, which isolate people from the community, inhibiting their ability to cope with daily life and access to appropriate sources of help and support. The service deals with issues of

- finance - ongoing budgeting and debt
- housing - tenancy
- rehabilitation - living skills
- loneliness - talking and listening, outings
- information and advice - benefit advice, contact with other groups
- advocacy - obtaining grants or crisis loans
- hospital discharge - settling in

In the study one user spoke of the role of the rural access service in hospital discharge. The user who lived in a remote rural location about one hour travelling time from the hospital had a referral to the rural access worker from the ward to provide transport home and help with settling in.
Twenty five percent of users with a psychotic diagnosis remembered being asked how they were getting home or if they needed any help with transport, compared with 41% of users with a non-psychotic diagnosis. A slightly higher proportion of users in the rural areas was asked about transport.

The majority of the key informants felt that transport was the responsibility of the patients and their relatives to organise; only in exceptional circumstances would transport be arranged by the ward staff. It is clear, however, that a number of users were not happy with this policy –

“they just sort of said ‘bye, see you around’” (5).

Fifteen percent of the psychotic group and 10% of the non-psychotic group, all of whom had made their own arrangements, felt that the transport arrangements were inadequate, unhappy about having to make their own arrangements or unaware that help might be available. One user reported that she only found out about help with transport after a number of years contact with services, and another that she only found out about help with transport from a friend and not from the services she was in touch with.

Some users felt that travelling home by bus was a difficult experience. One man described how he went home by bus but would have preferred someone to drive him as “it was a very traumatic experience”. He also commented that he felt “transport was a big thing” (14). Another described how he

"hated getting the bus, I thought everyone would know I was in a psychiatric ward. I would have liked a friend to take me in a car but I didn’t try to arrange it." (19)

One woman described a journey that was difficult because of the number of changes (taxi, train and bus) and the length (2 hours). This was not a remote rural area but within Greater Glasgow.

It is noteworthy that there was a small group of users who felt that providing transport was not appropriate and that it was important for themselves to make these arrangements as it indicated they were able to cope with this task –

“It’s not necessary I’m quite independent, it’s not like I’m confused or anything.” (12)

"They usually expect you to put on your own transport as they are training you to be independent…it’s much better ‘cos when you do it yourself you feel really chuffed about it." (22)

They also felt that they were not the “needy” ones and should not be in receipt of any transport services.

"I feel it is used for more needier people than I was, it just cost me a couple of pounds to get back by taxi." (108)
The users who spoke about transport issues all had a number of hospital admissions, both the group that saw transport as a difficult issue and the group that saw transport as something that encouraged independence. This suggests that longer contact with services exposes the issues relating to transport.

**MEDICATION**

Almost all of the patients were taking some sort of medication (98% pg; 91% npg). Twenty-seven per cent of the psychotic group were receiving medication through regular (depot) injections (22% combined with tablets) and 7% of the non-psychotic group (4% combined with tablets). Only eleven users in the sample (one with a psychotic diagnosis) were not taking medication (information was not available for one user). Two of these users had a number of previous admissions; one had refused to take medication and the other had previous admissions for alcohol detox only. One woman had stopped taking her prescribed anti-depressants by the follow-up stage and was taking a herbal remedy suggested by a friend. Two users reported using illicit drugs because they felt they were not prescribed adequate medication to control their symptoms.

**Changes in medication**

For both diagnostic groups, a strong relationship was evident between the number of admissions and whether the user was on medication before admission\(^\text{12}\). Thirty six (32%) of the users in the non-psychotic group and 11 (18%) of the users in the psychotic group were not taking medication prior to admission and were started on medication during the admission. Of those users already taking medication, 37 (33%) of the non-psychotic group and 21 (35%) of the psychotic group had their medication changed to another type whilst in hospital. The Time 2 interview data showed that still more changes to medication had been made. Similar proportions in each diagnostic group had had their medication changed (pg 62% and npg 63%), with the types of change i.e. dosage or type being similar. Slightly higher numbers in the non-psychotic group had the medication stopped altogether.

It is interesting to note that a difference between the 2 diagnostic groups in the incidence of readmission and change in medication can be detected. For the psychotic group, being re-admitted did not alter the incidence of having the medication altered. However, for the non-psychotic group those not re-admitted were more likely to have had the medication altered than those who were re-admitted\(^\text{13}\).

The main reason reported for changing the medication was perceived efficacy. Users felt that they were not getting sufficient or a reduced effect from the medication. For instance one user stated that

"these [medication] were changed during admission as the old ones were not working properly" (123).

\(^{12}\) pg chi square = 7.97, 1df, p,.01; npg chi-square = 9.40, 1df, p<.01  
\(^{13}\) chi-square = 4.39, 1df, p<.05
This is perhaps not very surprising as the poor efficacy of medication may have precipitated the hospital admission. The users who reported this in the main felt more effect from the new medication. The next most common reason for changing medication was because of side effects. Some users, however, were not sure why their medication had been changed; the opportunity may have been taken to review the medication of a user admitted on a selection of different drugs and to simplify the prescription.

The person most likely to have made the decision to change the medication in both groups was the psychiatrist. This was followed by the user in both groups, although in the psychotic group a higher proportion of users (22%) prompted the decision than in the non-psychotic group (16%). GPs featured more often in the non-psychotic group, with only one GP making the decision for a user with a psychotic diagnosis. When the user spoke about making the decision to change his or her medication it was usually in consultation with a mental health professional. One man decided himself on the dosage depending on how he felt that day. One woman refused to have the medication in her house because she had a young child and was not prepared to risk the child finding the tablets and ingesting them. Another man explained that he had made the decision to stop taking his medication but had become ill again; he felt he had not been fully informed of the consequences of doing this: "it should be highly indicated that you must take them" (14). Only 4 users reported having stopped taking their medication against the advice of or without informing the professionals involved in their care.

Information on medication

Information on medication and treatment is an important issue for the users of mental health services. The Phase 1 data from key informants indicated the generally poor quantity and quality of information given to users. Practitioners stated that information was given if requested but not routinely. There was also limited written information given to users. In the discharge protocols received, requirements to give users information about their medication were explicit but the type and depth of the information was not specified. Only one respondent detailed that patients on medication for the first time, or those changing their medication, would receive detailed verbal and written information. One respondent suggested that consultants were reluctant to provide too much information, although nurses wanted to provide more.

The majority of users in the sample (78% pg; 70% npg) could remember being given information about their medication at some point. However, 22% of the psychotic group and 30% of the non-psychotic group could not remember being given any information at all about their current medication. Users who did not remember being given any information on medication were much more likely to report not having had enough information and more likely to want more. However, a number of users (8pg; 17npg) who had been given information felt they had not received sufficient information to answer all their concerns.

♦ Greater Glasgow stood out as the area where both diagnostic groups felt they did not have enough information. Higher levels of satisfaction with information were in Highland and Forth Valley.

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14 pg chi-square = 18.84, 1df, p<.001; npg chi-square = 20.07, 1df, p<.001
15 pg chi-square = 16.03, 1df, p<.001; npg chi-square = 16.23, 1df, p<.001
There was a gender difference in the psychotic group in the perception of having enough information, women reporting less adequate information than men\(^\text{16}\).

Thirteen users in the non-psychotic group admitted for the first time could not remember being given information on medication. All those admitted for the first time with a psychotic illness recalled being given information. There was no relationship between the number of admissions and the perception of having adequate information for either diagnostic group.

By the follow-up stage, only a handful of users reported wanting more information about their medication, two in the psychotic group and five in the non-psychotic.

### Type of information

Across both diagnostic groups most information given to users about their medication was given verbally (only 13% in the non-psychotic group and 12% in the psychotic group received written information alone). Written information consisted primarily of the leaflet contained within the box of tablets. With the exception of users in Highland, only 10 users reported seeing any other sort of written information, for example in locally developed leaflets. The Highland example (see below) would suggest that written information was valued by users and could be referred to when at home. Information needs to be in a form that users understand and value. Two users reported that although they had been given leaflets about their medication, no-one had checked whether they understood the information.

There was not much evidence of the use of other forms of technology to give information to users. One user reported that she and her husband had been shown a video about the type of medication she was taking and she felt this was useful. Some users also spoke about finding their own information, including two who accessed information on the internet.

### Information source

The person most likely to give information to users was the psychiatrist. Other professionals (nursing, GP, pharmacist) were all involved in giving information but to a much lesser extent, with the exception of a pharmacist in Highland. There was one example of a user taking a new medication and being monitored closely by the pharmacist at the local hospital who had provided plenty of information. Another user attended a meeting organised by the CPN where the pharmacist from the hospital talked about a particular type of medication; she reported finding this useful and beneficial. Two users reported that they did not get much information from the hospital and were happier with the information from their GP. Although these were exceptional cases they are important as they highlight areas that need improving. There were 4 examples where the users had included their carer in the process of receiving information.

\[^{16}\text{chi-square} = 3.90, 1 \text{ df}, p<.05\]
Good Practice Example B: Pharmacy Information Service, Craig Dunain Hospital, Inverness

In response to a report compiled by the Highland Users Group (HUG) in 1996, the pharmacy department of Craig Dunain Hospital has developed new ways of delivering information to users of mental health services. The HUG reported that the majority of users they had spoken to had been given almost no information about the effects of taking their medication and there was a feeling that mental health professionals "could not be bothered" to provide information. The report acknowledged that the pharmacy service at Craig Dunain was willing to provide information on medication but that this resource was under used. It recommended that there should be better access to the pharmacy service; that the pharmacy service should hold clinics in the wards of Craig Dunain and other drop-in services; information should be provided in plain English. The response of the pharmacy service has been to:

♦ provide patient information leaflets about medication in reference folders on all wards
♦ have individual copies available for those patients who request them
♦ advertise the availability of nurses and pharmacists to clarify and further explain the written information
♦ train nurses to increase their knowledge and confidence in discussing medication with patients
♦ offer counselling sessions for particular drugs to all patients
♦ provide all patients with written information about all their drugs at the point of discharge with a telephone contact number in case of other queries
♦ deliver similar services in the community, hopefully on an increasing basis.

The response from users to this service can be seen in the comments made by the users discharged from Craig Dunain. Only 2 users from the sample of 16 stated they had not received any information about their medication. One user commented on the difference from a previous admission when information on medication was not given as freely. Eight users described how they had been given verbal explanations of the medication and written information to take away. Users stated how it was "reassuring" to be given the information and the opportunity to ask questions and that they had been able to speak to a pharmacist.

Two users reported that they believed professionals do not give information about side effects because they think that users will then believe they are experiencing the side effects.

"They never tell you about the side effects of any medication in case you imagine that you've got them." (368)

This directly challenges the views expressed by members of the Highland User Group who wanted quite detailed information about side effects and believed it was their right to know (HUG, 1996). The pharmacy information service in Highland is highlighted as an example of
good practice. This example is valuable as it demonstrates how services can respond to the concerns of service users. The users clearly valued the time taken by mental health professionals to provide them with the information necessary to allow them to make informed decisions about their treatment.

A handful of users reported that they did not want information about medication. They were quite happy as long as they felt they were getting some effect from the medication.

"All I know is they settle me down a bit... I don't sleep very well... as long as I feel alright I'm quite happy, I don't really need any more information." (3)

"It doesn't bother me... I just take it blindly." (321).

It is important for the professional to be aware that although a user may not want information on a particular occasion, he or she may well want to find out more at a later date.

**Supply of medication**

It is obviously important for individuals to be discharged with an adequate supply of medication and the majority of key informants at Phase 1 (34) reported that 7 days supply of medication was usually supplied to the user on discharge. Other informants said the amount varied from 3 to 5 days, with only 2 stating that it was less than 3 days. The number of days medication that was to be supplied was made explicit in the discharge policies that were scrutinised.

Most users received 7 days supply of medication (pg 77%; npg 79%). The remainder received less than this or could not remember. Most users received the supplies of medication from their GP (pg 83%; npg 88%). Ten users reported getting their medication from a hospital and 12 users from elsewhere, mainly depot injections from nursing staff, either community or day hospital, but in one case the nursing home staff where the user lived.

A small group of users spoke about difficulties in the supply of medication at the point of discharge. These difficulties either resulted from a breakdown of communication between the hospital and primary care or from problems accessing the GP after discharge. One man reported that difficulties in getting a GP appointment meant he missed 3 days medication. Another woman explained that as she left against medical advice she did not have medication and when she went to the GP the next day she had to wait for a fax from the hospital which delayed her prescription.

Communication breakdown was exemplified by the woman who had been discharged without any medication and had therefore assumed she should not be taking any. When she visited her GP some months later he asked how she was getting on with the medication and she told him she was not taking any. The GP referred to the discharge summary and she had been prescribed medication but it had never been supplied. The GP subsequently started the user on the medication she should have been taking since discharge.
There were a number of examples where services had tried to overcome medication supply problems, particularly in rural areas. One scheme in operation in Highland involved the user phoning the GP who sent the prescription directly to the chemist via computer. He could then collect the medication 2 days later from the chemist in the local town. Prior to this he had had to go to the Health Centre where they "checked their files", a second visit to collect the prescription and even a third visit if the chemist did not have the drugs in stock. He described this as "a bugbear" (325). In Western Isles, one user had his medication sent down to him when he telephoned the health centre.

Four people reported that their supply of medication was restricted because of the risk of suicide attempts. In one case a week’s supply of medication had been received by mistake rather than on a daily basis from the chemist.

Two users commented on the cost of medication. One woman had taken a few weeks supply of tablets into hospital with her and was unhappy when they were not returned on discharge. She was not aware that as she was in receipt of benefits she was entitled to free prescriptions. Another man reported that his medication cost £30 per month. He had started using a pre-payment certificate on the suggestion of the chemist. He was not happy that the hospital staff had not informed him of this option, although as hospital prescriptions are dispensed without cost, the issue would not arise at discharge. The HUG report (Highland Users Group, 1996) highlighted the cost of medication. Users were not aware of the pre-payment certificate scheme or had not used it as they did not know for how long they would be taking medication. The report recommended that prescriptions should be free for users taking medication long term.

Carers

A small number of carers had helped users find out information about their medication. There were also examples of users explaining how carers helped in monitoring medication. One woman explained that her "husband 'does pills' as I get muddled about them" (293). Another man told how his brother had "taken charge" of the medication as he used to get the dose wrong or forget to take it; he was quite happy with that arrangement. In the carer sample, 20 carers (34%) reported giving some help to the user with their medication, ranging from observing every dose to ensure it was taken, to monitoring supplies and prompting the user to make an appointment with the GP.

EMERGENCY CONTACT

The key informants from the wards and Trusts overwhelmingly suggested the ward as the first contact in emergencies and this was the information they passed on to users. This was followed by the GP and the CMHT/CPN service. A number of informants stated that emergency contact numbers were not given out as routine, but that users with special needs, for example on CPA or in contact with an assertive outreach team, did have access to emergency numbers.

Almost all users were able to say who they would contact in the event of an emergency. Only 17 were unsure or were not able to tell the researcher (Table 5.1). Twenty-five users with a
psychotic diagnosis and 40 users with a non-psychotic diagnosis (43% of the total sample) had a 
second person to contact if their first contact was not available.

Social workers were under-represented in the services that users would contact in an emergency. 
It could be argued that this is surprising given that local authorities have a duty under the Mental 
Health (Scotland) Act 1984 to provide an out-of-hours emergency and assessment service staffed 
by mental health officers.

Twenty-six users (51%) in the psychotic group and 38 (37%) in the non-psychotic group stated 
they had been given a specific number to ring if they needed to contact somebody in an 
emergency. This suggests that staff saw this as more of a priority for those users with a 
psychotic illness. The areas where most users had an emergency contact were Western Isles (7 
out of 12) and Fife (7 out of 13). The areas where few users had an emergency number were 
Tayside (2 out of 13) and Forth Valley (1 out of 14).

Table 5.1 Emergency contacts reported by users

<table>
<thead>
<tr>
<th>Type of contact</th>
<th>Psychotic</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Non-psychotic</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Total</td>
</tr>
<tr>
<td>GP</td>
<td>10</td>
<td>16</td>
<td>34</td>
<td>30</td>
<td>44</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPN</td>
<td>21</td>
<td>34</td>
<td>21</td>
<td>19</td>
<td>42</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>7</td>
<td>12</td>
<td>15</td>
<td>13</td>
<td>22</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital ward</td>
<td>5</td>
<td>8</td>
<td>11</td>
<td>10</td>
<td>16</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>11</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SW</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>10</td>
<td>12</td>
<td>11</td>
<td>18</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncertain</td>
<td>6</td>
<td>10</td>
<td>11</td>
<td>10</td>
<td>17</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>61</td>
<td>100</td>
<td>112</td>
<td>100</td>
<td>173</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Although 64 users had a specific number to call in an emergency, only a handful of users spoke 
about a dedicated crisis contact number for people with mental health problems in their area. A 
small number in Ayrshire and Arran spoke of using a helpline service, a freephone number 
operated by the Health Board at the weekends (12 midday to 12 midnight). Only a few people in 
other Health Board areas spoke about a dedicated helpline; as far as the research team could 
confirm, only in Lanarkshire (not included in Phase 2 of the study) did another helpline operate 
at the time of the research.

One quarter of users reported they would contact their GP and make use of the out-of-hours GP 
service. Some users preferred to do this above other options, and indeed one user pointed out 
that to receive input from the hospital she needed to be referred by the GP service. Users 
perceive that GPs act as gatekeepers to acute psychiatric services but at times question whether 
they have the expertise, especially out-of-hours. One woman explained she would not contact 
the GP because she did not think any action would be taken; she preferred to contact the 
Salvation Army.

One woman attempted to make contact with the emergency GP service late one night when she 
was feeling despondent and suicidal and met with a lack of understanding of her situation. It 
took a number of attempts to persuade the on-call service that she justified a visit. Prior to this
she had tried the Samaritans and the acute psychiatric ward for advice and help who both directed her to the on-call service. The doctor gave her some medication and said “everything seems worse at night”. When she contacted her own CPN and GP the next day they arranged for immediate admission to the acute ward. She felt that they knew her and understood how desperate she was. The out-of-hours services had not understood her needs; she considered she only asked for help when she really needed it and that her own perception of herself was questioned. This woman believed that there needs to be a dedicated 24 hour helpline for people with mental health problems.

Those who did not have a strategy to deal with a crisis situation included those who were unlikely to make voluntary contact with somebody if they were unwell. If they were feeling “really bad” they would not contact anybody, or “paradoxically, when I feel well, others think I am unwell” (335). Other users described the contacts they would make if they needed someone but these services would not be available outside office hours. One woman described how she had difficulty contacting someone out-of-hours.

"One weekend I tried to contact the CPN team and was told there was no-one available so I just had to wait ‘til Monday.” (7)

It is evident that users wish the reassurance of an out-of-hours service but the best way to provide such services needs careful consideration. Many users wanted to be able to contact a service where they were already known. In Greater Glasgow, the Resource Centres (CMHTs) operate evening and weekend services where the staff do not just attend to their own caseload but respond to emergency and out-of-hours situations.

SUMMARY

♦ The discharge event itself should be characterised by clarity in respect of transport, provision of medication, emergency contact arrangements and final notification to community services.

♦ The large majority of users organised their own transport on discharge and this was the preference of key informants and some users. A number of users, however, reported both practical and emotional difficulties in negotiating transport facilities.

♦ The majority of users were on some form of medication following discharge; one third of those already taking medication on admission had had it changed. There was evident scope for improving both the quantity and quality of information relating to medication. Women in particular reported inadequate information. The use of leaflets written in accessible language was commended, highlighting the need not only to provide information but to ensure that it has been understood. Normal practice was to supply 7 days medication on discharge; a small number of users detailed difficulties which they had experienced.

♦ A variety of strategies for crisis contact were reported by users; more consistent provision was sought.
CHAPTER SIX: COMMUNITY SUPPORT POST-DISCHARGE

The discharge event must be viewed in the wider context of support for patients. Its longer term impact is difficult to separate from the extent to which ongoing needs are met by support sources within the community. This chapter maps the needs identified for individuals by the Camberwell Assessment of Need (CAN), explores the role played by both informal and formal supports, and highlights areas of need identified as unmet. Aspects of community services which can be problematic are also identified, together with examples of good practice.

CAN DATA – NEEDS OF SERVICE USERS

For those individuals interviewed at both Time 1 and Time 2, the CAN data allow an examination of changes both in levels of need and in types of need over time. Table 6.1 and Figure 6.1 provide a summary.

Table 6.1 Camberwell Assessment of Need: mean number of needs over time

<table>
<thead>
<tr>
<th>Mean number of needs</th>
<th>Psychotic group</th>
<th>Non-psychotic group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1 total needs</td>
<td>4.6</td>
<td>6.4</td>
</tr>
<tr>
<td>Time 1 unmet needs</td>
<td>1.6</td>
<td>2.9</td>
</tr>
<tr>
<td>Time 2 total needs</td>
<td>3.8</td>
<td>5.3</td>
</tr>
<tr>
<td>Time 2 unmet needs</td>
<td>1.4</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Time 1 n=173; Time 2 n=128

The group of users with non-psychotic diagnoses consistently identified a higher number of needs and a higher number of unmet need. It can also be demonstrated that the psychotic population had access to higher levels of community support (see below). It has been argued by professionals within the psychiatric field that individuals with psychotic diagnoses may tend to underestimate need, while non-psychotic users may have a multiplicity of both social and health needs.

Figure 6.1 Types of unmet need identified by the sample

<table>
<thead>
<tr>
<th>Psychotic group (n=61)</th>
<th></th>
<th>Non-psychotic group (n=112)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top five need areas</td>
<td>Time 1 (rank)</td>
<td>Time 2 (rank)</td>
</tr>
<tr>
<td>Information (1)</td>
<td></td>
<td>Daytime activities (1)</td>
</tr>
<tr>
<td>Company (1)</td>
<td></td>
<td>Safety for self (self harm) (2)</td>
</tr>
<tr>
<td>Benefits (3)</td>
<td></td>
<td>Intimate relationships(2)</td>
</tr>
<tr>
<td>Daytime activities (4)</td>
<td></td>
<td>Money (2)</td>
</tr>
<tr>
<td>Psychotic symptoms (5)</td>
<td></td>
<td>Benefits (2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top five need areas</th>
<th>Time 1 (rank)</th>
<th>Time 2 (rank)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological distress (1)</td>
<td></td>
<td>Company (1)</td>
</tr>
<tr>
<td>Company (2)</td>
<td></td>
<td>Daytime activities (2)</td>
</tr>
<tr>
<td>Daytime activities (3)</td>
<td></td>
<td>Psychological distress (3)</td>
</tr>
<tr>
<td>Transport (4)</td>
<td></td>
<td>Safety for self (4)</td>
</tr>
<tr>
<td>Information (5)</td>
<td></td>
<td>Information (5)</td>
</tr>
<tr>
<td>Safety for self (self harm) (5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Another use of the CAN data is to look at how users’ perceptions of their needs have changed over time. Overall, there was a general decrease in identified need, as shown in the mean number of needs demonstrated in Table 6.1. For a number of users, however, needs increased, particularly the unmet needs.

Table 6.2  Camberwell Assessment of Need: Changes in unmet need over time

<table>
<thead>
<tr>
<th></th>
<th>Psychotic</th>
<th></th>
<th>Non-psychotic</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>%</td>
<td>number</td>
<td>%</td>
</tr>
<tr>
<td>Decrease in unmet needs</td>
<td>18</td>
<td>40</td>
<td>31</td>
<td>37</td>
</tr>
<tr>
<td>No change</td>
<td>16</td>
<td>36</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Increase in unmet need</td>
<td>11</td>
<td>24</td>
<td>28</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>100</td>
<td>83</td>
<td>100</td>
</tr>
</tbody>
</table>

The above table shows that more users in the non-psychotic group experienced an increase in unmet needs.

As highlighted in Chapter 2, an overall readmission rate of 27% was experienced by the sample. The breakdown by diagnostic group is shown in Table 6.3. In both diagnostic groups, a higher proportion of those users with increased unmet needs had been re-admitted to hospital. The difference was greater in the psychotic group, where 54% of those with increased unmet needs had been admitted, compared to 29% overall. In the non-psychotic group the difference was 32%, compared to 27%.

Table 6.3  Number of readmissions within six months by diagnostic group

<table>
<thead>
<tr>
<th>No of readmissions</th>
<th>Psychotic</th>
<th></th>
<th>Non-psychotic</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>%</td>
<td>number</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>32</td>
<td>71</td>
<td>61</td>
<td>73</td>
</tr>
<tr>
<td>1</td>
<td>10</td>
<td>23</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3+</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>100</td>
<td>83</td>
<td>100</td>
</tr>
</tbody>
</table>

There were no significant differences between those who were readmitted within the six month period and those not readmitted with respect to age, gender and number of previous admissions, save for the larger proportion of older (over 45 years) people with a psychotic illness who were admitted. There was no significant difference in the number of community supports at Time 1, having a CPN, or the level of satisfaction with the discharge process. Of the users re-admitted, more users in the non-psychotic group thought their mental health had been worse or static over the 6 month period than in the psychotic group (pg 38%; npg 64%)\(^{17}\). This may reflect the lack of insight often cited for the latter group. In addition, 8 users in the non-psychotic group and 2 in the psychotic group were admitted to wards other than acute psychiatric wards as a result of deliberate self harm.

\(^{17}\) Significant in the non-psychotic group only; chi-square = 8.12, 2df p<.05
Some users were not really aware of why they had been re-admitted. There was a detachment from the process, a compliance with what was expected, and an inevitability about being in hospital again. Only one person in the study spoke about this being a one-off episode, but this may be because others who think like this did not respond. A couple of individuals observed that they thought lack of support and being discharged too early contributed to their readmission. Many professionals would argue, however, that readmission should not always be considered as a negative outcome; it may offer respite, asylum, an opportunity to change or stabilise medication, or may be a planned response to emerging symptoms or relapse.

INFORMAL SUPPORT

The extent to which informal care featured in the range of support available post-discharge was explored in the interviews with both users and carers. As Twigg and Atkin (1994) discuss, carers of users of mental health services have not always been included in the debate around informal care. Informal support was clearly important for this sample; 90% of those discharged referred to some type of informal supportive relationship, with individuals highlighting how important the relationship was for them (Annex Two details the demographic characteristics of the carers). Users felt the relationships were important because the carers were "kind and caring", "understanding" and "sympathetic". A number indicated they would find it difficult to manage without the support of the carer.

"I don't know what I would do without him...we speak to each other every day." (182)

"She is always around and going to be available for me if need be." (335)

Another user felt that if her friends were not available to support her to the extent that they did she would be attending the day service provision more often.

The great majority of those carers interviewed reported helping the user every day (85%). Few carers were involved with physical care tasks but all carers reported that they ‘kept an eye on’ the individual they were helping. The other type of help which featured strongly was keeping the person company, an area identified as problematic for users by the CAN data (see above). Other types of help described by carers included observing for self harm or other ‘triggers’, looking after children, encouragement, emotional support, and, a phrase used by both users and carers, simply "being there".

This notion of being there for the user appeared very important to a number of those interviewed. The users were reassured just knowing that there was a sympathetic person to contact if needed. The carers also described how they were "there for them", suggesting that the carers understood how important this could be for users; that they were not alone and that they could make contact with another person when necessary. For some carers the notion of being there was not seen as anything out of the ordinary. One woman who cared for her daughter said that she could not be termed a carer and that she helped only in the “sense of being there” (424), implying that it was part of her mothering role. A husband said that he was there for his wife as “part of life's ups and downs” (288). Another carer who was a close friend of the service user described being there as part of the friendship relationship.
It is also important to note that 8 of the carers described the relationship with the user in reciprocal terms and the carer felt that they gained from the relationship. Three carers whose relationship with the user was that of friend spoke of this reciprocity. One woman spoke of herself and the carer having a mutually supportive relationship “we’re there for each other ...a listening ear” (311). Another woman described how both herself and the user had experienced alcohol problems and were therefore able to give support to each other. This reciprocal type of relationship was also described by partners, parents and grandparents.

Although the majority of users had some kind of informal support and the majority placed great importance on this support, it was not without difficulties. A number of users described how mental health difficulties and the caring role had placed a strain on the relationship. This was both with spousal relationships and other types. One man explained that he thought his wife, the carer, had "been through" more than him. He felt she had been "put on" after his discharge from hospital and had been left to cope on her own. Other users spoke about a lack of understanding from the carer, which led to difficulties.

"[My husband] doesn't have a clue, he says 'pull yourself together' or if I am bad and the housework is not done or his tea is not on the table he starts drinking." (160)

A number of users perceived that they were a burden to their carer.

“I feel it’s not fair on him [her son] to be always having to worry about me. He is only twenty and has his own life to lead and his own problems. I worry about getting older and what will happen when he leaves home altogether to get married and I am completely on my own.” (189)

**SUPPORT FROM COMMUNITY SERVICES**

As detailed in Chapter 2, the types of formal support received by users post-discharge included the CPN service, social work, psychiatric out-patient services, day services and voluntary sector support workers. Users were often in receipt of a combination of these services. Figures 6.2 and 6.3 detail the number of community supports received by the two diagnostic groups at the two interview points.
Figure 6.2  Number of community supports, Time 1

Figure 6.3  Number of community supports, Time 2
There was a significant difference in the number of community supports received by the two diagnostic groups.\textsuperscript{18} The majority of users in the non-psychotic group were at the lower end in terms of number of supports. In the psychotic group the majority of users were in the mid level of supports, with over 70% having 2 or 3 supports. At Time 2 all the psychotic users were in receipt of community support.

There was a significant difference in the number of community supports according to the length of the hospital stay: the longer the length of stay, the greater the number of supports put in place post discharge.\textsuperscript{19}

This number of supports can be compared to the levels of need recorded by the CAN data. Although the pattern is complex, there is a general trend towards those with higher levels of total need on the CAN being in receipt of higher levels of community support.

In the psychotic group slightly more males had higher numbers of supports. The reverse was true for the non-psychotic group where more females had higher numbers of support. There was no relationship in terms of age.

Greater Glasgow was the only area with individuals in receipt of 5 community supports; neither Forth Valley nor Western Isles had individuals with more than 3 supports. There were no users without support in Borders and Western Isles.

In the non-psychotic group, those with higher numbers of supports tended to be those with more than one admission. Few users in this group with one admission had more than one support contact. In the psychotic group there were few first time admissions, but only one first time admission did not have any community support. It seems likely that the psychotic group may be more urgently channelled towards a range of support services.

The number of community supports remained constant for 56% of the psychotic group between Time 1 and Time 2, with only 3 users (7%) having the level of community support increased. The picture for the non-psychotic group was quite different. Only 36% of this group had no change to the level of community support, with 41% experiencing a reduction and 23% having an increase in the levels of support. The difference in these changes for the two groups is significant\textsuperscript{20}.

There was no significant relationship between the number of community supports at Time 1 and whether an individual was readmitted. In the psychotic group, however, a larger number of those re-admitted (44%) had 2 community supports, whereas in the non-psychotic group a larger number of those re-admitted had 3 community supports.

\textbf{Out-patient psychiatry}

Phase 1 key informants reported that all patients discharged from an acute ward would have an out-patient appointment (OPA) approximately four to six weeks after discharge. The majority of wards sent the appointments to the patients. The remaining four wards gave the

\begin{itemize}
  \item difference at Time 2, chi-square = 14.38, 5df, p<.05
  \item chi-square = 12.76, 4df, p<.02
  \item chi-square = 7.1, 2df, p<.05
\end{itemize}
individual a card on leaving their ward with the date and time of the appointment. Several of the key informants considered six weeks was too long to wait before the appointment as people tended to panic at the thought of being on their own with no contact from services for such a long time.

Key informants were also asked what would happen if a patient failed to keep their appointment. It appeared that in the majority of cases the patient would be sent between one and three subsequent appointments. If there was cause for concern, the CPN would try to make contact with the individual (cause for concern was not defined by any of the key informants). Seven respondents indicated the GP would also be informed, but as one respondent indicated, many people discharged from acute psychiatric wards may not be in contact with their GP. Two respondents did not know what happened when a patient failed to attend an out-patient appointment and said it was not a ward concern.

Although the key informants in Phase 1 indicated that all users would have an OPA after discharge, this was not borne out in the sample. Slightly more users in the psychotic group reported having an OPA in the six week period following initial discharge than the non-psychotic group (pg 78%: npg 64%); a substantial minority therefore (n=47) did not have a follow-up appointment. At the Time 2 interviews, 82% of the psychotic group and 63% of the non-psychotic group had attended at least one OPA in the intervening period.

There were no differences between those people who had an OPA and those who did not on the following factors: number of admissions, admission type, age, gender or Health Board. Those users re-admitted during the study period were not more likely to have attended an OPA or to have been given one at discharge. The frequency of OPAs ranged from more than monthly to less than every 3 months for both groups. Although there was a high level of expressed satisfaction with the OPA service and the amount of contact, those with less frequent contact were more likely to be dissatisfied.

Some users saw the psychiatrist within a very short time after discharge and were surprised at how quickly they had an appointment. Twenty users spoke about seeing their psychiatrist every few weeks or more often, and having a number of appointments in the time between discharge and interview at 6 weeks. This suggests that for a minority of users the psychiatrist was willing to offer an intensive out-patient service. The most extreme example was a woman who initially had appointments with her psychiatrist on a daily basis. In addition to intensive out-patient services, there were examples of flexible out-patient services, with users reporting that they saw the psychiatrist at health centres, resource centres and other local clinics.

**Good Practice Example C: Home visits by psychiatrists in rural areas**

A small number of users in rural areas (Borders, Highland and Forth Valley) reported having the out-patient appointment in their own home. The psychiatrist would visit instead of the user making a difficult journey to the hospital.

There was also evidence to suggest that practitioners were taking steps to avoid duplication of services. A number of users stated that they had not attended an OPA because they were attending the day hospital where they would have contact with the psychiatrist. One man believed he was referred to the day hospital because an OPA could not be made in enough time for him.
GPs

This study did not seek to canvas the views of GPs on the acute discharge process. It is, however, possible to cite the views on their GP care volunteered by a number of users. After discharge from hospital most of the users had an appointment with their GP (pg 61%, npg 59%); for about half in each diagnostic group this was within the first week of being discharged. About a third of users had not seen their GP by the Time 1 interview. For many seeing their GP within a week of discharge, this was probably because of the need for continuing supplies of medication. This argument was confirmed at Time 2 when 66% of the psychotic group and 40% of the non-psychotic group stated that they only visited their GP for medication (n=61).

The views of users suggest that GPs have a limited role for this population, important for ensuring adequate supplies of medication and allowing access to secondary services. There was, however, a number of examples where the user felt that the GP was caring for their mental health. Slightly more users in the non-psychotic group (28%) than the psychotic group (18%) had contact with their GP primarily for their mental health. A good example of this was a woman who had a long history of deliberate self-harm which included interfering with a leg wound and preventing it from healing. This had led to a number of physical problems. The user felt that the GP and district nurse were understanding and willing to work closely with her to avoid the self-harming behaviour.

“They've been helping me with the mental health side…they haven't left me to cope alone] ...they've gone at my pace [letting her take responsibility for her medication and dressings].... they're there if I need them ...I can phone at any time… they're very understanding.” (292)

Community psychiatric nursing service

♦ In the psychotic group 45 out of 61 users (75%, 1 case unknown) had contact with a CPN at Time 1. At Time 2, 71% of this group had contact with a CPN (see Table 6.4). There had been 5 users discharged from the CPN service and 2 new referrals. Only 8 users in the psychotic group did not have any contact with a CPN over the study period.

♦ In the non-psychotic group 58 out of 112 users (52%) had contact with a CPN at Time 1. At Time 2 49% of this group had contact with a CPN (Table 6.4). There had been 12 discharges and 8 new referrals in this group, with 28 (34%) users not having any contact with a CPN over the study period.

♦ Only 7 cases with a psychotic diagnosis were first-time admissions. Five of these first-time admissions had a CPN at Time 1, with none of them having had contact with a CPN prior to admission. There were many more first-time admissions in the non-psychotic group. Less than 40% (13 out of 34) of the first-time admissions had a CPN at Time 1, with five users in this group having a CPN prior to admission.

♦ There was no difference in either group according to gender in those having CPN contact.

♦ There was a higher proportion of users in the top age range (45 upwards) with a non-psychotic diagnosis who had a CPN.
Tayside was the only area where a greater number of users with a psychotic diagnosis did not have a CPN than those that did. Ayrshire, Borders and Highland stood out in having a majority of users with non-psychotic diagnoses having contact with a CPN at Time 1. Ayrshire had a high number of users with contact with a CPN overall, reflecting the local policy of referring all acute discharges to the CMHT. There was at least one contact after admission, an assessment was carried out and a team decision was made as to whether continued contact was appropriate.

Table 6.4  Contact with CPN services

<table>
<thead>
<tr>
<th></th>
<th>Time 1</th>
<th></th>
<th>Time 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contact</td>
<td>Non contact</td>
<td>Contact</td>
<td>Non contact</td>
</tr>
<tr>
<td>number (%)</td>
<td>number (%)</td>
<td>number (%)</td>
<td>number (%)</td>
<td>number (%)</td>
</tr>
<tr>
<td>Pg</td>
<td>45  75</td>
<td>15  25</td>
<td>32</td>
<td>71  13</td>
</tr>
<tr>
<td>Npg</td>
<td>58  52</td>
<td>54  48</td>
<td>41</td>
<td>49  42</td>
</tr>
<tr>
<td>Total</td>
<td>103</td>
<td>60  40</td>
<td>73</td>
<td>57  55</td>
</tr>
</tbody>
</table>

* one missing value

These data indicate that contact with a CPN was much more likely for users with a psychotic diagnosis. In the non-psychotic group, 2 or more admissions and being older increased the likelihood of having contact with a CPN.

A number of users made specific comments about their satisfaction with the CPN service. Eight users commented on the relationship they had with the individual CPN and how they were happy with this, suggesting that they had forged a therapeutic relationship. The availability and responsiveness of the CPN was commented on by a number of users as the aspect of the service they were most happy with. Users emphasised that they could phone the CPN between arranged visits or that the CPN phoned them, in one case to remind the user of appointments as she often forgot to attend; the user really appreciated this type of input. CPNs who took time between face-to-face contact to maintain an awareness of the client’s situation were highly valued. Thirteen commented on the approach of the CPN and the type of support they gave. Often this was described as “a chat” or “just talking” and seemed to be relatively informal in nature. The Trust that had built up between user and CPN was commented on by 4 users. Two users spoke about the CPN involvement in decision-making about their care and treatment, while three others spoke about the social aspect of the CPN visiting.
Good Practice Example D: Discharge meeting organised by the CPN, North Cunninghame CMHT, Ayrshire

A number of people in the sample were discharged from the CPN service during the study period. On the whole those who were discharged felt this was appropriate. The example that stands out was one in which the CPN arranged a discharge meeting for the user, his parents, the GP, psychiatrist and the CPN. This user was being discharged from the CMHT and moving to another Health Board area. The user felt that the meeting helped to answer his questions and he felt confident to move to the new area. The CMHT also suggested that he make contact with the mental health services after he moved to ensure that if he became ill again he would know whom to contact.

Social work

♦ Contact with social work was less than with CPNs but similar patterns can be discerned.

♦ Slightly more users in the psychotic group had contact with a social worker (Time 1 pg 27%, npg 20%; Time 2 pg 27%, npg 18%). There was also a measure of continuity, with few users being discharged from the social work service.

♦ Individuals were much more likely to have social work contact if they had more than one admission. Only three of the users on their first admission had a social worker (1 pg, 2 npg).

♦ Only 2 users in the psychotic group with a social worker were re-admitted to hospital, whereas half of the users in the non-psychotic group with contact with a social worker were re-admitted.

♦ In the non-psychotic group few users over 45 years had a social worker whereas a high proportion of users under 24 had a social worker.

♦ There were no differences in social worker contact by gender.

♦ As outlined above, Ayrshire had a higher proportion of the sample with CPN contact. Conversely the users in this area had a lower proportion of users with social work contact, 14% compared to 21% for the whole sample. Half of the Borders sample had social work contact (3 out of 6).

Social work contact usually focused on a particular issue. In order of frequency these related to financial and benefits issues, housing issues and childcare issues. Contact, therefore, tended to be variable depending on when the user had a particular problem where they believed social work could help.

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21 This reaches statistical significance for the non-psychotic group only due to the small number of first time admissions in the psychotic group, chi-square = 6.42, 1df, p<.05.
22 Fisher's Exact Test:One-Tail, p<.05
23 chi-square = 7.92, 2df, p<.05
"I only see her [SW] once in a blue moon when I have a specific problem. She sorted out housing and benefit problems a couple of years ago, but recently hasn't done anything." (182)

"Contact with the social worker is on a need basis, and contact is variable, depending on my needs." (432).

There was, however, a small group of users who had a different relationship with their social worker. They had regular contact and the social worker operated more like a generic support worker, helping with any aspect of care and support. One woman spoke of an informal supportive relationship with the social worker: “[SW] takes me out for coffee, I’ve had a social worker for years” (187). Another user described how the social work contact was “largely just for a chat” (231). One man put great value on the relationship with the social worker, indicating that he was a great support and that the social worker had offered just to come and sit with him if he was having a difficult time when adjusting to being at home again after discharge.

“I find the change of environment difficult when coming out of hospital. Going from lots of company to living alone, asked a friend to come to stay on the first night out. The social worker visits might be useful, just for a coffee and a blether… In a crisis I would phone the social worker, he has offered to come and sit with me if necessary.” (99)

It might be thought that the users who described these relationships with social work did not have any other support mechanism but this did not appear to be the case. Of the 12 who described close and supportive relationships with a social worker, only two had no other support worker contact. Most, in fact, had at least two other service contacts.

**Voluntary sector support worker**

Smaller numbers of users were in contact with support workers from the voluntary sector. This differs from attending voluntary projects in that the workers operate outwith the project, visiting the user in their own home or providing other types of support service. At Time 1, 21 users (6 pg; 15 npg) were in contact with a voluntary sector worker. At Time 2 this had increased to 25 (pg 11; npg 14); however different users were in contact with the support workers. The majority of the users with voluntary sector support workers also had other community supports. This would suggest that access to voluntary sector services was assisted by having contact with statutory sector workers.

Most of the voluntary sector workers that users had contact with were from local associations for mental health. Two users were living in SAMH (Scottish Association for Mental Health) accommodation projects and had access to the support workers. Others had a support worker who operated more like a CPN with regular visits, usually in the user’s own home. Other services which users spoke of were befriending-type services and counselling.
Day activity

It is important to note that almost half of the user sample participated in no formal day activity, whether employment or the range of potential day support provision.

Table 6.5 Pattern of organised day activities for users

<table>
<thead>
<tr>
<th>Type of organised activity</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>In employment</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>Voluntary work</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Voluntary day service</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Statutory day service</td>
<td>49</td>
<td>28</td>
</tr>
<tr>
<td>Other day service</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>79</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
</tr>
</tbody>
</table>

* four users were attending both of these services

Employment

As can be seen in Table 6.5, only a small proportion of the sample had been involved in employment over the study period (Time 1 = 13%; Time 2 = 15%). Users who had left their jobs stated this was due to their mental health, with the stress of maintaining employment too high.

♦ Thirty-one users (6pg; 25 npg) were in employment directly before being admitted to the acute psychiatric unit.

♦ At the 6 week point, 6 users in the psychotic group were in employment (one of the group had stopped working and one other user had started working). In the non-psychotic group 17 users were in employment and the other 8 users had stopped working. Fourteen of the users still in employment were off sick at the time of the interview.

♦ There was no significant relationship between gender and employment for either diagnostic group (except that for both groups slightly fewer females who were not working wanted to work, possibly reflecting perceived gender roles and family commitments).

♦ There were no significant relationships between those users who were working and the number of admissions for either diagnostic group. Users with only one admission were not over represented in the employed group.

At the follow-up stage, 3 users in the psychotic group had continued to work, one was not working and one other user had started working. In the non-psychotic group, 13 had continued in employment, 4 had not and 2 other users had started working. Of those in employment one of the psychotic group was off sick, as were 3 of the non-psychotic group.

For those users who had been in employment during the study there were a number of post-discharge experiences. There was a small group of users who were happy to return to work.

24 total does not equal 100 as some users attended more than one day service
after discharge; they felt that it had helped them to be able to return to work and they had received support from their employer. For example, one woman who worked in a bakery felt that the support from her employer had been good. Since returning to work the manager took time to check how she was and the Occupational Health Nurse had visited her at home prior to her returning to work. She spoke about the support of her colleagues and was able to talk with them about their problems. She was particularly pleased that she had been able to cope with doing some overtime. One man described how being off work and in hospital had helped him to change his attitude towards work and life. His manager was supportive of his difficulties and he had colleagues with similar experiences. He described how being off work had

“opened a whole new way of life - more satisfied at work, more positive, relaxed” (98).

One woman who returned to her post in an NHS Trust said her colleagues had been supportive and she had been able to build her hours up slowly. Another woman felt that she had to be careful in her work as she did not want to take too much on. She was self employed and was able to vary her hours depending upon how she felt. She explained that her GP and psychiatrist had helped her recognise that the stress from working had affected her health.

Other users did not have such good support from their employer. One woman described how she had returned to work but one day acted out of character and started drinking alcohol whilst at work. She was suspended from work and disciplinary action was taken against her. It was decided that she was not at fault as she had not had the necessary support to return to work. Although she would not be returning to the post she was in, she had been assured another, more appropriate post would be offered to her.

One example where employer support was lacking was particularly disappointing as the user was an NHS employee. She was a trained nurse and had been in full-time employment throughout the period of her illness, being off sick only when in hospital and for a short period afterward. Before being off sick she had made a complaint about another member of staff who she believed was physically abusing patients. When she returned to work this member of staff threatened and bullied her. One incident took place in front of a patient on the ward where they worked. During this incident a remark was made implying that the woman was not fit to work because of the type of hospital she had been in, i.e. a psychiatric hospital. She felt very unsupported by the ward manager and, although the member of staff had subsequently left, she felt that insufficient action was taken by the hospital. She felt she relied on the Occupational Health Department, which had been much more supportive and encouraging. Overall she felt that she had coped very well with the difficult circumstances and was very pleased about this despite having little support from her line managers.

Support from employers would seem to be a random event, dependent upon the goodwill of individuals rather than an awareness from employers of mental health problems. One man spoke about how he returned to work earlier than the psychiatrist wanted him to because if he took any more time off sick he thought he would lose his job.

Two people were concerned about how their illness would be perceived if they returned to work. One of these had been admitted under a section and did not know how this would affect her chances of being accepted into the army. Another feared being labelled; although he wanted to be honest about the fact that he had been in hospital with mental health
problems, he thought the other workers would be hostile to him – “they’re [colleagues] liable to take it out on you” (321).

Other people were concerned about how working would affect their benefits. One woman described how she had been working casually and this was the only way she could manage financially. This is clearly not a problem specifically connected with mental illness but highlights the difficulties that users face in their everyday lives. One user who lived in a nursing home stated that because of the funding structures he would have to find alternative accommodation if he started working and felt he was in a ‘catch 22’ situation.

**Steps towards working**

Although few users in the sample were in paid work, others were involved in voluntary work, college and training courses. Individuals used a variety of employment services from mainstream career and college services to others dedicated to people with mental health problems. A number had been motivated to apply for work and training courses and felt that it was important that they did this for themselves. One man had arranged to do voluntary work for some months until he felt ready to apply for jobs in the area he was trained in; he turned down the offer from his CPN to use any back-to-work schemes. Reference to voluntary work was made often by users who felt this would be a way into paid employment. One woman had a job coach who helped her look for jobs and if she secured a post would attend the workplace with her for a limited period. She found out about this from a voluntary sector support service. The voluntary sector features heavily in the employment area with services geared towards retraining or work placement.

Some users who were attending other day services saw this as a step towards employment. One woman described how she benefited from the statutory day service because "it gives me a sense of achievement" (329). She felt that this improved her self esteem and consequently her employability. She went on to say

"*when nobody sees, say a broken leg, [to excuse unemployment] they think you're just lazy.*" (329)

Other users commented on day services giving them motivation to do things. One man stated that attending an industrial workshop had given him something to build his day around which was very important to him. Another man explained that he felt “not have anything meaningful to do during the day is the most depressing thing and makes me feel much worse” and that doing some vocational training reduced his isolation (14). For two users in the sample their reason for attending day services was to provide some training; these were both art and craft type activities and they had both been approached by the mental health professionals they were in contact with to do the training.

It was clear, however, that for a number of users there were difficulties in taking steps towards employment. Users spoke about not having the confidence to start something new or having started something then giving up as they felt they were not coping with it. One man felt the help he was getting from a Clubhouse project was beneficial but that he was still not ready to start a new venture.

"*I've taken a long time to get back into the swing of things and I'm still not there yet. I still have a bit to go.*" (351)
Another was concerned about the pressure he might be under if he took on voluntary commitments. One woman stated that she had ambitions to start a pre-nursing course at the local college: she felt she “had a brain and was not using it” (195). Users felt that they were not fulfilling their potential and in their present circumstances were not realising their goals. For these users more support was clearly required to enable them to be involved in useful occupation.

**Good Practice Example E: The Compass Centre, Irvine**

In Ayrshire and Arran users have access to a SAMH project, the Compass Centre, an industrial workshop training centre. Users can take part in training programmes covering areas such as office skills, information technology, picture framing, carpentry and craft, small craftwork and printing. Users receive guidance and support within these training programmes. They can also be supported to reach vocational outcomes such as qualifications and/or work experience. A number of users within the local area were attending this project and felt they had gained much from going there. One woman described how starting at the Compass Centre had been the most significant event in her life over the 6 months.

“It is just like a job and has got me into a routine… time has passed very quickly since coming here.” (163)

This woman described a sense of achievement from completing the different modules she had worked through. Another man who had started attending during the study period felt that with the Compass Centre, college attendance and other SAMH support he was able to start considering employment in the future.

**Day Services**

The day services that users might be attending could be statutory or voluntary, ranging from health-based day hospital through local authority or voluntary sector day centre to more informal drop-in type provision or different types of training schemes. Thirty (50%) of the psychotic group and 41 (37%) of the non-psychotic group were attending day services at Time 1. For both groups about two thirds attended statutory provision and one third voluntary. By the follow-up stage, disparity between the two diagnostic groups in attendance at day services had widened further (pg 57%; npg 25%). In the psychotic group, one third of those attending at Time 1 who were followed up at Time 2 had stopped attending; in the non-psychotic group it was one half. Only 4 users in each group had started attending since Time 1.

♦ There was no difference in attendance at day services for users with a psychotic diagnosis across the Health Board areas. For the non-psychotic group the pattern was more varied, with more users attending in Tayside, Borders, Fife and Ayrshire. A lower proportion of users were attending in Forth Valley, Greater Glasgow and Western Isles.

♦ In the psychotic group there was no difference in age between those attending and those not; for the non-psychotic group fewer older people (45+ years) were attending.
Non-psychotic group users were much less likely to be attending day services if they had been admitted to hospital for the first time. There is less of a difference in the psychotic group.

There was no difference in either group in the numbers of men and women attending.

Users with a non-psychotic diagnosis were much more likely to be attending day services if they had contact with a CPN. For the psychotic group no difference was present.

The areas with the most users attending voluntary projects were Glasgow and Ayrshire.

The users in the sample reported a number of different motivations for attending day services, including particular work or therapy as highlighted above, user support (see section on user groups below), and social reasons. For a substantial proportion it was the social aspects of meeting other people and getting out of the house that was important.

“It’s really good and gets me out of the house. Nothing really specific that makes it good, it just gets me out and meeting people.” (54)

Another woman attended a women’s group which involved doing some cooking, but her main reason for attending was for the social aspect, ”it’s really good fun to go” (261). Another man explained that he had stopped going to the statutory day hospital and started attending a drop-in group as it was more social than the day hospital. This range of experiences would suggest the need for a variety of approaches to respond to the range of needs and preferences. The provision of day activity in the specific form of a discharge group is detailed below.

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25 chi-square = 5.96, 1df, p<.05
26 chi-square = 4.21, 1df, p<.05
The Discharge Group at Hartfield House Day Hospital, Ayr, was started in January 1999 at the initiative of the group nurse on the admission wards at Ailsa hospital. The group nurse conducted a survey which indicated a need for a discharge group that could bridge the hospital-community transition. The group was developed to give users some support in the transitional period after discharge. It was felt that users were moving from the environment of intense input on the admission ward where they were taking part in groups and one-to-one sessions with their keyworker, to being at home with perhaps no input from any services. Users were also becoming frustrated with not being able to complete courses of groupwork they had started in the in-patient setting. The bridging discharge group also allows time for the community services to start their input for an existing contact or a new referral. The discharge group facilitator would see the user on the ward and then the user would attend his or her first session whilst still an in-patient. The discharge group would run for a further 5 weeks on the specified afternoon where users could take part in other day hospital activities as well as the discharge group activities. The group allows ongoing assessment of the user and staff can make referrals where appropriate. One user described how he was referred to the statutory day hospital to attend the discharge group. He was initially reluctant to go to the group and had some reservations, but when he did go it proved to be satisfactory. He had previously taken part in a conference where he had pointed out that there was a discontinuity between leaving hospital and returning home “to be picked up by the system” (106). Once he had finished the discharge group he picked up contact with his CPN again. At the follow-up stage he explained how he had been offered the opportunity to continue with the day hospital but felt that this was not necessary and that his experience of the discharge group was a positive one.

User groups and support from other users

For many, mental health service user groups have played an important part in raising the profile of their needs. Users have contact with other people who understand how they are feeling or have similar experiences. User groups take various forms, ranging from large organisations with substantial funding (for example, the National Schizophrenia Fellowship) to smaller groups of users within a particular locality (for example, organised from the hospital ward). Some groups are well known and have worked hard to raise the issues that concern users (for example, Highland Users Group). Some of the users in the sample had had contact with user groups and recounted their experiences, in particular the support they had received.

“[I can] drop my guard with other people in the same situation.” (101)

“You get the feeling that you’re not on your own, there are other people struggling.” (313)

This benefit can also be seen for users who attended both voluntary and statutory day services, with two women describing how they found it useful to attend the day hospital as they met people with the same problems. Two women who had attended National Schizophrenia Fellowship projects in different areas stated “I don’t know what I would do without the place, I would have been in hospital a lot more” (218) and “if it wasn’t for the
centre I wouldn’t have improved” (293). Another woman was particularly pleased with the contact with the Manic Depression Fellowship as her partner had been able to attend and that had helped him.

“It is good because they also do work with carers... my fiancé has attended a group and found this beneficial.” (125)

Another woman, unaware that such services were available, described how she would like to use a drop-in type service where she could go for a cup of tea and talk to people who knew what she was talking about.

User groups were not, however, valued by all users. One man described the user group as “just smoking and drinking coffee” (14). A small number of users did not want to be mixing with users from the hospital, summed up by one woman who noted that

“I feel like it would be going backwards to be in a group with other users. I know this is a selfish thought and I know I was one of them.” (165)

One young man was concerned that if he became involved in a user group he would be

“put in a situation where I took on other people’s problems... I want to get on with the rest of my life” (168).

This man also stated that his psychiatrist had advised him against attending any day services as the psychiatrist did not think it would be beneficial for him to be mixing with other people with mental health problems. This was also the case for one of the women who described how important the NSF project was to her: the psychiatrist had told her that she should get away from people with mental health problems. These responses highlight the dilemmas inherent in terms of the promotion of social inclusion and the provision of integrated or segregated resources to meet individual needs.

PROBLEMS WITH COMMUNITY SUPPORT SERVICES

Few users expressed outright dissatisfaction with specific community services, with 80%-90% of users expressing satisfaction with the different types of services. There were, however, some specific concerns highlighted by users.

Discontinuities

Discontinuities between hospital and community were highlighted in terms of out-patient appointments, CPN contact and access to day service opportunities.

Out-patient appointments

Users were unhappy with the length of time they had to wait after discharge before being seen by the psychiatrist. Several key informants from the wards also thought that the length of time before an out-patient appointment was too long.
"There is a too quick a change from seeing the doctor many times a week to seeing him once a month...I would have liked to have seen a doctor every two weeks for a period of some months but they are too busy for this sort of service." (152)

"I think it should be [made at time of discharge for shortly after]...sometimes it's 6/7 weeks ...you've been used to seeing them every week...especially when you've had a long stay." (293)

Six users had taken steps to make their own appointment with the psychiatrist when they had not received one within the preferred time scale. This may have been a result of the administrative system not working efficiently and one would have been received eventually; however, the users felt they had been waiting too long.

A small group of users reported that they had not received out-patient services and were unhappy about this. One man who had been re-admitted by the six week stage observed that

"at the time I was not bothered about this [not having an OPA] but in hindsight I wished I had been, it may have prevented further hospitalisation". (109)

Another woman described how she had never had an OPA after being discharged (more than 4 admissions) and she felt “like I have to start from scratch whenever I go back in” (23). One man said he had been given the choice of having an OPA and had declined but that in retrospect thought it would have been beneficial for him.

**CPN contact**

Users spoke about the gaps in CPN service. One woman who had agreed to have contact with a CPN found herself becoming unwell again after discharge before she had seen the CPN.

“[There is] a gap between leaving hospital and being seen by the community services...I feel that everyone should have a CPN in the first week after discharge.” (165)

Other users reported being informed on discharge that a CPN would be coming to visit them, but by 6 weeks following discharge no contact had been made. One man stated that he was “a bit disappointed they haven’t been in touch” and went on to explain that he had not taken any action to follow up for two reasons: he knew they were very busy and felt hesitant to put any pressure on them; and secondly, he felt he should not have to press for something that was in his care plan (320). Two users felt that they would have preferred the CPN to visit sooner than they did. One of these stated that a phone call probably would have been enough to reassure her. Other users reported that they had seen a CPN once and were expecting to have regular contact but they had not heard from the CPN again. One woman said that perhaps she had not helped herself by not telephoning the service to see what was happening. Two users commented on CPNs failing to keep appointment times. One user reported how his CPN would make appointments then ring to say he could not make it, arrange another time and then not arrive at that time either. Another user was disappointed in the cover
provided over the Christmas holiday period. He would normally see the CPN once a week but felt that when that was not convenient for the CPN it was changed.

Day service opportunities

Discontinuity was less evident in relation to day services. A handful of users reported that they had spoken to mental health professionals, either hospital or community based, about attending a service but at the point of interview had not heard when or whether they were able to attend. By the follow-up, as noted above, most of these users had had some contact with a day service, and for those who had not it was because they had chosen not to.

Perceived effectiveness of support

Those in receipt of CPN or social work support or attending day services voiced a number of criticisms. One woman described how the CPN did not visit often and that she did not find the visits useful.

“I do not see the point in talking and crying when he cannot do anything… I feel as if I am getting nowhere fast.” (406)

Other users felt the CPN was dismissive of their concerns. Whereas some users found benefit in the chance to talk or chat with the CPN, others expected more from the service. One man felt that the CPN would not be able to help because “they do not have a magic wand and say they are going to get rid of this depression” (109). He was clearly frustrated by the lack of definite therapy or intervention to help him.

Six users reported situations where changes were made to their community support because of changes in personnel. Whilst these situations were unavoidable the users reported having anxieties about the change of CPN and felt that it could be handled differently. One woman had not known why contact with the CPN had stopped; at first she was concerned about this and felt that she had been “dropped” by the service. After a while she felt that she had “proved that she could manage without their help” (260). Another man said that he knew the CPN was leaving shortly and did not know if the CPN would be replaced, and if he would still have contact. There were three cases (including the one described above where the user or the carer had taken steps to ensure a CPN was accessed. In one case the carer had to inform both the CPN and the social worker that the user had been discharged. Another man felt that his access to a CPN was being curtailed because of staff shortages and that he was not seen as a priority. He felt that users did not have any influence on the decisions or any choices in the services provided.

Some users reported that they had had contact with a particular community service but found that they did not benefit from it and had decided the particular type of service did not suit them. Fifteen users reported they had tried a day service or had attended prior to admission but had stopped attending.

“I went the first time but felt worse after I came home. I felt depressed after the visit, another patient was very down and this brought me down.” (109)

Another man and three women said that attending a day service had upset them and they found it stressful. The type of atmosphere in the day service was also cited as a reason for
not wanting to attend. This was firmly expressed by one woman who also believed that because she had turned down attending this particular day service she was not being offered any alternatives.

“It's only for sad people who drink coffee and smoke fags and just hang about, they have nothing else in their lives. I'm not being snobby but it's not my cup of tea, I don't want to sit around gossiping. It feels like 'cause I don't want to go there I can't have anything else, like I'm not grateful.” (23)

Other users expressed a similar lack of stimulus.

“All the patients did was play pool and drink tea all day. It was like being in hospital again.” (268)

Other users felt the environment created by the staff was not helpful for them. One was concerned that attendance at a day service in a smaller community would lead to other people gossiping about him. Another reported that the other patients did not speak to the patients they did not know.

One man explained that he very much enjoyed attending the day service but that he had had to leave his dog at home during the day. The dog had been causing a nuisance when left all day and the neighbours had complained. He felt that he was going to have to stop attending the day service so that his neighbours would not complain further. The day service was aware of the problem but had simply stated that he could not bring the dog with him; a more creative solution could have accessed care for the dog.

Another problem identified particular to day services was transport and travelling distance, with thirteen users reporting they had difficulties attending because of transport problems. Only three users had transport provided. One man described his travelling arrangement: he had to phone ahead and book a place on a bus and was also waiting for a bus pass. He explained that

“it would have been better if all that sort of thing could have been organised before being discharged as these are the things that really bother you at first.” (11)

Another man was waiting for a bus pass before he could attend a day service; the CPN was sorting this out but he was still waiting for the pass at the follow-up stage. Users have difficulties both using public transport because of the nature of their illness and affording the expense of travelling.
Good Practice Example G: Travelling Day Hospital, Easter Ross

The Travelling Day Hospital (TDH) operates out of Easter Ross Community Mental Health Team and consists of a team of 3 nurses and an occupational therapist. Each week-day the team travels to a venue, usually a community centre, and provides a service that includes groupwork, individual counselling, sports, leisure activities and crafts. The day follows a structured daily programme. Referrals can be made from any source, provided the GP is in agreement, and the team usually carry out an initial assessment in the user’s own home. The TDH team believe that many users are isolated within their communities; providing a service within the local community centres therefore encourages integration. The TDH team also attempt to challenge stigma associated with mental health and aims to be as accepted as the local playgroup or over 60s club.

Three users in the sample spoke about contact with the TDH. One user attended regularly and received his depot medication from the nursing staff. Another user was waiting for a referral at Time 1 but expressed how much better this would be than travelling into Inverness to attend a day service.

There was a small but important group of users who had not attended day services of any type over the period but would have liked to (pg 10; npg 13), in some instances because of limited services in their area. Three users stated that on the Uists there were no such facilities, with one saying she had thought about organising a self help group herself and another indicating that he would like to see a place where people with a mental illness could meet for a chat and maybe play pool. Others were not aware of any facilities in their area or did not know how to access them. One woman in north west Glasgow stated that “there are not enough resources on this side of the city” (368). One man explained how he would have liked to attend a support group or other out-patient facility, especially in the early days after discharge, but he was returning to work and was not able to. He suggested that such group support services should be available outwith working hours.

OVERALL SATISFACTION

Those users who were interviewed at Time 2 were asked to select one of four statements to summarise their experience of the discharge process. Table 6.6 reveals their responses.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Whenever I have had to go into hospital my return home has been</td>
<td></td>
<td></td>
</tr>
<tr>
<td>well planned and careful thought has been given to the support I</td>
<td>54</td>
<td>44.3</td>
</tr>
<tr>
<td>might need in the community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B I have had both good and bad experiences of being discharged from</td>
<td>35</td>
<td>28.7</td>
</tr>
<tr>
<td>hospital and getting support within the community and there is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>room for improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C I have had very little support when leaving hospital and coming back</td>
<td>31</td>
<td>25.4</td>
</tr>
<tr>
<td>home; there are several areas in which I would welcome support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D I was only in hospital once 6 months ago and have had no contact</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>with mental health services since</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>122*</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*6 missing values
It is important to note that one in four considered they had had little support; not dissimilar numbers had also had negative experiences at some point. Less than half of the respondents were able to express unqualified approval. The correlates of satisfaction were explored in some detail.

♦ There was a significant relationship between the level of satisfaction as determined by the selected statement and the number of community supports27, having had an out-patient appointment, and having a CPN.

♦ Involvement of family carers around discharge led to higher reported satisfaction28.

♦ There was no significant difference in levels of satisfaction by Health Board area, by urban-rural location, or by whether the individual was readmitted to hospital.

When stepwise logistic regression was applied in order to explore potential relationships further, the only significant explanatory variable was the number of community supports.

This analysis of the needs of those discharged from acute wards, the ways in which these needs are met through a variety of formal and informal community supports, and those needs which remain unmet, has highlighted the complexity of factors which impinge on the discharge process. The key features emerging from the analysis are summarised below.

SUMMARY

♦ The average number of needs identified on the Camberwell Assessment of Need at Time 1 was 4.6 for the psychotic group and 6.4 for the non-psychotic group. Unmet needs were recorded as 1.6 and 2.9 respectively. By Time 2, total needs had reduced to 3.8 and 5.3 for the two groups; unmet needs to 1.4 and 2.8.

♦ Needs that were commonly identified amongst those with both psychotic and non-psychotic diagnoses included daytime activities, company, benefits advice, information and safety of the individual. The non-psychotic group additionally cited psychological distress, while psychotic symptoms featured amongst the top five needs identified by the psychotic group at Time 1.

♦ An overall readmission rate of 27% was experienced amongst those interviewed on two occasions. A higher proportion of those whose unmet needs increased between the Time 1 and Time 2 interviews had been readmitted.

♦ There were no significant differences between those readmitted and those not in terms of age, gender, number of previous admissions, number of community supports, having a CPN, or the level of satisfaction with the discharge process.

27 chi-square = 21.33, 10df, p<.02
28 chi-square = 6.22, 2df, p<.05
♦ The support of informal carers was important to those who were interviewed, 90% referring to some form of supportive relationship. Of the carers interviewed, 85% reported daily contact.

♦ Formal support services in the community included the CPN service, social work, out-patient services, day services, and voluntary sector support workers. Those with higher levels of need (CAN) tended to be in receipt of higher levels of community support. Those in the psychotic group received higher levels of support than the non-psychotic group. Amongst the latter, those with more than one admission tended towards higher numbers of supports. The pattern of support was much more stable for the psychotic group than the non-psychotic group.

♦ Key informants indicated that all those discharged would have an out-patients appointment at four to six weeks. This was not the case, however, for the user sample: approximately a quarter of the psychotic group and a third of the non-psychotic group did not have a follow-up appointment. This did not appear to impact on readmission.

♦ CPN support was most likely amongst those with a psychotic diagnosis and for others who had had two or more admissions or were older (45+). Users were particularly appreciative of CPNs who were readily available and responsive. Contact with social workers was less than with CPNs but similar patterns were present: more contact with the psychotic group and with those with multiple admissions.

♦ Almost half the sample were not involved in any formal day activity. Just over one in 10 at Time 1 were employed, while 4 in 10 were attending some form of day services. Day service attendance had declined by Time 2.

♦ Specific problems with community support services were highlighted: discontinuity between hospital and community in terms of out-patient appointments, lack of contact from the CPN service and from day services. Changes in personnel could be unsettling for individuals, while transport and travelling distance could inhibit attendance at day services.

♦ Asked at Time 2 to select one of four statements to summarise their satisfaction with the entire discharge process, 25% considered they had had little support while 29% had had a mixed experience. Less than half of respondents were, therefore, able to express unqualified approval. There was a significant relationship between the level of satisfaction and both the number of community supports and the involvement of family carers around discharge.
CHAPTER SEVEN: CONCLUSIONS AND IMPLICATIONS

This final section of the report draws out the main conclusions from the investigation and highlights the implications of the research for policy and practice. These conclusions are discussed in the context of the key objectives of the study.

The study explored the experience of acute discharge for individuals who had spent a period of between a week and six months as a psychiatric in-patient. The research focused both on the immediate discharge event and on experiences during the subsequent six months. While the primary emphasis was on the account of the discharged individual and of any informal carer, perspectives were sought also from key support professionals, including CPNs, social workers and consultant psychiatrists. The front-line experience of discharge has been located within a broader organisational and policy context through interviews with key informants at ward, Trust, Health Board and Local Authority levels.

The initial mapping of discharge policy and practice was Scotland-wide and is therefore a reflection of policy and practice throughout the country at the time of these interviews. The more detailed study of individual cases was located within eight Health Board areas only, but the basis on which these were selected was designed to replicate national characteristics. The response rate amongst the sample of those discharged from psychiatric hospital was an overall 46%. Although less than ideal, and particularly low in Tayside, this is not dissimilar to the responses achieved by other major studies of psychiatric groups. Examination of potential non-response bias suggested only one major element of note: a lower response amongst those individuals with a psychotic diagnosis. Apart from this, it is not unreasonable to assume that the account and conclusions presented here can be judged characteristic for Scotland as a whole.

Whereas the discharge of individuals with mental health problems or learning disabilities from long-stay beds has had a high profile - indeed in media terms is often seen as the essence of community care – there has been less focus at all levels on the issues pertinent to the discharge of individuals with mental health problems from acute beds. The findings from this study suggest that acute discharge is a potentially complex process, requiring the coordination of a number of elements across a range of professionals. Moreover, there appear to be few definitive relationships within the process which would allow for prescriptive recommendations. Thus, there are few significant relationships between specific discharge outcomes and variables such as gender, Health Board area, age, employment status or number of admissions. Much of the activity is multi-professional in context which, as demonstrated elsewhere (www.integratedworking.org), is perhaps best characterised as a sequence of ‘drivers’ and ‘barriers’. The need for this to be achieved is reflected by the response of individual service users in terms of overall satisfaction. One quarter considered that they had received little support through their discharge, while less than a half were able to be totally positive. A number of correlates of this satisfaction could be identified: the number of community supports, receiving an out-patient appointment, having a CPN, and family carers having been involved over the discharge period.

The specific conclusions detailed below are grouped into the five areas highlighted within the specific objectives of the study:

♦ the impact of screening and admissions procedures on discharge
♦ the quality of assessment and discharge planning
♦ the impact of decision-making by both staff and patients on the quality of discharge planning
♦ the extent to which inter-agency and multi-professional relationships impact on the discharge process
♦ the support available to individuals on discharge from acute care.

By way of preface, it is important to note that for professionals the salience of acute discharge at operational and particularly strategic level was often low. Discussion of discharge policies and understanding of their relevance amongst key informants tended to be associated with longer-term patients rather than those discharged after a relatively short stay; indeed responses during the policy interviews of Phase 1 often referred to or assumed an interest in the non-acute sector.

SCREENING AND ADMISSION PROCEDURES

♦ Although over half of the Trusts and wards, when prompted, reported specific admission policies (Trusts) and protocols (wards) for acute psychiatry, they did not appear to feature prominently in the day-to-day practice of admission.

♦ During the admission process there could be a failure to pass information between the hospital and the community.

♦ Problems faced by service users in key areas such as accommodation and finance were not always identified on admission; moreover admission and discharge tended to be viewed as two distinct events rather than stages on a continuum leading to seamless transition to the community.

ASSESSMENT AND DISCHARGE PLANNING

♦ Ward staff tended not to comprehend the significance of the discharge event and the impact of the community based support resources. There was little evidence of active use of discharge protocols at ward level and little engagement of ward staff with community professionals.

♦ Consultant psychiatrists, whilst aware of potential networks, appeared constrained by perceived bureaucracy from proactive engagement in positive discharge planning. Discharge protocols or guidelines would be welcomed by most consultants, although rigid policies should be avoided.

♦ Service users were often ambivalent as to the importance of the discharge event itself, on the one hand recognising its potential importance as a rite of passage, on the other dismissing it as routine.

♦ Both the availability and the exchange of information was often inadequate. Individuals involved in the discharge process, both professionals and service users, could lack information across a range of issues and be unaware of how to access it.
There was substantial discrepancy in the information on diagnosis held by the individual and that attributed by the professional, with a user-professional agreement on diagnosis in only 45% of cases. It could be argued that the service user should have access to such information about them held by professionals.

**DECISION-MAKING AND PARTICIPATION**

The lack of salience of the discharge event highlighted above often led to both a lack of prioritisation of tasks related to discharge and, within the discharge process, a failure to distinguish between differing needs and priorities.

♦ Less than half of the user sample spoke of control and involvement in the decision to discharge, suggesting an opportunity for more active user participation.

♦ A number of carers also reported difficulties in gaining access to both information and to decision-making around the discharge process, and less than half reported involvement in the discharge decision-making.

♦ Although 65% of individuals spent time away from the ward on ‘pass’, there appeared to be little attempt to learn from the experience of individuals while they were away from the ward and to assess how prepared they were for discharge. This was indicative of staff attitudes on the ward for whom activity outwith the ward was of limited relevance.

♦ More than 20% of the users interviewed expressed some dissatisfaction with their notice of discharge, highlighting the need for better information exchange. Moreover there appeared to be little consistency in practice as to how much notice individuals received.

**INTER-AGENCY WORKING**

Acute discharge did not appear to be one of the areas where inter-agency working was well developed, although there was some variation across the accounts of informants and keyworkers. Problems were exacerbated by the disarray evident at boundaries, for example, between hospital and community base and between health and social care. Of particular importance in terms of practical impact were the very different time frames within which different professional groups, for example, GPs and social workers, were working.

♦ Admissions and discharges were not always communicated from the hospital to community-based professionals.

♦ Disjunctures between ward and community based staff were common. There was little evidence of ward staff being able to take an interest in individuals beyond the point of discharge, and although community based staff would on occasion follow-up individuals following admission to hospital, there was little opportunity for community-based staff to become involved on the ward.

♦ Issues that might be picked up on the ward, for example in relation to finance or accommodation, were often not followed through. Ward based staff were not well placed
to respond to such needs, while social work or housing staff were often not able to respond to users’ needs within the timescale of a short admission.

♦ Not all individuals received an out-patient appointment following their hospital discharge; others had to wait a considerable number of weeks. Moreover, there was some variation in policy and practice across different areas in the expectation of community involvement post-discharge. In one area it was policy to refer all acute discharges to the local CMHT for at least one contact.

♦ There was more evidence of linkages between professionals within the community than between those based in the hospital and those based in the community.

♦ Consultants reported discharging acute in-patients at a rate of 3 or fewer per week. It should therefore not be difficult to accommodate any follow-up required by social work or CPNs within current resources.

♦ The care programme approach (CPA), whilst occasionally allowing a swifter community response, appeared to have limited usefulness in acute discharge and should not be relied upon to improve the quality of acute discharge.

SUPPORT POST-DISCHARGE

Higher levels of support in the community were afforded to those individuals who had a psychotic diagnosis; this group reported both fewer total needs and a smaller number of unmet needs. Those individuals with a non-psychotic illness reported a higher mean number of both total and unmet needs. High levels of informal support (90%) were reported by individuals. Just over one quarter of individuals (27%) were readmitted to hospital within the six month period, with readmission being more likely if the number of unmet needs had increased. There was no direct association, however, between readmission and the number or type of community supports (including out-patient contact) that had been received post-discharge. Nonetheless individuals did highlight a number of shortcomings in the support they received, suggesting that greater access to sources of support in the immediate weeks post-discharge could be beneficial.

♦ There were uncertainties and excessive waiting times before some individuals accessed out-patient appointments, CPN support or various forms of day activity. Out-patient appointments with the psychiatrist were commonly arranged for six weeks post-discharge. While the GP may be considered an alternative resource in the interim, one third of respondents had had no contact with their GP by the time of the first research interview at six weeks post-discharge.

♦ The range of supports and services identified within the category of day activity is diverse. A close match needs to be ensured between the preferences of the individual and the nature of such activity, whether support to resume the independence of full-time employment, encouragement to access training and supported employment through models like Clubhouse, or the facilitation of entry to the most appropriate voluntary or

29 The international Clubhouse movement offers a model of support and rehabilitation for individuals who have experienced mental health problems based around the work-ordered day and a range of employment placements.
statutory day service. The transport implications of accessing service provision were not always addressed.

♦ Information about medication was important to individuals. Just under a quarter of the psychotic group and almost a third of the non-psychotic group could not recall receiving any information about their medication. The personalised information supplied in Highland was applauded. The need to provide information about prescription charges, eligibility for free prescriptions, and how to minimise costs was highlighted.

♦ A small minority of users were unsure whom they would or should contact in the case of an emergency. More reliable information as to the strategy for such an emergency would be welcomed.

GOOD PRACTICE STRATEGY

It is possible to highlight those elements which should feature in an acute discharge policy designed to maximise levels of effectiveness and satisfaction. Key features include:

♦ Identification at the admission stage of elements from the wider social context, for example accommodation or finance, which need to be addressed prior to discharge.
♦ Clear identification of lead responsibility in relation to the discharge planning for each individual.
♦ Agreement and implementation of protocols for the communication of information between hospital and community and between a range of different professionals. This should include details for the notification of GPs, consideration of the timing of the initial out-patient appointment, and communication of procedures to be followed for crisis contact.
♦ Involvement both of individual service users and, where relevant, their informal carers in the detail of decision-making, ensuring the provision of information necessary for this process.
♦ Clarification between psychiatrist and service user of the individual’s diagnosis and its implications.
♦ Provision for each individual of the details of medication and prescription arrangements, highlighting specific implications as appropriate.
♦ Comprehensive assessment of need and maximisation of the extent to which areas of unmet need are addressed.
♦ Specification of the routines for clarification of individual responsibilities within the multi-disciplinary work context.
♦ Clarification of any tie-in to existing care management or CPA procedures.
♦ Understanding of whether an individual can expect ongoing contact from professionals and the timing and arrangements for any review.

IMPLICATIONS FOR POLICY AND PRACTICE

A number of implications for policy and practice are implicit within the good practice strategy outlined above. Putting these within the wider context, the following implications can be highlighted.
Acutely discharged psychiatric in-patients should receive a priority service from CMHTs.

The response time of social workers and CPNs requires urgent consideration.

Consideration should be given to the identification for each locality of a discharge co-ordinator who would carry lead responsibility for all acute discharges within the designated area. This designated person could be responsible for screening all individuals on admission and identifying the smaller number for whom specific interventions around discharge are required. Wards from which individuals are discharged could be contacted on a daily basis. This would allow identification of new admissions who required to be screened and of individuals who were being discharged that day and for whom liaison requirements had been identified. The discharge co-ordinator would be responsible for creating a measure of continuity between hospital and community rather than the current disjunction. The role of discharge co-ordinator could be specified as part of the wider workload of a specific individual; this individual would most likely be either a CPN or social worker with dedicated time built in on a daily basis.

This screening and assessment of individuals on the ward by a discharge co-ordinator would contribute to the development of an ‘integrated care pathway’ for those individuals identified as requiring a range of inputs in order to sustain community placement. A thorough investigation of the extent and depth of screening is needed, along with an assessment of how ward staff deal with any difficulties, for example, accommodation or finance, that are identified.

Communication of information is key to an effective discharge policy. Consideration should be given as to how opportunities in these areas are to be maximised as part of the comprehensive discharge policy.

The effectiveness of communication between different professionals about the discharge of specific individuals should be maximised through the use of mechanisms such as fax and e-mail.

Details about and arrangements for transport, provision of medication, emergency contact arrangements and final notification to community services need to be communicated to professional staff, users and carers.

There should be more active consideration of the optimum timing and arrangements for individuals spending time on ‘pass’. Further, there should be discussion of individuals’ experiences whilst on pass, with consideration of any implications for the discharge process.

The role of discharge co-ordinator should embrace a ‘hands-on’ practice dimension which allows for immediate practical intervention where needed at the point of discharge. This could include, for example, arranging for the fixing of household items, accessing basic domestic requirements and sorting out transport, housing or benefit issues.
♦ It would be possible for the discharge co-ordinator to also assume a role during pass arrangements, acting as a link between community and hospital and allowing a closer ‘knit’ between these two elements.

♦ Some examination is required of the potential for reduction in readmissions through more effective discharge planning. There also requires to be a recognition of those individuals discharged from long-stay beds for whom periods of acute admission may be required.

♦ Working across different groups involved in discharge needs to embrace informal carers and to recognise both their need for information and consultation and the pivotal role which they often play in the discharge process.

♦ There needs to be ready access to information for individuals on a range of practical issues, including medication, diagnoses, benefits, transport and community based resources. It could be the responsibility of the designated discharge co-ordinator to provide access to this information for individuals, including detailed knowledge of specific local availability.

♦ Attention should be paid at a national level to the six-week benefits rule which can lead to artificial constraints on the length of hospital stay and the prospect of premature discharge.

♦ A more systematic approach is required to the provision of day support, training and employment opportunities within the community, including removal of benefit disincentives to employment.

It should be noted that since the completion of this study, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness has produced its Five Year Report, Safety First (2001). This demonstrated that in Scotland one quarter of suicides occurred within three months of discharge from psychiatric hospital, with a peak within one to two weeks following discharge. Moreover 35% took place before the first follow-up appointment. It should be noted, however, for the context of the current study, that figures available for England and Wales show that suicide is more likely amongst those with hospital stays of less than seven days. Amongst the recommendations of the Inquiry is that all individuals with severe mental illness or a recent history of deliberate self harm should be followed up through face-to-face contact with a mental health professional within one week of discharge. In England this is to be implemented by March 2002, together with access to crisis resolution (2004) and increased assertive outreach resources (2003). The study by King et al (forthcoming) is also of relevance, suggesting that continuity of contact may reduce suicide risk, with discontinuity of care from a significant professional being associated with increased risk of suicide. It is important, however, to appreciate that although the highest risk for discharged patients is immediately post-discharge, the incidence of suicide is low, between 1 in 500 and 1 in 1000 patients discharged.

An important statement in this context is the standard on discharge from hospital developed by the Clinical Standards Board for Scotland in relation to Schizophrenia (2001):

“When a person who has a diagnosis of schizophrenia is being discharged from hospital and care is being transferred to the community, those caring for

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the person both in the hospital and in the community work together, with the
person, so that the care provided after discharge is well co-ordinated, is
based on the person’s needs, and is reviewed regularly.”

Essential elements of this standard include: the requirement for discharge guidelines and the
involvement of all professionals caring for the individual in the community, especially the
GP; a comprehensive assessment of need; an assessment of the risk of self-harm and neglect
and how it is to be managed; the development of a care plan based on the needs and risk
assessment which details individual and agency roles and responsibilities, the identity of the
care co-ordinator, and procedures for crisis and respite provision; and specification of the
decision to include or not on the Care Programme Approach. Additionally, both user and
carer satisfaction with discharge planning arrangements should be audited.

The evidence from the study reported here would suggest that the challenge for service
provision is to ensure the full implementation of the standards, protocols and policies which
have been developed. There need to be clear levels of responsibility and accountability for
the routine procedures of good practice specified above, together with opportunities for the
introduction and development of those features of communication and responsiveness which
have emerged as the indicators of a quality service.
REFERENCES


Clinical Standards Board for Scotland (2001) *Clinical Standards: Schizophrenia*


Department of Health (1989a) *Discharge of Patients from Hospital*, DH Circ HC (89)5, London: HMSO

Department of Health (1989b) *Caring for People*, London: HMSO

Durgahee T (1996) Discharge of psychiatric patients into the community: how many more must die? *British Journal of Nursing* 5, 618-621


Gantt AB, Cohen NL and Sainz A (1999) Impediments to the discharge planning effort for psychiatric in-patients, *Social Work in Health Care* 29, 1-14


King C and Macmillan M (1994) Documentation and discharge planning for elderly patients, *Nursing Times* 90, 20, 31-33


McInnes E, Mira M, Atkin N, Kennedy P and Cullen J (1999) Can GP input into discharge planning result in better outcomes for the frail aged: results from a randomized controlled trial, *Family Practice* 16, 289-293

Marks L (1994) *Seamless Care or Patchwork Quilt? Discharging Patients from Acute Care*, London: King’s Fund Institute


National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001) *Safety First*, Five Year Report


National Schizophrenia Fellowship (Scotland) (1998) *Survey of Service Users’ and Carers’ Experience of Hospital Discharge*


Ryan A (1994) Improving discharge planning, *Nursing Times* 90, 20, 33-34


Scottish Office (1992) *Community Care: Guidance on Care Programmes for People with a Mental Illness Including Dementia*, Circular SWG 1/92


Scottish Office (1996) *Community Care: Care Programme Approach for People with Severe and Enduring Mental Illness Including Dementia*, Circular No SWG16/96


ANNEX ONE  RESPONSE RATES FOR USER SAMPLE

A1.1 This annex provides further detail on the case distribution model designed for the study and the response rates for the user sample. There is also full explanation of the response bias which the study encountered.

A1.2 The case distribution model developed in the design stage of the study set targets for the number of interviews in each area, which totalled 299 for the whole study (see Table A1.1). This model was designed to provide a random sample of patients discharged from acute psychiatric units across Scotland. The Health Board areas were selected on an urban/rural typology and represented half of the annual discharges in Scotland in any one year. Because of the potential non-response rate a replacement sampling technique was used. Where possible the initial sample in each area aimed to be above the target number and once these users had been approached, the number of non-responders was replaced by further cases from the sample in order to maximise responses and reach the targets set in the model.

Table A1.1  Model of case distribution

<table>
<thead>
<tr>
<th>Area</th>
<th>No of cases</th>
<th>adjusted</th>
<th>% of whole sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Glasgow</td>
<td>111</td>
<td>100</td>
<td>33</td>
</tr>
<tr>
<td>Highland</td>
<td>18</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>51</td>
<td>51</td>
<td>17</td>
</tr>
<tr>
<td>Fife</td>
<td>27</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>20</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Western Isles</td>
<td>4</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Tayside</td>
<td>55</td>
<td>55</td>
<td>18</td>
</tr>
<tr>
<td>Borders</td>
<td>13</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>299</strong></td>
<td><strong>299</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The adjustment in the second column reflects the weighting to include additional users from Western Isles at the expense of Glasgow.

RESPONSE RATE TIME 1

A1.3 The response to the study was below the expectations of the researchers. The response rate varied between the Health Boards areas, with Tayside having the poorest response (26%) and Forth Valley having the highest (82%). In no area did the study reach the targets set in the case distribution model (see Table 2.3). The reasons for non-response were recorded (see Table A1.2). Half of the individuals sampled declined to take part in the study. A fifth were deemed to be too unwell to take part, either by themselves, their carer or their keyworker. Of the 15% who were not in at the pre-arranged time, at least 2 further attempts were made to contact them. The individuals who were not traced were either not at the address taken from the hospital records or the address did not exist. Further investigation of these cases was not possible due to pressure of time. Another reason for the targets not being reached was the high number of discharges from acute psychiatric beds who were individuals with a primary diagnosis of substance misuse problems. This had not been anticipated by the researchers nor had been allowed for in the case distribution model developed at the earlier stage of the study.
Because of the low response rate the proportions of the sample might have been expected to differ markedly from the case distribution model described in the methods. In fact this was not the case, with only Tayside being underrepresented and this shortfall being made up by higher proportions of the sample in Ayrshire and Arran, Greater Glasgow, Highland and Western Isles.

**Table A1.2 Reasons for non-response at Time 1**

<table>
<thead>
<tr>
<th>Reason for non-response</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>refusal</td>
<td>102</td>
<td>50.0</td>
</tr>
<tr>
<td>unwell</td>
<td>43</td>
<td>21.1</td>
</tr>
<tr>
<td>not in</td>
<td>32</td>
<td>15.7</td>
</tr>
<tr>
<td>not traced</td>
<td>27</td>
<td>13.2</td>
</tr>
<tr>
<td>total</td>
<td>204</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**RESPONSE RATE TIME 2**

As expected there was some attrition between the first and second interview. Table 2.3 shows the response rates for each area and an overall follow-up rate of 74% was achieved. The reasons for non-response were the same as Time 1 with 20 refusing, 8 being unwell, 8 not being in despite at least 4 visits and joint working with community workers. Great effort was taken to trace individuals who had changed address with only 6 cases being untraceable, 2 of whom had moved to England and 1 who was roofless. Sadly, 3 of the individuals in the sample had died in the intervening months. There was no difference detected in the sample of those who responded at Time 2.

**NON-RESPONSE BIAS**

Non-response bias was examined on five factors; gender, age, length of stay, referral to aftercare and diagnosis. For three of these factors no non-response bias was detected. In the category of aftercare the only difference was that fewer users in the Greater Glasgow area were referred to aftercare than were not, the converse was true in all the other areas. For diagnosis a clear non-response bias was detected in that fewer users with a psychotic diagnosis responded to the study than did those users with a non-psychotic diagnosis.

- **GENDER** Seventy five males and 98 females responded compared to the non-responding group of 94 males and 109 females. Chi-square = .33, 1df, ns p>.05
- **AGE** A Mann-Whitney test on the age of individuals within the two groups demonstrates that there was no significant difference. M-W-U = 15612, ns p>.05.
- **LENGTH OF STAY** Likewise, a similar test on the length of stay in hospital of the two groups demonstrates no significant difference. M-W-U = 17147, ns p>.05.
- **REFERRAL TO COMMUNITY SUPPORT** In all of the study areas except Greater Glasgow Health Board there was no difference between the responders and non-responders with regard to referral to aftercare (Chi-square = 1.16, 1df, ns p>.05). Greater Glasgow was the only study area where the minority of the sample had been referred to aftercare. This may be due to local practice. There are also concerns over the reliability of the data from the Greater Glasgow Health Board area as the SMR4 data often proved to be inaccurate once contact was made with the individual and/or local services.
• **DIAGNOSIS**  The diagnoses were categorised into 6 groups for the purposes of this comparison. A difference can be seen between the responders and non-responders in two of the categories. Those individuals with a diagnosis of depression responded positively to the study (responders 55%, non-responders 44%). Those individuals with a diagnosis of psychosis responded negatively to the study (responders 34.5%, non-responders 65.5%). This gives a differential response rate between the those responders with a psychotic diagnosis and those with a non-psychotic diagnosis. Chi-square = 12.15, 1 df, p<.001). As we would expect significant differences between these groups and the response rates of each group was not unexpected, the data for these two main diagnostic groups have been presented separately on factors where there were good grounds for expecting a difference.
**ANNEX TWO SAMPLE CHARACTERISTICS**

Table A2.1 Sample characteristics (user)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Time 1</th>
<th></th>
<th>Time 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>%</td>
<td>number</td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>75</td>
<td>43</td>
<td>54</td>
<td>42</td>
</tr>
<tr>
<td>Female</td>
<td>98</td>
<td>57</td>
<td>74</td>
<td>58</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>less than 25 years</td>
<td>14</td>
<td>8</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>25-44 years</td>
<td>96</td>
<td>56</td>
<td>71</td>
<td>56</td>
</tr>
<tr>
<td>45 years and older</td>
<td>63</td>
<td>36</td>
<td>45</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>schizophrenia, including psychosis</td>
<td>33</td>
<td>19</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>schizoaffective disorder</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>bi-polar disorder</td>
<td>22</td>
<td>13</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>depressive disorder</td>
<td>76</td>
<td>44</td>
<td>62</td>
<td>48</td>
</tr>
<tr>
<td>post-natal depression</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>post-traumatic stress disorder</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>anxiety disorder</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>adjustment disorder</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>somatoform disorder</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>behaviour disorder</td>
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<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>eating disorder</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>personality disorder</td>
<td>19</td>
<td>11</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>substance misuse</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td>unspecified disorder</td>
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<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
<tr>
<td>Length of Stay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 days</td>
<td>11</td>
<td>7</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>8-14 days</td>
<td>43</td>
<td>25</td>
<td>32</td>
<td>25</td>
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<tr>
<td>15-28 days</td>
<td>40</td>
<td>23</td>
<td>31</td>
<td>24</td>
</tr>
<tr>
<td>&gt;1 month-2 months</td>
<td>49</td>
<td>28</td>
<td>31</td>
<td>24</td>
</tr>
<tr>
<td>&gt;2 months</td>
<td>30</td>
<td>17</td>
<td>25</td>
<td>20</td>
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<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
<tr>
<td>Type of admission*</td>
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<tr>
<td>Informal emergency</td>
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<td>92</td>
<td>73</td>
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<tr>
<td>Formal emergency</td>
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<td>10</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
<tr>
<td>Number of admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First</td>
<td>41</td>
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<td>31</td>
<td>24</td>
</tr>
<tr>
<td>Second</td>
<td>39</td>
<td>23</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td>Third</td>
<td>12</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

*Time 1, four cases unsure of type of admission; Time 2, 1 case unsure of type of admission*
<table>
<thead>
<tr>
<th>Fourth or more</th>
<th>80</th>
<th>47</th>
<th>58</th>
<th>45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPA</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>168</td>
<td>97</td>
<td>124</td>
<td>97</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Readmission within six months</th>
<th>26</th>
<th>15</th>
<th>35[^1]</th>
<th>27</th>
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</thead>
<tbody>
<tr>
<td>No</td>
<td>147</td>
<td>85</td>
<td>93</td>
<td>73</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In employment</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31</td>
<td>18</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>142</td>
<td>82</td>
<td>109</td>
<td>85</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of community supports</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>15</td>
<td>9</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>1</td>
<td>40</td>
<td>23</td>
<td>35</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>60</td>
<td>35</td>
<td>40</td>
<td>31</td>
</tr>
<tr>
<td>3</td>
<td>40</td>
<td>23</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>4</td>
<td>16</td>
<td>9</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100</td>
<td>128</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of community support[^2]</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-patient appointment</td>
<td>119</td>
<td>69</td>
<td>89</td>
<td>70</td>
</tr>
<tr>
<td>CPN</td>
<td>103</td>
<td>60</td>
<td>70</td>
<td>55</td>
</tr>
<tr>
<td>SW</td>
<td>39</td>
<td>21</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td>Day services</td>
<td>72</td>
<td>42</td>
<td>42</td>
<td>33</td>
</tr>
<tr>
<td>Voluntary sector support worker</td>
<td>21</td>
<td>13</td>
<td>25</td>
<td>20</td>
</tr>
</tbody>
</table>

[^1]: This includes 13 of the readmissions from Time 1 plus 26 new admission episodes
[^2]: Users may be in receipt of more than one service therefore totals are not meaningful
### Table A2.2 Characteristics of the carer sample

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Board of Residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forth Valley</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Fife</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Tayside</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Borders</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>25</td>
<td>43</td>
</tr>
<tr>
<td>Highland</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Western Isles</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>24</td>
<td>41</td>
</tr>
<tr>
<td>female</td>
<td>34</td>
<td>59</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100</td>
</tr>
<tr>
<td><strong>Relationship to User</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner/spouse</td>
<td>28</td>
<td>48</td>
</tr>
<tr>
<td>Parent</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>Son</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sibling</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Other relative</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Friend</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100</td>
</tr>
<tr>
<td><strong>Live at the same address</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>40</td>
<td>69</td>
</tr>
<tr>
<td>no</td>
<td>18</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100</td>
</tr>
<tr>
<td><strong>Length of time in caring role</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>&gt;1-2 years</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>&gt;2-3 years</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>More than 3 years</td>
<td>39</td>
<td>71</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100</td>
</tr>
<tr>
<td><strong>Caring for the whole length of illness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>51</td>
<td>89</td>
</tr>
<tr>
<td>no</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>100</td>
</tr>
<tr>
<td><strong>Type of support given</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help with personal care eg dressing, bathing</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Physical help eg walking, getting out of bed or up and down stairs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Help with paperwork or financial matters</td>
<td>34</td>
<td>59</td>
</tr>
<tr>
<td>Other practical help eg preparing meals, doing shopping, housework</td>
<td>38</td>
<td>66</td>
</tr>
<tr>
<td>Keeping the helped person company</td>
<td>49</td>
<td>84</td>
</tr>
<tr>
<td>Taking the helped person out</td>
<td>37</td>
<td>64</td>
</tr>
<tr>
<td>Giving medicine, including injections</td>
<td>20</td>
<td>34</td>
</tr>
<tr>
<td>Keeping an eye on the helped person to see s/he is alright</td>
<td>58</td>
<td>100</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>33</td>
</tr>
</tbody>
</table>

---

33 3 cases unknown
34 1 case unknown
35 Categories from Parker and Lawton (1994). Carers may be giving more than one type of support therefore totals are not meaningful; percentages are of the 58 carers
ANNEX THREE RESEARCH INSTRUMENTS

INTERVIEW SCHEDULE FOR HEALTH BOARD KEY INFORMANTS

1. Background context
   • What influences their current and future policies?
   • How is discharge defined in terms of acute mental health problems?

2. Priority Setting
   • To what degree is discharge in general an issue for the Board?
   • Where does acute psychiatric discharge fit into this larger picture?
   • How does it figure in relation to acute mental health services in general?
   • Has there been any specific activity around acute discharge in relation to MISG or any other specific monies?
   • Are there any target rates for discharge?
   • How are they set?
   • What is the total budget for mental health services?
   • What percentage (or amount) is spent on acute discharge?

3. Joint Working
   • Are there any sub-groups working on acute discharge specifically?
   • Are there any written protocols/policies developed jointly? (Board/Trusts/GPs)
   • Did you have any joint policies for health and social care needs before the framework document?
     • If so have these changed?
   • If not what steps have been taken to set up joint working around:
     - aims and objectives
     - resource allocation
     - needs assessment
     - service review and profiles
     - access to records

4. Inter-agency working
   • What are the arrangements for collaboration in relation to acute psychiatric discharge?
   • Who takes the lead on CPA?
   • Are there any formal/informal links with primary care and/or housing?
   • Are there any joint information systems?

5. Implementation, monitoring and review.
   • How are discharge policies implemented at Trust level
   • How are they monitored

6. Flexibility for change in shift from institutional to community care.
   • How are resources transferred into community services
   • To what extent has resource transfer created opportunities for acute discharge
   • Does the Board provide training for staff moving from in-patient services to the community.
   • Any future working on discharge planned?
INTERVIEW SCHEDULE FOR LOCAL AUTHORITY KEY INFORMANTS

Roles and structure

1. Could you describe your role at the Council in relation to mental health services?
2. Within your authority is mental health work carried out as part of the generic adult services?
3. Which voluntary organisations provide mental health services in your area?
   3a. What do they provide?
   3b. What proportion of MISG funding goes to the voluntary sector?
4. Apart from MHOs, are there social workers whose role is specifically mental health?
5. Does the local authority provide mental health services through:
   (Record all that apply)
   - hospital attached social workers
   - GP attached social workers
   - mental health resource centres
   - community mental health teams
   - area social work teams
   - out of hours teams
   - multi-disciplinary teams
   - other
6. Where are your MHOs placed within that structure?
   *Probe* Do they only carry out mental health work?
7. In general, what is the role of SW with regard to the discharge of people from hospital?
   *Probe* Are there joint protocols with HBs and Trusts?
8. How would you define acute psychiatric discharge?
9. Where does acute psychiatric discharge fit into the larger picture of discharge?
   *Probe* Are the protocols for general discharge the same for acute psychiatric discharge? If not, in what way is psychiatric discharge different?
10. What responsibilities do social workers have for acute psychiatric discharge?
11. What links are there between hospital based professionals and community based social workers?
12. What responsibilities do hospital attached social workers have for acute psychiatric discharge?

Priority Setting

13. What is the total social work budget for adult services at the Council?
13a. (if known) what percentage (or amount) of that is spent on mental health services?
14. Are there any specialist projects operating for people with acute mental health problems?
   (if yes)
   - are they joint with the Health Board?
   - are they joint with individual trusts/hospitals/units?
   - are they joint with voluntary sector organisations?
   - are they joint with the Housing Department?
   - are they joint with any other agencies?
15. Has there been any activity around acute discharge in relation to Mental Illness Specific Grant?
16. Have resource transfer monies been used at all around acute psychiatric discharge?
   (If yes) in what way?

Joint working at a strategic level

17. Which agency has lead responsibility for the Framework for Mental Health Services document?
18 Did you have any joint policies for health and social care needs (in mental health) before the Framework for Mental Health Services document was circulated?
   (If yes) Have these policies changed since the Framework document was circulated?
   (If yes) In what way have they changed?
19 What steps have been taken to set up joint working around:
   • aims and objectives
   • resource allocation
   • needs assessment
   • service review and profiles
   • access to records?
20 Are there any sub-groups working specifically on acute psychiatric discharge?
21 Are there any written protocols/policies about acute psychiatric discharge?
   (If yes)
   • were they developed jointly with the Health Board?
   • were they developed jointly with individual Trusts/hospitals/units?
   • were they developed jointly with the Housing Department?
   • were they developed jointly with any other agencies?
22 How do councils audit whether policies are being implemented?
22a What is done with the output of the auditing?
23 In what way are the contents of policies disseminated down to the front-line professionals?

Inter-agency working at the operational level

24 How comprehensive would you say local community mental health services are?
   Prompt - extent to which they meet the range of need - equality across localities
25 In what way do you think inter-agency working has impacted on the delivery of mental health services in your area?
   Probe - ask for practical examples
   Prompt - The next 4 questions are about the arrangements for collaboration, at the operational level, in relation to acute psychiatric discharge
26a What formal or informal links are there between social work and primary care?
26b What formal or informal links are there between social work and housing?
26c What formal or informal links are there between social work and voluntary organisations?
26d What formal or informal links are there between social work and the benefits agency?
27 What proportion of people discharged from acute psychiatric wards are referred to social work?
27a What type of cases tend to come to the attention of social work?
   Probe - what factors trigger referral to social work
28 Is social work involvement in these cases more often reactive or more often proactive?
29 Are there any joint information systems used jointly by social work and health staff?
   (If yes)
   Are they effective?
30 Which agency in your area has lead responsibility for the Care Programme Approach?
31 Are people discharged from acute psychiatric wards eligible for the Care Programme Approach?
31a Who in general would operate as the keyworker for someone on CPA?
32 Would individuals discharged from acute psychiatric wards be subject to care management?
32a What does care management involve?
32b Do cases remain open?
32c Is care management a distinct role or is it carried out alongside other tasks?
32d Who in general would act as the care manager for someone on care management?
33 Is there anything else that you would like to add?
INTERVIEW SCHEDULE FOR NHS TRUST AND WARD KEY INFORMANTS

NB Different responses will be probed as appropriate for formal and informal patients

• PRE-ADMISSION

1 Is it your Trust’s (or hospital’s) practice to accept referrals for admission from:

[CHECKLIST]
   a General Practitioners
   b Accident and Emergency Departments
   c Community Psychiatric Nurses
   d Social Workers/ Mental Health Officers
   e Key workers
   f People who self-refer
   g The Police
   h Others

2 Does the Trust (or hospital) encourage the use of or have a formal policy on informed consent, advance directives, living wills etc.?

• ADMISSION EVENT

3 Does the Trust (or hospital) use any type of admission protocol?

4 Could you describe the process of admission to an acute ward?
   
   Probe:
   Who are the main referrers?
   Is there an admission ward?
   Does it have dedicated staff?
   What forms and checklists are used at this stage?
   
   NB, Are any of these procedures different when a person has been formally detained?

5 What written and verbal information (if any) is given to the person being admitted?

6 What happens (if anything) to a person’s home following admission?
   
   Probe: Who secures their home following admission?

7 Who (if anyone) is initially informed of a person’s admission?
   
   Probe:
   Who (if anyone) is responsible for doing this?
   What other agencies and professionals are informed?
   What information is sought from them by hospital staff?
   Is a relative routinely informed?

8 Does the admission procedure differ for someone who is on CPA?

9 What access (if any) is there to advocacy/independent advice?
   
   Probe:
   Name of organisation/s
   Access at what stage?

10 Is the individual given a diagnosis, and if so, by whom?
   
   Probe:
   What explanation is there about it, the consequences, the medication etc.?
   Who would explain this?

11 What strengths and weaknesses do you perceive the Trust’s (or hospital’s) admission process to have?
• DISCHARGE PLANNING

12 At what stage (if any) is an individual assigned a named nurse?
13 Would the named nurse (or staff) provide a specific care plan?
14 At what stage (if at all) does planning for discharge begin?
15 Is a specific discharge plan produced?
16 Is this included in the care plan or is it separate?
17 Who takes responsibility for it?
18 Who would be involved in discharge planning?
   
   Probe:
   Which professionals?
   Would the person’s main carer be involved?

• DISCHARGE PLANNING AND INTER-AGENCY CONTACT

19 At what stage (if at all) is the GP contacted prior to discharge?
20 Whose responsibility is it to contact the GP?
21 How is the GP contacted?
   
   Probe:
   By letter from hospital
   By telephone
   Other
22 Who (if anyone) is responsible for welfare benefits?
   
   Probe:
   What happens when someone requests help with their benefits?
   What happens if someone wants to self-discharge to preserve their benefits?
23 Who (if anyone) is responsible for housing?
   
   Probe: What happens when someone requests help with housing?
24 Could you list any other agencies that hospital staff would contact prior to someone being discharged?

   NB, Are any of these procedures different when a person is on the Care Programme Approach?

• DISCHARGE EVENT

25 Who is involved in the decision as to the date of discharge?
26 Who is accountable for the actual discharge?
27 How much notice is an individual given of their discharge?

   At discharge [CHECKLIST]
28 Is the person’s home prepared for their discharge?
29 Who is responsible for this?
30 Is a forwarding address obtained?
31 Is a contact telephone number obtained?
32 Who is responsible for this?
33 Is the person given a telephone number for crisis or otherwise?
34 Are they given a written follow-up appointment?
35 Is the person given a letter for their GP?
36 How many days’ supply of medication are they given?
37 How much information is supplied about the medication?
38 What transport arrangements (if any) are made?
39 What transport arrangements (if any) are made for hospital follow-up appointments (rural)?
40 What procedures are in place for people who self discharge?
41 What procedures are in place for people being discharged to a different local authority area?
42 What procedures are in place for individuals who miss their hospital follow-up appointments?
   *NB*, Are any of these procedures different when a person is on the Care Programme Approach?
43 What strengths and weaknesses do you perceive the Trust’s (or hospital’s) discharge process to have?

• COMMUNITY FOLLOW-UP

44 Are there any specific liaison arrangements between your Trust (or hospital) and the community? (e.g. Is there a liaison officer?)
45 Who is responsible for the initiation of community follow-up?
   *Probe:*
   For those on Care Programme Approach
   For those not on Care Programme Approach
46 What procedures are in place for individuals who miss their community follow-up appointments?

• CARE PROGRAMME APPROACH

47 Who in your area takes the lead role for the Care Programme Approach?
   *Health Board or Local Authority or both.*
48 What would you consider to be the main aim of the Care Programme Approach?
49 Does your Trust (or hospital) have a designated person to co-ordinate/oversee the Care Programme Approach?
50 What are the criteria for inclusion on the Care Programme Approach in your Trust?
51 What policy and procedure documents does your Trust have that relate specifically to the Care Programme Approach?
52 Who makes the decision to put a person on the Care Programme Approach? Could you describe that process?
   *Probe:*
   What protocols are used?
   Who initiates the first meeting?
   Who would be invited to attend the first meeting?
   When is the key worker allocated?
   What factors indicate that someone requires CPA?
53 What arrangements are in place for monitoring and review of individuals on CPA?
54 Are people who are on CPA regularly invited to attend their review meetings?
   *Are their carers regularly invited to attend? Where do the review meetings take place?*
55 When would someone’s placement on CPA be terminated?
   *Probe:*
   Who would make the decision?
   What protocols are used?
   How would this be done?
Can people withdraw from CPA?

What (if any) systems are in use by professionals for keeping in touch and prompting action?

*Register, Micro-computers, databases, written communication.*

**OTHER ISSUES**

Is the practice of admission and discharge consistent throughout your Trust (or hospital)?

*Probe:*

What variations exist?

Why do they exist?

What are the consequences, for patients, for staff?

How are policy documents, guidelines and protocols produced in your Trust?

*Probe: Committees, working groups etc.*

What form of communication is used to convey the contents of policies and guidelines to the staff that carry them out?

*Probe: In service training, seminars, circulate literature etc.*

How is recent legislation implemented and what in general are the specific problems in implementing it?

How (if at all) do you monitor the implementation of policy procedures?

How (if at all) do you monitor the effectiveness of policy procedures?

Do you have any resources produced by other agencies (e.g. voluntary organisations or user groups) relating to admission/discharge/hospital stay?

Are these resources used?

Any other issues?
INFORMATION LEAFLET FOR POTENTIAL STUDY PARTICIPANTS

Acute Psychiatric Discharge Study

Researchers at Glasgow University are carrying out a project looking at people’s experiences of being discharged from psychiatric hospitals and psychiatric wards in general hospitals across Scotland.

We are interested in people’s experiences both when they have first been discharged and then again several months later. At this stage we are not asking you to be involved in this study but are informing you that you may be asked to take part approximately 6 weeks after you have been discharged. Not everyone who receives this sheet will be asked to take part but your name may be picked at random from a group of people discharged from your ward/hospital.

If you are chosen you will get a letter from us (Clare Armstrong or Lucy Simons) asking you to take part at a time and place convenient to you. The discussion will take about 45 minutes. All discussions will be strictly confidential and will allow you to give us your views about your discharge arrangements. You do not have to take part if you prefer not to and this will not affect any ongoing medical treatment. Please inform the charge nurse if you would prefer not to be included at this stage.

If you have any questions about the project please contact Clare Armstrong or Lucy Simons on 0141 330 3293 or you can write to us at: the Nuffield Centre for Community Care Studies, 7 Lilybank Gardens, Glasgow G12 8RZ.
PARTICIPANT INFORMATION SHEET

HOSPITAL DISCHARGE STUDY

This sheet is to give you further details about the research project we are carrying out into people’s experiences of being discharged from a psychiatric hospital or from a psychiatric bed in a general hospital. We are interested in the arrangements that exist for supporting people during and after discharge from hospital and how this affects the way individuals are able to cope. The project is trying to get a picture of people’s experiences in different parts of the country. It will therefore include individuals from across Scotland. The study is being carried out from the Nuffield Centre for Community Care Studies based at Glasgow University. The results of the research project will help to build up a picture of what works well and where things could be improved.

We are interested in people’s needs and experiences both when they have first been discharged from hospital and again after several months have gone by. With your agreement we would like to interview you on two separate occasions to find out your experiences. The first time will be when you have been out of hospital for about six weeks. The second time will be six months after this discharge from hospital.

The information will be collected by talking to you in your own home (or somewhere else if you would prefer), at a time that is convenient to you. It will probably take about 45 minutes to complete each interview. You can of course choose to stop being involved in the study at any point. All the information and views discussed will be treated as confidential and any information from interviews which is used in reports will be anonymous - no names will be used.

Taking part in this project is entirely voluntary. Neither participating or withdrawing will in any way affect your future care by any service provider. If you have any questions about the project please contact either Lucy Simons, Research Assistant or Professor A Petch at the Nuffield Centre for Community Care Studies, The Gregory Building, 27 Lilybank Gardens, Glasgow G12 8RZ, tel: 0141 330 3293.
INTERVIEW SCHEDULE WITH USERS DISCHARGED FROM HOSPITAL, TIME 1

Confirm details of:
- First admission?
- Type of admission?
- Length of stay?
- Diagnosis?
- Further admissions in the past 6 weeks?
- GP

1. Discharge planning
- notice of discharge?
- enough/too much?
- why?
- family/carers involved in discharge planning?
- time at home before being finally discharged? (on pass)
- if not would you have liked to?
- financial matters (benefits) addressed before being discharged? (immediate financial matters - has the individual got money to survive once discharged).

2. Transport
- mode of transport home?
- adequacy?
- transport to OPAs/ day hospital etc?
- adequacy?

3. Accommodation
- satisfaction with accommodation before admission?
- problems?
  prompt: gas, heating, electricity, generally habitable, neighbours, safety
- resolution of problems?
  prompt: re-housing, have you been asked?
- state of accommodation when you arrived from the hospital
  prompt: cold, damp, clean, water, gas, electricity connected, food, pets

4. Social activities
- attendance at a day centre or any other organised/unorganised activity?
- attendance preadmission. If so were you asked if this was satisfactory or offered anything else?
- If not attending preadmission how did you find out about it?
- satisfaction with the centre attended?
- If not attending now Why, are there any other activities you would like to do but have been unable to, have you been asked if you need assistance to pursue leisure or social activities?

5. Employment
- working preadmission
• working now?
• if unemployed would you like to work and what is stopping you?
• assistance in finding work?
• what sort of help would be beneficial?

6. Continuing care
• OPA on discharge?
  prompt: sent post discharge, written, verbal
• time waited until first OPA?
• given a discharge letter from the hospital to GP or was it sent?
• when did you first see your GP?
• how often after that?
• was that enough?
• do you have a CPN/social worker?
• Type of input and satisfaction?
• contact preadmission?
• if not who contacted them?
• when did you first see them?
  prompt: before discharge or after
• how often after that?
• is that enough
• who would you contact if you felt unwell?
• crisis number?

7. Medication
• tablets or injections?
• were you on these before admission?
• amount of information about your medication and in what form?
• is this enough?
• any side effects?
• were these side effects explained?
• number of days supply of medication on discharge?
• how are subsequent supplies obtained?

8. Care Programme Approach
• included on CPA - if so progress
• understanding of CPA?
• were you involved in the decision to go onto CPA?
• explanation of how?
• who is your keyworker?
• how would you contact them if you needed to?
• how often do you see your keyworker?
• how often do you have review meetings?
• has CPA made a difference to you?
• feelings about being on CPA?

9. Any other comments about discharge experience
INTERVIEW SCHEDULE WITH USERS DISCHARGED FROM HOSPITAL, TIME 2

Preamble - remind of previous visit; before interview pick out salient issues from first interview

case no
date of original interview
date of follow-up interview
interviewer

1. Admissions/Discharge
• I / we last interviewed you in .... Since that interview, have you been back in hospital

  if so, how many times
  when
  for how long
  what led to the admission(s)

  subsequent experiences of discharge
  information
  notice
  family / carer involvement
  preparation
  time on pass
  financial preparations
  transport
  community support

2. Mental Health
• How would you say your mental health has been over the last six months
  any points at which thought might have to go back in to hospital
  what (if anything) assisted at that point

3. Medication
• medication: changes and why

4. Significant issues
• What significant things have happened in your life since we last spoke (good/bad).

5. Accommodation
• Check accommodation situation:
  if moved, triggers and experience
  if problems at first interview, have they been resolved
  any ongoing/subsequent problems

6. Continuing Care
• Have you had ongoing contact with mental health workers
if so, check for each whether domiciliary visit or other, frequency, what each is
offering and satisfaction

CPN
social worker
support worker
GP - specifically for mental health
psychiatrist
specialist counsellor eg psychologist

does one of these operate as a key worker
how long expect to remain in touch with mental health services

7. Social Activities
• Do you have contact with mental health support activities: drop-in / social / day centre

what has been good about that, what bad
if stopped going, why

8. Formal Support
• Overall how do you feel about the amount of formal support you receive

and the quality of that support
• Could you give me an example of a situation where professional support was very important

and how about another occasion where support did not operate so well

9. Informal Support
• Informal support
  contact with family members - any particular support roles
  role of social network in sustaining in the community

• Overall how do you feel about the amount of informal support you receive

and the quality of that support

10. Employment
• Employment - changes since previous interview, satisfaction, assistance

11. CPA
CPA follow-up only relevant if get some at stage 1 or any subsequently placed
12. Statements

Which of the following statements best summarises your experiences of hospital discharge over the last six months

A Whenever I have had to go into hospital my return home has been well planned and careful thought has been given to the support I might need in the community.

B I have had both good and bad experiences of being discharged from hospital and getting support within the community and there is room for improvement.

C I have had very little support when leaving hospital and coming back home; there are several areas in which I would welcome support.

D I was only in hospital once six months ago and have had no contact with mental health services since.
INTERVIEW SCHEDULE WITH CARERS OF USERS DISCHARGED FROM HOSPITAL, TIME 2

Establish relationship to user - and terminology ie is carer ok or better use notion of support.
lives in same place or not
frequency of contact

1. Details of Support

- how long have you been involved in helping x
  establish nature of support that give ie

- what kind of help, if any, do you give to x - do you
  help with personal care eg dressing, bathing
  physical help eg walking, getting in and out of bed or up and down stairs
  help with paperwork or financial matters
  other practical help eg preparing meals, doing shopping, housework
  keeping the helped person company
  taking the helped person out
  giving medicine, including injections
  keeping an eye on the helped person to see that s/he is alright

- would you say you are involved in supporting x
  every day
  two or three times a week
  weekly
  once or twice a week
  less frequently

- are other friends or relatives involved in supporting x
  if you were not available to support x, what would happen

2. Discharge

  most recent discharge - when, were you involved, if so
  contact with x when in hospital
  told of discharge date? how? when?
  discharge discussed with you?
  by individual
  by hospital staff - who?
  involvement in case conference/discharge meeting
  involvement - too much, too little, about right

- in your opinion - discharge at an appropriate stage / too early / too late
  appropriate support offered
  would anything have improved the discharge process
3. Mental Health

- how has x’s mental health been over the last six months

4. Formal Support

- establish services carer aware of x receiving and rate how useful carer perceives them to be for user
- are you involved in these ongoing services (if any) - if so, how, what good about the involvement, what could be improved
- do you think x gets too much / too little/ about right amount of support
- what do you consider to be most useful for him/her
- what do you consider to be least useful for him/her
- what, if anything, like to see changed

5. Support for Carer

- how about support for yourself as the carer
  - do you receive the information you wish about x’s situation and support available
  - do you have contact with any service or group to support you as the carer?
    if so, what, how often, what do you find helpful, less helpful
- what other sources of support, if any, do you have (eg friends, other relatives)
  - what would you like, if anything, by way of support

6. Statements

Ask the carer to look at the carer statements and ask which one they feel applies best to the user.

Which of the following statements best summarises his/her experience of hospital discharge over the last six months

A Whenever he/she has had to go into hospital his/her return home has been well planned and careful thought has been given to the support he/she might need in the community.

B He/she has had both good and bad experiences of being discharged from hospital and getting support within the community and there is room for improvement.

C He/she has had very little support when leaving hospital and coming back home; there are several areas in which he/she would welcome support.

D He/she was only in hospital once six months ago and have had no contact with mental health services since.
INTERVIEW SCHEDULE WITH COMMUNITY KEYWORKERS

Interviews will be conducted at the same time as the completion of a CAN in relation to a specific user (mostly over the telephone).

User number

Keyworker type
1= CPN, 2= SW

Health Board
A=Ayrshire and Arran, B=Borders, C=Glasgow, D=Highland, E=Fife, F=Forth Valley, G=Tayside, H=Western Isles

Section A: general

1.1 What contact, if any, do you normally have with hospital wards over admissions and discharge?
Check how long it takes to receive written information about a patient after discharge
if no contact go to sub-section 2
1.2 What form does the contact take?
prompt:- method, frequency, at whose initiative
1.3 What does the contact generally relate to?
1.4 In what way is it of benefit?
1.5 In what ways could it be improved?

2.1 Do you have contact with other professionals in relation to hospital discharge?
if no go to sub-section 3
Prompt: other professionals involved in a case
♦ When and how does this come about?
♦ what ways could it be improved? ****

3.1 Do you have contact with informal carers in relation to hospital discharge?
If no go to sub-section 4
3.2 When and how does this come about?
3.3 In what way is it of benefit?
3.4 In what ways could it be improved?

4.1 What do you think are the most important factors around hospital discharge?
4.2 What needs to be done to get these right?
4.3 If a patient was discharged from hospital today, how long would it be before you were able to see him/her?

Section B: specific

In relation to x (and possible y if more than one)

1.1 When did you become involved in this case?
1.2 Were you involved when x was discharged from hospital?

2.1 Was there contact between you and the hospital?
if no go to question 2.6
2.2 Who did you have contact with?
2.3 How was this initiated?
2.4 Did this assist you in supporting x?
2.5 What could have been improved?
   go to sub-section 3
2.6 Would this have been of benefit? (Only if answered no to question 2.1)
   If no go to question
2.7 Why?
2.8 When would you have liked contact?
2.9 With whom?
2.10 How should it be arranged?
   go to sub-section 3 ****
   Explain (only if answered no the question 2.7)
3.1 Was there contact between yourself and other community-based professionals around the discharge of x?
   If no go to question 3.6
3.2 Who did you have contact with?
3.3 How was this initiated?
3.4 Did this assist you in supporting x?
3.5 What could have been improved?
   go to subsection 4
3.6 Would this have been of benefit? (only if answered no to question 3.1)
   If no go to question 3.11
3.7 Why?
3.8 When would you have liked contact?
3.9 With whom?
3.10 How should it be arranged?
   go to sub-section 4
   ♦ Explain (only if answered no to question 3.6)
4.1 Was there contact between yourself and any informal carers around the discharge of x?
   If no go to question 4.6
4.2 Who did you have contact with?
4.3 How was this initiated?
4.4 Did this assist you in supporting x?
4.5 What could have been improved?
   go to subsection 5
4.6 Would this have been of benefit? (Only if answered no to question 4.1)
   If no go to question 4.11
4.7 Why?
4.8 When would you have liked contact?
4.9 With whom?
4.10 How should it be arranged?
   go to sub-section 5
4.11 Explain (only if answered no to question 4.6)

5.1 Are there any ways in which the discharge arrangements for x could have been improved?

6.1 Any other comments?
POSTAL SURVEY WITH CONSULTANT PSYCHIATRISTS

DISCHARGE OF ACUTE PSYCHIATRIC PATIENTS

1. Do you have current consultant responsibility for acute in-patients aged between 16 and 65?
   - Yes [ ]
   - No [ ]

If the answer to the above is NO, then please do not complete the rest of the questionnaire but please return the uncompleted form in the envelope provided.

2. Is there an existing discharge policy for acute psychiatric patients in your Trust?
   - Yes [ ]
   - No [ ]
   - Don’t Know [ ]

3. If yes, do you use it?
   - Yes [ ]
   - No [ ]
   - Don’t Know [ ]

4. If NO or DK, would you like one to be developed?
   - Yes [ ]
   - No [ ]
   - Don’t Know [ ]

5. If yes, what would the benefits be?

6. How much notice of discharge do you give to acute patients?
   - Percentage of patients
     - <25% [ ]
     - ~50% [ ]
     - >75% [ ]
   - 1-3 days [ ]
   - 1 week [ ]
   - more than 1 week [ ]
7 How many patients, on average, do you discharge each week?

8 What percentage of acute discharges include the involvement of a
   social worker  <25%  ~50%  >50%
   CPN
   advocacy worker
   voluntary agency

9 Are there any problems involving the above in the discharge of acute patients?
   If so, please give examples

10 How many acute patients do you have on the Care Programme Approach at present?

11 Do you believe these patients have benefited from CPA?
   Yes  No  Don’t Know

12 If YES, in what way?

Thank you very much for your time. Please return the form in the enclosed envelope.