A Mixed Method Approach Investigating The “Revolving Door” Patient With Severe Mental Health Problems

By

Efpraxia Rameshwar, RMN, BSc (Hons), PGCEA, MSc

Submitted for the Degree of Doctor of Philosophy (PhD)

European Institute of Health and Medical Sciences, University of Surrey

September 2004

© Efpraxia Rameshwar 2004
ABSTRACT

This research study investigates the “revolving door” (RD) phenomenon, from a string of data gathered through a series of six quantitative and qualitative studies within four phases; examining the relationships, associations and differences between the demographic and clinical characteristics of patients with three or more readmissions over a period of 24 months (RD patients) and a comparison group of patients with one or two admissions (Non-RD patients) during the same period; it also examines the costs of inpatient care and explores the views, perspectives and perceptions of patients and named nurses regarding the quality of care. The research study introduces a theoretical framework, developed by the current researcher, comprising of four dimensions; the Individual- the Social- the Organisational- the Professional, known as the ISOP multi-dimensional framework. The framework utilising theoretical suppositions, offers a theoretical explanation of the RD phenomenon.

The research consists of six separate but interlinked studies within four phases utilizing an integrated mixed method approach (triangulation) of quantitative and qualitative designs. Data are gathered from various sources including; the Trust computerized patient administration system (phase I), face to face semi-structured interviews with (a) patients and (b) staff (phase II), patients’ nursing and medical records (phase III) and focus group interviews with (a) patients and (b) staff (phase IV). Analysis of data utilizes quantitative and qualitative techniques.

The analysis of the computerized data shows a range of 3 to 9 re-admissions over a period of 24 months for the RD group. There is a higher proportion of RD female patients (n=172) to RD male patients (n=113). RD male patients are the youngest
group with a mean age of 33.96 years. There are higher proportions of patients with a diagnosis of affective disorders, then schizophrenia followed by personality disorder in both RD and Non-RD groups. However, there are higher numbers of RD female patients diagnosed with personality disorder. Overall, there are more RD patients who are single. RD patients tend to stay longer (Mean=42.48 days) in inpatient facilities than Non-RD patients (Mean=37.22 days) and tend to receive more out patient appointments (mean=11.16) and day care places (Mean=89.82) than Non-RD patients (Mean=7.97, out patients and Mean=61 day care places).

The face to face interview indicates that RD patients are more dissatisfied with their inpatient care, their involvement in their care plan, the information they receive and their discharge plan, than Non-RD patients. The investigation of patients’ records shows lack of patient involvement in their care plans, lack of advice given to them on discharge, poor pre-discharge assessment of patients needs, and lack of relapse plans. The focus group interviews reveal that both patients and staff perceive pre-discharge preparation to be inadequate; patients believe they need more intensive support in the community and attribute social isolation, lack of friendships and lack of significant others as influencing factors to their relapse and hospital re-admission.

The current study identifies a number of variables associated with the relapse and patient readmission. Through the ISOP multi-dimensional framework it offers a deeper understanding of the factors involved and adds significantly to the comprehensives of the RD phenomenon; it furthers the development of the theoretical framework and provides additional evidence contributing to the body of knowledge regarding the “revolving door” patient".
ACKNOWLEDGEMENTS

I wish to thank my supervisors Professor Karen Bryan and Professor Ian Robbins for their guidance, encouragement, support and valuable comments and contributions to this study.

I would like to express my gratitude to my husband for encouraging and urging me to continue with the study when on many occasions I became disillusioned, frustrated and totally bored.

I also convey my appreciation to the Trust IT Department for extracting the data from the Trust Administration System.

I extend my thanks to the Trust Finance Department for their help with the financial figures and costs.

Last but not least, I wish to thank all the subjects (patients and staff) who willingly participated in the study offering their experiences and views and hence adding a more realistic and comprehensive picture to the overall results.
LIST OF TABLES

Phase I: Computerised Data
Table 1: RD Status and Gender 106
Table 2: Mean Age and Gender of Sample 107
Table 3: Diagnosis, Gender and RD Status 109
Table 4: Marital Status, RD Status and Gender 110
Table 5: RD Status, Mean Number of Admissions and Gender 112
Table 6: Diagnosis and Mean Number of Admissions 113
Table 7: Mean Number of LOS and Diagnosis 114
Table 8: CPA Level and Diagnosis 116
Table 9: Day Care Places and Diagnosis 120
Table 10: Summary of Key findings 121

Phase I: Cost Analysis of Inpatient Care
Table 1: LOS of RD and Non-RD Patients 124
Table 2: Admission Status and Duration of Stay of RD and Non-RD Patients 124
Table 3: Costs of Inpatients in Site A 125
Table 4: Costs of Inpatients in Site B 126
Table 5: Annual In-patient Budget (2002/03) 126

Phase II: Exploratory Face to Face Interview with Patients
Table 1: Patient Age, Gender, MHA, Ethnicity, Marital Status 138
Table 2: Gender, Employment, Living Circumstances, Diagnosis
Table 3: RD and Non-RD Patients Reason for Admission
Table 4: RD and Non-RD Patients' Compliance with Medication
Table 5: RD and Non-RD Patients Rate of the Ward Environment
Table 6: Satisfaction with DP and Willingness to Return to the Same Ward
Table 7: Summary of Key Findings

Phase III: Review of Patients Medical and Nursing Records
Table 1: Patients Discharge Plan Assessment
Table 2: Patient Pre-Discharge Assessment
Table 3: Aftercare and Support arrangements
Table 4: Information Given to Patients' on Discharge
Table 5: Summary of Key Findings

LIST OF GRAPHS

Phase I: Computerised Data
Graph 1: Diagnosis and RD Status
Graph 2: Marital Status
Graph 3: Number of Admissions
Graph 4: RD Status and CPA
Graph 5: RD/Non-RD Status and Legal Status
Graph 6: Mean Number of OPA, Gender and RD Status
Graph 7: Diagnosis and Mean Number of Out Patients' Appointments
Graph 8: Day Care Attendance, Gender and RD Status

Phase II: Exploratory Face to Face Interview with Patients
Graph 1: RD and Non-RD Patients Degree of Expectations with Care
## LISTS OF DIAGRAMS

<table>
<thead>
<tr>
<th>Category</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Theoretical Framework and the Literature Review</strong></td>
<td></td>
</tr>
<tr>
<td>Diagram 1: The ISOP Multi-dimensional Theoretical Framework</td>
<td>13, 15</td>
</tr>
<tr>
<td><strong>The Methodology of Individual Studies</strong></td>
<td></td>
</tr>
<tr>
<td>Diagram 1: The Six Studies within the Four Phases of the Research</td>
<td>98, 99</td>
</tr>
<tr>
<td><strong>Discussion of the Findings</strong></td>
<td></td>
</tr>
<tr>
<td>Diagram 1: The Four Phases and Six Studies of the Research</td>
<td>194, 195</td>
</tr>
<tr>
<td>Diagram 2: The ISOP Multi-Dimensional Theoretical Framework</td>
<td>196, 235</td>
</tr>
<tr>
<td>Diagram 3: The Modified Multi-Dimensional Theoretical Framework</td>
<td>237</td>
</tr>
<tr>
<td>Diagram 4: A Holistic and Interactive Process of Managing High Risk Patients</td>
<td></td>
</tr>
</tbody>
</table>

## LIST OF FLOW CHARTS

<table>
<thead>
<tr>
<th>Category</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Overall Research Plan and the Research Methodology</strong></td>
<td></td>
</tr>
<tr>
<td>Flow Chart 1: The Research Plan/Research Process</td>
<td>73, 74</td>
</tr>
<tr>
<td>Flow Chart 2: The Methodology Framework</td>
<td>81</td>
</tr>
<tr>
<td><strong>The Methodology of Individual Studies</strong></td>
<td></td>
</tr>
<tr>
<td>Flow Chart 1: The two Sites of the Trust, Including Daily Cost of Inpatients</td>
<td>98, 123</td>
</tr>
</tbody>
</table>

## CONTENTS

### CHAPTER ONE

1.1. INTRODUCTION/ BACKGROUND

1.2. The Scope of the Research Study 2
1.3. The Rationale of the Study 3
1.3.1. The National Context of the RD Phenomenon 3
1.3.2. National (Organisational/Bed Occupancy) Issues 6
1.3.3. Professional and Clinical Issues 8  
1.3.4. Costs Issues (National) 11  
1.3.5. Summary of Key Issues 12

CHAPTER TWO 13

2.1. THE THEORETICAL FRAMEWORK AND THE LITERATURE REVIEW 13

2.1.1. Introduction of the ISOP Multi-dimensional Theoretical Framework 13  
2.2. The Four Dimensions and Elements of the Framework 16  
2.2.1. The Individual Dimension and its Elements 16  
2.2.2. The Social Dimension and its Elements 18  
2.2.3. The Organizational Dimension and its Elements 21  
2.2.4. The Professional Dimension and its Elements 23  
2.2.5. Conclusions 26

2.3. THE LITERATURE REVIEW 28  
2.3.1. Introduction 28  
2.3.2. Search Strategy for Identification of Studies 28

2.4. The Individual Dimension 29

2.4.1. Definitions of the "Revolving Door" and Perceptions of Being Ill 29  
2.4.2. Demographic Characteristics as Predictors of Patient Re-admissions 31  
2.4.3. Clinical Characteristics as Predictors of Patient Re-admissions 32  
2.4.4. Patients Compliance with Medication and Pharmacological Interventions 37  
2.4.5. Life Style of Drug and Alcohol Misuse as Predictors of Patient Readmission 41

2.5. The Social Dimension 42  
2.5.1. Social Support as a Contributory Factor to Patient Relapse 42  
2.5.2. The Role of the Family in the Care of RD Patients 43  
2.5.3. Social Networks/ Friendships as Buffers Against Relapse 45  
2.5.4. Marital and Employment Status as Provision of Social Support 46  
2.5.5. Stigma as a Prelude to Patient Readmission 47
2.6.  The Organizational Dimension
2.6.1.  Inpatient Admission as a Required Option Treatment for the Revolving Door Patient
2.6.2.  Length of Stay (LOS) in Inpatient Facilities as a Predictor of Patient Readmission
2.6.3.  Community Care (Assertive Community Treatment Outreach Service, Early Intervention) and Patient Readmission
2.6.4.  Out Patient Appointments, Day Care Places, Residential and Non-residential Treatment as Follow-up Arrangements
2.6.5.  Service Models and Treatment Programmes for Revolving Door Patients
2.6.6.  Costs of Care of the Revolving Door Patient

2.7.  The Professional Dimension
2.7.1.  Nurses Role and Nursing Interventions in Care Planning
2.7.2.  Nurses Role in the Discharge Planning Process
2.7.3.  Discharge Planning as Preventative Measure to Patients Relapse
2.7.4.  Family/Carer Involvement in Discharge Planning
2.7.5.  Nurse/Patient Relationships
2.8.  Limitations of the Literature

CHAPTER THREE
3.1  THE OVERALL RESEARCH PLAN AND THE METHODOLOGY

3.1.1.  Introduction
3.2.  The Research Plan and the Research Process
3.2.2.  Submission to the Ethics Committee
3.2.3.  Identification Of RD and Non-RD Patients
3.2.4.  Transfer of Data from Excel into SPSS
3.2.5.  Agree Procedure for Notification of Patients Discharge
3.2.6.  Conduct of Exploratory Face to Face Interview with Patients
3.2.7.  Conduct Face to Face Interview with Named Nurses
3.2.8.  Review of Patients' Medical and Nursing Records
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.9. Conduct Focus Group Interview with Patients</td>
<td>79</td>
</tr>
<tr>
<td>3.2.10. Conduct Focus Group Interviews with Nurses</td>
<td>79</td>
</tr>
<tr>
<td>3.2.11. Extracting and Synthesizing Data from all Studies</td>
<td>79</td>
</tr>
<tr>
<td>3.3. Practical Issues During the Research Process</td>
<td>79</td>
</tr>
<tr>
<td>3.4. THE METHODOLOGY FRAMEWORK</td>
<td>81</td>
</tr>
<tr>
<td>3.5. Overall Aim of the Research Study</td>
<td>82</td>
</tr>
<tr>
<td>3.5.1. Overall Objectives of the Research Study</td>
<td>82</td>
</tr>
<tr>
<td>3.6. Primary Questions</td>
<td>82</td>
</tr>
<tr>
<td>3.7. Secondary Questions</td>
<td>83</td>
</tr>
<tr>
<td>3.8. Overall Principles and Theoretical Perspectives</td>
<td>83</td>
</tr>
<tr>
<td>(Research Paradigms)</td>
<td></td>
</tr>
<tr>
<td>3.9. Summary of Features of Positivist and Naturalist Research</td>
<td>87</td>
</tr>
<tr>
<td>3.10. Overall Research Design and Rationale</td>
<td>88</td>
</tr>
<tr>
<td>(A Mixed Approach-Triangulation)</td>
<td></td>
</tr>
<tr>
<td>3.11. Methodological Rigour</td>
<td>89</td>
</tr>
<tr>
<td>3.12. The Sampling Process</td>
<td>91</td>
</tr>
<tr>
<td>3.13. The Research Setting</td>
<td>93</td>
</tr>
<tr>
<td>3.14. Ethical Issues</td>
<td>94</td>
</tr>
<tr>
<td>CHAPTER FOUR</td>
<td>98</td>
</tr>
<tr>
<td>4.1. THE METHODOLOGY, DATA COLLECTION ANALYSIS AND FINDINGS OF THE INDIVIDUAL STUDIES</td>
<td>98</td>
</tr>
<tr>
<td>4.1.1. Introduction</td>
<td>98</td>
</tr>
<tr>
<td>4.2. Phase I: Computerised Data and Data Analysis</td>
<td>100</td>
</tr>
<tr>
<td>4.2.1. The Aim of the Study</td>
<td>100</td>
</tr>
<tr>
<td>4.2.2. The Objectives of the Study</td>
<td>100</td>
</tr>
<tr>
<td>4.2.3. The Study Design and Rationale</td>
<td>102</td>
</tr>
<tr>
<td>4.3. The Study Population</td>
<td>102</td>
</tr>
<tr>
<td>4.3.1. (A) RD Patients</td>
<td>102</td>
</tr>
<tr>
<td>4.3.2. (B) Non-RD Patients</td>
<td>102</td>
</tr>
<tr>
<td>4.4. Description of the Tools Used</td>
<td>102</td>
</tr>
<tr>
<td>4.4.1. Reliability and Validity of the Computerised Data System</td>
<td>103</td>
</tr>
</tbody>
</table>
4.5. The Analysis

4.6. THE FINDINGS
4.6.1. Demographic Variables
4.6.2. Age of the Sample
4.6.3. Marital Status
4.6.4. Frequency of Re-admissions
4.6.5. Marital Status and Readmission
4.6.6. Length of Stay (LOS) in Hospital
4.6.7. The Care Program Approach
4.6.8. Legal Status of Patients
4.6.9. Out Patient Appointments and RD Status
4.6.10. Day Care Attendances

4.7. COST ANALYSIS OF INPATIENT CARE
4.7.1. Inpatient Costs for RD and Non-RD Patients
   (April 2000-April 2002)
4.7.2. Calculation of Costs

4.8. PHASE II: EXPLORATORY FACE TO FACE
   SEMI-STRUCTURED INTERVIEW WITH PATIENTS (STUDY (A))
4.8.1. Introduction
4.8.2. The Aim of the Study
4.8.3. The Objectives of the Study
4.8.4. The Study Design and Rationale
4.8.5. The Sample
4.8.6. The Interview Process
4.8.7. Rationale for the Development of Semi-structured
   Interview Schedules
4.8.8. Description of the Tools Used (Patient Semi-structured
   Interview Schedule (IS) - Appendix 1)
4.9. The Process of Developing the Interview Schedules
4.9.1. Selecting Items for Inclusion
4.9.2. Designing the Individual Questions
4.9.3. Designing the Layout and Presentation of Questions
4.9.4. Composing the Wording
4.9.5. Coding the Responses of the Questionnaires
4.9.6 Reviewing and Finalising the Interview Schedules
4.9.7 Reliability and Validity of the Interview Schedules
4.10. The Analysis

4.11. THE FINDINGS
4.11.1. Demographic Characteristics
4.11.2. Number of Re-admissions (RD Patients)
4.11.3. Inpatient Care Items (Patient Involvement in Their Care Plan/Co-Ordination of Their Care)
4.11.4. Patient's Relationship with Their Named Nurse
4.11.5. Access to Treatment/Therapies
4.11.6. Advice/Information on Medication, Treatment, Illness, Services
4.11.7. Patients' Expectations, Needs and Satisfaction With Care Received
4.11.8. Aspects of Care Appreciated Most
4.11.9. Aspects of Care Appreciated Least
4.11.10. Patients' Discharge Care Plan
4.11.11. Participation in Discharge Programs In Preparation For Discharge
4.11.12. Social Networks and Support

4.12. Phase II: Face to Face Interviews with Named Nurses (b)
4.12.1. Introduction
4.12.2. The Aim of the Study
4.12.3. The Objectives of the Study
4.12.4. The Study Design
4.12.5. The Sample
4.12.6. Description of the Tools Used
(Nurses' Semi-structured Interview Schedule (IS) Appendix 2)
4.12.7. The Interviews
4.13. The Analysis

4.14. THE FINDINGS
4.14.1. Description of Participants
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.14.2. Contributory Factors To Patients Relapse And Readmission</td>
<td>154</td>
</tr>
<tr>
<td>4.14.3. Patient Admission</td>
<td>155</td>
</tr>
<tr>
<td>4.14.4. Nurses Opinions about Standards of Care/Co-ordination of Care,</td>
<td>155</td>
</tr>
<tr>
<td>Patient Inpatient Involvement</td>
<td></td>
</tr>
<tr>
<td>4.14.5. Nurse Patient Relationship</td>
<td>156</td>
</tr>
<tr>
<td>4.14.6. Access to Psychological Treatments/Therapies</td>
<td>156</td>
</tr>
<tr>
<td>4.14.7. Information Items</td>
<td>156</td>
</tr>
<tr>
<td>4.14.10. Patients' Compliance with Treatment/Medication</td>
<td>157</td>
</tr>
<tr>
<td>4.14.11. Patients' Discharge Preparation and Plan</td>
<td>157</td>
</tr>
<tr>
<td>4.14.12. Nurses Willingness to be Admitted Into The Same Unit</td>
<td>158</td>
</tr>
<tr>
<td>4.15. Summary Of Key Findings</td>
<td>158</td>
</tr>
<tr>
<td>4.16. Phase III: Patients Medical and Nursing Records</td>
<td>160</td>
</tr>
<tr>
<td>4.16.1. Introduction</td>
<td>160</td>
</tr>
<tr>
<td>4.16.2. The Aim of the Study</td>
<td>160</td>
</tr>
<tr>
<td>4.16.3. The Objectives of the Study</td>
<td>160</td>
</tr>
<tr>
<td>4.16.4. The Study Design and Rationale</td>
<td>161</td>
</tr>
<tr>
<td>4.16.5. The Sample</td>
<td>162</td>
</tr>
<tr>
<td>4.16.6. Description of the Tools Used (Pro-forma)</td>
<td>162</td>
</tr>
<tr>
<td>4.16.7. Reliability and Validity of Patients Records</td>
<td>163</td>
</tr>
<tr>
<td>4.16.8. The Analysis</td>
<td>164</td>
</tr>
<tr>
<td>4.17. THE FINDINGS</td>
<td>164</td>
</tr>
<tr>
<td>4.17.1. Discharge Plan and Assessment</td>
<td>164</td>
</tr>
<tr>
<td>4.18. Further Observations Relevant To Patients Records</td>
<td>167</td>
</tr>
<tr>
<td>4.18.1. Risk Assessment</td>
<td>167</td>
</tr>
<tr>
<td>4.18.2. Patient Assessments</td>
<td>167</td>
</tr>
<tr>
<td>4.18.3. Care Plan</td>
<td>167</td>
</tr>
<tr>
<td>4.18.4. Evaluation Form and Progress Notes</td>
<td>168</td>
</tr>
<tr>
<td>4.19. PHASE IV: FOCUS GROUP INTERVIEW WITH PATIENTS (A)</td>
<td>170</td>
</tr>
<tr>
<td>4.19.1. Introduction</td>
<td>170</td>
</tr>
<tr>
<td>4.19.2. The Aim of the Study</td>
<td>170</td>
</tr>
<tr>
<td>4.19.3. The Objectives of the Study</td>
<td>170</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>4.19.4. The Study Design and Rationale</td>
<td>171</td>
</tr>
<tr>
<td>4.20. The Sample</td>
<td>172</td>
</tr>
<tr>
<td>4.21. The Tools Used to Collect the Data (Interview Schedule Appendix 6)</td>
<td>172</td>
</tr>
<tr>
<td>4.22. The Interview</td>
<td>173</td>
</tr>
<tr>
<td>4.23. Reliability and Validity of Focus Group Interviews</td>
<td>173</td>
</tr>
<tr>
<td>4.24. The Analysis</td>
<td>174</td>
</tr>
<tr>
<td>4.25. THE FINDINGS</td>
<td>176</td>
</tr>
<tr>
<td>4.25.1. Emerging Themes</td>
<td>176</td>
</tr>
<tr>
<td>4.25.2. Discharge Interventions</td>
<td>176</td>
</tr>
<tr>
<td>4.25.3. Nurse/Patient Relationship</td>
<td>177</td>
</tr>
<tr>
<td>4.25.4. Purpose and Meaningfulness</td>
<td>179</td>
</tr>
<tr>
<td>4.25.5. Social Isolation</td>
<td>179</td>
</tr>
<tr>
<td>4.25.6. Stigma/labelling</td>
<td>180</td>
</tr>
<tr>
<td>4.25.7. Struggling for Control</td>
<td>181</td>
</tr>
<tr>
<td>4.26. Summary of Key Findings</td>
<td>183</td>
</tr>
<tr>
<td>4.27. PHASE IV: FOCUS GROUP INTERVIEW WITH STAFF (B)</td>
<td>184</td>
</tr>
<tr>
<td>4.27.1. Introduction</td>
<td>184</td>
</tr>
<tr>
<td>4.27.2. The Aim of the Study</td>
<td>184</td>
</tr>
<tr>
<td>4.27.3. The Objectives of the Study</td>
<td>184</td>
</tr>
<tr>
<td>4.27.4. The Sample</td>
<td>184</td>
</tr>
<tr>
<td>4.28. The Interview</td>
<td>185</td>
</tr>
<tr>
<td>4.29. Description of the Tools (Interview Schedule -Appendix 7)</td>
<td>186</td>
</tr>
<tr>
<td>4.30. THE FINDINGS</td>
<td>187</td>
</tr>
<tr>
<td>4.30.1. Themes</td>
<td>187</td>
</tr>
<tr>
<td>4.30.2. Reasons for Relapse and Re-admission (Legitimate and illegitimate)</td>
<td>187</td>
</tr>
<tr>
<td>4.30.3. Staff Perceptions and Feelings Regarding Patients Re-admissions</td>
<td>189</td>
</tr>
<tr>
<td>4.30.4. Community Support and Resources</td>
<td>191</td>
</tr>
<tr>
<td>4.30.5. Professional Practice</td>
<td>191</td>
</tr>
<tr>
<td>4.30.6. Summary of Key Findings</td>
<td>193</td>
</tr>
</tbody>
</table>
CHAPTER FIVE

5.1. DISCUSSION OF THE FINDINGS

5.1.1 Introduction

5.1.2 The ISOP Multi-dimensional Theoretical Framework

5.2. THE DISCUSSION

5.2.1. The Individual Dimension

5.2.2. Definitions of the "Revolving Door" (RD) Term and Perceptions of Being Ill

5.2.3. Demographic Characteristics as Predictors for Patient Readmission (Gender and Age)

5.2.4. Clinical Characteristics as Predictors of Patient Readmission

5.2.5. Compliance with Medication

5.2.6. Life Style of Drug/Alcohol Misuse

5.3. The Social Dimension

5.3.1. Social Networks and Friendships as Buffers Against Relapse

5.3.2. The Role of the Family in the Care of RD Patients

5.3.3. Marital and Employment Status as Provision of Social Support

5.3.4. Stigma as a Prelude to Patient Re-admission

5.4. The Organisational Dimension

5.4.1. Re-admission as a Required Option Treatment for the Revolving Door Patient

5.4.2. Length of Stay (LOS) in Inpatient Facilities as a Predictor of Patient Re-admission

5.4.3. Cost of Inpatient Care

5.4.4. Quality of Care in the Inpatient Setting

5.4.5. Community Care and Patient Readmission

5.4.6. Out Patients Appointments/Day Care Places

5.5. The Professional Dimension

5.5.1. Nurses Role in the Discharge Planning and the Care Programme Approach (CPA)
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5.2. Nurse Patient Relationships</td>
<td>229</td>
</tr>
<tr>
<td>5.5.3. Struggling for Power and Control</td>
<td>230</td>
</tr>
<tr>
<td>5.5.4. Information/Advice Received</td>
<td>232</td>
</tr>
<tr>
<td>5.6. “Fittingness” of the ISOP Multi-dimensional Theoretical Framework</td>
<td>233</td>
</tr>
<tr>
<td>5.7. The Theoretical and Practical Implications of the Research</td>
<td>236</td>
</tr>
<tr>
<td>Viewed Through the Modified Framework</td>
<td></td>
</tr>
<tr>
<td>5.8. Assessment and Planning</td>
<td>237</td>
</tr>
<tr>
<td>5.8.1. Risk Assessment tool</td>
<td>237</td>
</tr>
<tr>
<td>5.8.2. Care Protocols, Policies, Strategies</td>
<td>238</td>
</tr>
<tr>
<td>5.8.3. Developing a Specific Data Base for Monitoring the RD Patient</td>
<td>238</td>
</tr>
<tr>
<td>5.8.4. Community Care</td>
<td>239</td>
</tr>
<tr>
<td>5.9. Discharge Planning</td>
<td>239</td>
</tr>
<tr>
<td>5.9.1. Pre-discharge Planning</td>
<td>239</td>
</tr>
<tr>
<td>5.9.2. The Discharge Plan Must be Comprehensive</td>
<td>240</td>
</tr>
<tr>
<td>5.9.3. The Discharge Plan Must be Consistent</td>
<td>241</td>
</tr>
<tr>
<td>5.9.4. The Discharge Plan Must be Enforceable</td>
<td>241</td>
</tr>
<tr>
<td>5.10. Education</td>
<td>242</td>
</tr>
<tr>
<td>5.10.1. Quality of Care</td>
<td>242</td>
</tr>
<tr>
<td>5.10.2. Education and Awareness of Nurses of the RD Phenomenon</td>
<td>242</td>
</tr>
<tr>
<td>5.10.3. Patient Education</td>
<td>243</td>
</tr>
<tr>
<td>5.10.4. Public Education and Raising Awareness</td>
<td>244</td>
</tr>
<tr>
<td>5.11. Advocacy</td>
<td>245</td>
</tr>
<tr>
<td>5.11.1. Establishing networks within various community agencies</td>
<td>245</td>
</tr>
<tr>
<td>5.11.2. Community Living Skills Training</td>
<td>246</td>
</tr>
<tr>
<td>5.12. Limitations of the Study and Suggestions for Further Research</td>
<td>247</td>
</tr>
<tr>
<td>5.13. Strengths of the Current Research Study</td>
<td>249</td>
</tr>
<tr>
<td>5.14. Contribution of the Current Study to the Body of Knowledge</td>
<td>250</td>
</tr>
<tr>
<td><strong>CHAPTER SIX</strong></td>
<td></td>
</tr>
<tr>
<td><strong>6.1. SUMMARY AND CONCLUSIONS</strong></td>
<td>252</td>
</tr>
<tr>
<td><strong>APPENDICES</strong></td>
<td></td>
</tr>
<tr>
<td>Appendix 1</td>
<td>255</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>259</td>
</tr>
<tr>
<td>Appendix</td>
<td>Page</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>262</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>263</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>264</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>265</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>268</td>
</tr>
</tbody>
</table>

REFERENCES 271
1.1. INTRODUCTION AND BACKGROUND

The problem of the "revolving door" patient warrants considerable research interest as a distinct phenomenon separate from the factors which cause patients' relapse. The literature refers to people with multiple readmissions as "revolving door" patients or "recidivists". These are people with severe mental illness who go back and forth between acute inpatient units and the community. The "revolving door" phenomenon was first described in the 1960s in association with the process of de-institutionalisation of psychiatric patients. To politicians revolving door patients pose significant problems with resources and bed utilisation (Shepherd et al 1997, Fakhoury and Priebe 2002); to service providers they cause major concerns regarding care, treatment and costs (Geller 1993, Semke and Hanig 1995). Equally to the service users themselves and their carers frequent psychiatric hospital admissions constitute a profound disruption to patients' life; stressful situations, alienation and exclusion from social situations, loneliness, unemployment and poverty, stigma and discrimination (Kammerling and O'Connor 1993, Britten 1998).

This research study investigates the association between the frequency of psychiatric hospital readmissions and the characteristics of people with severe mental illness, known as "revolving door" patients. It seeks to contribute to a theoretical understanding of the RD phenomenon by proposing a multi-dimensional theoretical framework which might help to explain the factors contributing to patients relapse and the reasons for repeated hospitalisations.
It identifies models of care/interventions that may help to reduce the pattern of repeated hospital admissions.

The literature review revealed no standardised definitions of patients with frequent readmissions and therefore to avoid pointless debate on the subject, the Trust definition of “revolving door” where the current study is carried out of “Adult psychiatric patients age 17 plus years with three or more admissions within a period of 24 months” will be used throughout this research. For the purpose of the study the definition excludes patients with a primary diagnosis of substance misuse and dementia. These people have been excluded as they are a distinct group presenting with a diverse set of psycho-social problems, and the course of their illness, treatment, care and management are different from patients with severe mental health problems included in the research.

The DOH (1994b) in their report of Psychiatric Nursing condemns community care for its failure to provide adequate care for psychiatric patients particularly those with repeated and frequent inpatient admissions. More recent reports such as the National Service Framework (DOH 1999), the NHS Plan (DOH 2000) and the Mental Health Policy for Adult Inpatient Care (DOH 2002) stipulate that improvements need to be made in the care of the severely mentally ill. Adult Inpatient Services need to change and advance and Community Assertive Teams need to be established, shifting the focus of mental health care from hospitals to the community.

1.2. The Scope of the Research Study

This study investigates the “revolving door” phenomenon, from a string of data gathered through a sequence of six quantitative and qualitative studies within four phases of the
research process; it examines the relationships, associations and differences between the demographic and clinical characteristics and compares the views, perspectives and perceptions of revolving door (RD) patients with a comparison group known as non-revolving door (Non-RD, patients with one or two admissions during a period of 24 months). The research study introduces a theoretical framework, developed by the current researcher, comprising of four dimensions; the Individual- the Social- the Organisational- and the Professional, known as the ISOP multi-dimensional theoretical framework. Through this framework the RD phenomenon can be explained using theoretical suppositions.

1.3. The Rationale of the Study

1.3.1. The National Context of the RD Phenomenon

Since the introduction of anti-psychotic drugs in the 1950s there has been an emphasis to run down large psychiatric hospitals and develop community services. To date the closure of these hospitals has largely been accomplished; during the last 10-15 years, England entered a new phase of community care (Johnson et al 2001). A number of developments in community mental health orientated treatment programs including the introduction of assertive community treatment, service management models (such as case and care management, assertive outreach and the introduction and implementation of the Care Programme Approach -CPA) are now in progress.

However, despite these developments in recent years community care for the severely mentally ill received a great deal of scrutiny and criticism from politicians and managers due to a number of high profile inquiries of homicides such as those of Christopher
Clunis and Andrew Robinson (DOH 1994a, Woodley Team Report 1995). Indeed, opponents of community care indicate increase in homelessness, random and motiveless acts of violence and aggression, incidents of suicide and self harm, and cases of neglect and unacceptable standards of care in residential homes concerning people with mental health problems (Harrison et al. 1995).

Sederer et al. (1995) indicate that despite the great advances in psychiatry, a significant proportion of patients will have several episodes of severe mental illness. Many individuals will only accomplish partial recovery and therefore will require several hospitalisations during the course of their illness. Indeed, as Sullivan et al. (1995) argue, for people with chronic exacerbating illness such as resistant schizophrenia and those patients with multiple diagnoses and complex behavioural problems, including patients with substance misuse and personality disorders, hospital readmissions may be unavoidable. According to Leff et al. (1995) an estimated half a million psychiatric patients from the UK and USA live in the community. The probability of relapse and hospitalisation of some of these patients is very high. Indeed, a review of findings of several controlled studies by Weiden and Olfson (1995) suggests that relapse rates may be as high as 75% after one year and 87% after two years of discharge for patients with a diagnosis of schizophrenia.

The focus of community care is to provide health and social care for people with a wide range of mental health and social problems, away from traditional inpatient settings in their own homes or in a "homely environment" (Nocon and Qureshi 1996). Care in the community is provided by a wide variety of agencies including health and social services, voluntary and private sectors. For effective care there needs to be co-ordination and adequate community support and services. The amount of resources
however required to meet the health care demand, according to the Audit Commission (1986) and Harrison et al (1995) is often insufficient. The White paper (DOH 1998) "Modernising Mental Health Services, Safe Sound and Supportive" suggests that community care has failed for a small but significant number of people even though many benefited from community services. The lack of co-ordination and communication between the agencies providing support and facilities has a significant impact on patient repeated hospitalisations, their outcomes and quality of life (The Health of the Nation, Building Bridges DOH 1989). Indeed, Marchall et al (1996) argue that the health status of some mentally ill deteriorates thus hospital admission rates increase due to the failure of timely intervention and lack of appropriateness of care by the caring agencies; Furthermore, a high proportion of mentally ill patients due to the pervasive nature of their illness (Sullivan et al 1995), non compliance with medication and treatment, substance misuse problems, and missed appointments (Higgins et al 1999), loose contact with the caring services and therefore readmission may become inevitable.

Ward et al (1998) argue that community care has developed to the detriment of inpatient care. But even with the recognition that patients with mental health problems are becoming much more difficult to manage, in comparison with community settings, inpatient services have been neglected. Furthermore, many experienced and skilled staff are attracted into the community setting and there is little developmental support or educational opportunities directed towards inpatient services (Ward et al 1998). Indeed, in the Trust where the current study is undertaken shortage of regular and trained staff and the absence of relevant training (such as cognitive behaviour therapy, relapse prevention programmes, counselling skills etc.), particularly amongst nursing staff is an issue of continuous discontentment.
1.3.2. National and Organisational Bed Occupancy Issues

The programme of closing large psychiatric hospitals and the provision of acute inpatient services in smaller district general hospitals caused grounds for concern about the adequacy and utilization of acute beds (Tyrer et al 1989). Research on acute bed usage suggests that a frequently re-admitted small group of patients use a disproportionate amount of inpatient services, which has now become a major national problem (Lelliot et al 1994, Sederer 1995). Indeed, according to Appleby et al (1993) and Mojtabai et al (1997) although the movement of de-institutionalisation decreased the length of stay in hospital facilities the readmission rate of patients with mental health problems has increased significantly. The reduction of beds has been achieved in part by reducing the length of stay in hospital. But Appleby et al (1993) stipulate that the reduction in length of stay has caused shorter discharge and readmission intervals amongst patients with schizophrenia. A study by McLean and Leibowitz (1990) in an inner London hospital revealed that 60% of admissions to its acute beds were re-admissions of patients with long term mental health problems. Thus short frequent admissions seem to be the common pattern of hospital care for the severely mentally ill people (Marshall 1999).

The inappropriate use of acute beds and their location together with a shortage of 24-hour services in the community resulted in many patients being constantly readmitted into inpatient facilities. Indeed, continued re-hospitalisation has an important implication for inpatient treatment, support and follow up in the community of the severely mentally ill (Sederer 1995). The current research study is in line with the national targets and programme deemed to be priorities for investigation in the field of mental health. The national programme of Research and Development (Policy Research Programme DoH 1998), the National Service Framework (DOH 1999), the NHS Plan (DoH 2000) and the
Mental Health Policy for Adult Inpatient Care (DoH 2002) identify the improvement of adult inpatient services and community care of the severely mentally ill as key target areas in Mental Health. Thus the study is pertinent to clinical and managerial implications concerning patients, staff and the organisations. The study intends to provide information that may be useful for the development of policy and future planning of safe, appropriate and effective services. The strategic direction of the Trust and the key objectives of the business plan are set in the context of the national agenda and as indicated by national research these objectives are imbedded in the development of acute and Assertive Outreach services, having major implications on the use of acute beds and hence the care and management of the “revolving door” patient (Hirch 1988, Royal College of Psychiatrists 1988, Lelliott et al 1994, Strathdee 1996).

A local trust audit, on the length of stay of patients admitted to the acute inpatient wards, by the researcher and the medical director revealed that out of 25 patients with protracted lengths of stay (stay over 90 days) 72% had between 3-10 previous re-admissions. A following audit on the use of acute psychiatric beds in the trust revealed a significant problem with revolving door patients. 66 (8%) out of 851 completed episodes met the Trust definition criteria (three + admissions over a period of two years) however 31 (3%) of those patients had a primary diagnosis of substance misuse. These patients were also found to have longer lengths of stay than patients with only one or two admissions thus having a significant impact in bed management. Although the recommendation for bed occupancy by the then HA, (also the national recommendation) was 90% the trust's bed occupancy was around 100-110%. A national 3 year study by Higgin's et al (1999) of 11 acute inpatient sites in various areas in England including inner London, reported similar findings with this Trust regarding bed occupancy; they
found that nine sites had bed occupancies above 85%; one of which was 153%, and four sites had 100% occupancies. This is an ongoing dilemma which has major implications on nurses' and other staff's workload, patient and staffs' safety, and the effectiveness of treatment programmes and interventions.

1.3.3. Professional and Clinical Issues

Service failure to provide effective care for the revolving door patient and their frequent relapse and re-admission into acute inpatient wards pose significant professional and clinical challenges for practitioners' specifically medical and nursing staff (Ward et al 1998, Marchall 1999). The lack of resources and co-ordination of services both in hospital and community settings has led to insufficient and inappropriate care for these patients. Furthermore, difficulties with recruiting and retaining skilled and trained staff have left the services struggling to cope with high service demands (DOH, Modernising Mental Health Services 1998).

The severity of patients' illness and the treatment and care of these people in acute inpatient psychiatric services pose further complications. In Higgins et al (1999) study, the inner London sites reported particular difficulties in the management of mix case patients as the majority were severely mentally ill especially with schizophrenia (51%), highly dependent (12%), compulsory detained (47%) or being closely observed (30%). A significant proportion of readmissions were emergency 25%-33% across sites and 50% in inner London. The emergency admissions were increasingly associated with drug and alcohol problems particularly in young men among 18-25 years old. The national picture reflects a similar pattern in the Trust where the current research is undertaken; regarding the severity of diagnosis, mix of patients, the significant number of
patients under close observations on a daily basis and the pattern of emergency admissions coming through the Accident and Emergency department.

Nationally, the acute inpatient services are under constant pressure regarding high bed occupancies, increase of staff shortages, and staffing levels having to be complemented with agency staff. As a consequence, the principles of “therapeutic community” and safe delivery of care are difficult to operate in practice; placing patients at risk and nurses and doctors providing treatment of low frequency and duration thus putting them at risk of malpractice (DOH 1998, Johnson et al 2001). Indeed, the Audit Commission (1994) the Mental Health Act Commission (1995) NHS Executive (1996) and the Modernising Mental Health Services White Paper (1998) query the suitability of acute inpatients services as a safe and therapeutic environment.

A spot check observation on interactions of 309 mental health units across England and Wales by the Sainsbury Trust/MHA Commission (1998) found very little interaction between nurses and patients. In 25% of the units visited, the observers found no interaction at all and in 32% only one nurse was interacting with patients. In a previous study Airdoos (1991) observed and documented 158 transactions between psychiatric nurses and their patients over a five month period and suggests that nurses consider nursing care plans to be time consuming they are not liked by everyone, and they are not used rigorously by all professional nurses. The author comments that the effectiveness of the care plans had not been investigated and had not been demonstrated. The author further examined whether nursing care plans existed and whether they had been followed by comparing them with the transactions. In general nurses did not follow care plans even though they thought they had. These findings are substantiated by a local snapshot audit examining nursing documentation in the acute
inpatient services of the trust. The audit revealed a number of weaknesses in the recording of information in various areas such as; incomplete care plans, incomplete risk assessments, gaps in the Care Programme Approach (CPA) reviews and inadequate discharge planning. It could be argued that these findings are a reasonable reflection of the day to day practice at ward level about acute inpatient care; in that delivery of health care sometimes relies on previous experience, intuition and local practice. Glazer and Ereshefsky (1996) argue that poor discharge planning leads to poor co-ordination of care and the lack of accurate and complete documentation leads to poor multi-professional and inter-agency communication. Hence, the way the medical and nursing professions operate, the organisation of patient care and the ward environment needs to be explored further.

The current study aims to provide an accurate profiling of the revolving door patient and contribute to the accumulation of evidence about patients who are at risk of future relapse. This information might be useful for health care professionals and managers when planning care and appropriate interventions including discharge care plans for these patients. Continuous feedback will facilitate the monitoring of progress for patients with long term mental health problems and may prevent repeated hospitalisation and if the patients are readmitted their length of stay may be reduced. Nurses may feel less frustrated with repeated admissions and more satisfied with their jobs.

From local data and the literature review the study aims to highlight effective clinical interventions and make recommendations, in the care and management of the revolving door patient, training of nurses in areas such as risk assessment, relapse-prevention strategies and care planning. Clearly nurses’ training is central to the provision of care for the revolving door patient and therefore the necessity to explore these issues further
whilst making recommendations for “best practice” will have a significant impact on the role of the named nurse as the primary care co-ordinator. Hence a co-ordinated and systematic approach to patient care might increase patient and staff satisfaction and might reduce the patient readmission rate.

1.3.4. Costs Issues-National

Whilst patients quality of life is the primary concern of health care practitioners cost effectiveness and efficiency is equally high on the agenda of managers and policy makers regarding policy and planning processes (Beecham et al 1996). National research on aggregate expenditure indicates that approximately £2 billion is spent, with 90% on NHS and 10% on social services departments on adult mental health services in the UK (District Audit Report 1995). In 1998 the government pledged an extra £700 million, aiming to give people with mental health problems a full range of “safe, sound and supportive” services to help them to live in the community (DOH 1998). In the USA the estimated aggregate annual cost of patients with schizophrenia was $19 billion in 1995 (Weiden and Olfson 1995).

Therefore the cost of re-hospitalisation for multiple re-admissions places a high economic burden on the distribution and allocation of resources. Indeed, according to Rabinowitz et al (1995) the “revolving- door” (RD) patient not only is the most difficult to treat but also the most expensive for the mental health care system. Direct costs are easier to calculate including for example inpatient care, outpatient care, day care, treatments/therapies, community care and medication. Whereas, indirect costs such as loss of productivity, emotional and psychological burdens, stress, stigma and discrimination are very difficult to estimate. A study by Creed et al (1997) compared
costs of day hospital and inpatient treatment of patients with a diagnosis of schizophrenia over a period of 12 months. They found that direct costs were greater for inpatient care although indirect costs were greater for day patients. Indeed, Johnstone and Zolese (1999) report that inpatient care makes up around 80% of the mental health resource costs. However, despite the care in the community policy much of the NHS money is tied up in hospital provision. The current study undertakes a cost analysis to be utilised by managers of the Trust.

1.3.5. Summary of Key Issues

- Increase rate of relapse and re-admission of RD patients into inpatient services since the deinstitutionalisation policies
- Failure of services (community and inpatient settings) in the treatment and care of the severely mentally ill
- Insufficient and inappropriate clinical care of RD patients placing them at risk of relapse and re-admission
- Increase in bed occupancy and increase in LOS of RD patients (bed blocking)
- Increase in workload for clinicians placing them at risk of malpractice
- Lack of training and education of inpatient care staff
- Increased difficulties in recruitment and retention of trained staff
- Severity of diagnoses and illness of RD patients
- High costs of RD patient care
2.1. THE THEORETICAL FRAMEWORK AND THE LITERATURE REVIEW

2.1.1. Introduction of the ISOP Multi-dimensional Theoretical Framework

This section proposes a multi-dimensional theoretical framework developed by the current researcher. The framework, underpinned by the various factors related to the RD phenomenon from previous studies, has been developed concurrently with the reviewing of the literature. There is no existing theory in the literature that explains the "revolving door" concept. Consequently, the framework draws from various suppositions regarding the profile, the characteristics of RD patients and reasons of their frequent re-admissions and aims to provide an integrated theoretical foundation for the understanding of the RD phenomenon.


The different factors described in various research papers were explored and utilized by the current researcher under four interrelated dimensions- the Individual, the Social, the Organisational and the Professional- to construct the ISOP multi-
dimensional theoretical framework as shown in diagram 1. Each dimension consists of diverse elements. The Individual dimension covers the elements of individuals' perceptions about their own illness, the definitions of the term “revolving door”, demographic and clinical characteristics of patients illness, medication and non-compliance with medication and the use of illicit drugs/alcohol; the Social dimension includes the elements of social support systems within the family, friends and social networks and marital and employment status; it also covers the attitudes of society members (stigma) towards mental illness; the Organisational dimension encompasses elements of the quality of treatment and various operational service models within and outside the hospital setting and the costs of mental illness; the Professional dimension is concerned with the quality of care provided by professionals (nurses), discharge planning and nurse patient relationships. The framework, through each dimension and the interrelation between them, attempts to provide theoretical explanations and enhance theoretical understanding regarding the revolving door phenomenon.
Diagram 1. The ISOP Multi-dimensional Theoretical Framework

The Investigation

The RD phenomenon

The Dimensions

The Individual

Definitions
Perceptions of being ill
Demographics
Predictors of readmission
Compliance
Life style

The Social

Social support
Role of the family
Social networks
Marital and employment status
Stigma

The Organisational

Inpatient admission
Length of stay
Community care
Patient readmission
Out patient appointments
Service models and treatments
Costa of care

The Professional

Nurses Role
Nursing Interventions
Nurses Role in the Discharge Planning Process
Discharge Planning as Preventative Measure
Family/Carer involvement
Nurse/Patient Relationships
2.2. The Four Dimensions and Elements of the Framework

2.2.1. The Individual Dimension and its Elements

Getting inside the experience of the individual may be a key to understanding patients' encounters with health and illness and their need for hospitalisation. The concepts of health, illness and sickness have been studied by various medical sociologists. The World Health Organisation (WHO) defines health as "a state of complete physical mental and social well being and not merely the absence of disease or infirmity". Mental health problems however, are viewed differently from physiological sickness; very often, they are perceived as personal attributes rather than disease. According to Christopoulos (2001) in the field of medical sociology whilst "disease" describes the biomedical changes in health, "illness" refers to the subjective-personal experience of disease. Radley (1994) argues that effectively, disease refers to the psycho-physiological changes in the body, something that doctors diagnose and treat; for example heart disease or diabetes. Illness on the other hand can be taken to mean the experience of the disease including the physiological, psychological and emotional changes occurring and the consequences for the individual of having to live with the disease, as in the experience of mental illness such as schizophrenia or depression.

Jones (1991) explains that there are individuals and groups whose behaviour is not culturally or socially of what is expected in every section of society. Those peoples' behaviour is considered deviant or odd by others. Deviance is explained by the labelling theory, as a process whereby an individual or group is successfully defined or labelled as deviant by others and the label becomes part of their identity. Mental illness is a very good example of deviant behaviour. According to Scheff (1966) labelling a person as mentally ill, it spurs the individual to grasp on to the notion and play the role of the mentally ill; the label becoming part of the person's self-concept,
often because such individuals have sustained stereotyped behaviours associated
with mental illness. Once the individual adopts and undertakes the label and role of
the mentally ill, such as in the case of psychiatric revolving door patients, it is very
difficult due to social forces to return to their "normal" role. Hence, in accordance
with this perspective the personal experience of illness of people with long-term
severe mental health problems may influence their needs and expectations for
frequent hospital re-admissions. Parsons (1952), Scheff (1966) and Radley (1994)
argue that playing the stereotyped role of mentally ill the individual may be admitted
into hospital; taken care of and allowing the individual to remove themselves from
everyday responsibilities, stresses and demands.

Within the Individual dimension frequent re-hospitalisation is also associated with the
demographic differences of patients, such as age (usually younger age) and gender
(mostly male) (Haywood et al 1995, Sanguinetti et al 1996). Other researchers
explain the RD phenomenon as a function of patients’ symptoms related to their
diagnosis for example schizophrenia and psychotic disorders, affective disorders,
and personality disorders (Green 1988, Grossman et al 1993). Furthermore, other
studies attribute the lifestyle and attitudes of individuals towards treatment; for
example alcohol and drug misuse (Sullivan et al 1995, Haywood et al 1995, Higgins
et al 1999), and failure to comply with treatment and medication (Swett 1995, Price

Within the individual dimension various studies defining or assigning a label of
"revolving door" and examining the demographic and clinical characteristics of
revolving door patients are reviewed; in order to enhance understanding between the
relationships of the variables and the prediction of frequent re-admissions; the review
also takes into account several research papers investigating patient compliance with
medication and their lifestyle of drug and alcohol misuse.
2.2.2. The Social Dimension and its Elements

Christopoulos (2001) asserts that being ill affects one's role in society. Sickness is defined as a social condition applying to individuals deemed by others to be ill or diseased. This role is justified in society as long as the sick person complies with the culturally determined parameters of being ill. For example, accepting medical treatment and trying to regain health as quickly as possible. Society then endorses such sickness and supports individuals to resume control and return to their normal responsibilities (Radley 1994). However, society's behaviour towards others is based on what one knows or thinks about the individuals; whilst it legitimises the sick role where is deemed justified, it shuns individuals who appear to feign sickness or abuse the sick role by straining social resources for their own secondary gains (Christopoulos 2001).

It is argued that societal influences can trigger clinical symptoms such as misdirected aggressive tendencies, depression, and psychotic symptoms (Alarcon et al 1999). It is possible that whilst some societies may be able to prevent directly or indirectly, others could encourage the manifestation of some psychiatric disorders. Thus, the manifestation of some mental illnesses could be culturally determined.

Recent health policy aims to shift the burden of care of mentally ill people away from traditional hospitals towards the community (DOH 1998). Indeed, it is argued that society has a moral and ethical responsibility for its sick and disabled citizens (Carpenter 1999). However as Marshall (1996) argues even though community care has helped many who should not have been in institutions there was a failure of the government to recognise that for many the institution provided a place of sanctuary. Indeed, many researchers believe that repeated hospital admissions of psychiatric patients are a product of societal problems resulting from the 1960s de-institutionalisation policies, as little consideration was given to the humanness,
effectiveness of treatment and quality of life of discharged individuals (Geller 1993, Fakhoury et al 2002). It has been suggested that in some cases patients are discharged without any preparation or co-ordination of care across agencies, resulting in individuals loosing contact with services, becoming socially isolated, homeless, or ending up in forensic secure units and prisons (Glazer et al 1996).

There is a general agreement of a positive correlation between physical and mental health and strong social support; hence, inclusion and meaningfulness, relationships and friendships which the RD patients sustain within the social groups they live in and belong have a distinct bearing on the maintenance of their well being and their full integration in the community (Davidson et al 2001). Previous research (Brewin et al 1991) has demonstrated that certain interactions between members of the society and patients can either improve or worsen their mental health. Studies focusing on the concept of expressed emotion (EE) stipulate that the social environment created by the family of patients with schizophrenia is classified by either high or low EE. EE is characterised by three principle elements; criticism, hostility and emotional over-involvement. Living with families who are rated as high EE has been identified as a risk factor of relapse for patients with a diagnosis of schizophrenia (Leff and Vaughn 1985). Increasingly attention has been invested into the significant importance of social support systems in the patients’ community as they can provide richness to relationships and enhance their quality of life (Beels 1981) or if the family is described as having ‘expressed emotion’ this may indeed prove to have a detrimental effect on the patient (Brown et al 1972).

Within the Social dimension research further suggests that patients who are single, unemployed and living alone are disproportionately heavy repeat users of the mental health services. Researchers stipulate that the association between socio-economic (including marital and employment) status and admission to hospital for mental illness has been acknowledged for the past 50 years (Kammerling et al 1993,
Postrado et al 1995). Studies indicate that between 61% and 73% of people with severe mental health problems are unemployed despite of many wanting to work (Society Guardian 2001). However, most people with severe mental illness are unable to work in the present job market. Only few employers are prepared to provide support to these individuals (Repper et al 1998). As a result of long term unemployment individuals with mental health problems are further isolated by poverty.

Stigma surrounding people with severe mental illness is another element within the social dimension. Because society does not understand and accepts the behaviour of people with mental health problems it alienates them and excludes them from social situations, avoids living near them, working with them, socialising with them; very often causing long term problems for the individuals; indeed, exclusion from social situations, living alone and loneliness, or living in overcrowded conditions, discrimination and stigma is associated with higher rates of psychiatric illness (Thornicroft 1991). Goffman (1963) perceived stigma as a deeply discrediting attribute established through the interaction between the individual and society. Mental health problems according to Goffman's theory are discreditable; that is individuals can hide their mental health problems from society; however, the symptoms of severe mental illness and frequent hospitalisations and visits to psychiatric outpatients are visible to the world. Therefore they become discredited and stigmatised by society. People who are discredited through social interaction, they internalised society's attitudes about them with the consequences of self-derogation, self-hate, suspiciousness, depression, hostility, anxiety, defensiveness, and bewilderment. Price (1996) supports Goffman's views arguing that when patients encounter a prolonged problem and having to rely on others for care and support their definition of self-esteem may be re-aligned; their patterns of social engagement, social networks, friendships, their behaviour and relationships with
others and how they cope with their experience of illness changes. Hence deeper understanding and acceptance of their illness and behaviour and strong social support may significantly improve the quality of life of severely mentally ill people and reduce their need for frequent re-admission.

Society assumes responsibility for the severely mentally ill people through the family, friends, social networks and social support systems and by accepting the individual through the reduction of stigma and discrimination. Hence, within the Social dimension, social factors such as family relationships, employment, marital status, friendships, social networks and stigma and the associations between these variables and frequency of re-admissions are reviewed.

2.2.3. The Organisational Dimension and its Elements

Over the past 50 years the concept of de-institutionalisation and decentralisation has been the major driving force in psychiatric care all over the western world (Heggestad 2001). The large psychiatric hospitals have gradually closed and replaced by small inpatient units with a small number of beds attached to district general hospitals. At the same time the concept of community care has emerged and developed and new mental health policies have been introduced continually encompassing new service and management models; such as case management and assertive outreach treatment, early intervention treatment, and the care programme approach (CPA) (Johnson et al 2001). It has been estimated that assertive community care reduces the demand for hospital beds (Tyrer et al 1998). Indeed mental health policy in many countries favours community care including home treatment, out patients, day care, and rehabilitation. Hence, the longer term support systems on which people with mental health problems depended upon they now form a complex interrelated network of health, social, voluntary and other informal services (Flannigan et al 1994).
However, inadequate funding and resources to carry out the de-institutionalisation policy and the rapid reduction of hospital beds remain a public concern (Shepherd et al 1997). Wells (1992), Appleby et al (1993) and Marshall et al (1997) argue that the closure of many state psychiatric hospitals has led to a substantial increase in admissions of the chronic severely mentally ill. The bed occupancies of many acute psychiatric units are very often between 100%-120% (the national recommended level is 90%), used particularly by difficult to manage patients with severe mental illness (Marshall 1996, Shepherd 1998). Indeed, several studies demonstrate high rates of inpatient services utilisation; a small group of individuals use a disproportionate amount of these services, and the rate of repeat users is increasing steadily accounting for 20-32% of the total admissions (Axelrod et al 1989, Semke and Hanig 1995, Leff 1995, Weiden et al 1995). Accumulating evidence both from research and local reports shows that the needs of this relatively small but significant group of people are not being adequately met (NHSE 1996) in hospital or in the community settings.

According to Glazer et al (1996), fragmented unmanaged and uncoordinated systems of care delivery may contribute to the high relapse and readmission rates of patients. Nonetheless, in line with these transformations, the development and implementation of the National Service Framework for Mental Health (DoH 1999) and the National Health Service Plan (DoH 2000) seek to support changes and new developments, and reduce variations in services. An integrated service underpinned by the CPA with a range of facilities extending from acute inpatient services to community, concentrating on the needs of these people is highly recommended (Audit Commission 1994).

Appleby et al (1993) argue that in part the reduction in hospital beds has been achieved through the shortening of the length of inpatient stay. In their review the authors found that the median stay dropped from 35 days in 1970 to 14 days by
1986; albeit such a brief stay may be consistent with the de-institutionalisation policies this cannot be generalised to all patient groups. Although community care may change the pattern of hospital admission to shorter durations a degree of inpatient care is likely to remain an integral part of psychiatric provision (Johnstone and Zolese 1998). Therefore, it is important to determine the effect of different inpatient lengths of stay and consider the costs of care. It is argued that hospitalisation is a frequent and high cost consequence of severe mental illness (Fenton et al 1998). Knapp et al (2002) found cost variations related to age, gender and length of stay, although costs are reported to be generally the same or even less for discharged patients living in the community. Some research suggests that outpatient and day care services are more humane and cost effective provided their treatment capacity is increased (Appleby et al 1993).

Within the Organisational dimension the patients’ experiences of inpatient care, the various models of care such as community care including out patients, day care services, case management and assertive outreach treatment and care costs, are reviewed.

2.2.4. The Professional Dimension and its Elements

When the individual becomes ill, they depend on other people for care and support. Their normal requirements and expectations go beyond their own coping strategies, family and social support, with almost everyone needing health care from more than one profession. Parkin (1995) argues that the current state of flux in the NHS has resulted with several multi-professional groups working together in teams and common understanding and goals collaboration and participation within the professions has proliferated. Indeed, there is a change of shift from multi-disciplinary care, (based on the premise that health care is delivered by members from different disciplines with different skills working within a team) to inter-professional care. A
team characterised by trust, tolerance, the need of dynamic interaction amongst professionals (Headrick et al 1998) and a willingness to share responsibility thus blurring professional boundaries. Reflected in the current thinking of the new NHS, (The NHS Plan DOH 2000), it attempts to overcome the professional divide by bringing the professions together in greater mutual knowledge and understanding, through inter-professional training and education. Also with a growing emphasis of involving patients and carers, so that challenging professional opinion is now normal rather than deviant (Nolan 1995, Headrick et al 1998, DOH 2000).

Although the diversity and complexity of the health care environment and the importance of inter-professional input to the care of RD patients is fully acknowledged, within the scope of this research (Phase II and Phase IV) the focus subscribes to the role of nurses, the nurse/patient relationships and the perception and involvement of patients with their discharge planning. As nurses, provide the bulk of the workforce and are at the centre of providing care (Jones 1991).

The review of mental health nursing (DOH 1994) emphasises the importance of psychotherapeutic approaches such as counselling and the nurses’ key role in the planning, co-ordination and delivery of patient care, with nursing care planning, although according to Higgins et al (1999) the report neglects to address the nurses changing work-loads. However, according to Gourney et al (1995) and Glazer et al (1996) there are no guidelines on best practice hence the delivery of health care relies on previous experience and local practice. Hurst (2000) argues that the slow development of therapeutic nursing is a consequence of several factors; a) the prominence of the medical model in nurse education and the importance given to signs and symptoms of patients illness, b) the diversity of patients mental health problems and the complexity of their needs, c) the changing relationships between nurses and patients, d) and the increase in administrative duties and paper work undertaken by nurses.
Health care delivery involves relationships between professionals (nurses) and patients. Though these relationships are based on power and knowledge, influencing the way patients respond to treatment (Carr-Hill 1995). Indeed, according to Wicks (1998) there is a division between professionals and their clients based on knowledge, power and authority. Therapeutic relationships should be based on mutual trust and respect, participation and commitment and should be carried out within a caring nurturing environment that encourages open communication, honesty, and genuineness. However, previous research indicates that patients have fleeting relationships with their named nurses who spend most of their time in the office, answering telephone calls and engaging in administrative duties (Higgins et al. 1999, Hurst 2000). Within the concept of power, conflict can arise about the way decisions are made and about who makes the decisions. According to (Cahill 1998) although some nurses may support the concept of patient empowerment their socialisation to their role as “expert practitioners” may be so deeply ingrained that they maintain patient participation as an extension of their power base rather than as a collaborative venture. Hence, Sines (1994) emphasises the importance of nurses relinquishing power to patients, arguing that patients know best of what changes need to be made.

The development of a centralised and co-ordinated discharge care plan is another major concern within the Professional dimension of the model. Yet many health care services experience difficulties with discharge planning. Statutory requirements (Shepherd 1998) designed to reduce lengths of stay combined with internal cost containment have increased the pressure on early discharge leaving patients in many instances inadequately prepared. Consequently, inappropriate and insufficient discharge planning often results in patients’ readmission. On the other hand delayed discharge causes burdens on patients themselves, being labelled “bed blockers”, (Strathdee 1996) as well as straining the funds of the inpatient services whose
resources can better be used on acutely ill patients. Encouraging and involving patients in their care is central to the improvement of the quality of health care; a view endorsed by the government (DOH, NHS Plan 2000) making it more compulsory rather than discretionary. This dimension incorporates the elements of nurse/patient relationships, discharge planning, patient and carer involvement in the care plan, and effective treatment programmes.

2.2.5. Conclusions

The development and introduction of the multi-dimensional theoretical framework might help to reasonably explain the “Revolving Door” phenomenon and provide some answers towards the prevention of patient re-admission. Breaking the cycle of re-admissions requires the concerted efforts of the government, the health and social care organisations, the professionals and service users and their families working together in partnership. Four dimensions, the Individual-Social-Organisational and Professional make up the ISOP theoretical framework; each dimension containing various elements that link and sometimes overlap with each other.

Within the Individual dimension the elements reviewed are around the concept of how individuals perceive their illness, the definitions of revolving door, and the demographic and clinical characteristics, of the RD patient. The Social dimension incorporates the contributory factors to patient relapse, including social support, friendships and networks, and attitudes towards mental illness (stigma); the Organisational dimension looks at the impact of the various systems and service models of care, including inpatient and outpatient care, assertive community treatment and case management; the Professional dimension examines the nurse patient relationships, and clinical practices within the professions, including discharge planning.
Utilizing the ISOP theoretical framework the researcher was able to highlight several factors under one umbrella, exploring and explaining the reasons for the relapse and re-admissions of the revolving door psychiatric patients in an integrated approach.
2.3. THE LITERATURE REVIEW

2.3.1. Introduction

The literature was reviewed concurrently with the development of the ISOP multidimensional theoretical framework. This review is intended to include relevant and new research publications. The purpose is to identify gaps in current knowledge, to build on existing knowledge and ideas, to make comparisons and identify opposing views, to identify information and ideas that may be relevant to the current study and to increase theoretical understanding of the subject area of the "revolving door" phenomenon.

An extensive review of the literature revealed few British studies regarding the RD phenomenon and related issues such as operational definitions, reasons for relapse and readmission, nursing care and management and effective treatment programmes. The literature is also notable in its lack of studies on properly controlled evaluation models of nursing care and management including inpatient and community facilities (Ward et al 1998). Hence, the current review considers studies from an international perspective and covers the years from 1970-2004. For the most part any literature prior to this period is not included.

2.3.2. Search Strategy for Identification of Studies

The objectives of the search were to identify relevant studies in the following areas:

- Definitions of "revolving door" patient
- Predictive factors and characteristics of the revolving door patient
- Contributory factors to patient relapse (including, individual, social, organisational and professional)
- Nursing interventions/dischARGE planning
• Issues regarding discharge care planning
• Family involvement in discharge planning
• Community studies (Assertive Outreach and Case management studies)
• Treatment and care programmes for the revolving door

The following electronic databases were searched for relevant literature through the Ovid library accessible to the researcher through an ID code and password via the internet. Ovid library gave the researcher access to MEDLINE, CINAHL, Cochrane library, PsycInfo, Ovid Journals and EBM review data bases. In addition, the researcher obtained further relevant articles using the various journal references quoted by other authors. Manual searches were also conducted at the trust’s library examining journals such as the BMJ, JAN, Issues in Mental Health Nursing, Hospital and Community Psychiatry and Psychiatric Services.

The review is concerned with studies using different methodological approaches including Randomised Control Trial (RCT) examining care programmes for the revolving door patient, designed to reduce the chances of relapse and inpatient readmission after discharge.

2.4. The Individual Dimension

2.4.1. Definitions of the “Revolving Door” and Perceptions of Being Ill

There is no consensus in the definition or the criteria used by various authors in defining the revolving door patient. Some prefer not to define the term at all, whilst others use a more precise definition. Indeed, the bulk of literature on patients who use psychiatric inpatient services repeatedly, do not specify the number of admissions over a period of time or the duration of admissions. Some authors propose definitions covering “patients with many hospital admissions of brief
duration. These definitions though, hardly seem to be agreeable, as they offer no clear-cut distinctions between chronic and RD patients. Indeed, the definition of RD varies from one research paper to another; however, it is usually based on the number of previous hospitalisations within a given time limit.

Glazer et al (1996) define RD as those patients who had two relapses or re-hospitalisations within one year. Clearly, within the parameter of this definition the probability of relapse and re-hospitalisation is very high. Woogh (1986) suggests that any patient with four or more admissions should be classified as RD. The authors however, recommend no time limit in this definition. Tomasson et al (1998) on the other hand, offer a more precise definition by suggesting at least four admissions within 30 months. Kastrup (1987) and Rabinowitz et al (1995), define RD patients as those with four or more admissions with less than 2.5 years in between consecutive admissions. In a longitudinal random sample study of 2220 patients Rabinowitz et al, found almost an identical pattern of relationships between predictors of two or more, three or more and the RD group with four or more admissions. Also, these same variables predicted almost equally as well for each group.

Regarding the RD concept, the literature suggests that there is no consistent definition of patients with frequent readmissions. Most authors refer to them as “revolving door” whilst some refer to them as “recidivists” or “frequent repeaters” of psychiatric services, varying in the number of readmissions and the interval period they occur. Albeit, those terms are used interchangeably by many researchers. Nevertheless, the common denominator of being classified RD, is having three or more admissions into inpatient services. The operational definition of RD patient used throughout this research is the Trust classification of “adult patients with three or more admissions over a period of 24 months”. For the purpose of this research, the definition includes adults with a diagnosis of severe mental illness but excludes patients with a primary diagnosis of drug and alcohol misuse and dementia.
2.4.2. Demographic Characteristics as Predictors of Patient Re-admissions

Although the revolving door syndrome is well known to clinicians there are no defined essential features of these patients. Indeed, the literature reveals that there is no consensus amongst the various papers as to the predictive demographic characteristics contributing to patients relapse and repeat hospitalisations.

A retrospective study by Labbate et al (1997) comparing 46 patients admitted to a USA hospital three or more times over a period of four years, with a control group admitted for the first time without subsequent admissions during one year, found that frequent relapse patients were more likely to be older than the patients in the control group. However, Sanguinetti et al (1996) in their study of 2200 involuntary admissions in USA found a higher readmission risk amongst those patients who were younger (between 25-34 years) and male. In line with the above, Fernando et al (1990) examining the progress of 70 revolving door patients in the community revealed that the majority of their patients were male (59%) and young (M=33.6 years). Saarento et al (2000) in a comparative study of 837 patients admitted into four Nordic hospitals reported that the younger age group (between 18-44 years) were significantly more likely to be readmitted than the older age group. The same study also reports that males have a higher risk of readmission than females.

Haywood et al (1995) findings agree with the previous research in that men (64%) had more frequent re-admissions than women (43%) in their study. Parker et al (1995) in a prospective study of 144 patients predicting hospital readmission of patients with schizophrenia they report a slightly higher number of women (52%) than men (48%) however they agree with some authors regarding the age of RD patients as being younger with a mean age of 34.8 years. A retrospective study by Korkkela et al (1995) in Finland and another study of secondary computerised data analysis by Vogel et al (1997) in a psychiatric hospital in Switzerland revealed that being female
however, and of younger age, were predictors of the RD phenomenon. The data of 255 patients in Lyons et al study (1997) support the above research studies revealing that predominantly their readmitted sample was female (60.7%) and the mean age was 30.8 years. However, they found no differences between readmitted and not readmitted patients in age or gender.

2.4.3. Clinical Characteristics as Predictors of Patient Re-admissions

Some studies suggest that predictive factors of readmission can be identified early during the patient’s admission stage. Swett (1995) in a prospective study of 189 patients examined factors predicting early readmission (within 30 days of discharge) to a state hospital in New Hampshire. In his study, patients were assessed shortly before discharge using the Brief Psychiatric Rating Scale (BPRS) and the Nurses Observation Scale for Inpatient Evaluation (NOSIE). Patients who were re-admitted within 30 days were compared on the BPRS and NOSIE ratings as well as diagnosis, demographic characteristics, length of stay and number of previous admissions with those who were not readmitted. The scores on thought disorder and self neglect factors on the BPRS were significantly higher for those patients who were readmitted within 30 days of discharge.

A similar study by Nicolson et al (1996) complemented the results of Swett’s study and their data further suggest that patients with repeated admissions who present with low global level of functioning, violent behaviour, patients requiring admission to a locked ward and high levels of psychopathology are at greater risk of early readmission. Another significant finding in this study was that patients who required readmission had a higher number of previous admissions. These findings were also confirmed by a study conducted by Saarento et al (1997) during a three year follow up study of 537 new psychiatric patients. They aimed to describe the utilisation of
inpatient care in a comprehensive community care system in Finland including units for inpatient care, day care, out patient care and rehabilitation services. They identified 25 patients who met their RD criteria and found that these patients maintained the same relative frequency of being re-admitted into inpatient facilities. The authors point out that the patients BPRS score can change over time therefore discharge scores may be less relevant predictors of readmission's beyond 30 days after discharge. Also other unknown influencing factors on patient's condition increase over time. However, the above studies suggest that early identification of these factors may enable staff to prospectively address them during the patient's admission although none of the studies define the criteria or parameters for the revolving door patient.

Another retrospective study by Monnelly (1997) examined 531 patients' records in a USA hospital. They identified 243 patients who were re-admitted within 30 days of discharge and compared them with a control group of 288 patients not readmitted for at least 6 months. The results confirm the findings of the previous studies indicating that the stronger predictor of early readmission was the greater number of previous admissions. They also found that the patient's instability in the five days before discharge was an indicator of early re-admission.

A Finnish retrospective study of predictive factors of frequently hospitalised psychiatric patients by Korkeila et al (1998) identified a small proportion of patients who needed frequent re-admissions and also long lengths of treatment. The study revealed that the extended community care did not seem to reduce their need for hospitalisation and the most predictive factors of repeated admissions were the number of previous admissions, (consistent with the findings of the above studies) long lengths of stay (LOS) and a diagnosis of psychosis or personality disorder. An Australian prospective study by Daniels et al (1998) on rates of hospitalisation over a 5-year period found similar predictive factors such as; patients with more previous
admissions had more admissions than patients' with fewer previous admissions. Patients with a diagnosis of schizophrenia 79% followed by bipolar disorders 59% and depression 48% was also a predictive factor.

A further retrospective study by Labbate et al (1997) compared 46 patients with a major depressive disorder (MDD) admitted to a USA hospital three or more times over a period of four years, with a control group admitted for the first time without subsequent admissions during one year of the study period. The authors found that frequent admissions among patients with MDD were common. In comparison to the control group, frequent relapse patients were more likely to suffer recurrent depression, receive a diagnosis of personality disorder, receive ECT or have a medical condition contributing to their admission. According to Seeman (1999) depression and anxiety are much more common in women than in men however the author warns that culture and expectation play an important part in the definition of psychiatric illness. Indeed in study by Lyons et al (1995) most female patients were admitted with a primary diagnosis of a major affective disorder (63.5%).

Rabinowitz et al (1995) in a study of a longitudinal random sample of 2220 psychiatric patients attempted to predict RD individuals at first admission. Using 9 predictive variables the authors were able to predict RD patients in 74% of cases. In their study, RD patients were compared with non-RD patients. Patients with schizophrenia were the largest diagnostic RD group, although the length of time since first admission and consequent re-admissions was not clear, RD patients had longer average lengths of stay, RD patients were older and more educated, were single, unemployed, and not able to take control of their own affairs. The authors found almost an identical pattern of relationships between predictors of two or more, three or more and four or more admissions, unlike the previous studies in which the number of previous admissions was their stronger predictor variable.
In a retrospective study, Sanguinetti et al (1996) examined the clinical characteristics of 2200 involuntary admissions in Philadelphia USA. They identified 88 high-risk patients with three or more admissions and concluded that the diagnosis of schizophrenia and psychosis clustered in this sub-group. In addition being young male, unemployed and of African American background was also a contributing factor of greater likelihood of readmission.

A study of secondary computerised data analysis by Vogel et al (1997) in a psychiatric hospital in Switzerland revealed that psychotic disorders (25%) affective disorders (35%) and substance related disorders (24%) were the major predictors of readmission. In addition their results highlighted longer duration of illness, being female, younger age, and poorer psychosocial adjustment during the past year as predictors of the RD phenomenon. Although Seeman (1999) asserts that substance misuse and schizophrenia are commoner in men than women. A study of readmissions in Norway by Heggestad (2001) found a higher risk of early re-admissions (30 days following patients discharge) among patients younger than 45 years of age and among patients with affective psychoses than any other group of patients. Marital and gender status showed no statistical significance among the different groups. However the author found a statistically significant difference in gender among patients readmitted within 60 days of discharge; in that being male gave a higher risk of readmission.

Walker et al (1996) interviewed patients 6 months after discharge from a rural and an urban hospital in Greenville USA, to determine if they have been readmitted. The authors used the North Carolina Functional Assessment Scale (NCFAS) and the Global Assessment of Functioning (GAF) to compare scores between rural and urban patients. Their results indicated similarities in the two settings and the authors concluded that previous history of admissions and non-compliance with outpatient treatment was strong indicators of readmission. Looking at re-hospitalisation and
follow up of 580 inpatients discharged from two health maintenance organisations (HMO) in Providence USA, Schonbaun et al (1995) found that readmission was less likely to occur among patients who were followed up within 30 days of their discharge. Also patients who had contact with psychiatric services prior to admission were more likely to be admitted, however a pre-admission relationship with a mental health practitioner suggested that patients were more likely to make a follow up visit.

In a study of 559 patients in Baltimore USA, patients were assessed at 2 and 12 months following discharge. Patients were grouped into those who were re-admitted and those who were not readmitted at the two points of follow up. Patients were assessed and compared on subjective and objective quality of life, symptom severity at first follow up and previous re-hospitalisation. The authors Postrado et al (1995) found that the re-hospitalised group had more severe symptoms and they had a previous history of re-admissions. Re-hospitalised patients stated more dissatisfaction with family relations and were more likely to report offending behaviour than the non-re-hospitalised group. However the two groups did not differ in other quality of life domains and in global quality of life.

According to Brooks (1995), the many changes in the health sector and the increase in public expectations on treatment and medical effectiveness, together with technological and medical advances, demands the need for a systematic assessment and information on patient outcomes and the accumulation of evidence about the patients' quality of life in the community. This will enable clinicians, patients and managers to make decisions about the desired course of individual treatment in hospital and community follow up and develop clinical guidelines and protocols based on research evidence. Identification of predictive characteristics of the revolving door patient will lead to recognition of training needs on risk assessment and early warning signs about future relapse. In conclusion the most consistent variables of patient readmission seem to be the number of previous
admissions. Although different studies demonstrate that socio-demographic characteristics and diagnosis are not consistent predictors of the RD phenomenon.

A study by Haywood et al. (1995) of 124 RD patients with a diagnosis of schizophrenia, schizoaffective disorders, and major depressive disorders found that associated problems of alcohol and drug misuse and non-compliance with medication were the two key factors related to patients’ frequency of re-admissions. Rabinowitz et al. (1995) however, considering the rates of drug and alcohol misuse and legal status in their study of 2220 psychiatric patients did not show any differentiation between RD and non RD patients.

2.4.4. Patients Compliance with Medication and Pharmacological Interventions

Many authors (Muliak 1992, Haywood et al. 1995, Glazer 1995, Kemp et al. 1996) cite patient’s non-compliance with medication as one of the most significant factors for repeated hospitalisations. Haywood et al., (1995) suggest that patient education regarding their medication may prevent RD behaviour and hence reduce re-hospitalisation. Indeed, Kemp et al. (1996) in a randomised controlled trial of 25 patients with acute psychosis, found that the experimental in comparison to the control group showed a significant difference in their attitudes, and insight into their illness, hence, a great improvement with medication compliance after receiving compliance therapy (based on a cognitive behavioural intervention). In the study the experimental group received compliance therapy and guided problem solving aiming to help patients change their behaviour while avoiding confrontation. The interventions consisted of 6 sessions of 20-60 minutes twice a week. In the first two sessions of therapy subjects were invited to review their history of illness and conceptualise the problem. In the next two sessions the discussion was more
specific focusing on symptoms and side effects of medication. In the last two sessions the stigma of medication therapy was tackled. Compliance rating was blind and the patient's named nurse scored it. All ratings were repeated before discharge and after the intervention. The study indicates that the intervention group was 5.2 times more likely to show compliance (95% confidence interval) and global functioning of this group was also enhanced. As compliance was assessed by various indirect measures the researchers argue that self report measures of attitudes to drug treatment was correlated with an observer rater measure, showing a strong correlation of $r>0.68$, thus entrusting the study’s concurrent validity. Although, the data of this study have important implications for practice, the findings cannot be generalised to other populations because the sample size was small. However, further research needs to be undertaken to establish the positive effects of medication compliance with different groups of patients.

Delaney (1998) in a comparative study at a Community Mental Health Centre in Miami assessed the effectiveness of medication and psychosocial rehabilitation in a sample of sixty patients with schizophrenia or schizo-affective disorder who had more than five years history of non-compliance with medication. The patients were divided into two main groups; the traditional and the clubhouse group, each consisting of three different treatment sub-groups using the variables of medication and therapy modalities. The traditional group consisted of patients receiving traditional treatment with depot medication only, oral medication only, and a combination of depot and oral. The clubhouse group consisted of patients receiving a focus clubhouse psychosocial rehabilitation treatment (including participation in temporary meaningful employment, valuing human relationships, social support, etc.), on management of medication and depot medication only, oral medication only, and a combination of depot and oral. The author found that over the six-month period of the study the clubhouse group patients had fewer inpatient hospital days, a total of 158 days, as
opposed to 176 days of patients in the traditional group. A two-sample independent t-test of means demonstrated significance at .05. An interesting interaction in this study was also the finding that the clubhouse focus group on oral medication had the lowest readmission rate to inpatient units. The author assigns this factor to the “humanness” stable and structured environment of the psychosocial rehabilitation clubhouse and the early intervention from staff. The highest rate of readmission was found amongst patients who were on combination of both oral and depot medication. It would have been useful however, for planning future treatment programmes if the author identified which specific factors in the clubhouse promote patient willingness and acceptance to treatment and reduction of readmission. Though, when interpreting the results, one needs to be aware of the limited power of .30 of the study due to the small sample size used although the author states the difficulties in the recruitment of revolving door patient as research subjects.

In a study conducted by Weiden et al (1997) 63 patients with schizophrenia that met their criteria for revolving door were recruited. The patients were assessed using the “Revolving Door Inventory” (RDI) instrument developed by the authors, aiming to operationalize a decision-making process regarding medication. When the relapse was deemed to be caused by non-compliance of medication or substance misuse, depot therapy such as Haloperidol Decanoate or Fluphenazine Decanoate was recommended. Whereas, when the relapse was judged to be from non response to typical anti-psychotics, medication was switched to atypical such as Risperidone or Clozapine. Consequently, identifying the primary cause of patient relapse was a very important step in the assessment. The major finding of their study was that it is possible to rapidly assess and implement an appropriate medication intervention for about 50% of revolving door acute admissions by either giving them depot or atypical antipsychotic medication. However, although there is no guarantee that any of these options will work for any given patient the authors recommend that persisting with
either approach over a long period of time will help to break the revolving door cycle for a large number of psychiatric patients.

Another study by Glazer et al (1996) focuses on pharmaco-economic analysis on which a decision model is based for detecting the most cost effective medication therapy for the revolving door patient over the first post-discharge year for patients with schizophrenia. Their model involves three stages: The first stage is to define the pharmaco-economic problem the second is to identify all medication treatment options of clinical practice and the third stage is to identify the possible outcomes of therapeutic alternatives. Nevertheless, although this approach may seem useful it has not been tested. It is based on a hypothetical model using probability and assumptions from published data and clinician experience and “typical costs” were based on the authors’ institutions that may not be applicable to other organisations. There seems to be a number of limitations with this approach that uses only pharmacological intervention as the main focus of treatment. Firstly, this option may only work with the revolving door patients who have a diagnosis of schizophrenia or other psychotic illness and therefore not appropriate for revolving door patients with different diagnoses. Secondly, there is a presumption or over estimation that the major contributory factor for patient relapse and readmission is due to non-compliance or non-response to medication.

Compliance as Glazer et al (1996) suggest, is a combination of many circumstances. These include patient’s acceptance of the therapy, which again depend on many other factors; for example the psychopathology, knowledge and acceptance of illness, stigma, therapeutic association, and side effects. Thirdly, the authors confirm that their assessment is based on the best clinical judgement of the team although the validity of their judgements has not been tested using for example a randomised controlled trial. Indeed, anecdotal evidence suggests that clinician decisions are quite often, influenced by personal bias. Hence, more evaluative and conclusive
studies on pharmacological interventions using controls need to be undertaken in order to be able to generalise the results and highlight the effectiveness of medication strategies. Furthermore, as Fernando et al (1990) suggest longer duration of medication, complexity of medication regime, social isolation, the presence of anxiety and co-existing drug or alcohol use have been reported to reduce medication compliance.

2.4.5. Life Style of Drug and Alcohol Misuse as Predictors of Patient Readmission

The general approach amongst the various models of relapse prevention is that it focuses on the identification of the possible risk factors including patients' life style of drug and alcohol misuse. Shaner et al (1995) argue that many patients with severe mental illness have problems of drug and alcohol dependence. In their study in Los-Angeles they evaluated 105 male patients with schizophrenia and drug use. They found that patients with substance misuse on average had frequent hospitalisations and many were homeless, therefore creating additional problems for themselves, the health and social care systems.

Sanguinetti et al (1996) found positive urine toxicology in 19% of the RD sample in their study. The authors stipulate that substance use may play a role in the early recovery from psychiatric relapse thus increasing the risk factor of patient readmission. However they found no significant difference between those with first admission and revolving door patients. Their data suggest that even though substance misuse is a complicating factor early identification of this and immediate treatment of a different level (such as immediate referral to substance misuse services) is warranted. Lyons et al (1995) identified that patients readmitted within six months of their hospital discharge had greater substance misuse complications
and Haywood et al (1995) has shown that co-existing substance related disorders are predictors of hospital re-admissions. In a prospective study of 351 RD psychiatric patients in Iceland, Tomasson et al (1998), found a significant association between patients with poly-substance misuse and those with more than three readmissions. Storch (1993) examining a day treatment program of 28 patients (14 men and 14 women) with various psychiatric diagnoses found that 13 men and 3 women had substance misuse problems. The majority of patients with substance misuse problems had a diagnosis of either personality disorder or affective disorder.

2.5. The Social Dimension

2.5.1. Social Support as a Contributory Factor to Patient Relapse

Jones (1991) argues that health and illness do not exist in isolation but in the context of socio-political, cultural and societal interactions. According to Langford et al (1997) scientists have recognised for many years that there is a positive relationship between social support and health. Similarly, there is a causal relationship between stress and relapse of illness. Marlatt and Gordon (1985) stipulate that relapse occurs when a person backslides or falls back into a former or worse condition.

According to Mwaba et al (1998) every model of psychiatric illness suggests its own approach to the prevention of relapse and treatment of the revolving door patient. The general approach however amongst the various social models is that relapse prevention should focus on assessment and identification of the possible risk factors within the social environment; such as the patient’s inability to cope with stress, suicidal thoughts, suicidal attempts and self care neglect. Mwaba et al (1998) studied 30 black South African psychiatric patients with a history of relapse. They used unstructured interviews to obtain patients views on contributory factors to
relapse. Their study revealed that patients perceived lack of proper supervision at home, lack of social support and difficulty in coping with stress in their families and communities as contributory factors to their relapse. However, because of the small sample size involved and also the sample being of a black South African origin the findings of Mwaba’s et al study have limited applicability and generalisability to the UK population. Nevertheless, Weller and Muijen (1993) support the above authors’ findings by arguing that social factors such as lack of social support and homelessness are major contributory factors to hospital re-admissions; furthermore, these same factors were causing discharge delay from hospital. In their study, they show consistently a relapse rate of about 40% within a year following discharge.

2.5.2. The Role of the Family in the Care of RD Patients

The process of deinstitutionalization resulted in the families of discharged hospital patients becoming the “institution of choice” (Parker 1993). In the last two decades an extensive literature on family factors has recognized the significance of the emotional environment within the family in predicting relapse amongst psychiatric patients. Schizophrenic patients returning home after a period of hospitalisation to families characterised by high levels of expressed emotion (EE, i.e. criticism, hostility and emotional over involvement, or a combination of all factors) are approximately four times more likely to relapse in the nine months to two year period following hospital discharge than those returning to an atmosphere characterised by low EE (Brewin et al 1991). Although the first studies have been conducted with patients with schizophrenia expressed emotion environment studies are not exclusive to these patients and their families. Leff and Vaughn (1985) assert that living with relatives with high EE is an important predictor of psychiatric patients’ relapse and hospital re-admission. Also unresolved problems with the family may increase the level of stress in the environment and hence increase the probability of patient
relapse. In Mwaba et al study (1998), death of a spouse or a close family member and going through the grieving process, was reported as a further significant factor which contributed to patients relapse.

Loukissa (1995) found that even though the family was seen as a significant source of support in the community however there was no knowledge or preparation for this caring role. Another multi-centre study of 709 patients and their key relatives in 30 Italian mental health departments by Magliano et al (2002) found that 97% of the relatives interviewed reported a feeling of loss, and 83% admitted of crying or feeling depressed. Furthermore, 73% of relatives had neglected their hobbies and 68% had difficulties in going on holidays because of the patient's condition. Their burden was reported higher when relatives received poorer support from professionals, and less practical social support from social networks. Goynea (1989) explored the relationships between support groups and perceived benefits of care givers of patients with Alzheimers disease. The data suggest that support groups have centred more on education and peer support and focused less on the families' emotional needs and how the disease affected other members of the family.

Loukissa (1995) suggests that family burden increased responsibility and strain in families of having to care for a mentally ill relative and this could be reduced by re-hospitalising the patient. Halford and Hayes (1991) however, highlight that family psycho-education and social skills training improved patients and their families' interactions and hence the family burden reduced the patients' rates of relapse. Although many social research studies suggest that the RD phenomenon may have its origin in the family social/environmental domain, in contrast Haywood's et al (1995) study found that the family environment or housing and money problems were not significantly associated with the number of patient re-admissions. Nonetheless, the authors justify their findings arguing that as their sample were state hospital patients their socioeconomic problems were common regardless of the frequency of
their hospitalisation and hence those problems did not serve as differential characteristics. The above studies strongly suggest that families experience burden; Thus there is a need to consider family needs alongside those of the patient. Educating families is important so that they can clearly understand the possibility of relapse, the resultant risks, and to be able to identify and cope with potential relapses; education and support can reduce the distress and burden and hence contribute to a stress free environment for the family member who is mentally ill.

2.5.3. Social Networks/ Friendships as Buffers Against Relapse

Many studies have investigated the relationship between social networks and friendships and frequent hospital re-admissions. In a study by Wiersma et al (1997) and Mwaba et al (1998) of RD patients’ the authors cite loneliness and isolation and lack of close friendships as significant factors of patient relapse and re-admission into hospital. Other research studies support the findings of the above studies highlighting that people with schizophrenia or recurrent psychosis have limited networks; hence in the absence of traditional social support they tend to depend on family, other psychiatric patients and the mental health services (Henderson 1981, Nieminen 1986, Cresswell et al 1992). Indeed, Cresswell et al (1992) observe that usually the social networks of people with schizophrenia comprise of 4-5 people in comparison to around 40 people consisting in the networks of “normal” individuals.

Involvement in meaningful social networks and closeness of interpersonal relationships are crucial to the fulfilment of patients’ particular roles and social functioning within the society they live in. A small scale study of nine patients with severe mental illness by Bradshaw and Haddock (1998) using a semi-structured interview found that five subjects lived alone and four lived with their parents. The study reports the introduction of an organised befriending scheme providing a service
for each patient seeing a volunteer on a weekly basis; 44% of subjects reported an increase in their social activity, 67% thought that it had improved their confidence in social situations, 56% reported an increase in their energy and interest to go out and all subjects found the scheme very helpful. Although the number of patients involved in the study is relatively small, nevertheless the project provides some valuable insights to the positive effects of social support and the psychological well being of patients with severe mental illness, especially of those living alone. In a further qualitative study by Jackson and Stevenson (1998) the authors report that mental health service users want nurses to spend time with them in social ordinary relationships as well as in more therapeutic situations. The people interviewed thought that good nurses were those who gave their time and energy, emotional commitment and knowledge. The evidence from these studies indicates that social networks and befriending have a buffer effect on patient relapse and the frequency of hospital readmissions.

2.5.4. Marital and Employment Status as Provision of Social Support

In a longitudinal cross sectional study by Sherbourne and Hays (1990) of 2,349 adult patients, suffering from medical problems and depression, the authors found a positive correlation between marital status and mental health outcomes; Married people were found to be healthier in a number of different dimensions including mental health than unmarried people. However these results may not be true of RD patients with severe mental illness. Indeed, a study by Wiersma et al (1997) of patients with long term mental health problems demonstrated that the large majority of the study population had never been married or they were divorced or widowed (64%). Furthermore only a small minority (less than 15%) had a regular job or sheltered employment. Fifty three percent of Axelrod et al's (1989) study sample were single, 28% were married and 18% were separated divorced or widowed. An
Italian study by Magliano et al (2002) revealed that 80% of their sample of 709 patients were single and only 18% were employed. Furthermore, the same study reports that family burden was found to be significantly related to patients’ disability and unemployment.

A study by Parker et al (1995) revealed a very low rate of employment (11%) amongst their sample of schizophrenic patients and only few subjects (8%) were married. Saarento et al (2000) found an increased risk of readmission amongst patients living alone in comparison to those living with others and an increased risk amongst those who were unemployed in comparison to those in employment. Further confirmation regarding RD patients and unemployment is found in two separate retrospective studies by Weller and Muijen (1993) and Sanguinetti et al (1996) highlighting that patients with higher re-admission rates had higher unemployment rates. Furthermore 79% of the sample in Sanguinetti’s et al study has never married.

A study by McGrew et al (1995) on RD clients admitted to an assertive treatment programme however, did not show a significant improvement in obtaining competitive employment. These results may not be surprising as other studies (Solomon 1992) found that higher functioning clients drop out of these programmes. Hence the clients remaining in the assertive treatment programs are those with severe mental illness and therefore more unemployable than higher functioning patients. It could be argued that being employed and being married or having a relationship helps individuals to stay out of hospital but not necessarily in better mental health.

### 2.5.5. Stigma as a Prelude to Patient Readmission

A study of 13 revolving door patients by Mawba et al (1998) reported that stigma attached to mental illness made patients feel rejected by their own families and the
community at large; this resulted in stress, loneliness and isolation. The stigma of being a psychiatric patient was found to be a contributory factor to relapse in their research. Indeed the stigma attached to psychiatric illness and to people, who suffer from it, is a major obstacle to treatment, care and the quality of life of the individual (Sartorious 2001).

In a study by Pyne et al (2004) the authors conducted face to face interviews with 54 depressed subjects attending out patient clinics. They compared their responses with 50 never-depressed subjects from a primary care clinic. There was a significantly (p<001) higher level of perceived stigma amongst the depressed patients. Furthermore, their data suggest that greater depression severity appears to be a stronger predictor of perceived stigma. This finding is of major concern as other studies found that greater perceived stigma may represent a barrier to care amongst those most in need of psychiatric care; therefore setting up a vicious cycle of psychological impairment, relapse and re-admission (Searle 1999, Link et al 2001).

Indeed, according to Corrigan (2004) the psychological distress experienced by people with mental illness may interfere with their personal well-being and prevent them from accomplishing life goals and relishing life opportunities. Hence, a more rigorous research and understanding of stigma and its effects on patients with severe mental illness is needed. Policies, public education and international strategies tackling stigma, discrimination and prejudice and erasing its effects need to be realistically implemented.
2.6. The Organisational Dimension

2.6.1. Inpatient Admission as a Required Option Treatment for the Revolving Door Patient

Whilst community mental health teams manage to follow up and monitor patients with severe mental illness a significant number of RD patients remain difficult to engage and may require frequent inpatient admissions (Sederer et al 1995). The influence of the ward atmosphere on the treatment of psychiatric inpatients has been acknowledged long ago since the classical description by Goffman of the harmful effects of the “total institution” (Wing et al 1970). However, since the concept of the total institution the emphasis of inpatient psychiatric care has shifted from “custodial” to a short-term intensive treatment of the severely mentally ill (Middelboe et al 2001). Indeed, inpatient care strategy for coping with a reduced bed capacity and still achieving a high patient turnover or productivity include retaining short stays and high bed occupancy rates.

An experimental study of 57 revolving door male subjects, with a serious and persistent mental illness, was conducted by Dilonardo et al (1998) in USA, to explore the effects of scheduled intermittent hospitalisation, hospital utilisation and patients’ self-esteem. The theoretical framework of self-care (self-care was defined by the authors as behaviour undertaken by an individual to promote health, prevent illness, or treat or cope with an illness, including all aspects of daily life that influence stability) informed the authors decision in following this model. On admission to a general psychiatric service all patients were screened for eligibility in the study using frequent re-admissions as the main variable.

Subject’s self-esteem using the Rosenberg Self-Esteem Scale (RSE) and community adjustment using the Personal Adjustment and Role Skills Scale (PAL-C)
were measured at intake, at one year, and after the intervention was terminated at two years after discharge from the index admission. Following the intake data, subjects were randomly assigned to an experimental or control group. Experimental subjects were scheduled for four admissions per year each lasting 11 days with intervals of 11 to 13 weeks between hospitalisations. In addition to planned hospitalisations, both groups were able to gain emergency admission into hospital if required. The study took two years to complete. Overall compliance of the 26 experimental subjects with scheduled admissions was 77.4%. The impact of scheduled hospitalisation on patient's self-esteem and community adjustment was measured at one year after patient's discharge from their index admission. The study showed a significant difference in the two groups. Whilst there was a decrease on the negative emotions score for the experimental group, from a mean=SD of 17.46=2.58 at study entry to 13.69=4.42 at one year, the score for the control group remained essentially the same from a mean=SD of 16.80=3.62 at intake to 15.57=4.75 at one year.

Another significant finding of this study was that the experimental group's self esteem increased from entry to one year of study whereas self-esteem remained the same for the control group during the two measurement points. The research however did not show a difference on bed utilisation between the two groups. The study suggests that scheduled intermittent hospitalisation is a success and hence a viable and promising alternative to traditional crisis emergency admissions for the revolving door patient. However, considering the scant resources and cost of inpatient services, the closure of acute hospital beds and the movement towards de-institutionalisation this model presents several problems; one potential problem of scheduled intermittent hospitalisation is the concern that patients admitted through this route are not sufficiently ill to require hospitalisation. Many admissions to acute psychiatric units constitute an emergency and thus limit the potential of planned admissions.
Moreover, the findings of this study are in part contradictory to those of earlier as well as more recent research (Kustrup 1987, Postrado et al 1995, Nicolson et al 1996, Saarento et al 1997), showing that the best predictor for patient readmission is previous hospitalisations particularly the number and length of hospitalisations. Besides, all subjects in Dilonardo et al study were male, most were Afro-American, 56 of 57 subjects were single and more than half were living alone. Although the authors state that many subjects are living alone it is not known whether any of the subjects are homeless in which case it would make the hospitalisation programme seem rather an attractive option. Consequently, the results are biased and only applicable to the sample population of the study. However, further research to establish more potential benefits for patients with varying diagnoses is necessary if this kind of treatment might be considered in the future.

According to Kangas et al (1999) the quality of inpatient care is considered essential to institutional survival. Indeed, Nieminen et al (1994) observed that motivated patients seem to benefit from inpatient experience based on a therapeutic community setting. The authors contend that the accepted practice of reserving hospitalisation as a last resort may in fact negatively influence the well-being of individuals with severe mental health problems. Previous research however, by Tyrer et al (1989), suggests that inpatient care should represent the entry point in the treatment system at only exceptional circumstances where community care has failed. Another quasi-experimental study by Wayne et al (1998) indicates that acute in-patient care showed no significant differences in psychological functioning and satisfaction for patients treated in an alternative community residential care treatment setting. There is also concern that the programme of in patient care treatment will foster patients' hospital dependency in the long term and hence encourage the patient's revolving door career. Indeed, coupled with acute bed shortages and increased financial constraints this line of approach may not be practical or the most efficient.
2.6.2. Length of Stay (LOS) in Inpatient Facilities as a Predictor of Patient Readmission

Length of Stay (LOS) in hospital is becoming a widely used outcome indicator of NHS organisations performance, because it can be measured objectively. However, the question of “how long should a patient with serious mental illness stay in hospital for maximum benefit” remains unanswered. This is because LOS is dependent upon many factors such as diagnosis, socio-demographic factors, type of treatment and psychological factors (Stevens et al 2001). In a prospective study of 163 psychiatric patients by Axelrod et al (1989), the mean LOS of subjects’ current hospitalisation was 23.3 days, whilst a study by Wells (1992) reports an average LOS of 30 days. The average LOS in Germany for 4706 patients with psychiatric disorders was reported as 39.5 days (Stevens et al 2001).

Korkeila et al (1998) argue that a LOS of over 30 days increases the patients’ readmission risk. In agreement, a study by Saarento et al (2000) the authors found an increased risk of readmission amongst non-psychotic patients with LOS between 15-30 days and amongst those with LOS of more than 60 days. A systematic review by Johnstone and Zolese (1999) of four RCT studies involving 628 patients comparing planned short hospital stay (1 week to 21-28 days) against long hospital stay (29-94 days) or standard care for people with serious mental illness indicates no difference between the two groups as regards to readmissions and losses to follow up. However, the patients allocated to planned short stay had more successful discharges on time than patients allocated to long hospital stays or standard care. Some evidence also showed that patients with shorter stays had a greater opportunity of finding employment.

In contrast, a Norwegian study by Heggestad (2001) examined the association between patient turnover and readmission. The highest level of patient turnover
gave a hazard ratio for readmission of 3.37 (95%CI=2.39-4.75) compared to the lowest level, supporting the author's hypothesis of an association between high patient turnover and early readmission.

Appleby et al (1993) in a retrospective study of 1500 subjects examined the relationship of hospital stay and subsequent length of community survival of patients with schizophrenia admitted to a public mental health system. The authors' hypothesised that patient's time in the community before relapse was directly related to duration of hospital treatment. The most significant finding in their study was that patients with shorter lengths of stay were more likely to be readmitted within 30 days of discharge than patients who were treated for longer periods of time. As this study was limited to patients with schizophrenia the results cannot be generalised to other conditions. Furthermore as the study was retrospective causal connections between the levels of psychopathology and other confounding factors such as dual diagnosis and length of stay could not be confirmed. However, a collaborative study in Italy by Barbato et al (1992) investigating the role of short impatient treatment patterns of care and outcome on 30 patients from 34 small psychiatric units found a wide variability depending on individual services, culture and clinical models of practice in different areas.

2.6.3. Community Care (Assertive Community Treatment, Outreach Service, Early Intervention) and Patient Readmission

The cycle of re-admissions of people with severe mental illness has led managers and clinicians, to develop a model of continuous, comprehensive and highly flexible community care known as Assertive Community Treatment (ACT), (Burns et al 1995). This model of treatment originated in the USA, and is usually characterised by a full range of medical, psychosocial and rehabilitation services led by a community based team operating 7 days a week, 24 hours a day. Early randomised
control trials in USA, comparing outcomes between patients who received ACT and patients who received standard community care, demonstrated benefits in clinical status, medication compliance and quality of life as well as reduction in costs and inpatient service utilization (Burns et al 1995).

Another study by McGrew et al (1995) on the outcomes of 212 clients at risk of re-hospitalisation, in Indiana USA, found a reduced rate of re-admissions by one third and a reduced inpatient LOS by 50% following admission to an assertive community program. Improvement was progressive with continued reductions over an 18th month period. Case managers reported of their clients as having increased self reliance and independence, improved daily living skills and improved family and social support. Although in the study, corroborative evidence to support the case managers' views was limited.

In another study, McLean et al (1990) surveyed a number of patients with several re-admissions (60% of all admissions, constituted re-admissions) to inpatient facilities in an inner London teaching hospital and found that the level of support this group was receiving in the community was insufficient. They set up a supernumerary multi-disciplinary outreach service, which was easily accessible to the users with long-term mental illness, where the traditional service was perceived to be ineffective or inappropriate. The service was tailor made to patients' needs in order to address some of their problems. As Marshall (1992) argues in order for the chronically mentally ill to survive in the community the setting must have the safeguarding of an institution but without the restrictive and abnormal environment typical of the institutions.
2.6.4. Out Patient Appointments, Day Care Places, Residential and Non-residential Treatment as Follow-up Arrangements

Several studies have indicated the importance of effective after care in the prevention of hospital readmission. Winston et al (1977) were able to demonstrate that patients diagnosed with schizophrenia who were assigned to an after care treatment programme, were admitted to hospital at a lower rate than those who had no after care treatment intervention. Wolkon and associates (1978) were able to show that incidence of drop out of after care treatment was significantly higher if contact with the patient was not made within a few days of discharge.

In a study by Weller et al (1993), the authors contend that day and home care treatment aim to maximise the patient's independence by supporting them in their own environment, and teach them daily living skills that are relevant to community functioning. Tanzman (1993) in a survey of user preferences found that the majority of patients like the independent living arrangements with flexible support, rather than the traditional supervised group homes and hostels and the stigma of having to live with a group of people with severe mental illness.

Another intervention approach used mainly in the USA is the involuntary outpatient commitment (OPC) for revolving door patients. A revised out patient commitment law became effective in 1981 for mentally ill patients considered to be capable of surviving safely in the community with supervision from family friends or others, patients needing treatment to prevent further deterioration or disability which would predictably result in dangerousness, and finally patients whose current mental state or the nature of their illness would negate their ability of making an informed decision about voluntarily seeking or complying with recommended treatment. In OPC the court orders treatment in the community rather than treatment in hospital.
Fernandez et al (1990) in a large-scale study in USA examined admission rates and lengths of stay both before and after outpatient commitment of 4,140 patients in a three year period to establish the impact of this approach on the revolving door syndrome. The study showed a significant (p<.0001) reduction of 82.2% in the total number of admissions from 3.66 before outpatient commitment to 0.66 after, and a reduction of 33.3% in the total length of stay in days from 57.6 before to 38.4 after outpatient commitment. Consequently, outpatient commitment can be regarded as an alternative treatment to hospitalisation whereby psychotherapy, rehabilitation and stability are provided for a targeted group of patients in a less restrictive environment. Even though the study showed significant reductions in hospital admissions and lengths of stay it cannot be concluded however, that outpatient commitment is the primary cause of these reductions. Admissions occurring at private facilities may result in under-representation of readmission and length of hospital stays.

Another American study by Hiday et al (1991) examined compliance of revolving door patient with outpatient commitment. The study indicates greater compliance among patients attending OPC than those involuntary hospitalised. Nevertheless, both studies are limited in what they have to offer in terms of effective treatment programme for the revolving door patient. Patient outcomes regarding social and psychological functioning and reduction of symptoms have not been addressed by either study. Indeed, although OPC is effective in getting and keeping target groups in treatment that provides stability it is no solution by itself to the problem of maintaining and supporting the revolving door patient in the community. Although the above studies have shown that Out Patients reduce the frequency of readmissions in contrast Korkeila et al (1995) study found that the most powerful predictive factor was the patient's previous outpatient contacts (P=0.005). At discharge 78% of patients had follow-up treatment of which 28% had previous readmissions. Of these patients 8% had more than 3 admissions to the psychiatric inpatient unit.
2.6.5. Service Models and Treatment Programmes for Revolving Door Patients

Available literature on psychosocial/behavioural treatment for the RD patient from 1990 onwards is sparse. The majority of the literature on psychosocial and behavioural interventions covers the 1970s period, as there has been a tendency in the past to equate psychiatric rehabilitation with the resettlement of institutionalised patients from the large psychiatric hospitals to the community (Weller et al 1993). Geller (1993) believes that neither patient's disobedience with treatment nor non-compliance with medication explains the frequency of re-admissions. He proposes ten clinical principles and outlines four strategies based on these principles to guide the development of treatment planning for RD patients whose constant hospitalisation has become a way of life. He uses a case study approach with three different patients to demonstrate their applicability to practice.

The author being inspired by Pinel's comments in 1891 that patients need to be treated in an enlightened fashion by using "compassion, coercion, and common sense" developed the following principles: i) the patient’s behaviour is in response to some kind of personal or interpersonal deficit; ii) the institutional setting has a special social meaning for the patient; iii) the problems and solutions are at the interface between hospital and community care; iv) the patient’s autonomy has limits; v) the treatment plan must be consistent, comprehensive and enforceable; vi) all treatment sites involved with the RD patient must endorse the treatment programme; vii) the patient must understand the treatment plan; viii) the treatment plan should be reviewed regularly at scheduled times by the providers of care and the patient; ix) the treatment plan should be modified according to patterns of behaviour, not isolated instances of behaviour; x) the treatment plan should be long term and designed to meet long standing problems.
Delaney (1998) notes that current researchers and mental health practitioners strongly emphasise that the rehabilitation model used with severely physically disabled people should be adapted and used as a conceptual rehabilitation model to serve the needs of psychiatric patients. Another study by Perry et al (1999) in a randomised controlled trial examined a sample of 69 patients with bipolar disorder who had a relapse in the previous 12 months. The experimental group received 7-12 treatment sessions (treatment occurred in two stages; training the patient to identify early signs of manic or depressive relapse separately and producing and rehearsing an action plan once the early signs have been identified) from a research psychologist plus routine care. The controlled group received routine care alone. The researchers measured the psychiatric and social functioning of the patients through a standardised interview every 6 months for 18 months.

They found a significant difference in the number of relapses in the 25\textsuperscript{th} centile time between the first manic relapse in the experimental group - 65 weeks compared to 17 weeks in the controlled group. However, the experimental treatment had no effect to first relapse or number of relapses with depression but significantly improved overall social functioning and employment over 18 months. Therefore teaching patients to recognise symptoms of manic relapse and seek early treatment is associated with important clinical improvement in time to first manic relapse and the reduction in the number of relapses, but not to depressive relapses and cumulative improvements in social functioning and employment indicate the effectiveness of a specific treatment intervention.

2.6.6. Costs of Care of the Revolving Door Patient

The vast majority of research on cost effectiveness reveals that the revolving-door pattern of care can be very costly. In recent years concern about cost containment has helped sustain the popularity of short hospitalisations, speedy discharge and
focus the attention on aftercare and out patient programmes (Wells 1992). Indeed, Stevens et al 2001) stipulate that direct illness costs are significantly associated with the duration of inpatient admission. Even though the total number of revolving door patients may not be large, nevertheless, because of the frequency of their readmissions they use a disproportionate amount of inpatient resources (Geller 1993). Albeit patients with frequent readmissions constitute between 15-30% they account for more than 50% of occupied bed days (Lelliot et al 1994).

Dilonardo et al (1991) in their study of the use of inpatient psychiatric care highlight the issue of decrease of LOS of long stay patients. However, as the number of their admissions increased considerably their mean cumulative LOS remains constant. Hence, patients with frequent readmissions receive more fragmented care at greater expense, with no more days out of hospital.

2.7. The Professional Dimension

2.7.1. Nurses Role and Nursing Interventions in Care Planning

Nursing theorists such as Henderson (1982) suggest that there is more to nursing than problem solving. Indeed, a review of Mental Health Nursing by the Department of Health (DoH 1994) emphasised that the nurses’ primary work should be focusing on appropriate interventions for people with severe mental health problems. However, Gourney et al (1995) argue that there are no guidelines or available standards of good practice enabling nurses to develop and plan the care of patients. They examined eleven districts in England, Scotland, Northern Ireland and Wales and found that there was lack of training of staff in appropriate interventions for the severely mentally ill (e.g. family and cognitive behavioural interventions and medication management) and many services gave low priority to post qualification training and development of
nurses. Another major finding in this study was that multi-disciplinary team reviews for discharge planning were an established process only in six out of the eleven districts visited. Even though, these six districts met only partially the criteria of the authors' protocol for multi-disciplinary review. However, the role of the named nurse in providing 24 hour and co-ordinating the care given by others means that the exchange and transfer of information with the multi-disciplinary team is a significant nursing activity.

2.7.2. Nurses Role in the Discharge Planning Process

Lowenstein (1994) assert that discharge planning places the role of the nurse in a pivotal position in the care process. Examining the role of the nurse, Schneider (1992) proposes that the most appropriate professional to take on the role for the responsibility of discharge planning co-ordinator is the clinical nurse specialist, for such a function requires expertise in various roles, namely; administrator, practitioner, consultant, educator and researcher. An USA qualitative study by Belcher et al (1990) on lead nurses perceptions about patient care issues found that nurses' ability to provide adequate discharge planning for patients and supporting chronic psychiatric patients in the community were major concerns. However, the sample size of this study was very small (only four lead nurses were interviewed and all from the same institution) to draw conclusions and make generalisations. Development of discharge programmes and outcome-orientated research on effectiveness of nursing interventions continues to be needed as it is still in its infancy even today.

Krupa et al (1988) suggests that when planning a patient's discharge, nurses should be considering the following principles: a) Be client-centred: the discharge plan must be compatible with the patients, interests and preferences and needs; b) Involve the patient: the plan must involve the patient identifying their own needs, and choosing the
appropriate resources; c) **Adopt a holistic approach:** the plan must include medical management, psychotherapy and counselling vocational and educational opportunities, environmental resources and supports, living skills, socialisation, recreation/leisure opportunities, housing and financial management; d) **awareness of values:** nurses should avoid making judgements based on their own biases that may interfere with the course of preferred or needed treatment for the patient; e) **recognise there is a continuum of services:** select appropriate services and be aware of the range of choices available that may be used in the future; f) **be an advocate for the patient:** nurses must be prepared to actively negotiate with services to meet the needs of patients, and eliminate barriers that may prevent patients achieving their full potential; g) **maintain a flexible definition:** nurses should assist patients find viable alternatives and develop a programme of activities that is perceived as meaningful, valuable interesting and productive; h) **be prepared to stay involved:** nurses referring a patient to a community service should be willing to review the discharge plans with the patient, identifying any problems or concerns, and implementing new plans as required; i) **give discharge planning the status it deserves:** comprehensive and effective discharge planning should begin on the day of the patient’s admission and should be viewed as an important component of hospital treatment not as “add-on”. Nurses should be receiving training regarding discharge planning; j) **be innovative:** nurses should be aware of potential difficulties that patients may face in the community and be sensitive to the subtle needs and be able to provide a level of support needed to initiate a smooth transition from hospital to community.

In another study investigating the management of early post discharge adjustment reactions following psychiatric hospitalization, Wells (1992) suggests a number of interventions that could be delivered by a psychiatrist and psychiatric nurse in order to ease the difficult transition from hospital to community. For Wells, psychiatric patients frequently experienced serious symptoms and disturbances in very early post
discharge period, which he viewed as adjustment reactions rather than symptoms of the primary illness. The interventions included; social skills training, learning therapies and family counselling and more importantly scheduling initial office visits within three days of discharge. In accordance with such findings, McIntosh & Worley (1994) propose an additional intervention of telephone follow-up and aftercare groups which consequently eased the patients transition from hospital to community, helped to prevent rapid re-admission, and a feedback loop was provided to the nurse on discharge planning. Indeed, all of the above principles apply to discharge planning today, and the researcher of the current study will be considering these when developing standards for discharge to be used by named nurses.

2.7.3. Discharge Planning as Preventative Measure to Patients Relapse

Many researchers agree (Williams et al 1988, Evans et al 1993, Weinberger et al 1996) that appropriate discharge planning is an effective method of reducing hospital re-admissions and the length of stay in in-patient facilities. On the other hand, inadequate planning leads to rapid re-hospitalisation with increased psychiatric morbidity and costs (Peterson 1986, Youssef 1987). Sharma et al (1995) considered the extent to which particular pre-discharge interventions affected psychiatric patient’s attendance to initial aftercare appointments. Although the data did not yield a statistically significant difference, the authors were able to show that attendance at initial aftercare appointments was greater from those who received a pre-discharge intervention than those who had not.

Examining the contribution of hospital discharge planning in meeting the needs of patients, Mamon et al (1992) found that from interviewing a random sample of 919 admissions to five hospitals, 33% of respondents reported that at least one or more of their needs were not being met. The authors concluded that enhanced discharge planning to meet the specific patients’ needs may save future costs by incurring a
reduction in the number of re-admissions. Furthermore, Kanter (1991) stipulates that in order to achieve maximum benefit from hospitalisation within the context of a long term community plan, there needs to be greater collaboration between hospital and community treatment staff at the discharge planning stages of care. This was reinforced in a research study to explore discharge planning outcomes by Rhoads et al (1992). The study revealed a need for comprehensive discharge planning involving both hospital and home healthcare agencies.

The Department of Health (1993) proposed ‘Supervised discharge’ for some severely mentally ill patients after discharge. The department identifies five conditions needed to make supervised discharge effective. Firstly, an assessment of pre discharge problems and pre discharge needs is to be carried out in collaboration with the patient and the team. The agreed discharge plan is to be explored and tested prior to the actual transition. Secondly, the bridge into the community setting provides ongoing access to the patient. Thirdly, patients and all professionals involved understand the long-term role of the key worker/named nurse and every patient must feel in charge of their own care plan. Fourthly, nobody is to be left to fall through the net for lack of continuing support. To ensure this does not occur clients must reside in a specified place to enable the team to monitor their progress closely from day one of discharge. Finally, medical treatment, occupation, education and training are to be routinely available from a multi-disciplinary team, and emphasis is laid on the gentle transition from in-patient to aftercare. In a response to this report, Rainsford and Caan (1994) observe how this may be unsuccessful unless services use the opportunity creatively to facilitate the transition of patients from hospital to the community as some patients disappear after only a period of very short contacts.

Although in the UK the Department of Health supports discharge planning (DoH 1989), however, Young et al (1991) found a great variability in the implementation of discharge planning policy across regions and districts. In addition to variability and
implementation, Alberti (1992) identified that in 26.2% of the discharge forms and computerised data analysed one or more errors were present, thus highlighting the need for correct and appropriate communication through such mediums. This paradigm was re-iterated by Pears et al (1992) when reviewing computerised hospital discharge data that revealed inaccuracies. These studies therefore suggest that there are underlying problems with communication and the recording of vital information, which could impede the smooth transition of the patient from hospital to community. Cohen et al (1997) in an USA study examined the relationship between discharge planning and psychosocial needs of 494 patients prior to discharge. They developed a Discharge Planning Inventory to track progress of relevant post discharge care (e.g. housing, benefits and daily living activities) and support. The results indicated that discharge plan was optimal in terms of resources and support for only one third of admissions.

Using a psycho-educational approach Hochberger & Fisher-James (1992) found that due to their lack of resources and poor social skills, patients benefited in terms of planning and problem solving having attended weekly groups focusing on issues surrounding discharge (e.g.: medication compliance, employment, loneliness and fear of failure). The authors illustrated their approach with a case example being successful in developing new coping skills and reduced the number of patient readmission into hospital. In a subsequent study Hochberger (1995) offers the intuitive notion that discharge planning can be considered as part of the psychiatric rehabilitation model in a similar way to that of the physical rehabilitation process. He proposes a checklist that should be pertinent to the discharge planning if this rehabilitation is to be effective and emphasises that it should be used as a multi-disciplinary tool to regularly review the patients discharge needs. Areas highlighted include; medications, activities of daily living, mental health after care residence, and physical health care.
A qualitative study by Forchuk et al (1998) using a transitional model of care on patient discharge promoted partnership among clients, the hospital, and the community, thus demonstrating improvement in clients’ quality of life and reduction in societal costs. Maintenance of relationships was the critical issue of their project. The intervention used in this study was a planned period of overlapping services. The overlap involved the public health nurse seeing the client six months prior to discharge or the hospital nurse continuing to see the client for as long as necessary after hospital discharge until the client and the public health nurse established a therapeutic relationship. However, this was only a pilot study, and the authors do not specify the sample size, or how participants were selected for the study. This in itself is a source of bias as perhaps only willing and motivated subjects participated in the study, thus skewing the results towards favourable outcomes.

Caton et al (1984) studied the impact of a discharge planning process on a sample of chronic schizophrenic patients over a one-year period from four different in-patient units, using clinical and social functioning and re-hospitalisation as outcome measures. 119 subjects (18-55 yrs) were selected on the basis of being chronically mentally ill with schizophrenia and had had at least two previous inpatient episodes. Patients, staff from the inpatient unit and the patients’ carers or next of kin were assigned to the discharge planning schedule. The schedule was developed for the purpose of the study and reflected the clinical decision making process concerning the release of patients into the community.

The schedule took the form of a three-part interview eliciting information regarding the adequacy of living arrangements, economic stability, daily activities and community treatment. The staff questionnaire in addition incorporated ratings for patient prognosis after one year. Patients’ were interviewed the day prior to discharge and the staff and carers were interviewed once the plans were firmly set, typically within a week of discharge. In addition, patients were interviewed every...
three months for one year after discharge using the Community Care Schedule, which was a companion instrument to the Discharge Planning schedule, in order to rate aspects of the community environment. Other data was obtained regarding the patients clinical condition at discharge and quarterly intervals thereafter, and patient self-reports of drug and treatment compliance every three months. The research findings revealed that adequacy of discharge planning varied significantly across the in-patient units. The authors attributed this disparity to communication between in-patient and out-patient staff, staff patient ratios, and staff effort. In addition, the authors found that adequacy of discharge planning for after care and patients' economic situation considerably influenced both treatment compliance at three month follow-up and rates of early hospital readmission.

Finally, it was concluded, that policy makers should be sensitive to the different needs of the patient during community adjustment. For, given the impact of the environment on patient outcomes (particularly the longer the patient is residing in the community), it is suggested that discharge planning should account for different interventions during different junctures of a community episode. Although the reviewed paper offered an important and in-depth contribution towards a better understanding of the efficacy of good discharge planning, the methodology could be criticised for not incorporating community staff questionnaires. For, if one is to highlight the need for communication between in-patient and community services the inclusion of community staffs' ratings is an essential dimension. Moreover, the study failed to establish clear conclusions as to the direct cause and effect of specific elements of the discharge plan, this aspect would have been better accomplished with the inclusion of a control group.

Zolik and associates (1968) found that patients with pre-release plans had lower readmission rates than did patients without plans. However, the authors failed to address the specific kinds of pre-release plans on outcomes thus the value of
discharge planning, as a therapeutic intervention, has not been adequately explored.

In an experimental study, Altman (1982) reported on the efficacy of a discharge planning programme designed and implemented by a community support system (CSS) to initiate links before patient's release into the community with the aim of reducing hospital re-admissions. The programme took the form of a collaborative discharge planning meeting (CDP). Members of the CSS became involved at the discharge level allowing an informal introduction and the patient a chance to build a relationship with the carer who will assist in the transition into the community. The first appointment for after discharge is arranged before the patient leaves the hospital.

It was stipulated that the inclusion of a CDP would also stimulate more appropriate and realistic referrals by the discharging facility, but also ensure that the vital connection is made because of staff members’ collaborative work with the patient. Present at the CDP's were discharging and therapeutic teams (from the inpatient setting and the community), and if appropriate the patient and or his/her family. Using participation in aftercare programmes and hospital re-admissions as indicators to the efficacy of CDP, the authors revealed that admission rates were nearly three times greater for the control group as compared with those assigned to the experimental condition. The findings were attributed to the higher compliance to aftercare with the patients' involvement in the CDP programme. The authors conclude that CDP integrates a supportive link into the community, and this may in turn lead to increased involvement in after care treatment.

2.7.4. Family/Carer Involvement in Discharge Planning

According to Youssef (1987) discharge planning should be initiated at the time of admission and patients and their families should constitute an integral part of the process. Although it has been recognised that family involvement plays a vital role in
the successful re-entry of patient into the community, contemporary discharge planning seems to neglect this. This is typified by Fisher et al (1992) suggesting that the family mediates the patient's attempts to relate to the broader context of the community. Indeed, these comments reflect the current situation.

Allen (1998) stipulates that the involvement of carers in the planning of after-care and treatment post-discharge of people with mental health problems should be integral to the care programme approach. However, in practice carers still feel excluded and ignored by mental health professionals (qualitative survey in inner city area). The concept of "discharge crisis" (Youseff 1987) is a common feature in studies exploring the arena of hospital re-admission. In his recommendations, Youseff suggested that psychiatric staff should involve families of patients in the discharge crisis planning process after finding that many families were ill prepared for the discharge of their relatives.

Stemming from this, in an experimental field study of 40 patients randomly assigned to two conditions, experimental and control, Buckwalter et al (1982) indicated that inclusion of families in the discharge planning of patients shows more satisfaction with services in the aftercare period. Focusing on the re-integration of depressed patients after psychiatric hospitalisation, by using Katz adjustment scales, BECK Depression Inventory MICHAUX general and specific stress indices and Administration scheme as outcome measures, results indicated that family centred discharge nursing interventions with a cognitive behavioural orientation help patients adjust more adequately to the post hospital environment. However, the researchers were not able to identify which factors caused the more positive effects, family involvement or nursing interventions. Moreover, subjects were not followed up over a longer period therefore the long-term needs of patients with enduring mental health problems and their families were not addressed by the study.
Furthermore, as Youssef (1987) pointed out one of the family’s greatest need for support is when the patient is about to be discharged from hospital. Other research studies indicate that carers are not prepared for the discharge of their relatives. Patient readmission into hospital is often precipitated by the patients and families inability to cope with a crisis at home (Allen 1998). In a quasi-experimental study by Youssef (1987) 30 subjects were randomly assigned to two groups: a control and an experimental group. Families and patients in the experimental group were involved in a family education programme regarding the patients’ illness, problems, and the meaning of hospitalisation, twice a week on three consecutive sessions each lasting one hour. All patients in the study were followed up for one year after discharge to assess the effectiveness of the education programme in reducing patient readmission. The results of the study indicated a marked improvement on the functional level of the experimental group. The t value was 2.048 at the 5% level thus showing statistically a significant difference between the two groups. The readmission rate of the experimental group was half that of the control group even though the Chi-square test showed no statistical significance.

Although the study demonstrated the impact of family-patient education on readmission rates and functional levels, it may be suggested that the sample size was too small to render reliable/valid data. This study should be replicated with a larger sample size and control of the various extraneous variables should be made more rigorous in order to draw more definitive inferences and conclusions. Furthermore, the author did not consider more intensive follow up that could have assessed the relationship between compliance to after care treatment and later readmission.
2.7.5. Nurse/Patient Relationships

The realm of discursive psychology is becoming increasingly incorporated into research governing interpersonal relationships that exist in health care settings. Research of this kind considers words, utterances and text as part of every day professional discourse (Macleod Clark 1996). This theoretical perspective assumes that professionals have as set of meanings/beliefs that are translated into their practice through the medium of conversation and communication (verbal and non-verbal and seeks to explore how professional practice is articulated as discourse in written or conversational accounts. Research has predominantly focused on professional and patient interactions (Macilwaine 1983, Macleod Clark 1996).

However, in a prospective study, the content analysis of nurses’ reports about events in the community, collected over a period of four months, Higgins et al (1999) was able to demonstrate the overwhelming importance nurses’ placed on domesticity and ordinary living in their accounts of daily events. This was particularly prevalent in accounts of admission and discharge and the way in which it disrupted ‘ordinary life’. The author suggests that the nurses should fully consider the real impact of admission and discharge to patients and integrate this into their every day discourse. Although the findings introduced a new dimension to the investigation of interpersonal interactions the sample used in the study was very small and focused only on the accounts of one senior nurse, therefore it could be argued that the findings were unrepresentative of the nursing population.
2.8. Limitations of the Literature

The literature review of the "revolving door" patient highlights a number of gaps and limitations including; the bulk of the research literature on RD patients originates from the USA, with only few studies from England and other parts of Europe; hence, the interpretation of findings need to be considered within the various cultural and sociological factors involved. Because of the complexity of the topic, there is no consensus in the definition, predicting characteristics, and reasons for re-admission of the "revolving door" patient. This lack of consensus raises a methodological question as to the best way of studying the phenomenon of the revolving door patient. The notable lack of studies on randomized controlled trials (RCTs) involving the "revolving door" patient as their sample constitutes another limitation. Indeed a search through several electronic databases for RCTs on treatment for the RD patient by Johnstone et al (1999) identified only four trials. Two trials however, were undertaken in 1975, one in 1976 and the forth in 1979. Identifying effective treatment programs for the revolving door patient can be a major challenge as very often this group, because of the high risk of attrition has been excluded from clinical trials for new treatments. Studies on optimal treatment for the revolving door patient are very often conducted with other patient samples and therefore a key research question of what is an optimal treatment for the revolving door patient is likely to remain unanswered.

There is only sparse literature on the effectiveness and role of the nurse in discharge planning. Thus, the importance of the role of discharge planning in the care of the revolving door patient is not, successfully answered by previous studies and hence it comprises a further limitation within the literature. The literature review reveals that there is no standardised definition but the number (usually 3+ admissions) of re-admissions within a specified time span are the common attributes of the RD patient. Previous research has not reached conclusive declarations in predicting the factors
contributing to RD patients relapse and readmission and hence much remains to be learnt in this area. The review through the ISOP multi-dimensional framework highlights many factors within the individual, the social the organizational and professional dimensions having a significant impact on the revolving door patient. Hence, the problem and solution of the revolving door phenomenon lies within the integration of all these dimensions.
3.1 THE OVERALL RESEARCH PLAN AND THE OVERALL METHODOLOGY

3.1.1 Introduction

This chapter reports the four phases of the research including six inter-related individual studies (as shown in Flow Chart 1 and Flow Chart 2). It discusses the overall research plan (Flow Chart 1) through a focused step by step approach unfolding the sequence of activities undertaken throughout the research process.

Underpinned by a methodology framework (Flow Chart 2) it establishes the overall aims and objectives of the research; the key research questions set the context of the research problem that would be leading to theoretical generalisations. Through the same framework this chapter argues the philosophy of the two paradigms (positivist and naturalist) embracing the overall research methodology; it further discusses the research design and rationale and examines the methodological rigour of the research and describes the sampling strategy. It describes the setting where the research takes place and examines the practical and methodological issues concerned with the research process the research participants, and the design of the overall study.
3.2. The Research Plan and the Research Process

To achieve the aims and objectives of the study and facilitate the research process the study followed a step by step plan congruent with the flow chart (Flow chart 1).

Flow Chart 1: The Research Plan and the Research Process

3.2.1: Developing the research questions, aims and objectives and formulating the research proposal

3.2.6: Conducting face to face semi-structured interview with patients of study (a) in phase II

3.2.7: Conducting face to face semi-structured interviews with named nurses of study (b) in phase II

3.2.8: Reviewing the patients medical and nursing records of study in phase III

3.2.9: Conducting focus group interview with RD patients for study (a) in phase IV

3.2.10: Conducting focus group interview with nurses for study (b) in phase IV

3.2.11: Extracting and synthesising data from various studies together

3.2.2: Submitting the proposal to the ethics committee and communicating the research plan

3.2.5: Agreeing Procedure for notification of patients discharge

3.2.3: Identifying the RD and Non-RD patients from the Trust's IT system for Computerised data of (CD) study in phase I

3.2.4: Transferring CD data from Excel spreadsheet into SPSS and prepare data for analysis
3.2.1. Developing the Research Questions

Identifying the research questions and the aims and objectives at the outset of the research is one of the most important steps in the research process (Tate et al 1999). Through the review of the “revolving door” patient literature a number of primary and secondary questions were developed in order to guide and focus the investigation. Based on the research questions the aims and objectives were identified and a research proposal was formulated.

3.2.2. Submission to the Ethics Committee

The research proposal highlighting the purpose and methodology including copies of the semi-structured interview schedules (appendices 1 and 2) and consent forms (appendices 3 and 4) was submitted to the District Ethics Committee and the Trust Research and Development Group. Ethical approval was obtained in September 1999. In order to protect the participants rights a consent form requiring the subject’s signature and including a statement of the research purpose, reasonably foreseeable benefits, a statement that participation in the study is voluntary and that consent may be revoked at any time (given to all subjects (patients and staff) prior to their participation in the research). According to Munhall (1989) informed consent is a static concept in the past tense. Thus a consent obtained at the start of the research does not necessarily suffice throughout. Indeed, for that reason approval was renegotiated by the ethics committee in December 2001. The initial proposal was circulated to seven consultant psychiatrists, the service leaders and the ward managers of the acute inpatient services in order to inform, communicate the plan, and to seek support in conducting the research.

Agreement was also obtained to use the Trust’s computerized database system, and patient’s medical and nursing records. Access to patient information was established
through a written request to the Health Records Manager complying with the Trust's confidentiality policy and procedure on patients' records and patients' data information systems. This was also included in the proposal to the ethical committee. Confidentiality and anonymity of subjects has been assured by assigning an identification code (ID) to all participants. The ID codes are accessible to the researcher only and the responses to the semi-structured interviews and focus group interviews have been used for the purpose of this research. At no time names of participants or responses to the interviews have been given to or discussed with third parties.

Considering the ethical issues, some potential benefits of this research have been identified at the outside of the planning. These include anticipated reduction in patients' rate of relapse and readmission, reduction in their length of stay, increased interval between discharge and readmission, increased satisfaction with discharge care plan, increased compliance with treatment and medication and maintaining contact with services during follow-up.

The potential hazards include patients disclosing personal confidential information, such as suicidal ideas, or the expression of anger and harm towards self or others, that may not be known to staff members. Such disclosure constitutes a potential risk to the individual concerned or others; in this case the researcher has a duty of responsibility to inform staff members but also the subjects would be made aware of the researcher's actions.

3.2.3. Identification of RD and Non-RD Patients (Phase I- CD Study)

The researcher, working in collaboration with the Information and Technology (IT) department, has identified two groups of patients from the Trust Computerised Patient Administration System. Firstly, RD patients (n=285) who were admitted into the adult
acute inpatient wards of the Trust, three times or more (trust's criteria of revolving door patients) within the last two years from April 2000 to April 2002. Secondly, Non-RD patients (n=654) (those patients with less than three admissions) admitted over the same period. There was a restriction regarding the diagnosis on both groups, since those patients with primary diagnosis of drug and alcohol misuse and dementia were excluded from the study.

3.2.4. Transfer of Data from Excel into SPSS

RD and Non-RD patients' data were inputted by the IT department into two different Excel spreadsheets and emailed to the researcher under a confidential password accessible only to the researcher. The data were transferred from Excel into SPSS version 11.5 in three different files; they were then cleaned, coded and prepared for analysis by the researcher. One data file containing information on RD patients', the second file containing data on Non-RD patients, and the third file combining both sets of data (N=939).

3.2.5. Agree Procedure for Notification of Patients Discharge

For the second phase of the study, a meeting was arranged with all staff of the acute wards, including Community Psychiatric Nurses (CPNs) to discuss the purpose of the research. During the meeting an appropriate procedure of communication and notification of RD patients' discharge was agreed between the ward managers, the researcher and the Patients' Affairs Officer (PAO). Due to the variability in admission and discharge patterns (i.e. staggered admissions and discharges), the PAO agreed to provide a list of all admissions on a weekly basis. Through this list, the researcher was able to identify the RD patients who were admitted into the acute inpatient wards.
3.2.6. Conduct of Exploratory Face to Face Semi-Structured Interview with Patients (Phase II-Study a)

The researcher maintained daily contact with the ward managers/nurse in charge to find out the patients’ date of discharge (on average there were 2-3 discharges per week). The researcher would then call the ward and make an appointment to interview patients face to face (n=9) by means of a semi-structured interview schedule, at least two days prior to their discharge. Patients’ records and relevant documentation were also examined to enable completion of specific questions of the research; such as, patient diagnosis, previous re-admissions within the last two years, and reason for admission.

3.2.7. Conduct Face to Face Semi-Structured Interview with Named Nurses (Phase II-Study b)

During phase II named nurses (study b) were contacted and those agreeing to participate were interviewed face to face (n=6) by the researcher using a semi-structured interview schedule. Depending on the nurses' availability, three interviews took place immediately following the patient's interview and three took place within seven days following the patient’s discharge.

3.2.8. Review of Patients’ Medical and Nursing Records (Phase III)

Arrangements were made via the Patients’ Affairs Office for the researcher to review the medical and nursing records of patients for phase III of the research. Thirteen records of those patients discharged from in-patient care within the last two months of the date of the review, were selected using a purposive accessible sample (records were selected from the list of consultants).
3.2.9. **Conduct Focus Group Interview with Patients (Phase IV-Study a)**

During phase IV of the study, with agreement with the ward managers the researcher arranged a focus group interview (study (a)) with nine RD in-patients consenting to participate in the study. The interview took place in a quiet area attached to the inpatient unit.

3.2.10. **Conduct Focus Group Interviews with Nurses (Phase IV-Study b)**

Following patients interviews, nurses willing to take part in the study, were asked to share their views and perceptions, regarding various issues on the readmission of RD patients, in a focus group interview (Phase IV, study (b)). The interview took place in the same area as the patients' interviews.

3.2.11. **Extracting and Synthesizing Data from all Studies**

All data from the various studies within the research were extracted and synthesised to make comparisons and generalisations.

3.3. **Practical Issues During the Research Process**

The first practical issue encountered during the initial stages of the research was the setting up of a communication system of exchanging information between the researcher and the ward staff. The ward staff cancelled two meetings arranged by the researcher to explain the research procedure. The reasons given at the time included staff shortages, staff sickness or no knowledge about the meeting. Despite the researcher’s efforts to set up a system of communication regarding the patients discharge from inpatient care, the communication system broke down on several
occasions due to the same reasons cited above. The researcher then agreed to liaise with the Patients' Affairs officer to obtain weekly admission and discharge lists. There were also some difficulties in recruiting subjects for the face to face interviews. An assumption was made that patients discharge date was agreed at least two weeks prior to the actual date of discharge. However, in almost all cases the discharge date was decided either one day before or on the same morning of the patient's discharge (during the patient ward round). This gave insufficient time for the researcher to arrange an interview with the patient and consequently with the patient's named nurse. Furthermore, internal re-organisation of the acute inpatient services meant that patients were spending all day in the day centre, engaging in therapeutic programmes; hence access to the patient population proved challenging. The researcher was able to arrange seven interviews with patients after 4 o'clock the day before discharge. Two interviews took place on the same day the patients were leaving the hospital.
3.4. THE OVERALL METHODOLOGY FRAMEWORK

The framework in Flow Chart 2 is based on the philosophy of the two research paradigms – positivist and naturalist- explaining the development and rationale for the methodology of the current research. It provides a guide through the four phases of the research, comprising six studies. Each study provides a continuum with the other and this is discussed in the next chapter (Methodology of Individual Studies).

Flow Chart 2: The Overall Methodology Framework

[Diagram showing the methodology framework with phases and studies]
Before establishing the appropriate details of the research designs the overall aim and objectives of the study must be set. These are as follows:

3.5. Overall Research Aim

➢ To increase theoretical understanding and provide further explanations of the RD phenomenon

3.5.1. Overall Research Objectives

➢ To identify models of care/interventions that may reduce the pattern of repeated hospital admissions
➢ To identify key variables that would predict a revolving door pattern
➢ To undertake a cost analysis of RD patients over the study period
➢ To extract and synthesise data from the six studies within the four phases in order to identify emerging patterns throughout the research process

3.6. Primary Questions

a. What are the factors impacting/influencing the RD phenomenon?
b. Can differences in the demographic characteristics between RD and Non RD patients predict a readmission risk?
c. Does the relationship between the demographic and clinical variables and readmission risk show a common pattern across age, gender and diagnosis?
d. Can potential RD patients be identified at an early stage during their first admission?
e. What is the impact of discharge planning in the care of the RD patient?
f. Do availability and accessibility of community support and resources prevent patient readmission risk?
3.7. Secondary Questions

a. What is the extent of the RD problem?

b. Why do some patients become "Revolving Door"?

c. Is the RD problem significant to a specific group of patients only?

d. What are the existing strategies regarding the RD patient problem?

3.8. Overall Principles and Theoretical Perspectives (Research Paradigms)

The choice of methodology depends on an understanding of the competing philosophies or principles within which research designs are rooted. Research designs are embedded in paradigms which guide the inquiry towards an understanding of a phenomenon (Parse 1987). A paradigm is defined by Kuhn (1970) as a world view about the phenomena under investigation, referring to the beliefs shared by members of a specific scientific society thus establishing the development of scientific knowledge. It is more of a philosophy rather than a methodology underpinning the way the research should be conducted, how the questions should be asked and how they should be answered. Traditionally, there are two main paradigms within the health and social sciences. One is often referred to as the positivist or quantitative paradigm; being the dominant paradigm in many disciplines and usually associated with the scientific method (Fielding at al 2001). The other is the naturalist or constructivist paradigm and is usually linked with a qualitative approach to research (Lincoln and Guba 1985). Indeed, the concept of a paradigm has been used to categorise and differentiate research into two distinct approaches; quantitative and qualitative (Easterby-Smith et al 1991, Kelly et al 2000).

According to Gliner et al (1999) quantitative and qualitative researchers often operate within a discrete set of assumptions and fundamental beliefs about the world and what is to be learnt. These assumptions and beliefs however, may be seen as mutually
exclusive and inevitably conflicting (Lincoln and Guba 1985). Whilst quantitative researchers utilise a deductive approach, that is, they begin their inquiry with a known theory and tests, usually by attempting to provide evidence for or against a pre-specified hypothesis, qualitative researchers use an inductive method; making observations in order to expand a new hypothesis or develop and contribute to a new theory (Casebeer 1997). It is argued that each of these paradigms has to some extent been elevated into a stereotype, often by the researchers maintaining opposite beliefs (Easterby-Smith et al 1991).

Further assumptions and beliefs characterise and differentiate the two research approaches. Positivist/quantitative researchers are interested in truth and prediction; hence they believe that reality is concerned with external and objective forces operating from outside the individual, influencing human behaviour (Morse 1991, Haase and Myers 1998). In line with this paradigm the social world has parallels with the natural world and hence in order to study the social world the application of the scientific quantitative method seems to be the most appropriate (Duffy 1987).

It is important to note however, that even some "positivist" researchers disagree with some of the ideas, arguing that these views are based on several assumptions; for example that reality is external and objective, that knowledge is only significant if it is based on observations of the external reality, and that all factual propositions can be reduced into elementary propositions independent of one another (Duffy 1987). One of the strongest criticisms of the positivist paradigm is that of Habermas (1970) arguing that judgements are not value free, as any form of knowledge is an instrument of self-preservation. Indeed, according to Easterby-Smith et al (1991) human interest not only guides the thoughts, plans and structures of individuals but also influences the way enquiries are made and how knowledge of the world is constructed.
Alternatively, naturalist/qualitative researchers (Haase and Myers 1998, Munhall 1989) are concerned with the internal and subjective dimensions of human consciousness. Therefore, it is necessary for the researcher to get close to the subjects in order to understand human behaviour. According to Husserl (1973) (the founder of naturalist research) the naturalist or constructivist paradigm is concerned with “things” themselves which he saw as true examples of a phenomenon. He suggests that the phenomenon cannot be separated from the experience and the way to gain access to the phenomenon is through pre-reflective descriptions of it in the persons own words. Hence he speaks of “lived experiences” a concept that became the trademark of naturalist research (Duffy 1987, Easterby-Smith et al 1991).

The principal idea of naturalist research is that reality is socially constructed by the individuals themselves rather than objectively determined by outside influences. The approach then is individualistic focusing on the persons unique experiences and the task of the method is to investigate describe and give meaning to all phenomena according to the participants own unique experience and reality. Though, this approach is subjective and cannot be generalised (Webb 1989).

Both paradigms however, have been criticised by their opponents. Whilst the positivist paradigm is often criticised for its failure to recognise the social construction of research, the naturalist paradigm is seen as a soft option, methodologically inferior, and lacking the scientific and statistical rigour of the experimental method (Webb 1989). Even though, many researchers (Munhall 1989, Duffy 1985, Silverman 1985, Corner 1991) argue that the scientific method, the positivist paradigm, has been the most prevalent encouraged and rewarded method used in nursing and social and behavioural sciences research, when it comes to the application of research it becomes more difficult to distinguish clearly the researcher's worldview of the phenomenon; particularly, when the researcher from one standpoint produces ideas which are parallel with the other.
Indeed several researchers (Corner 1991, Begley 1996, Kelly et al 2000) observe that although at the philosophical level the distinction between the two paradigms may be very clear, when it comes to the question of research design and the application of methodology the distinction breaks down.

Nevertheless, it is useful to distinguish between quantitative and qualitative research methods in order to understand the underlying assumptions of both approaches and to make judgements about which methodology is most appropriate when planning a research study. From criticisms of the philosophies that underlie the two approaches the use of a variety of methods has gained popularity, leading to a fuller and complete picture of the subject being studied by approaching it from a number of different perspectives (Webb 1989, Dootson 1995, Begley 1996). These “perspectives” being of different researchers, different data collection methods, different research populations or a combination of any of these. The method of integrating different approaches together is called triangulation (Bradley 1995, Dootson 1995, Begley 1996) and this may add validity to research findings because triangulation is based on more comprehensive data. Indeed, the researcher of this study recognizes that the nature of the subject under investigation lends itself to a mixed method approach; the two paradigms are interdependent and that both have great contributions to make towards addressing the research questions. Hence the development of the current design of each of the six studies of the research occurred within the context of positivist and naturalist paradigms, using quantitative and qualitative techniques. The key philosophical ideas of the two paradigms are summarised below.
### Summary of Features of Positivist and Naturalist Research

<table>
<thead>
<tr>
<th>Positivist/Quantitative Research</th>
<th>Naturalist/Qualitative Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>External objective reality of the world</td>
<td>Internal subjective reality of the world</td>
</tr>
<tr>
<td>Highly valued in scientific research</td>
<td>Thought of as &quot;soft option&quot; in scientific research</td>
</tr>
<tr>
<td>Patterns of human behaviour can be identified</td>
<td>Patterns of human behaviour cannot be predicted</td>
</tr>
<tr>
<td>Observer is independent</td>
<td>Observer is part of what is observed</td>
</tr>
<tr>
<td>Science is value free</td>
<td>Research is driven by human interest</td>
</tr>
<tr>
<td>Researcher focuses on facts</td>
<td>Researcher focuses on meaning</td>
</tr>
<tr>
<td>Researchers looks for causality and fundamental laws, reduce phenomena to simplest elements, formulates and tests hypotheses</td>
<td>Researcher tries to understand what is happening, looks at the totality of the situation and develops ideas through induction from data</td>
</tr>
<tr>
<td>Concepts are operationalized so that they can be measured</td>
<td>Multiple methods are used to establish different views of phenomena</td>
</tr>
<tr>
<td>Large samples are used</td>
<td>Small samples are investigated in depth or over time</td>
</tr>
<tr>
<td>Researchers attempt to attain hard, numerical, replicable and reliable data</td>
<td>Researchers attempt to attain, rich, deep and valid data</td>
</tr>
</tbody>
</table>

*Table adapted from Easterby-Smith et al (1991) Management Research An introduction. (Page 27)*
3.10. Overall Research Design and Rationale- A Mixed Method Approach-
(Triangulation)

The research design is more than simply a method by which data are collected and analyzed. It refers to the overall organisation of the planning, constructing and structuring the research project (Seaman 1987, Easterby-Smith 1991). What kind of evidence is collected from where, by what method, and how in the light of such evidence interpretations are made in order to provide sufficient answers to fundamental research questions. It also includes plans for specifying appropriate sampling methods and ensuring generalizability of findings (Polgar 1995). Oppenheim (1992) argues that there is no one best method but a good design should make it possible to answer the research questions and draw valid inferences from the data in terms of generalisations, association and causality. Stinson et al (1986) also specify that the most appropriate design depends on many complex factors including; the subjects involved in the study, the level of knowledge and previous research in the area, accessibility of reliable and valid instruments and human resources available.

Breakwell et al (2000) suggest that research designs differ in terms of several characteristics such as; the control the researcher has over the data, the setting, the way the sample is selected, and how the data are collected and analysed. These characteristics are dependent on one another and ultimately influence the decision regarding the research design. Hence, the different studies within the four phases of the current research utilised diverse research designs drawing from both quantitative and qualitative research methods depending on the following essential issues:

i. ethics, accessibility and the study population

ii. sources, type and accessibility of data and information

iii. methods of data collection

iv. analysis of data -quantitative or qualitative

v. research questions
3.11. Methodological Rigour

Methodological rigour is always debated as an important issue in both quantitative and qualitative research (Koch and Harrington 1998). This section attempts to discuss the rigour of the methodology within the four phases of the research. In attempting to examine the subject of rigour various questions emerge including; will the research stand up to an outside scrutiny, will anyone believe or agree with the researcher's findings and will readers of the study understand the philosophical underpinnings of the methods used?

Hinds et al (1990) argue that some researchers believe quantitative research methodologies to be more rigorous than qualitative methodologies, viewing qualitative research findings and conclusions with suspicion. The danger of this view, Hinds et al warn, is that highly relevant research which applies to clinical situations might be discarded for being unscientific. Similarly, researchers favouring qualitative methods might agree with readily quantitative findings that have not been critically reviewed (Hinds et al 1990).

However, Henwood and Pidgeon (1992) argue that there are no methodological criteria capable of ensuring the absolute accuracy of either quantitative or qualitative research. Though, a number of technical terminologies such as reliability, validity and generalizability, have been suggested in order to examine the notion of rigour. But the meaning of these concepts varies considerably according to the philosophical research paradigm. For example as Kirk and Miller (1986) assert, the concepts of validity and reliability were initially developed for use in quantitative research. In qualitative research reliability and validity cannot be defined and evaluated in the same way because the methods used are quite different compliant to a different paradigm (Webb 1992). Instead terms such as “credibility”- a notion expanded which identifies strategies for mindful enquiry (Guba and Lincoln 1981), “trustworthiness”-
the importance of the researcher's own perspectives and interpretations (Miles and Huberman 1884) and "reflexivity"—sensitivity in the way which the researcher and the research process have shared the collected data including the role of prior assumptions, experience and personal biases—(Koch et al 1998) have been suggested as criteria of rigour in qualitative research.

The current research utilises a mixed method approach combining a diverse set of quantitative and qualitative techniques within each study at the level of sampling, study design, data collection and data analysis. Data was collected through various sources including the Trust’s computerised system, patients and nurses, and patients records, allowing the researcher to explore similarities and diversities in different situations. Mitchell (1986) and Duffy (1987) suggest that this approach provides a comprehensive collection of information which is designed to reveal a richer set of data; it tests the reliability of the data, increases the likelihood of determining negative cases, and reduces any potential bias. Furthermore, the mixed approach according to Dootson (1995) is increasingly utilised amongst nurse researchers. Clark (1998) asserts that the movement of triangulation methodology is an indication of implicit acceptance of post-positivism philosophy, leading to diverse truths seen through a combination of approaches recognising that truth can be reached through the synthesis of different forms of enquiry. Sandelowski (2000) argues that mixed method research is a dynamic option for expanding the scope and improving the analytic power of studies. Indeed, the current research study combines different techniques, and synthesises the analysis of data from all six studies, increasing the validity of the findings (Mitchell 1986, Norman et al 1992) and thus improving the purpose and the analytic power of the research study (Sandelowski 2000).

By combining methods the current study shows not only credible evidence but also reveals variances and contradictions which may lead to new areas for further research (Duffy 1987). Silverman (1985) and Begley (1996) argue that the totality and fullness
of data, and the combination of methods can give a more accurate picture of the population studied, can enhance understanding and therefore can contribute towards the theoretical knowledge of the RD patient phenomenon. According to Bliss (2001) having a wide range of investigative methods promotes innovation, and encourages the vitality of research-intensive disciplines. Some nurse researchers stipulate that triangulation of paradigms is a way forward that deserves affirmation, although this method has not been fully explored or supported (Dootson 1995, Bliss 2001). It attempts to overcome the deficits and biases that can occur with a single method, it achieves research comprehensiveness and allows cross validation of methods and data (Duffy 1987, Polit and Hungler 1997).

The mixed method approach offers an opportunity to deepen the insights into research knowledge, strengthening the confirmation and completeness of data, developing sensitive and appropriate methods and accelerating the advances in theoretical knowledge (Webb 1982, Begley 1996). Mixed method research merits continued development and respectful evaluation. Thoughtful critique of mixed method research will foster an understanding of its relevance and refine its implementation (Bliss 2001)

3.12. The Sampling Process

Selecting an appropriate group of a population from which to collect data is extremely important. Sampling is the process of selecting a portion from the target population to study (Polit and Hungler 1997). The target population in this study are the "Revolving Door" patients in one NHS Mental Health Trust. The number of revolving door patients that were admitted within the two year period of April 2000- April 2002 determined the sample size in the current research. Approximately 500 severely mentally ill patients are admitted to the acute adult inpatient units per year. Of these,
generally 15% of patients (excluding patients with primary diagnosis of drug and alcohol misuse and dementia) are identified as RD in any given year. Over the two year period approximately 1000 patients were admitted into the Trust.

In phase I, Computerised data and cost analysis study, all RD patients, (constituting a total population sample, N=285/30%), identified within the last 24 months have been included in the study. For comparison, all Non-RD patients (total population, N=654/70%), admitted during the same period of the study have also been identified for data analysis.

During phase II (exploratory face to face semi-structured interviews- study a) of 12 in-patients, nine patients, yielding 75% compliance rate, (comprising a purposive sample) were recruited according to their status for discharge through a list supplied by the Patients Affairs office. Six named nurses (study b), constituting a purposive sample (yielding 100% response rate), were also interviewed using the same method.

In phase III of the study, thirteen (65%) medical and nursing patients records (purposive sample) were accessed from a list of 20 recently discharged patients (over the last two months) through the patients’ affairs office; the records were selected in accordance to their accessibility at the time of data collection.

The sample in phase IV of the study (focus group interviews) (n=9, 100% compliance) was selected according to their revolving door status (purposive sample) at the time when a focus group interview was arranged with the ward managers. Following the patients interview four nurses (purposive sample) working in the acute inpatient units were also interviewed through a focus group.

With reference to the patients’ interviews in phase II and Phase IV of the study all participants were assessed as capable of being interviewed by the researcher and the care team.
3.13. The Research Setting

The study was undertaken within a Specialist Mental Health and Learning Disabilities NHS Trust. The Trust was formed in 1999 following the merger of four previous hospital trusts. The new Trust covers four main localities, across a wide area of around 200 sites. Locality one and two serve clients with mental health problems. The research was carried out in these localities. Localities three and four serve residents with learning disabilities whose needs may come under the category of health care, social care or both. Five Community Mental Health Teams (CMHTs) serve patients in locality one and two. Each team has responsibility for the community and out patient management of people with severe mental illness within its boundaries. All members of the team except the psychiatrists are allocated a case load of patients for whom they act as care co-ordinators.

The total population covered by the Trust is around 500,000 of mixed socio-economic backdrop. 97% of the population comes from a white ethnic background. The localities are co-terminus with the County Council for Social Services. Acute inpatient care for patients in locality one is provided by two acute admission wards and a close supervision intensive care ward, based at a Department of Psychiatry attached to a district general hospital. Ward A comprises of 17 beds, and is staffed by two ward managers working opposite shifts, a total of six staff nurses, and a total of four nursing assistants covering a 24 hour shift. Currently the ward has a total of five vacancies. Two consultant psychiatrists are responsible for the clinical care of patients. Ward B comprises of 23 beds, three of which are detoxification beds.

Four consultants, (one with responsibility for patients with drug and alcohol abuse), cover the ward, two ward managers on opposite shifts, seven staff nurses and seven nursing assistants covering a 24-hour shift. The ward currently has three vacancies. The intensive care ward comprises of four beds has one consultant, one ward
manager, five staff nurses, six nursing assistants, two enrolled nurses and two vacancies. Bank and agency nurses cover the vacant posts in all three wards. In locality two a 20 bedded inpatient unit based at a ward attached to a general hospital, caters for acute inpatients. The unit is covered by three consultant psychiatrists, two ward managers, seven staff nurses, and seven nursing assistants. However, there are plans to merge the two acute inpatient services in the very near future.

3.14. Ethical Issues

Ethical issues can be approached from different philosophical perspectives depending on the values held by scientists that it is better to know than not to know, the values held by human subjects in safeguarding their rights and the values held by the society at large regarding the benefits of research to society (Seaman 1987, Leino-Kilpi and et al 1989).

These issues are also fundamental in the current study including the feasibility of studying the “revolving door” topic and having patients with mental health problems as research subjects. In particular, the aspects of informed consent, the subjects’ voluntary participation throughout the research process, the confidentiality and anonymity of their responses, the collection of data from various sources including patient records and hospital computerized data bases, processing the data and publishing the research results (Polit and Hungler 1997).

In order to arrive at a proper ethical evaluation, the feasibility, significance and purpose of the study, the values and underlying implications of the research and who benefits from it (Fredman et al 1992 and Breakwell et al 2000) were identified at an early stage by the researcher. Indeed, specific questions based on the objectives of the study were formulated at the outset of the planning of this research. The questions however, about whom the research benefits pose different ethical dilemmas for the
researcher. The first dilemma reflects the view that the research is utilitarian in which case subjects are used as means to an end, hence, any public benefit from the research could override the benefits of the individual. Indeed, subjects in this research are used as means to an end -sources of data collection and information through face to face interviews and focus group interviews. If one is involved with this kind of research however, there must be a certainty on the balance between beneficial and harmful effects (Woodhouse et al 1995). The potential benefits and hazards of this research have been identified during the initial stages of the planning.

The second dilemma, is that the benefit of the individual should override any other benefits. In other words the individual is not a means to an end but an end in itself. Hence, to protect participant's rights ethical approval was sought and obtained by the Trust's ethical committee.

Another dilemma involves the collection of patients' data from a variety of sources. The ethical concerns with this stage of the process are the accuracy of the information collected and the treatment of the participating subjects as sources of information. The patients and their named nurses were used as a source of information through the semi-structured face to face and through the focus groups interviews. Information was also obtained from the Trust's computerized database system, personal documents, and patient's medical and nursing records. As it is implied throughout this paper the same ethical considerations of subjects rights, as well as the question of validity and mutual trust between the researcher and the subject is an essential element throughout the research process.

Other ethical considerations raised within the research design are; what kinds of data are produced, the privacy, confidentiality, achieving accurate portrayal, inclusion and exclusion of information and the reliability and validity of the data (Munhall 1988). This ultimately depends on the methodological choice and the research design of the
study. It is argued that all study design options may result in some undermining of research ethics. For instance, in this study a variety of research quantitative and qualitative designs were used if the study design discourages or limits participation it may detrimentally affect sampling strategies and restrict generalizability of the findings (Coughlin 1992). However, the selection and size of the sample (N=RD=285 N=Non-RD=654) in the current research should eliminate or minimize potential sources of bias. In some cases to avoid value conflicts, triangulation may help to reduce some ethical issues embedded in the research design. According to Schrock (1984) what data is collected depends to a large extent what is considered to being important. Indeed, the guiding principles of the researcher are obviously to provide the best available treatment/care for each individual patient. These principles include beneficence-the duty to maximize benefits to participating individuals and to society at large and nonmaleficence- the duty to prevent harm to subjects (Woodhouse et al 1995).

Health care research findings are published for different reasons; to disseminate pertinent information, to meet requirements for academic qualifications, or for the researchers own aspirations (Hamblet 1996). The ethics directly involved with publication include the principles of veracity, beneficence and nonmaleficence. In other words research results must be truthful and honest in that avoiding the deliberate misinterpretation of data, or deliberately omitting data, reporting facts that were never proven, or misusing confidential information. Fraudulent publication will not be of any benefit but it may cause harm to patients or staff (Hamblet 1996).

According to Punch (1986) ethical issues can be in conflict with personal and professional interests. In other words very often research is carried out for the investigators career. Johnson (1992) however, points out that there is nothing wrong with personal motives related to the educational and academic advancement of the scientist. Indeed, the Royal College of Nursing (1977) and the British Psychological
Association (1978) advocate that health care professions have an obligation to improvement of practice which presupposes a commitment to research.

The ethical principles of beneficence, nonmaleficence and respect of subject's rights, provide a guiding framework for designing, collecting, analyzing and publishing research findings. Awareness of these principles at every stage and ongoing consideration of the participating subjects' rights, data confidentiality, rigorous and robust research methodology and awareness of the researcher's own values and relationship with the participants would enable the current researcher to continue with the quest for knowledge. The researcher, however, is aware that there must be a balance, and the commitment to advance scientific knowledge should not override all other considerations.
4.1. THE METHODOLOGY THE DATA COLLECTION THE ANALYSIS AND FINDINGS OF THE INDIVIDUAL STUDIES

4.1.1. Introduction

This chapter reports the aims and objectives, design and rationale and the sample of each study as shown in diagram 1; it details the tools for data collection used in each study and examines the reliability and validity of each study. It further describes the method of analysis and the findings of the six studies within the four phases of the research; Phase I- Computerised data and cost analysis of inpatient care, Phase II-Exploratory face to face interview with patients-(study a) and face to face interview with named nurses (study b), Phase III- Review of medical and nursing records, and Phase IV- Focus group interview with patients (study a) and focus group interview with staff-(study b). The data from each study are analysed separately and the findings are presented at an individual level; however each study builds on the next, thus providing an enriched source of data on the revolving door patient. Comparisons between studies are made where appropriate.
Diagram 1: The Six Studies within the Four Phases of the Research

Phase I
- Computerised data and cost analysis of inpatient care
  - Design: Secondary retrospective analysis

Phase II
- (a) Face to face semi-structured interview with patients
- (b) Face to face semi-structured interview with named nurses
  - Design: Mixed quantitative qualitative

Phase III
- Review of medical and nursing records
  - Design: Secondary retrospective analysis

Phase IV
- (a) Focus group interview with patients
- (b) Focus group interview with staff
  - Design: Qualitative
4.2. PHASE I: TRUST COMPUTERISED DATA AND COST ANALYSIS

4.2.1. The Aim of the Study

➢ To determine a predictive model of the RD phenomenon through the association of data between RD and Non-RD groups

4.2.2. The Objectives of the Study

➢ To identify the socio-demographic (age, gender, marital status) characteristics of "Revolving Door" patients re-admitted (Patients with 3+ admissions) to the inpatient units of a Mental Health NHS Trust over a period of 24 months.

➢ To identify the clinical (diagnosis, number of readmissions, legal status, CPA, out patients appointments, day care places) characteristics of "Revolving Door" patients.

➢ To obtain data (socio-demographic and clinical) on Non-RD patients (those with less than three admissions over the same period of 24 months) and compare them with those of the RD group.

➢ To establish inpatient costs for both groups

4.2.3. The Study Design and Rationale

The design of the computerised data study in phase I, is located within the positivist paradigm and uses a quantitative secondary retrospective data analysis. Nicoll et al (1999) states that secondary data analysis occurs when pre-existing data are re-examined to answer current research questions. According to Pollack (1999) the use of
secondary data as a method in nursing research has increased considerably and gained popularity in recent years.

Even though this method provides the main thrust of data collection and research design, for the purpose of the current research, it is necessary to be seen within the context of all six studies as each study complements one another, the four research phases merge and the analysis of the data make use of an integrated approach.

Studying patients with mental health problems, and establishing associations between variables, making generalisations and comparisons between RD and Non-RD patients, and deriving at meaningful conclusions, increasing theoretical understanding, thus achieving the key aim of the research requires access to a large sample of patients (Nicoll et al 1999). Because of the large sample required the potential pool of subjects could not be accessed through other primary methods such as face to face interviews and focus group interviews. Furthermore postal questionnaires would not be appropriate for the research population (people with mental illness).

Moreover, the patient population in this Trust is over-studied; many multi-professional staff undertaking research whether for a degree or Trust related projects tend to repeatedly use the same subjects. Consequently, these subjects are generally more reluctant (Nocon and Qureshi 1996) to participate in research and therefore to avoid overburdening them, obtaining data from an existing database was deemed a viable and appropriate option. Because of the vast volume of information required for the current study and as secondary data are inexpensive, (current research data are free) and less time consuming than primary data and the analysis is easier, this approach was considered quite feasible. Lastly, in order to provide answers to the research questions, to establish the prevalence of the RD phenomenon, to identify the distribution of the RD
4.3. The Study Population

4.3.1. (A) RD Patients

The research population involved in the computerised data study are adult psychiatric patients between 17 to 80 years old with a diagnosis of severe mental illness; patients with a primary diagnosis of drug and alcohol misuse and dementia were excluded from the study. The sample includes all revolving door (total population) (N=285) male and female patients (those patients with at least three re-admissions from April 2000-April 2002).

4.3.2. (B) Non-RD Patients

The study population comprises of a sample of 654 (total population) adult psychiatric patients between the ages of 17-80, admitted to the inpatient units of the Trust over the same period as the RD patient group and who at the phase of the study had only one or two previous admissions (known as Non-RD patients). The sample includes men and women with any diagnosis of mental illness except those with a primary diagnosis of drug and alcohol misuse and dementia.

4.4. Description of the Tools Used (Trust Patient Administrative Data System)

Data for this study were gathered through the Trust Patient Administrative Data System. This is a computerised data base system maintaining patient clinical information,
registering episodes of patient admissions and discharges. The central system of the information is held in the IT department. All Community Mental Health Teams and Patient Affairs department are networked to the system, having a “read only” access to the information. Designated individuals from each clinical team are able to log on via a unique and confidential password and identify patient information through the system. The patients' records department enter all data into the central system from the clinical information collated through the teams’ co-ordinators.

4.4.1. Reliability and Validity of the Computerised Data System

The current study identified that using the computerised data base system is a reliable, valid and relatively easy method to capture demographic and clinical information on revolving and non-revolving door patients. The total population was used and the size in this study (N=939) is large enough allowing for the confidence level to be set at 95% and the P value at 0.05 (Pallant 2001).

According to Marasovic et al (1997) computerised systems have the ability to replace paper documents of patients' medical and nursing records. Indeed, many researchers argue that patient computerised data base systems are clinically superior, improving the quality, accuracy, timely capture and retrieval of patient data (Hammond et al 1991). Prior to working with the data the research problem was conceptualised within a theoretical framework (the ISOP multi-dimensional theoretical framework) and the variables required for the investigation were identified and matched within the overall design of the research, therefore strengthening the reliability and validity of this approach (Polit and Hungler 1997). Furthermore the data of the research can be replicated, generalisations can be made and conclusions can be drawn offering the
researcher ready access of large data sets including multiple variables. Pollack (1999) argues that well conducted secondary analysis research presents a powerful approach to understanding better the associations within variables that otherwise would not be uncovered.

One of the problems however with computerised data is the consistency of the approach and by whom data are coded (one example is how diagnosis is coded) and entered onto the central system; thus the researcher has no control of the kind of data (for example patient employment status was not recorded at the time of the study) or the quality of the data. In this Trust however, the Health Records Department filters all information received by the teams and enters the data onto the system using a standardised format and codes. Furthermore all information is quality control through the Trust Data Quality Manager.

4.5. The Analysis

Data were collated, cleaned and variables were put into numeric codes for analysis. Some small categories (with less than 5 patients in their cells) such as diagnosis (neurotic and behavioural disorders) and marital status (divorced, separated and widowed) were merged to form larger categories for the ease of analysis.

Nominal and categorical data were examined using frequencies, cross-tabulation and the Pearson's chi-square test in non-parametric statistics to study the statistical significance between variables; also to test associations between the variables in the RD and Non-RD groups. Descriptive statistics including mean, standard deviation, median, and mode were calculated. The independent T-Test and the one way ANOVA, and
Games-Howell post hoc test were used to investigate differences in the means of demographic data between RD and Non-RD groups (interval data). The significance level was set at 0.05. The statistical software used was SPSS version 11.5 for Windows.

Variables of interest include; number of readmissions (dependent variable) and a range of independent variables such as; demographic characteristics of RD and Non-RD patients for example age, gender, marital status, length of stay (LOS), diagnosis, Care Program Approach (CPA) status, legal status, number of Out Patient Appointments (OPA) and number of day care places.
4.6. THE FINDINGS

4.6.1. Demographic Variables

Table 1: RD Status and Gender

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>NON-RD</td>
<td>328</td>
<td>326</td>
<td>654</td>
<td></td>
</tr>
<tr>
<td>RD</td>
<td>113</td>
<td>172</td>
<td>285</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>441</td>
<td>498</td>
<td>939</td>
<td></td>
</tr>
</tbody>
</table>

From the total sample of 939 patients, there is almost an equal distribution between Non-RD (N=328) male and Non-RD (N=326) female patients. However there are significantly more RD female (N=172) than RD male (N=113) patients (Chi-Square=8.792, DF=1 and P=0.003).

4.6.2. Age of the Sample

The mean age of the total sample is \( M=38.65 \) years, SD=13.038, the median is 37 and the range is from 17 to 80 years. 159 (16.9%) patients are under 25 years of age, the majority 275 (29.3%) are within the 26-35 year age bracket and 22 (2.3%) are over 65 years old.
Table 2: Mean Age and Gender of Sample

<table>
<thead>
<tr>
<th>RD Status</th>
<th>Gender</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-RD</td>
<td>Male</td>
<td>39.26</td>
<td>328</td>
<td>12.731</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>40.43</td>
<td>326</td>
<td>13.147</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>39.85</td>
<td>654</td>
<td>12.943</td>
</tr>
<tr>
<td>RD</td>
<td>Male</td>
<td>33.96</td>
<td>113</td>
<td>13.333</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>37.17</td>
<td>172</td>
<td>12.415</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>35.90</td>
<td>285</td>
<td>12.860</td>
</tr>
<tr>
<td>Total</td>
<td>Male</td>
<td>37.90</td>
<td>441</td>
<td>13.079</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>39.31</td>
<td>498</td>
<td>12.979</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>38.65</td>
<td>939</td>
<td>13.038</td>
</tr>
</tbody>
</table>

The mean age values of the total sample were compared to identify differences in the means between Non-RD and RD groups and gender. In general men are younger (M=37.9) than women (M=39.31). However, the RD male group is the youngest with a mean age of 33.96. The independent T-Test showed a significant difference (P=0.0001) between the mean ages of RD (M=35.9, SD=12.860) and Non-RD groups (M=39.85, SD=12.943).
As shown in the graph above the majority of patients in both groups have a diagnosis of affective disorders (Non-RD, N=323/49% and RD, N=103/36%), and then schizophrenia (Non-RD, N=194/30%, and RD, N=92/32%). It is observed however that whilst the Non-RD group exceeds in all other diagnoses, there are significantly more patients (N=72/25%) with a diagnosis of personality disorder in the RD group than in the Non-RD group (N=48/7%). Chi-Square=67.290, DF=3, P=0.0001.
Table 3: Diagnosis, Gender and RD Status

<table>
<thead>
<tr>
<th>Gender</th>
<th>Diagnosis</th>
<th>Non-RD</th>
<th>RD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Schizophrenia</td>
<td>112</td>
<td>47</td>
<td>159</td>
</tr>
<tr>
<td></td>
<td>Affective disorders</td>
<td>157</td>
<td>31</td>
<td>188</td>
</tr>
<tr>
<td></td>
<td>Neurotic &amp; behavioural disorders</td>
<td>35</td>
<td>12</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Personality disorders</td>
<td>24</td>
<td>23</td>
<td>47</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>328</td>
<td>113</td>
<td>441</td>
</tr>
<tr>
<td>Female</td>
<td>Schizophrenia</td>
<td>82</td>
<td>45</td>
<td>127</td>
</tr>
<tr>
<td></td>
<td>Affective disorders</td>
<td>166</td>
<td>72</td>
<td>238</td>
</tr>
<tr>
<td></td>
<td>Neurotic &amp; behavioural disorders</td>
<td>54</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Personality disorders</td>
<td>24</td>
<td>49</td>
<td>73</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>326</td>
<td>172</td>
<td>498</td>
</tr>
</tbody>
</table>

As shown in the above table in the Non-RD group the majority of male and female patients are diagnosed with affective disorders and the minority (equal distribution between men and women) with a diagnosis of personality disorder. In comparison amongst the RD group whilst the majority of male patients are diagnosed with schizophrenia, the majority of females are diagnosed with affective disorder. There are also twice as many RD women with a diagnosis of PD than in the RD male, Non-RD male and Non-RD female group. The Chi-Square test was performed to establish differences between the diagnosis and the Non-RD and RD groups. Within the male group it showed a significant difference (Chi-Square=22.926, DF=1, P=0.0001) regarding affective disorders and within the female group it showed a significant difference in relation to the diagnosis of PD (Chi-Square=52.240, DF=1, P=0.0001).
4.6.3. Marital Status

Graph 2: Marital Status

As shown in the above graph from a total sample of 939 the majority (450/52%) of patients are single (79 cases marital status is unknown).

Table 4: Marital Status, RD Status and Gender

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>RD status</th>
<th>Gender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Single</td>
<td>Non-RD</td>
<td>162</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>RD</td>
<td>92</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>254</td>
<td>196</td>
</tr>
<tr>
<td>Married</td>
<td>Non-RD</td>
<td>90</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td>RD</td>
<td>12</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>102</td>
<td>168</td>
</tr>
<tr>
<td>Separated, divorced</td>
<td>Non-RD</td>
<td>34</td>
<td>63</td>
</tr>
<tr>
<td>and widowed</td>
<td>RD</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>39</td>
<td>101</td>
</tr>
</tbody>
</table>
The above table shows that there is a higher proportion of single RD (N=173/63.6%), to single Non-RD patients and a higher proportion of married Non-RD (N=214/36.4%) to married RD patients (N=56/20.6%) (Chi-Square=8.034, DF=1, P=0.005). There is also a difference between the two groups regarding the status of separated, divorced and widowed (Chi-Square=8.134, DF=1, P=0.004)

4.6.4. Frequency of Re-admissions

Graph 3: Number of Admissions

From the total sample (N=939), 458/70% of Non-RD patients had one admission and 196/30% had two admissions over a 24 month period. The RD group had between 3-9 admissions with the majority 136/48% of patients having had three admissions, 81/28% had four, 34/12% had five, 29/10% had 6, 2/0.08% had 7 and 3/0.09% had 9 admissions over a period of 24 months. The total mean number of admissions for both RD and Non-RD patients is M=2.09, SD=1.415, the median is 2, the minimum is 1 and maximum is 9,
with a range of 8 re-admissions. The mean number of readmissions for RD patients is $M=3.92$ and $SD=1.52$.

Examining the age and RD status, the majority ($N=116$) with readmissions cluster within the 25-36 years age group. Next the patients in the age group of 17-25 had 58 readmissions between them, and then the 36-45 years old had between them 49 admissions; followed by the 46-55 age groups with a total of 34 admissions, then the 56-65 years old with 19 admissions. The patients over 66 years old had the least admissions ($N=9$). Younger patients (those less than the mean age of 38.65) are readmitted more frequently than older patients (those over 38.65 years) (Chi-Square=45.340, $DF=7$, $P=0.0001$).

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-RD</td>
<td>1.30</td>
<td>328</td>
<td>0.457</td>
</tr>
<tr>
<td>Male</td>
<td>1.30</td>
<td>326</td>
<td>0.461</td>
</tr>
<tr>
<td>Female</td>
<td>1.30</td>
<td>654</td>
<td>0.458</td>
</tr>
<tr>
<td>Total</td>
<td>1.30</td>
<td>654</td>
<td></td>
</tr>
<tr>
<td>RD</td>
<td>3.75</td>
<td>113</td>
<td>1.264</td>
</tr>
<tr>
<td>Male</td>
<td>3.75</td>
<td>113</td>
<td>1.264</td>
</tr>
<tr>
<td>Female</td>
<td>4.03</td>
<td>172</td>
<td>1.062</td>
</tr>
<tr>
<td>Total</td>
<td>3.92</td>
<td>285</td>
<td>1.152</td>
</tr>
<tr>
<td>Total</td>
<td>1.93</td>
<td>441</td>
<td>1.310</td>
</tr>
<tr>
<td>Male</td>
<td>1.93</td>
<td>441</td>
<td>1.310</td>
</tr>
<tr>
<td>Female</td>
<td>2.24</td>
<td>498</td>
<td>1.486</td>
</tr>
<tr>
<td>Total</td>
<td>2.09</td>
<td>939</td>
<td>1.414</td>
</tr>
</tbody>
</table>

As shown in the table above there is no difference between the mean number of admissions of male and female Non-RD patients. However, RD females have a higher readmission rate ($M=4.03$, $SD=1.062$) than any other group in the sample, although there was no statistical difference between the RD men and the RD women.
Table 6: Diagnosis and Mean Number of Admissions

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>N</th>
<th>Mean no of admissions</th>
<th>Std deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>286</td>
<td>2.17</td>
<td>1.331</td>
</tr>
<tr>
<td>Affective disorders</td>
<td>426</td>
<td>1.83</td>
<td>1.156</td>
</tr>
<tr>
<td>Neurotic and behaviour</td>
<td>107</td>
<td>1.61</td>
<td>1.122</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>120</td>
<td>3.28</td>
<td>1.936</td>
</tr>
</tbody>
</table>

As revealed in the above table patients with a diagnosis of personality disorder are readmitted more frequently than any other diagnostic group, followed by patients with a diagnosis of schizophrenia. Patients with neurotic and behavioural disorders have the lowest rate of readmissions. The one way ANOVA, between groups analysis of variance showed a statistically significant difference (F=42.253, P=0.0001) between the four diagnostic groups. The Post Hoc comparisons using Games-Howell test indicate a significant difference between the mean of personality disorder and schizophrenia (P=0.0001) and affective disorder (P=0.0001) and neurotic disorder (P=0.0001). It also shows a significant difference between the mean of schizophrenia and affective disorder (P=0.002) and between schizophrenia and neurotic behavioural disorder (P=0.0001). The test showed no significant difference between affective and neurotic disorders.

4.6.5. Marital Status and Readmission

Examining the marital status and readmission, single patients are re-admitted more frequently than married people. 78 single people had 3 admissions, 53 single patients had 4 admissions, 22 single patients had 5, 16 single had 6, 1 had 7 and 3 had 9 admissions. Whilst married people had between 3-6 readmissions, 38 married people had 3 admissions, 8 had 4, 5 had 5, and another 5 had 6 readmissions. There is a significant difference between the two groups and number of readmissions (Chi-Square=45.696, DF=14, P=0.0001).
4.6.6. Length of Stay (LOS) in Hospital

It is noted that within the data there are extreme outliers in both the RD and the Non-RD groups of patients (i.e. those patients with 0 LOS and those patients who virtually live in hospital with LOS of 618 days). However, the sample consists of too many patients who are extreme outliers therefore to remove them from the analysis would alter the nature of the sample. Hence as well as the mean the median the lower and upper bounds are calculated. The mean number of LOS of the total sample is $M=38.82$ days, and the median=20 days; the lower bound is 34.72 and the upper bound is 42.91; the minimum is 0 and the maximum is 618 days. 321/34% of patients stay over the nationally recommended standard of 30 days. 92/10% of patients LOS was more than 90 days, of which 24 patients LOS was over 200 days and 15 patients LOS was more than 300 days.

For Non-RD patients the $M=37.22$ days, the lower bound is 32.72 and the upper bound is 41.72 days. For the RD group of patients the $M= 42.48$ days, the lower is 33.8 and the upper bound is 51.17 days. The Independent T-Test showed no significant difference in the mean LOS of the two samples, the RD and the Non-RD. Also, with reference to gender there is no statistical difference in LOS among male ($M=37.76$) and female groups ($M=39.76$).

Table 7: Mean Number of LOS and Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>N</th>
<th>Mean LOS</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>286</td>
<td>59.66</td>
<td>49.18</td>
<td>70.15</td>
</tr>
<tr>
<td>Affective disorder</td>
<td>426</td>
<td>32.67</td>
<td>28.49</td>
<td>36.85</td>
</tr>
<tr>
<td>Neurotic and behavioural disorders</td>
<td>107</td>
<td>16.95</td>
<td>10.80</td>
<td>23.11</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>120</td>
<td>30.34</td>
<td>20.13</td>
<td>40.75</td>
</tr>
</tbody>
</table>
The one way ANOVA, Post Hoc test showed a significant difference between the mean LOS of schizophrenia and the mean LOS of affective disorder (P=0.0001) between the mean LOS of schizophrenia and neurotic and behavioural disorders (P=0.0001) and between the mean LOS of schizophrenia and the mean LOS of PD (P=0.001).

4.6.7. The Care Program Approach

Graph 4: RD Status and CPA

From a total sample of 939 patients, 759 patients are registered on the Care Program Approach (CPA); 185/38% Non-RD patients are on standard and 303/62% are on enhanced CPA. Within the RD group, the proportion of patients on enhanced CPA is significantly higher (whilst 60/21% are on standard, 211/78% are on enhanced CPA). (Chi-Square=19.822, DF=1 and P=0.0001).
Table 8: CPA Level and Diagnosis

<table>
<thead>
<tr>
<th>CPA Level</th>
<th>Diagnosis</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>55</td>
<td>245</td>
</tr>
<tr>
<td>Enhanced</td>
<td>199</td>
<td>514</td>
</tr>
<tr>
<td>Total</td>
<td>254</td>
<td>759</td>
</tr>
<tr>
<td></td>
<td>Affective disorders</td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>125</td>
<td></td>
</tr>
<tr>
<td>Enhanced</td>
<td>207</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>332</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neurotic &amp; behavioural</td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Enhanced</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personality disorder</td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Enhanced</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>103</td>
<td></td>
</tr>
</tbody>
</table>

With reference to diagnosis, from a sample of 759 there is a significant proportion of patients with a diagnosis of schizophrenia (Chi-Square=32.284 DF=3, P=0.0001) on enhanced rather than standard CPA.

4.6.8. Legal Status of Patients

Graph 5: RD/Non-RD Status and Legal Status

As shown in the above graph the majority of patients in both groups are admitted on an informal basis with no significant differences between the two groups.
4.6.9. Out Patient Appointments and RD Status

A total of 767 outpatients appointments were received by the sample over 24 months. The total mean number of outpatient appointments received is $M=9.08$, $SD=7.766$, the median is 7 the minimum is 1 and the maximum is 61 appointments. In total RD patients received more appointments ($M=11.16$, $SD=7.844$) than Non-RD patients ($M=7.97$, $SD=7.500$). The independent T-Test showed a significant difference ($P=0.0001$) within the means of the two groups.

Graph 6: Mean Number of OPA, Gender and RD Status

As the graph shows, female RD patients received more ($M=13$) appointments than their RD male counterparts ($M=8$); they also received more appointments than the men ($M=8$) and women ($M=8$) in the Non-RD group. The independent T-Test showed a significant difference ($P=0.001$) between gender and out patients appointments.
Patients with a diagnosis of PD received the highest number of appointments (M=10.54, SD= 8.786), followed by patients with a diagnosis of schizophrenia (M=9.38, SD= 7.902) then by patients with a diagnosis of affective disorder (M=9.20, SD=7.550). The least number of appointments were received by patients with neurotic and behavioural disorders (M= 5.80, SD=5.960). A one way ANOVA, Post Hoc test (Games-Howell) between groups was conducted to compare differences between the means of out patient appointments and various diagnoses. There was a statistically significant difference at the p<0.05 level between schizophrenia and neurotic and behaviour disorders (P=0.002) between affective disorders and neurotic and behaviour disorders (P=0.002) and between PD and neurotic and behaviour disorders (P=0.001).
4.6.10. Day Care Attendances

The total mean number of day care attendances received by RD and Non-RD patients over a period of 24 months is $\bar{M}=72.81$, and the median is 39 day care places, the minimum is 1 and maximum is 415 places. RD patients received more day care places ($\bar{M}=89.82$) than Non-RD patients ($\bar{M}=61$). The independent T-Test showed a significant difference ($P=0.001$) between the means of the two groups.

While, RD males received almost equal number (Mean=67) of day care places with Non-RD males (Mean=65), RD females received significantly more (Mean=106) day care places than their Non-RD female counterparts (Mean=58) (Chi-Square=23.942, DF=1, $P=0.0001$).
### Table 9: Day Care Places and Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>N</th>
<th>Mean</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>115</td>
<td>76.67</td>
<td>61.06</td>
<td>92.28</td>
</tr>
<tr>
<td>Affective disorder</td>
<td>155</td>
<td>66.87</td>
<td>53.82</td>
<td>79.93</td>
</tr>
<tr>
<td>Neurotic and behaviour disorders</td>
<td>24</td>
<td>59.29</td>
<td>30.22</td>
<td>88.36</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>50</td>
<td>88.84</td>
<td>65.17</td>
<td>112.51</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>344</td>
<td>72.81</td>
<td>64.07</td>
<td>81.55</td>
</tr>
</tbody>
</table>

Patients with PD received more day care places ($M=88.84$) than any other diagnostic group. Patients with neurotic and affective disorders received the least day care places ($M=59.29$). The one way ANOVA test showed no significant differences between the mean number of day care places and diagnoses.
Table 10: Summary of Key findings

<table>
<thead>
<tr>
<th></th>
<th>RD Group</th>
<th>Non-RD Group</th>
<th>Both Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>285 (30.4%)</td>
<td>654 (69.6%)</td>
<td>939</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Higher proportion of female (N=172) to male (N=113) patients (Chi-Sq=8.792 P=0.003)</td>
<td>Equal distribution of males (N=328) and females (N=326)</td>
<td>Male (N=441/47%) Female (N=498/53%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>RD patients are younger (M=35.9) than Non-RD patients (t test, P=0.001)</td>
<td>Non-RD patients are older (M=39.85) than RD patients</td>
<td>The total mean age of the sample (M=38.65 years) The majority of patients are between 26-35 years old In both groups male patients are younger than female patients</td>
</tr>
<tr>
<td></td>
<td>RD male patients are the youngest group with a mean age of 33.96</td>
<td>Non-RD females are the oldest group with a mean age of 40.43</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Almost an equal distribution of RD patients with a diagnosis of affective disorders and schizophrenia. Higher proportion of female patients diagnosed with PD (Chi-Sq=52.240 P=0.0001)</td>
<td>Higher proportion of Non-RD men are diagnosed with affective disorders (Chi-Sq=22.926, P=0.0001) Equal proportion of male and female patients diagnosed with PD</td>
<td>More females than males patients have a diagnosis of affective disorders (N=238) More females are diagnosed with PD (N=73) and neurotic disorders (N=60)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td>More RD males are single than RD females More RD females than RD males are separated, divorced or widowed</td>
<td>More Non-RD males than RD males are married (Chi-Sq=8.034, P=0.005) More Non-RD females than Non-RD males are married</td>
<td>The majority of patients (N=450) are single and more males (N=254) than females (N=196) are single More females (N=168) than males (N=102) are married</td>
</tr>
<tr>
<td><strong>Number of re-admissions</strong></td>
<td>All RD patients had 3-9 re-admissions. Mean number of readmissions (M=3.92) RD females have a higher readmission rate than any other group (M=4.03)</td>
<td>All Non-RD patients had 1-2 re-admissions (Mean =1.3)</td>
<td>Both groups (M=2.09) Male (M=1.93) Female (M=2.24) Mean admission number for all diagnoses: PD (M=3.28), Schizophrenia (M=2.17) Affect disorders: (M=1.83) Neurotic/behaviour: M=1.83</td>
</tr>
<tr>
<td><strong>CPA level</strong></td>
<td>Higher proportion of RD patients are on enhanced rather than standard CPA (Chi-Sq=19.822 P=0.0001)</td>
<td>Higher proportion of Non-RD patients on enhanced CPA.</td>
<td>From N=759, the majority of patients in both groups (N=514) are on enhanced CPA</td>
</tr>
<tr>
<td><strong>Diagnosis and CPA</strong></td>
<td>Four times more RD patients with a diagnosis of</td>
<td></td>
<td>More patients with a diagnosis of schizophrenia</td>
</tr>
<tr>
<td>Legal status</td>
<td>schizophrenia are placed on enhanced rather than standard CPA</td>
<td>(Chi-Sq=32.284 P=0.000) and PD are on enhanced CPA</td>
<td>Majority are informal patients</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>LOS</td>
<td>The RD mean number of LOS in days is (M=42.48)</td>
<td>The Non-RD mean number of LOS in days is (M=37.22)</td>
<td>The total mean number of LOS in days is (M=38.82)</td>
</tr>
<tr>
<td></td>
<td>There is no difference between RD and Non-RD patients in LOS, or between LOS and gender</td>
<td>Patients with a diagnosis of schizophrenia tend to stay longer than any other group ((M=59.66)) and (t) test ((P=0.0001))</td>
<td></td>
</tr>
<tr>
<td>Out patient appoints</td>
<td>RD group mean number of appointments ((M=11.16)) (t) test ((P=0.0001))</td>
<td>Non-RD mean number of out patient appointments ((M=7.97))</td>
<td>Total mean number of OPA ((M=9.08))</td>
</tr>
<tr>
<td></td>
<td>RD females received more ((M=13)) appointments than RD males ((M=8)) ((\text{Chi-Sq}=41.959, P=0.0001))</td>
<td>RD females received more out patient appointments than any other group ((M=10.54)) The ANOVA test showed ((P=0.002))</td>
<td>Patients with a diagnosis of PD receive more out patient appointments than any other group ((M=10.54)) The ANOVA test showed ((P=0.002))</td>
</tr>
<tr>
<td>Day care attendance</td>
<td>RD female patients receive ((M=106)) day care places</td>
<td>Non-RD females received ((M=58)) day care places</td>
<td>The total mean number for day care places is ((M=72.81))</td>
</tr>
<tr>
<td></td>
<td>RD males receive ((M=67)) day Care places</td>
<td>Non-RD males received ((M=65))</td>
<td>RD females receive more day care places than Non-RD females ((\text{Chi-Sq}=23.94, P=0.0001))</td>
</tr>
<tr>
<td></td>
<td>Day care places and diagnosis: PD ((M=88.84)) Schizophrenia ((M=76.67)) Affect. Disorder ((M=66.87)) Neurot/beh. Dis ((M=59.29))</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.7. COST ANALYSIS OF INPATIENT CARE

4.7.1. Inpatient Costs for RD and Non-RD Patients (April 2000-April 2002)

Flow Chart 1: The two Sites of the Trust, Including Daily Cost of Inpatients

The flow chart in figure 1 shows the number of patients admitted to each of the two sites of the Trust, classified by the type of ward and admission status of patients (RD and Non-RD). It also shows the daily costs for inpatient stay; the costs are different in the two sites of the Trust, and they are higher in the intensive care wards.
Whilst there is a reduction of costs in site A after a period of 20 days the costs remain the same in site B throughout the patients' stay.

Table 1: LOS of RD and Non-RD Patients (N=939)

<table>
<thead>
<tr>
<th>Admission Status</th>
<th>Length of Stay (LOS)</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimum</td>
<td>Maximum</td>
<td>Mean</td>
<td>Lower Bound</td>
<td>Upper Bound</td>
</tr>
<tr>
<td>RD</td>
<td>1</td>
<td>618</td>
<td>43.4</td>
<td>34.5</td>
<td>52.2</td>
</tr>
<tr>
<td>Non-RD</td>
<td>1</td>
<td>568</td>
<td>38.2</td>
<td>33.6</td>
<td>42.8</td>
</tr>
</tbody>
</table>

Table 1 shows the minimum, maximum, mean and lower and upper bound of the LOS of RD and Non-RD patients admitted to the inpatient units from April 2000 to April 2002.

Table 2: Admission Status and Duration of Stay of RD and Non-RD Patients

<table>
<thead>
<tr>
<th>Admission Status</th>
<th>Duration of Stay (≤20 days)</th>
<th>Duration of Stay (≥20 days)</th>
<th>Number of patients</th>
<th>Per cent of Total (%)</th>
<th>Number of patients</th>
<th>Per cent of Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Number of patients</td>
<td>Per cent of Total (%)</td>
<td>Number of patients</td>
<td>Per cent of Total (%)</td>
</tr>
<tr>
<td>RD</td>
<td>149</td>
<td>52.3</td>
<td>136</td>
<td>47.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N= 285</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-RD</td>
<td>337</td>
<td>51.5</td>
<td>317</td>
<td>48.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=654</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 shows the number and percentages of RD and Non-RD patients’ duration of inpatient admission. 149/52.3% RD patients stayed from 1-20 days, and 136/47.7% RD patients stayed more than 20 days. 337/51.5% of Non-RD patients stayed from 1-20 days, and 317/48.5% stayed more than 20 days.
4.7.2. Calculation of Costs

The costs were calculated by the number of patients \times the percentage of the total patients \times the cost per day \times the mean LOS. The upper bound and lower bound of LOS were also considered in the calculations. The costs were calculated for both, site A (all the wards were put together) and site B as there are differences in costs. The calculation formula was devised by the Trust Financial department.

Table 3: Costs of Inpatients in Site A (N=360, RD=107, Non-RD=253)

<table>
<thead>
<tr>
<th>Admission Status and Mean LOS at 95% CI</th>
<th>Site A-Acute wards</th>
<th>Site A- Intensive Care Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-20 days £210</td>
<td>&gt;20 days £140</td>
</tr>
<tr>
<td>RD (Mean LOS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M=43.4</td>
<td>£476,662</td>
<td>£289,825</td>
</tr>
<tr>
<td>LB=34.6</td>
<td>£380,012</td>
<td>£231,059</td>
</tr>
<tr>
<td>UB=52.2</td>
<td>£576,607</td>
<td>£348,592</td>
</tr>
<tr>
<td>Non-RD (MLOS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M=38.2</td>
<td>£941,943</td>
<td>£591,382</td>
</tr>
<tr>
<td>LB=33.6</td>
<td>£828,518</td>
<td>£520,168</td>
</tr>
<tr>
<td>UB=42.8</td>
<td>£1,055,375</td>
<td>£662,552</td>
</tr>
</tbody>
</table>

Table 3, shows the costs of patients (RD and Non-RD) in site A; those staying from 1-20 days and those staying more than 20 days. As there are variations in the means of LOS between RD and Non-RD patients the costs of the lower and upper bounds of LOS were also considered within the calculations.
Table 4: Costs of Inpatients in Site B (N=579, RD=142, Non-RD=437)

<table>
<thead>
<tr>
<th>Admission Status and Mean LOS at 95% CI</th>
<th>Site B-Acute wards</th>
<th>Site B-Intensive Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20 days £139</td>
<td>&gt;20 days £139</td>
<td>1-20 days £513</td>
</tr>
<tr>
<td>RD (Mean LOS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M=43.4</td>
<td>£318,660</td>
<td>£290,633</td>
</tr>
<tr>
<td>LB=34.6</td>
<td>£254,047</td>
<td>£230,702</td>
</tr>
<tr>
<td>UB=52.2</td>
<td>£383,273</td>
<td>£349,563</td>
</tr>
<tr>
<td>Non-RD (MLOS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M=38.2</td>
<td>£1,000,844</td>
<td>£942,543</td>
</tr>
<tr>
<td>LB=33.6</td>
<td>£880,320</td>
<td>£829,046</td>
</tr>
<tr>
<td>UB=42.8</td>
<td>£1,121,360</td>
<td>£1,056,047</td>
</tr>
</tbody>
</table>

Table 4, shows the costs of patients (RD and Non-RD) in site B.

Table 5: Annual In-patient Budget (2002/03)

<table>
<thead>
<tr>
<th>Department</th>
<th>Budget 2002/03</th>
<th>Forecast Outturn</th>
<th>Forecast Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Admin</td>
<td>1,104,000</td>
<td>1,114,157</td>
<td>13,082</td>
</tr>
<tr>
<td>Res. Rewards Mh</td>
<td>3,000</td>
<td>1,383</td>
<td>-1,617</td>
</tr>
<tr>
<td>M H Misc Pat. Serv.</td>
<td>1,500</td>
<td>880</td>
<td>-620</td>
</tr>
<tr>
<td>Ward A</td>
<td>1,115,380</td>
<td>1,183,120</td>
<td>67,740</td>
</tr>
<tr>
<td>Site B (intensive care) CSU</td>
<td>486,140</td>
<td>564,803</td>
<td>78,663</td>
</tr>
<tr>
<td>Ward B</td>
<td>518,760</td>
<td>601,125</td>
<td>82,365</td>
</tr>
<tr>
<td>Ward C</td>
<td>620,959</td>
<td>790,170</td>
<td>169,211</td>
</tr>
<tr>
<td>I C U Site A</td>
<td>399,504</td>
<td>469,854</td>
<td>70,350</td>
</tr>
<tr>
<td>E C T</td>
<td>41,902</td>
<td>45,389</td>
<td>3,487</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,291,145</strong></td>
<td><strong>4,770,881</strong></td>
<td><strong>482,661</strong></td>
</tr>
</tbody>
</table>

*Trust Finance Department April 2002-2003*
The table above shows the Trust's annual budget for inpatient care (all diagnoses) for 2002/2003. As indicated above the financial analysis of the revolving door patient provides a useful guide to help managers and clinicians in the prioritisation and allocation of treatment resources.

Thus the findings of the current study may contribute towards the cost savings by establishing the reasons for admission of the revolving door patient, and facilitating Trust staff to use the information and plan a more efficient and effective programme of patient relapse that may reduce the patient readmission rate.
4.8. PHASE II: EXPLORATORY FACE TO FACE SEMI-STRUCTURED INTERVIEW WITH PATIENTS (STUDY A)

4.8.1. Introduction

Following analysis of the computerized data and in order to seek answers to questions that could not otherwise be asked it seemed appropriate to follow a purposive sample of patients to explore their views and seek feedback about inpatient care and discharge planning through an exploratory face to face interview; thus adding to the richness of the data already obtained.

Phase II comprises of two studies; the first (a) is an exploratory face to face interview concerned with patients' views and perceptions regarding in-patient care prior to discharge and discharge planning, and the second (b) focuses on the perspectives of their named nurses. A semi-structured interview schedule (appendix 1) was used to gather the data of the study (a).

4.8.2. The Aim of the Study

➢ To explore and determine patients' views and perspectives on the quality of care they received whilst inpatients

4.8.3. The Objectives of the Study

➢ From the subjects' perspectives to establish reasons for relapse and repeated admissions of RD patients into the acute psychiatric wards in a Mental Health NHS Trust.
➢ To establish reasons for admission for Non-RD patients.
To obtain patients (RD and Non-RD) views on care they received during their admission, and discharge phase.

To compare responses from the two groups.

4.8.4. The Study Design and Rationale

This study utilizes a mixture of descriptive and exploratory -quantitative and qualitative research designs, by means of an exploratory face to face interview using a semi-structured interview schedule of highly structured and open items. The interview approach is described by Fontana and Frey (1994) as an art of asking questions and listening. Breakwell et al. (2000) suggest that face to face interviews can be used at any stage of the research including the initial phases to identify areas for more detailed exploration.

Jones (1985) highlights the significance of some kind of structure, regarding the effectiveness of the interview; furthermore to avoid researcher bias Easterby-Smith (1991) argues that open ended items should also be included in the gathering of information. Considering the research sample (patients with mental illness) and having specified the research questions, aims and objectives of the study, these were operationalized into a series of highly structured and open questions. This method was useful in obtaining information directly from service users, aiming to explore and discover what they think about mental health services and what their needs and expectations are regarding their discharge plan and community follow up and support.

A further function of the exploratory face to face semi-structured interview is to describe the characteristics of a representative sample (De Vaus 1996). During this phase the characteristics of the revolving door and Non-RD patients are described.
Hence, the data collection strategy was tailored specifically to elicit precise and original information from a purposive and accessible sample.

Over the past couple of decades NHS policies have clearly stipulated the involvement of service users in the development of services (DOH-NHS Quality of Care 1997, Crawford et al 2002). The inclusion of service users is of particular importance in collecting valuable information and gaining individual perspectives regarding aspects of their care. Hence, this method was deemed crucial in complementing the data collected through the computerized data based system. The data obtained from this study can also be placed alongside the data collected from the other studies through the various phases of the research. Because of the nature of the sample, the time and costs constrains however, the researcher was able to interview a small sample (N=9) of patients.

4.8.5. The Sample

Over the data collection period of four months 12 in-patients were identified by the researcher together with the ward managers of the acute in-patient services as meeting the criteria of a representative sample for this study; adult RD and Non-RD patients admitted to acute inpatient services, from Jan 2002-April 2002, with a diagnosis of severe mental illness. Patients with a primary diagnosis of drug and alcohol misuse and dementia were excluded. During this period, nine patients yielding a 75% response rate consented to be interviewed whilst three patients one male and two females, declined for personal reasons. All participants were interviewed during the last three days of their discharge. The sample is purposive-representative of the target population- comprising of five RD (four males and one female) and four Non-RD (two males and two female) patients, with varying diagnoses, between 18-68 years of age.
4.8.6. The Interview Process

The key to a successful interview is the development of a trusting relationship between the researcher and the participants of the study. However, the presence and personality of the interviewer can have an influence on the participants' responses (Hagemaster 1992). Hence, in order to make the interview process a comfortable, relaxed and enjoyable experience, the researcher explained the purpose, the potential benefits of the research, and assured confidentiality of their responses and personal data. The researcher assigned an ID code to each participant to ensure anonymity of the data.

All interviews took place with no interruptions in a quiet and relaxed atmosphere in a ward office, lasting from one to one and half hours. According to Bogdan and Taylor (1975) comfort and interruptions are both important factors to the success of interviews.

4.8.7. Rationale for the Development of Semi-structured Interview Schedules

The majority of research studies around the revolving door patient (Appleby et al 1993, Sanguinetti et al 1996, Monnelly 1997), focus on secondary analysis of retrospective information; frequently, patient's medical and nursing records or hospital-computerised systems are used as sources of data collection of patient demographic information. Since there is lack of more dynamic and holistic approaches investigating the wider aspects of patients and nurses perspectives, there is a need for prospective studies to examine these perceptions and views, and the care in hospital and its co-ordination through discharge planning and follow up in the community. Indeed, the current research aimed to address these aspects through the development of two semi-structured interview schedules, serving as
exploratory tools; one to gather information from patients and one to collect data from their named nurses.

4.8.8. Description of the Tools Used (Patient Semi-structured Interview Schedule (IS) - Appendix 1)

The patient interview schedule (IS) (appendix 1) is confidential with a combination of highly structured and open-ended questions. The IS comprises five sections. The first section (A) focuses on the admission details of patients, including reasons for admission. Section B is designed to elicit information on patients' demographic details such as age, gender, marital status, employment status, ethnic group, and living circumstances. Section C is concerned with the attitudes/perception on the care patients received while inpatients in the acute setting focusing on the following areas: co-ordination of their care, their involvement in the care, their relationship with their named nurse, the empathic qualities of their nurse, access to therapies, advice on information given regarding their medication, treatment and services and ward environment.

The respondent is requested to give only one answer out of five possible Likert scale responses, ranging from very poor to excellent. Within this section, items on whether patients comply with medication; (responses range from always to never) whether the care patients received match their needs and expectations (responses range from yes all to none) and whether they were satisfied with their care, (responses range from extremely dissatisfied to extremely satisfied) are included. Open-ended questions in this section elicit information on aspects of care that patients appreciated most and least. Section D seeks information on participants' involvement in their discharge plan, their discharge preparation and readiness for discharge (all require dichotomous responses of either yes or no). Their satisfaction with their
discharge plan requires responses from extremely dissatisfied to extremely satisfied. Open-ended questions ask whether patients attended any programs in preparation of their discharge and whether they have been referred to any professionals for aftercare support. The final section E deals with patients’ social networks and support and the questions are highly structured requiring a tick in the appropriate boxes.

4.9. The Process of Developing the Interview Schedules

Adams et al, (1995) recommend that measurement tools must be based on theory must be relevant and appropriate to the unit of analysis and must be relatively simple to administer. The authors suggest that reviewing the literature to identify key concepts and definitions can be very helpful. However, a survey of the literature revealed no readily available tools for investigating revolving door psychiatric patients’ responses regarding inpatient care and discharge planning. This may reflect the lack of consensus amongst researchers regarding the definition of RD patients, characteristics and contributory factors to readmission of patients with repeated hospitalizations.

Nevertheless, as a first step in study (a) of phase II, the literature was examined to identify what previous studies revealed about the characteristics of the revolving door patient, and possible reasons and contributory factors for repeated admissions. Literature reviewed included; Wells (1992), Sharma et al (1995), Glazer et al (1996), Sanguinetti et al (1996), Korkeila et al (1998), Daniels et al (1998). All variables identified in the current research intended to be used in the analysis of the results were identified (for example; socio-demographic characteristics, frequency of admissions, discharge care plan and follow up plan). Items designed to gather clinical information such as, diagnosis, MHA status, were also included to help identify the characteristics of the revolving door patients. Apart from section A, which,
4.9.1. Selecting Items for Inclusion

Some articles revealed that central to the prevention of patients multiple re-admissions is the delivery of high quality care in inpatient facilities, a comprehensive inpatient care, a follow up plan and a co-ordinated community care plan (Wells 1992, Sharma et al 1995, Glazer et al 1996). Hence, a list of items was drawn up and selected for inclusion from the literature. The question themes arose from the research problem, each question addressing a different variable (Oppenheim 1992). In order to establish whether questions covered the full range of appropriate elements all items of the interview schedules were matched with the objectives of studies (a) and (b) in phase II.

4.9.2. Designing the Individual Questions

The design of the individual questions was developed to provide maximum scope as regards to the range of responses allowed. Some are closed dichotomous yes or no response questions and others take the form of alternative statements such as checklists/multi-dimensional categories using a Likert rating scale in which the respondent is asked to select and tick one of the categories presented. Likert scale questions are usually developed to measure opinion or attitudes allowing a greater range of flexibility to respondents (Oppenheim 1992). Furthermore, some questions were designed in an open ended way to permit patients and nurses as much freedom as possible in describing the subjective nature of their experiences (Polit et al 1997) regarding reasons for admission, contributory factors to their relapse, aspects of care appreciated most and least, whether anything more could have been done to prevent re-admission. Both, patient (appendix 1) and named nurse (appendix 2) interview
schedules were designed with the view that they would be completed through a face
to face semi-structured interview with the researcher.

4.9.3. Designing the Layout and Presentation of Questions

Different authors recommend a different sequence of questions. For instance Stone
(1993) suggests that questions should be presented in a format that starts from
general and neutral issues to the specific and more sensitive, leaving the
demographic details to the very last. However, the researcher of the present study
favours Easterby-Smith et al (1993) and Polgar et al (1995) who suggest that it is
best if questions on demographic details and facts are asked first because they are
easily answered and serve as a warm up as to what follows. Opinion questions
because they require thinking and reflection should be asked later. Both interview
schedules finish by thanking the respondents for taking part and invite them to
comment on any additional information that might have been missed out.

4.9.4. Composing the Wording

According to Stone (1993) the golden rule about the wording of the questionnaire is
to be brief and to avoid any kind of bias and jargon. Therefore the wording of the
schedules was very carefully selected to ensure that it is user friendly, and jargon
free.

4.9.5. Coding the Responses of the Questionnaires

Each question was given a code in advance and a database was developed using
SPSS version 11.5.
4.9.6. Reviewing and Finalising the Interview Schedules

A review of the draft interview schedules was undertaken during an afternoon meeting with various professionals including, the medical director, the research co-ordinator, a service user representative, ward managers and a Community Psychiatric Nurse (CPN). This was to enable the researcher to assess the feasibility of this study, evaluate the content, length, sequencing, sensitivity, layout, relevance, user friendliness, practicality and appropriateness of questions. Also, to check that all items of the interview schedule were easily understood, to foresee any later problems with completion and if possible anticipate and reduce bias. Where appropriate, questions were revised and refined to reflect more accurately the study’s objectives, and research primary and secondary questions.

4.9.7. Reliability and Validity of the Interview Schedules

Breakwell et al (2000) argue that the interview technique yields data that are reliable and valid as any other research method, although this approach relies on subjects giving accurate and complete answers to questions posed.

The semi-structured interview schedule was constructed using a systematic set of questions, aiming to provide internal consistency across responses, offering one way of assessing the validity of data (Oppenheim 1992). Of course consistency of responses does not guarantee accuracy; however, through a face to face semi-structured interview the researcher was able to clarify issues. Furthermore the validity of the patients’ data was established by gathering additional evidence from their named nurses.

Content validity refers to the capacity of the items to represent the domain under study (Oppenheim 1992). This was established through evidence used from the relevant literature on revolving door patients. Furthermore, content validity was
substantiated by incorporating the comments and advice from various “experts” (Pope and Mays 2000a) including the researcher’s supervisors at Surrey University. Integrating their comments and suggestions into the final construction of the interview schedules (for example- what aspects of care the patients appreciated most and least and their willingness to return to the same ward if they needed similar treatment in the future-) ensuring that the data would yield the information required of the population under study. Thus the combination of practical and technical expertise helped the capture of important information relevant to the study’s objectives and created an interview schedule that could be considered credible, reliable and valid (Pope and Mays 2000b). Apart from the purpose of research the current interview schedules have many other potential clinical uses including; audit, evaluation, patient screening and sharing and communicating information with a multi-disciplinary team.

4.10. The Analysis

The aim of the research, the research questions and the type of data determine the level of analysis (Bryman and Cramer 1992). In this study quantitative (numerical) as well as qualitative (words) data were collected for analysis. Within the context of quantitative analysis, the responses (nominal data) of nine patients (5 RD and 4 Non-RD) were inputted into SPSS version 11.5 and were analyzed using frequencies in descriptive statistics. However as the sample size was small significance levels were not calculated. The responses to the open ended items of the semi-structured interview schedule were cited verbatim within the text directly as cited by the participants.

The results of this study link with the results of study (b) and wherever appropriate, comparisons of data between the two studies are made.
4.11. THE FINDINGS

4.11.1. Demographic Characteristics

Table 1: Patient Age, Gender, MHA, Ethnicity, Marital Status

<table>
<thead>
<tr>
<th>N</th>
<th>M</th>
<th>Age</th>
<th>MHA</th>
<th>Act</th>
<th>Ethnicity</th>
<th>Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>RD Patients</td>
<td>4</td>
<td>1</td>
<td>Mean=48.3</td>
<td>2</td>
<td>100% white</td>
<td>3M single, 1M separated, 1F married</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>&gt; 65</td>
<td>N=2</td>
<td>Informal</td>
<td>(S3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Range=18-68</td>
<td></td>
<td>1</td>
<td>white</td>
<td></td>
</tr>
<tr>
<td>Non-RD patients</td>
<td>2</td>
<td>2</td>
<td>Mean=45.2</td>
<td>4</td>
<td>100% white</td>
<td>1M &amp; 1F married, 1M single, 1M divorced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt; 65</td>
<td>N=4</td>
<td>Informal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Range=18-64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A total of five RD subjects all white, four males and one female were interviewed. Their age ranged from 18 to 68 years. The mean age was 48.33. Two patients were over the age of 65. Two male patients were informal and two males and one female were on section 3 of the MHA. Three male patients were single, one male was separated and one female patient was married.

Four Non-RD patients, two males and two females were interviewed. Their mean age at 45.2, was lower than the mean age of RD patients. The age range was 18-64 hence all participants were less than 65 years old. All subjects were informal admissions. As with the RD patients, Non-RD patients were white. This is not surprising as according to the last census in 1991 the population in Surrey is predominantly white (97.2% of population is white).
As shown in table 2, a total of four RD patients, three males and one female were unemployed and only one male was employed. One male was living alone and three males and one female were living with others, (family, or in hostel accommodation). One male had a diagnosis of recurrent bipolar disorder, one male had a primary diagnosis of depression and a secondary diagnosis of alcohol misuse and a male and female had a diagnosis of bipolar schizoaffective disorder.

As regards to Non-RD patients a male and a female participant were employed, one female was unemployed and one male was retired. One male and one female were living alone and one male and one female were living with partners. One male and one female had a diagnosis of depression and one male and one female patient had a diagnosis of bipolar affective disorder.

4.11.2. Number of Re-admissions (RD Patients)

Two male patients had four readmissions within two years and another male patient had six previous admissions. Two female patients had three and six readmissions respectively.
Table 3: RD and Non-RD Patients’ Reason for Admission and Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Reason for admission</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>RD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>patients</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Non-RD</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>patients</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

Reasons identified for admission were extracted from patients nursing and medical records. Depression accompanied by suicidal thoughts was recorded as a main reason for the admission of three RD patients. One male patient was admitted following an arson attack and a female patient was admitted having had paranoid ideas, triggered by marital problems and arguments with her husband.

Reasons identified for admission for the Non-RD group included; two patients had suicidal thoughts, and depression, one patient was displaying bizarre behaviour and delusions, and the forth patient had a break down following physical ill health which was not treated adequately by the acute general health care services.

4.11.3 Inpatient Care Items (Patient Involvement in Their Care Plan/Co-Ordination of Their Care)

When RD patients were asked to give their opinion on the co-ordination of their care, one patient said it was excellent, one said it was very good, one stated that it was satisfactory, one poor and one said that it was extremely poor. When the same patients were asked how they rated their involvement in their care plan one patient rated this as excellent, another as very good, two patients as very poor, and one participant rated their involvement as extremely poor. When Non-RD participants were asked to give their opinion on the co-ordination of their care, one patient said it was excellent, and three said it was very good. All four patients felt a
sense of involvement in their care plan. One patient rated their involvement as excellent, two as very good and another as satisfactory.

4.11.4. Patient’s Relationship with Their Named Nurse

One RD patient stated that their relationship with their named nurse was very good; one rated the same as satisfactory, one as very poor (the patient commented that the time the nurse spends with him is very limited) and two did not wish to respond. Three Non-RD patients said that their relationship with their named nurse was very good, and one rated their relationship as satisfactory.

When participants were asked to rate the empathic qualities of nurses seven patients three RD and four Non-RD, highly praised the empathic qualities of nurses. Two patients, a male RD and a female Non-RD, commented on their named nurse’s ability to listen and understand their problems “I like her she always listens when I want to talk” and ”she seems to understand what I am going through”.

4.11.5. Access to Treatment/Therapies

RD patients rated the access to treatment and therapies as poor (N=3) as very poor (N=1) and extremely poor (N=1). Non-RD patients reported access to treatment/therapies as satisfactory (N=2) and poor (N=2). Three patients mentioned that they would like better recreational facilities and commented on the shortages of staff (therapy professionals) making access to treatment/therapies difficult.

4.11.6. Advice/Information on Medication, Treatment, Illness, Services

Participants were asked to rate the information they received regarding their medication, treatment, their illness and various services. All RD patients rated the advice/information on medication as either poor or very poor. Two participants stated
that they had only received partial information and four said that they did not receive any information on their medication. When patients were asked to rate the information they received regarding their illness one patient stated it was satisfactory, two subjects stated that it was poor, one extremely poor and one patient did not respond. Regarding their treatment patients rated the information they received, as follows; two RD rated the information poor, two patients very poor and two participants did not respond. Patients were asked to rate the information they received on the various services. One RD patient said it was poor, one patient stated the information they received was very poor and one patient said it was extremely poor. Two patients did not wish to comment.

When Non-RD patients were asked if they had received information regarding their medication only one Non-RD patient said that they received complete information, two stated that they had only received partial information and one patient did not respond. Patients were asked to rate information they received on the various services. Two Non-RD patients said they had received excellent information and two patients stated the information they received was very poor. When patients were asked to rate the information they received regarding their illness three Non-RD patients stated they received very good, and one patient said the information they received was poor. Regarding their treatment overall, patients rated the information they received, as follows; two very good, one satisfactory and one patient rated the information poor.

The above findings can be summed up by the comments of one Non-RD patient; “it’s nice to have access to information, but the nurses don’t tell you; you have to find out for yourself. I find out because I am interested”.

142
Table 4: RD and Non-RD Patients' Compliance with Medication

<table>
<thead>
<tr>
<th>Compliance with medication</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>6</td>
</tr>
<tr>
<td>Most of the time</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1</td>
</tr>
<tr>
<td>RD</td>
<td>2</td>
</tr>
<tr>
<td>Non-RD</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
</tr>
</tbody>
</table>

Six participants, two RD and four Non RD stated that they always comply with medication; one RD patient stated that they comply most of the time and one RD patient complies sometimes saying, "when I feel that the medication doesn't work I stop taking it". One RD patient did not respond.

Table 5: RD and Non-RD Patients' Rate of the Ward Environment

<table>
<thead>
<tr>
<th>Ward Environment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>4</td>
</tr>
<tr>
<td>Good</td>
<td>2</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>2</td>
</tr>
<tr>
<td>Poor</td>
<td>1</td>
</tr>
<tr>
<td>Very poor</td>
<td>1</td>
</tr>
<tr>
<td>RD</td>
<td>2</td>
</tr>
<tr>
<td>Non-RD</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
</tr>
</tbody>
</table>

When participants were asked to rate the ward environment including its safety, four subjects, two RD and two Non-RD said it was very good, one RD and one Non-RD stated that it was satisfactory, one RD and one Non-RD said it was poor. The Non-RD patient claimed "I don't feel safe, there are no locks on the doors and others can have access to your room". One RD rated the environment as very poor commenting on the high noise; "it is very noisy here, some patients make a lot of noise, shouting and screaming most of the time".
4.11.7. Patients' Expectations, Needs and Satisfaction with Care Received

When RD patients were asked whether the care they received matched their needs and expectations one subject stated that all their needs and expectations were met, two patients agreed that some of their needs/expectations were met and a further two participants chose not to respond to the question. When the same subjects were asked how satisfied they were with the care they received, one patient was very satisfied, one was dissatisfied, two were quite dissatisfied and one subject did not respond. A male patient suggested; "I need appropriate medication, accommodation and intensive treatment to stop me revolving".

When Non-RD patients were asked whether the care they received matched their needs and expectations three subjects responded that all their needs and expectations were met whilst one participant stated that only some of their needs and expectations were met. When patients were asked how satisfied they were with the care they received, three participants stated that they were very satisfied, and one was quite satisfied. A female Non-RD patient stated that she had no preconceptions and therefore did not know what to expect.

Graph 1: RD and Non-RD Patients' Degree of Expectation With Care
4.11.8. Aspects of Care Appreciated Most

When patients were asked to give specific examples of the things they appreciated most during their care, the majority of their comments were related to staff attitudes. The following exemplars extracted from the semi-structured interview schedules illustrate their views and perceptions; two males an RD and a Non-RD patient stated that “nurses are very caring”, a further RD male patient commented on the “caring attitude and professionalism of nurses”, and a female Non-RD patient said “when staff speak to you they do it with respect”. A female Non-RD patient was appreciative of the fact that “nurses listened to me when I needed assistance, and this helped me to make the right decision” and a female RD patient commented on the “kindness of staff and the privacy given to me when my husband visited me on the ward”. An RD male mentioned the specific group meetings he participated in and a female Non-RD appreciated the physical environment saying, “they build modern hospitals”.

4.11.9. Aspects of Care Appreciated Least

When patients were asked to report on the things they appreciated least, the following are some of their comments. A male RD patient said, “I find it hard to put my feelings across and staff do not understand my problems”, another RD male stated that “staff do not listen to my problems and going to meetings is a waste of time” and a third RD male patient found that being “sectioned under the MHA and contained on the ward is very restrictive”.

A female Non-RD patient reported that “when I requested to have a bath at 6.30 a.m. the nurses refused without giving any explanation, and this made me feel like a naughty child”. One RD and a Non-RD male patient commented that the lack of therapies was something, they did not appreciate.
4.11.10. Patients’ Discharge Care Plan

Only one male RD patient knew the date of his discharge and only one male patient stated that they had the opportunity to discuss their community needs with their named nurse or care co-ordinator. Reasons cited included; “my care co-ordinator is on leave”, I am not sure who my care co-ordinator is”, I don't think I have been allocated a care co-ordinator “. When participants were asked whether their discharge needs and expectations were met one RD patient stated that some of his needs and expectations regarding the discharge plan were met whilst the remaining four patients stated that none of their needs and expectations were met. A female patient reported that “the process of getting discharged takes too long”.

From the group of Non-RD patients' one patient knew the date of their discharge and two patients stated that they discussed their community needs and discharge plan with their named nurse or care co-ordinator. Two patients’ felt their discharge needs and expectations were met.

4.11.11. Participation in Discharge Programs in Preparation For Discharge

Participants were asked to report whether they attended any programs in preparation of their discharge; a male RD patient stated that he attended training on daily living skills, however he commented “I don’t feel ready for discharge; I was not given any information about what I need to do when I am out of hospital”. A female RD patient stated that she did not attend any programs, she did not receive any information regarding her discharge, and complained about her physical needs (care of feet and teeth) not being met. A male RD patient and female Non-RD patient did not attend any programs, though the Non-RD patient felt that she was ready for discharge. A male Non-RD patient attended cooking sessions and two male RD and a female Non-RD attended group meetings and they were given the telephone numbers of the
following services; their care co-ordinators, helpline, extended hours service, assertive outreach team, the CMHT, and social services. When patients were asked whether they felt ready for discharge only three patients gave a yes response.

Table 6: Satisfaction with DP and Willingness to Return to the Same Ward

<table>
<thead>
<tr>
<th></th>
<th>Satisfaction with DP</th>
<th>Willingness to return to same ward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfaction</td>
<td>Dissatisfaction</td>
</tr>
<tr>
<td>RD patients</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Non-RD patients</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

One male RD patient showed satisfaction with their DP and his involvement; and the same patient stated that he would be willing to return to the same ward if he required similar treatment in the future. However his return would be conditional “provided certain patients were not there”. Three patients' two males and a female stated dissatisfaction with their DP and their involvement and would not be willing to return to the same ward if they needed future treatment. On male patient cited the following reasons; “I don’t like the staff, I don’t’ like the environment it’s very untidy and I don’t’ like the way the unit is run”. However, being “revolving door” and as a male RD patient pointed out “we have no choice” indeed, their options may be limited and the expectation from both patients and staff is that they would be readmitted in the future. Furthermore if they are put on section under the MHA, (they are admitted into hospital without their will), this might also cause some resentment.

When patients were asked if they would recommend the service to a family member or friend two said yes, two said no and one was a missing response. All four Non-RD patients were satisfied with their DP, and their involvement. Two patients felt that all their needs and two stated that some of their discharge needs were met. They all
stated that they would return to the same ward if they needed similar treatment in the future and would recommend it to a family member or friend.

4.11.12. Social Networks and Support

Participants were asked to report on their social network and support when they are in the community; overall RD patients cited family members, friends, ex-psychiatric patients, drop-in centers, a clubhouse and their local church as contacts and sources of support. One RD member mentioned a “strained relationship” with his parents and a single female RD patient cited “loneliness and isolation are my problems in the community”.

All Non-RD participants mentioned their family and friends as being the sources of their support, commenting “my husband is very good to me; he supports me” “I have many friends who look out for me”.
Table 7: Summary of Key Findings (Phase II-Study (A)): Exploratory Face to Face Semi-structured Interview with Patients

<table>
<thead>
<tr>
<th>RD Group</th>
<th>Non-RD Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age=48.33</td>
<td>Mean Age =45.2</td>
</tr>
<tr>
<td>Higher proportion of single patients</td>
<td>Higher proportion of married patients</td>
</tr>
<tr>
<td>Higher proportion of patients on MHA section</td>
<td>Lower proportion of patients on MHA section</td>
</tr>
<tr>
<td>Reasons for relapse “mental deterioration” social isolation and inadequate follow up, lack of support (Focus group studies) Similar reasons were cited</td>
<td>NA</td>
</tr>
<tr>
<td>Most are dissatisfied with their involvement in their care plan/discharge plan and their needs and expectations being met</td>
<td>Most are satisfied with their involvement, discharge plan and their needs and expectations being met</td>
</tr>
<tr>
<td>Dissatisfied with the information received</td>
<td>Satisfied with information received</td>
</tr>
<tr>
<td>Satisfied with ward environment</td>
<td>Satisfied with the ward environment</td>
</tr>
<tr>
<td>Praised empathic quality of nurses</td>
<td>Praised empathic quality of nurses</td>
</tr>
<tr>
<td>Some RD patients appreciated the caring attitudes of nurses, listening and empathy</td>
<td>Non-RD patients appreciated the listening skills and the respect they show to patients</td>
</tr>
<tr>
<td>Some RD patients did not appreciate that nurses are not able to listen and understand their problems</td>
<td>An Non-RD patient felt she was treated like a child</td>
</tr>
<tr>
<td>Some found going to meetings a waste of time</td>
<td></td>
</tr>
</tbody>
</table>


4.12. PHASE II: FACE TO FACE SEMI-STRUCTURED INTERVIEWS WITH NAMED NURSES (STUDY B)

4.12.1. Introduction

Subsequent to patients face to face interview their named nurses (responsible for coordinating the care of the nine patients included in the study) were also interviewed face to face by the researcher through the use of a semi-structured interview schedule (appendix 2). The purpose of the interview was to obtain named nurses opinions regarding the care delivered to patients and validate and compare these with the patients’ responses.

4.12.2. The Aim of the Study

➢ To explore and determine named nurses views and perspectives regarding the quality of RD and Non-RD patients care

4.12.3. Objectives of the Study

➢ To obtain named nurses views on the care received by RD and Non-RD patients.
➢ To obtain named nurses views regarding patient discharge planning during the patient’s admission and discharge phase.
➢ To compare and validate patients’ and nurses’ responses regarding the above issues
4.12.4. The Study Design and Rationale

In addition to the patients' data their named nurses responses were also gathered using the same method of a face to face semi-structured interview; the aim was to obtain additional information on the same issues from the nurses perspectives and to validate the data already obtained, hence asking similar questions and employing the same method was regarded an appropriate technique. As a means of data collection interviews can be versatile, flexible and adaptable adding to the understanding of the participants' perspectives (Polit and Hungler 1997).

4.12.5. The Sample

Six nurses were identified as named nurses of the patients already interviewed during study (a) of phase II (named nurses are responsible for the co-ordination of patient care, including nursing care plans, discharge plan and patient reviews). All nurses, three males and three females agreed to participate in study (b) constituting a purposive sample. All named nurses, were qualified, with previous psychiatric experience ranging from three to more than twenty years and were between 26-50 years old.

4.12.6. Description of the Tools Used (Nurses' Semi-structured Interview Schedule (IS) Appendix 2)

The named nurse semi-structured interview schedule (appendix 2) is confidential. It is constructed in four sections. The first section (A) seeks information on named nurses' demographic details such as age, gender, job title, length of time in present position, number of years of psychiatric experience, and courses attended since qualification. Section B is concerned with nurses' opinion regarding the contributory factors to patients relapse (open ended question) whilst, section C matches the
inpatient care items of the patients' IS regarding the nurses perceptions on the standard of patient care, co-ordination of care, patient involvement in their care the nurse patient relationship, access to treatment and therapies advice on information given to patient on medication, on their treatment their illness, services and ward environment. The questions in section C are highly structured requiring the participants to choose one of five Likert type responses ranging from very poor to excellent. In addition this section covers the patients compliance with medication (responses ranging from always to never) and whether the care plan matches the patients needs and expectations (responses ranging from yes all to none) Section D reflects the items of the patients' IS regarding discharge planning; asking whether patients are adequately prepared for discharge (responses of yes or no) whether the plan matches the patients needs and expectations (responses from yes all to none) and how satisfied they are with the patients discharge plan (responses range from extremely dissatisfied to extremely satisfied). The layout and design is comparable to the patients' interview schedule consisting of open ended and highly structured questions.

4.12.7. The Interviews

Three interviews took place following the patients' interviews and three were carried out within seven days of the patients discharge depending on the nurses' availability. All interviews were conducted in a comfortable office adjacent to the wards, with no interruptions. Interviews lasted from 30–45 minutes. The nurse participants were the named nurses of the nine patients already interviewed during study (a).

The face to face interview gave an opportunity to the nurses to clarify issues with questions. For example a female nurse felt that the question about “whether nurses would be willing to be admitted to the same ward they were working if they ever
needed psychiatric treatment” should be omitted; she felt that the responses to this question were quite obvious (categorical no).

4.13. The Analysis

The named nurses quantitative responses to the highly structured items were coded and inputted into SPSS version 11.5 and analyzed using frequencies in descriptive statistics; The qualitative responses to the open ended items were written verbatim in the text.
4.14. THE FINDINGS

4.14.1. Description of Participants Characteristics

A total of six, three male and three females named nurses were interviewed face to face. One nurse was between 26-30 years old and had less than one year of psychiatric experience. Two nurses were between 31-40 years of age, one of which had worked between 8-15 years and the other had over 15 years of psychiatric experience. Of three nurses between the ages of 41-50 years, one had between 1-3 years and two had more than 15 years of psychiatric experience. One nurse was a deputy ward manager and five were staff nurses. Two nurses attended an in-house risk management course, two attended a mandatory in-house training, and two did not attend any course since qualification.

4.14.2. Contributory Factors to Patients Relapse and Readmission

Nurses were asked to report on the contributory factors to their patient's relapse and readmission. Amongst the reasons given included; one male nurse talked about a patient who is non-compliant with medication; “he does not take his medication at the right time or the right dose; he also lacks confidence and self esteem and is dependent on others, he is institutionalized”. Another male nurse cited non-compliance with medication concerning his patient, highlighted the lack of structure in the patient’s day, and mentioned that the patient also abuses alcohol. A third male nurse spoke about a patient’s “dangerous behaviour of setting fire to a bungalow he broke into”. A female nurse stated that her patient’s “long term mental health problems of low moods and depression, and her husband’s inability to cope with her” led to the patient’s readmission.
Another female nurse cited patient's "extreme financial worries, mental state of low mood and suicidal thoughts". In summary amongst factors contributing to patients' relapse gathered from nurses interviews included; non compliance with medication, extensive financial worries that led to depression and suicidal thoughts, family unable to cope with patients long term mental health problems, alcohol abuse and extreme dangerous behaviour.

4.14.3. Patient Admission

Named nurses were asked to respond whether in their opinion their patients' admission could have been prevented. One female and a male nurse stated that admission could have been prevented for their patients; the female nurse felt that her patient was admitted into the psychiatric hospital following inadequate care and follow-up from a general hospital after a spinal surgery. The male nurse reported that his patient was admitted because of previous suicidal attempts therefore "it was a safe step to take for his and our benefits".

The remaining four nurses two males and two females stated that patients needed to be admitted into hospital and admission could not have been prevented. Two nurses however felt that more intensive community and social support (more input from other agencies such as social services) would help to prevent patients' readmission.

4.14.4. Nurses Opinions about Standard of Care/ Co-Ordination of Care, Patient Involvement

When nurses were asked to rate the standard of patient care, all six nurses rated this as very good. Three nurses said that co-ordination of care was excellent and the other three stated that it was very good. When nurses were asked to rate the
patients' involvement in their care plan three nurses said it was excellent, two said it was very good and one nurse thought it was satisfactory.

4.14.5. Nurse Patient Relationship

All nurses reported a good relationship with their patients' however a female nurse mentioned "the shortages of staff and the lack of time as being crucial in preventing them spending quality time with patients". All six nurses reported of showing empathy with patients, and being able to listen and understand their problems.

4.14.6. Access to Psychological Treatments and Therapies

Regarding access to treatment and therapies nurses' opinions differed; four participants stated that patients have access to a wide range of treatments and therapies whilst the other two reported that access to these is very limited. As a female nurse observed; “we don’t have enough psychologists and occupational therapists on the ward, because of recruitment difficulties” supported by a response from a male nurse who commented “we have a shortage of people from the therapy professions and most of the time, it’s to do with financial resources”.

4.14.7. Information Items

All nurses reported that information received by patients on medication, their illness, treatment and services was either very good or excellent.

When nurses were asked to give their opinion regarding the ward environment four nurses stated that the ward environment was very good describing it as "bright and cheerful"; one nurse said it was satisfactory and one nurse reported that it was poor. The same participant felt that the ward was very "untidy and needed decoration".


Nurses were asked to report whether the care the patient received matched their needs. Five nurses reported that the care plan matched the patients’ needs. However according to one male nurse his patient’s needs were not met as "patient is not compliant with the prescribed treatment. He refuses to participate in group programs".

4.14.10. Patients’ Compliance with Treatment and Medication

Regarding treatment and compliance with medication nurses confirmed patients’ responses in that some patients comply and others comply some of the time. A male nurse reported that when some patients “are not well, they don’t participate in the treatment programs and they believe they don’t need medication or treatment”.

4.14.11. Patients’ Discharge Preparation and Plan

When nurses were asked whether in their opinion patients were adequately prepared for discharge all six nurses responded that patients were adequately prepared. Nurses were asked whether patients were ready for discharge. Five nurses except one stated that the patients were ready for discharge and five nurses responded that the discharge plan met the patients’ needs and expectations and five nurses were quite satisfied with the patient discharge plan. The participant, who
reported that the patient's plan has not met their need, commented that “the discharge destination was not appropriate and hence the patient had to wait on the ward until an appropriate accommodation became available”.

4.14.12. **Nurses Willingness to be Admitted Into The Same Unit**

Nurses were asked whether they would be willing to be admitted to the same ward, or whether they would recommend it to a family member or friend; all six nurses answered no to both questions, but they justified their responses stating; “I wouldn’t like to be admitted as a patient in the same work area where I am known by colleagues”, “the unit is in my local area therefore I would prefer to go to another area”, “I have been in this unit for a long time and I would have to change my relationship with patients”, “I wouldn’t like to be admitted on this ward, not because of inadequate care but because I am a member of staff”.

4.15. **Summary of Key Findings and Comparison with the Previous Study**

- Four nurses are quite satisfied with the standard of care whilst two nurses are not, and three nurses feel that co-ordination of care is excellent. (When comparing nurses with patients responses there seems to be more agreement with the nurses’ statements in that the majority of patients also felt that the standard of care is good).

- All nurses are satisfied with the patients discharge plan and five out of six feel that patients were adequately prepared and ready for discharge. However this is contrary to RD patients’ responses in that half of them felt that they were not adequately prepared for discharge, and seven including RD and Non-RD patients, did not know the date of their discharge.
• All six nurses are satisfied with the patients' involvement in their care plan. (There seems to be an imbalance of responses from patients; whilst three RD participants rated their involvement as very poor, all Non-RD patients rated their involvement as good).

• Five out of six nurses state that the ward environment is very good or satisfactory (with regards to patients, six (including RD and Non-RD) patients rated the environment from satisfactory to very good whilst three participants rated the same as poor or very poor.

• All nurses reported that they would not be willing to be admitted in the same ward if they ever needed treatment in the future. (In comparison one RD patient and four Non-RD patients would be willing to return to the same ward).
4.16. PHASE III: REVIEW OF PATIENTS MEDICAL AND NURSING RECORDS

4.16.1. Introduction

Consequent to patients and staff conflicting responses about the quality of care during the face to face semi-structured interviews, RD patients’ nursing and medical records were examined by the researcher and a research assistant; with the aim of delving further and identifying in more detail about what is involved in patients’ discharge care plan focusing on pre-discharge assessment, the patient readiness for discharge, assessment of community needs and expectations, after care arrangements, relapse-plan and information given to patients.

Through this phase of the research, the medical and nursing inpatient records were used to provide clinical information on patients' process of discharge. The records map patient progress against the aims and objectives of their care plan, documenting the various professionals assessments of needs, risk factors and views including; treatment, medication, nursing, medical and other professional treatment and care (e.g. psychology, occupational therapy, art and music therapy). Although there is a multi-professional input, the ultimate responsibility of care co-ordination and keeping the care plans up to date rests with the patients' named nurses.

4.16.2. The Aim of the Study

➢ To review RD patient medical and nursing records in order to identify the processes involved during their discharge planning.

4.16.3. The Objectives of the Study

➢ To identify the level of patient involvement in their discharge care plans
➢ To examine patient follow up and after care plans to determine what is written regarding, assessment of community needs and patient expectations, discharge preparation and relapse plan
➢ To determine the level of patient support and aftercare arrangements following their discharge

4.16.4. The Study Design and Rationale

In this study a quantitative secondary retrospective data analysis through patients' records was employed. Scott (1990) considers documentary sources of information of all kinds to be the “accounts, returns, statutes and proclamations that individuals and groups produce in a written text in the course of their everyday practice and they are geared exclusively to their immediate practical needs”. Mason (1999) states that nursing care plans are written, structured records of action of patient care. Therefore, documentary evidence is a central part of health care research. Patients' records are considered to be amongst the most detailed existing accounts of the clinical course of illness and response to treatment (Pollack 1999). However, although documentary information features prominently in contemporary society, textbooks on research methods have generally failed to recognize this and focus their discussions on questionnaires, interviews, and participant observations (Scott 1990, Reed 1992). Indeed the researcher's own experience confirms this, as searching through the literature very little information on documentary sources as a subject of research methodology was found.

However following the patients and named nurses responses during the face to face interviews, the medical and nursing records were examined in order to observe further the process of patient's discharge. The intention was to produce further information and integrate the data with the two previous studies in phase II, and to
augment and cross validate the information already obtained through the previous phases of the research.

4.16.5. The Sample

Nursing and medical records of thirteen recently discharged RD patients (last two months) forming a proportion of 65% of the total sample, were obtained from a list of twenty patients registered through the patients' affairs office. The records were selected in accordance to their accessibility at the time of data collection thus constituting a convenience sample. Seven records were not accessible to the researcher; three records were used by the RMO at the time of the review and four records were held on the wards for various reasons. The patients records reviewed were under the care of six consultants covering various localities of the trust. All patients on discharge had a diagnosis of severe mental illness according to the ICD-10 (International Classification of Diseases, 10th version). The range of inpatient readmissions was from 3-9 over a period of 24 months.

4.16.6. Description of the Tools Used (Pro-forma)

A pro-forma (appendix 5) was developed by the researcher to record patient clinical patient information; the themes that needed to be examined emerged through the responses of face to face interviews with patients and staff regarding patient discharge planning; therefore the pro-forma is designed to elicit data in four main areas; a) patients discharge plan and assessment; including date of discharge, summary of discharge letter, multi-professional involvement in DP, patient involvement, carer involvement, discharge preparation programme and patient relapse plan; b) patients pre-discharge, assessment including, readiness for discharge, assessment of potential risk factors, assessment of patient community
needs, and patients expectations of community support; c) aftercare and support arrangements including; destination address, a named care co-ordinator, a named carer/relative, financial issues, living circumstances, out patient appointments, frequency of CPN visits, other professionals involved in care, day center, and day hospital arrangements; d) information given on discharge including, medication, what to do in crisis, and who to contact in an emergency. All items of the pro-forma are highly structured requiring a choice of three responses; Yes, No or Not Applicable (NA) and placing a tick in the appropriate box.

4.16.7. Reliability and Validity of Patients Records

The major threats to reliability with patients' records (secondary data analysis) arise from the accuracy, specificity of the variables (mental health history, care plan, discharge plan, information given to patients, etc.) and completion or missing of data (Pollack 1999). The data were extracted from the records by two researchers, the study researcher and a research assistant, using a standardized pro-forma. A discussion and agreement between them took place before inserting a tick into the appropriate box on the pro-forma, thus strengthening reliability (ref).

Validity refers to the appropriateness of the logical consistency of the data representing the concepts intended by the researcher (Breakwell et al 2000). The researcher decided from the outset what data were relevant to the research questions and to the aims and objectives of the study.

One problem with this method is that the researcher has no control over the quality of the recorded information (i.e. the consistency, accuracy and completeness of data). Secondly data from patients' records may not be suitable for the purpose of research; data might be subjective representing professionals' views of a situation that changes over time. However collecting data through the patients' records for the purpose of
the current study is a useful and viable approach in particular as the data are examined in combination with the other data of the research and relationships are identified.

4.16.8. The Analysis

The information gathered from each record was discussed and agreed between the researcher and the research assistant prior to recording the observations on the pro-forma. Each pro-forma was examined manually and data were aggregated for analysis using frequencies in descriptive statistics. Content analysis of discharge plans was also carried out.

The results are tabulated below and graphs are used to highlight key findings; also to establish whether patients and staff responses in the two previous studies can be corroborated or refuted.

4.17. THE FINDINGS

4.17.1. Discharge Plan and Assessment

Table 1: Patient Discharge Plan Assessment

<table>
<thead>
<tr>
<th>Discharge Care Plan</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge date clearly stated</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Discharge summary and copy of letter to GP</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Evidence of multi-professional involvement in DP</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Evidence of patient involvement in DP</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Evidence of carer involvement in patient's DP</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Evidence of patient discharge preparation program</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Relapse plan for patient</td>
<td>1</td>
<td>12</td>
</tr>
</tbody>
</table>
When patients records were reviewed (as shown in table 1), the discharge date was clearly stated in 8 records, there was evidence of a discharge summary and copy of a discharge letter to the patients GP in 10 records, from the patient CPA documentation there was only evidence of a multi-disciplinary involvement in 5 patient records; the records showed that only 5 patients and 4 carers were involved in their discharge plan. Only five records indicated that there was some kind of discharge preparation for patients, and only one record showed evidence of a relapse plan for patients.

Table 2: Patient Pre-Discharge Assessment

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there any evidence of assessment of patient's readiness for discharge?</td>
<td>4</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Is there any evidence of pre-discharge assessment and potential risk factors for patient?</td>
<td>4</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Is there any evidence of pre-discharge assessment of patient community needs (including resources)?</td>
<td>6</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Is there any evidence that patient's expectations of community support and after care needs have been identified?</td>
<td>1</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

Only four patients were assessed regarding readiness for discharge and four patients records showed evidence of risk assessment. Regarding patients community needs six patients were assessed; with reference to expectations of community support and aftercare needs there was evidence of assessment in one patient record.
Table 3: Aftercare and Support Arrangements

<table>
<thead>
<tr>
<th>Aftercare and Support Arrangements</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there any evidence indicating that the following aspects of patients discharge been identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>prior to discharge?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Destination address</td>
<td>11</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Care co-ordinator</td>
<td>10</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Carer/relative</td>
<td>7</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Financial issues/concerns</td>
<td>7</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Living circumstances identified (e.g. patient living alone)</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out Patient Appointment dates, and who to see</td>
<td>9</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Frequency of CPN visits</td>
<td>7</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Other professionals involved in patient’s care</td>
<td>5</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Other services involved in patient’s care</td>
<td>6</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Details of attendance at day centre, day hospital etc. (if applicable)</td>
<td>8</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Regarding aftercare and support arrangements 11 records showed a discharge destination address, 10 records showed that a care co-ordinator had been allocated, 7 records indicated that a carer/relative had been informed, 7 records suggested that financial issues, and 12 records showed that the living circumstances of patients had been considered. There was an entry in nine records regarding out patient appointments, 7 entries regarding CPN visits, 5 records indicated other professionals involved in patients’ care, 6 records showed other services involved and 8 records showed details of day services, and day hospital involvement.

Table 4: Information Given To Patients on Discharge

<table>
<thead>
<tr>
<th>Details of Information given on discharge</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>What to do in crisis</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Who to contact in emergency</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

As regards to information given to patients on discharge, there was no evidence in the records about advice on medication, only one entry on what to do in crisis, and only two records showed any evidence regarding who they could contact in case of emergency.
4.18. Further Observations Relevant To Patients Records

4.18.1. Risk Assessment

Although there was a risk assessment in 90% of records reviewed, this was undertaken one or two days following the patients' admission. There was no evidence of risk assessment done prior to patient discharge. Care plans did not always reflect patient risk assessment. (Doctors usually undertake risk assessments, whereas nurses write the care plans.)

4.18.2. Patient Assessments

The type of assessments found in patients' notes included; nursing, medical, occupational therapy and psychological assessments each done by a different professional. This practice sometimes causes a great deal of duplication (e.g. patient history, demographic data) and leads to several uncoordinated, non-holistic unidimensional patient care plan.

4.18.3. Care Plan

Different care plan formats exist. Some are standardised pre-typed with headings and gaps to be filled in, (e.g. specific for patients on MHA sections, and patients with low compliance of medication) and others are hand-written. The review of case notes revealed that although RD patients have a nursing care plan for each readmission, all nursing care plans seem to be identical or quite similar. Furthermore, as indicated in the patients records the majority of care plans were not signed by the patient except the one of the index admission. All subsequent care plans are not signed, suggesting that these are copies of the first, confirming RD patients' views regarding minimal involvement in their care plans. Although nurses write most care plans, occupational therapists seem to have their own care plans for patients which
are not linked to the nurses care plans. The review revealed no continuation, monitoring and implementation of care plans.

4.18.4. Evaluation Form and Progress Notes

Content examination of evaluation forms indicated that there is no link of these to the care plan. Evaluation forms seem to describe the daily progress of the patient as well as reporting activities and significant events on a daily basis. The daily progress notes are recorded in a similar manner as the evaluation forms.
Table 5: Summary of key Findings

<table>
<thead>
<tr>
<th>Area of Evidence</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge date clearly stated</td>
<td>8</td>
</tr>
<tr>
<td>Discharge summary and copy of letter to GP</td>
<td>10</td>
</tr>
<tr>
<td>Evidence of multi-professional involvement in DP</td>
<td>5</td>
</tr>
<tr>
<td>Evidence of patient involvement in DP</td>
<td>5</td>
</tr>
<tr>
<td>Evidence of carer involvement in patient’s DP</td>
<td>4</td>
</tr>
<tr>
<td>Evidence of patient discharge preparation programme</td>
<td>5</td>
</tr>
<tr>
<td>Relapse plan for patient</td>
<td>1</td>
</tr>
<tr>
<td>Evidence of assessment of patient’s readiness for discharge</td>
<td>4</td>
</tr>
<tr>
<td>Evidence of pre-discharge assessment and potential risk factors</td>
<td>4</td>
</tr>
<tr>
<td>Evidence of pre-discharge assessment of patient community needs</td>
<td>6</td>
</tr>
<tr>
<td>Evidence of patient’s expectations of community support and after care</td>
<td>1</td>
</tr>
<tr>
<td>Destination address</td>
<td>11</td>
</tr>
<tr>
<td>Care co-ordinator identified</td>
<td>10</td>
</tr>
<tr>
<td>Carer/relative identified</td>
<td>7</td>
</tr>
<tr>
<td>Financial issues/concerns</td>
<td>7</td>
</tr>
<tr>
<td>Living circumstances identified (e.g. patient living alone)</td>
<td>12</td>
</tr>
<tr>
<td>Out Patient Appointment dates, and who to see</td>
<td>9</td>
</tr>
<tr>
<td>Frequency of CPN visits</td>
<td>7</td>
</tr>
<tr>
<td>Other professionals involved in patient’s care</td>
<td>5</td>
</tr>
<tr>
<td>Other services involved in patient’s care</td>
<td>6</td>
</tr>
<tr>
<td>Details of attendance at day centre, day hospital</td>
<td>8</td>
</tr>
<tr>
<td>Advice on medication</td>
<td>0</td>
</tr>
<tr>
<td>Advice on what to do in crisis</td>
<td>1</td>
</tr>
<tr>
<td>Advice on who to contact in emergency</td>
<td>2</td>
</tr>
</tbody>
</table>
4.19. PHASE IV: FOCUS GROUP INTERVIEW WITH PATIENTS (STUDY A)

4.19.1. Introduction

Phase IV introduces two studies conducted through focus group interviews: study (a) focuses on RD patients perspectives about their care and follow up in the community and study (b) is concerned with staffs' opinions regarding similar issues. The focus group interviews were undertaken following on from the previous studies; in order to explore further and gather information collectively about the RD patients' opinions and views and establish personal perspectives regarding reasons for their relapse and re-admission, discharge preparation and community support; and to validate, strengthen and make comparisons with the findings of the previous studies of the research.

4.19.2. The Aim of the Study

➢ Within a group setting to identify patients views and perspectives regarding various aspects of their care in hospital and community settings

4.19.3. The Objectives of the Study

➢ Within a group setting, to identify patients' perspectives on reasons for relapse and re-admission into hospital
➢ To obtain RD patients views regarding their inpatient care
➢ To establish RD patients perspectives on discharge preparation, discharge care plan, and community support
4.19.4. The Study Design and Rationale

In this study an exploratory qualitative design utilising an interactive group interview method was employed to reveal participants’ views and attitudes, on various issues concerning the research questions. A focus group is defined as an “organised group interaction and discussion to explore a specific set of issues generating descriptive or exploratory information” (Kitzinger 2000). Focus group interviews are different from other types of interviews in that they generate data emerging through interaction with other group members (Kitzinger 2000). According to Mays and Pope (2000) using group interviews researchers are able to observe parts of interactions that are similar to naturally occurring data, that is, as data would be collected through observation. Clarke (1999) argues that focus groups are likely to bring the researcher closer to the research theme through a direct and powerful experience with relevant individuals. This is one of the reasons the approach was selected in the current study; in order to obtain information from participants in an interactive group setting that would be difficult to collect on an individual basis, about their views, attitudes, experiences, perspectives, and their understanding and priorities regarding key issues during their admission, discharge and follow up processes (Kingry et al 1990).

Furthermore, Kitzinger (2000) suggests that focus groups are appropriate for vulnerable populations such as older adults and people with mental health problems as these groups may feel disempowered. Hence, the group setting enables individuals to feel safe in a relaxed atmosphere with other people with similar situations, it empowers and supports individuals and therefore helps them to be more willing to share their thoughts and feelings and enables them to participate more in discussions (Peters 1993, Daly et al 2001).
Another reason for this approach was the selection of a purposive sample whereby RD patients were specifically selected to participate in a focus discussion regarding the issues under investigation and hence providing a greater degree of spontaneity in the expression of views than other alternative methods (Daly et al 2001). In addition, according to Sim (1998) focus group interviews are economical enabling the researcher to tap into the views and perspectives of many participants simultaneously.

4.20. The Sample

From a total of 44 in-patients nine subjects (20%) from two acute wards were identified as meeting the “RD” patient criteria. All nine participants (purposive sample of 5 male and 4 female) agreed to be interviewed yielding a 100% compliance rate. The participants were between 24-40 years old and had various diagnoses including: bipolar effective disorder, schizophrenia, depression and personality disorder; one male patient had a multiple diagnosis including schizophrenia, personality disorder, depression alcohol and drug misuse and another male patient had a diagnosis of obsessive compulsive disorder. The number of in-patient previous re-admissions ranged from 3-10 within the last 24 months.

4.21. The Tools Used to Collect the Data (Interview Schedule Appendix 6)

A series of open-ended questions (appendix 6) were used wishing to capitalize on patients shared experiences, feelings, opinions and perceptions about a given problem (e.g. why are they revolving?). At the same time encouraging them to explore issues of importance to them regarding pre-discharge preparation, discharge care planning, and community support.
4.22. The Interview

The focus group interview was conducted by the researcher and a research assistant. Once the purpose of the interview was explained the researcher sought participants’ written consent for their involvement in the study. The interview took place in the acute inpatient unit of the Trust in a quiet room lasting approximately one and half-hours. When asked, most patients indicated that they would feel uncomfortable to fully participate in the focus group if their responses were taped; also for reasons of confidentiality the researcher decided against recording the interview on tape. Nevertheless, the researcher and the assistant employed written notes and this was more acceptable to the participants.

The aim was to generate data based on participants’ attitudes/views towards their discharge process and their understanding regarding their community needs and follow up. Indeed, focus group interviews are particularly suited to the study of attitudes and experiences, embracing user recognition, consultation and inclusion as integral parts of the research process (Lane et al 2001).

4.23. Reliability and Validity of Focus Group Interviews

Whilst in quantitative research the concepts of reliability and validity are used to evaluate statistical findings in qualitative research employing the term “credibility” is more appropriate (Byrne 2001). A focus group interview is a qualitative process and essentially an interpretive process, requiring the input of the researchers own perspectives. The credibility of the current study was assessed in different ways. Firstly, the data of the focus group interview were gathered and categorised into themes by two people confirming each others interpretations (inter-rater reliability) (Mays and Pope 1995). Content analysis of the data was undertaken by the researcher and a research assistant. Categories were generated separately by the
two researchers and then synthesized and refined to provide the final coding frames thus helping to maximize the credibility of the method (Barbour 2001).

Secondly the categories and themes emerging from the data were checked by members participating in the study allowing them to challenge the researcher's assumptions (Sim 1998); and finally the data from the focus group interviews were triangulated (Koch et al 1998, Mays and Pope 2000) with the data from the previous studies looking for patterns of convergence to develop or substantiate an overall impression within the discussion section of this research. However, because of confidentiality concerns as well as the participants being anxious the interviews were not tape recorded; this might have missed some important issues. Nevertheless, two researchers were making written notes which were compared, confirmed each others data and synthesised before the creation of themes.

4.24. The Analysis

The written notes were compared for inter-rater reliability then collated and synthesised. The analysis of the information followed the qualitative process of content analysis described by Cavanagh (1997) and Woods et al (2002). The interview was conducted as an integrated part of the previous studies hence the main analytic categories were already identified through the core research questions. Key concepts such as discharge preparation and follow up, resources/support needed in the community, and feelings/perceptions about re-admission formed the key codes. Using Miles and Huberman (1994) model of content analysis, the data were displayed, cleaned and coded and similar structures formed the categories. Thereafter a second level of codes was assigned and meanings to words and sentences formed themes trying to raise questions aiming to describe the perspectives of participants. Similar data were grouped together and meanings were clustered into categories and themes (appendix 6).
Data were checked with participants to enhance their credibility, and interpreted and triangulated during the discussion phase of the research. The analysis of data in this study does not endeavour to generate theoretical generalisations but it rather attempts to express collective information in the context of the interaction amongst participants; an approach that is lacking when gathering data from questionnaires (Sim 1998).
4.25. THE FINDINGS

4.25.1. Emerging Themes

During the patients interview the following themes emerged; these themes represent the patients' perspectives of what they considered important in keeping them out of hospital and maintaining their well being in the community:

1. Discharge interventions
2. Nurse/patient relationships
3. Purpose and meaningfulness
4. Social isolation
5. Stigma and labeling
6. Struggling for control

4.25.2. Discharge Interventions

The initial discussion focused around discharge preparation for community and what the patients felt was effective in keeping them out of hospital. The views of participants were that not enough preparation takes place prior to their discharge; in their perception the two groups (running in the inpatient unit at the time of the interview) -Coping with Anxiety and Coping with Depression- were not very effective. They were described by a male (M2) and a female (F1) participant as “childish” and a further female (F2) as “patronizing” and “trivial’. There was a consensus amongst the participants that these programmes might only help them in the short, but not in the long term. Two participants, one male (M1) and one female (F2) reported (the remaining patients agreed) that the groups did not enabled them to apply the skills in real situations when needed.
A female participant (F3) reported as part of her discharge plan, she was going home on leave at the weekend but did not feel ready for it. However, she accepted that going on leave was part of her care plan in preparation of her discharge. According to two participants views (one male (M4) one females (F2)) “there is nothing happening on the ward. We don’t have a psychologist or occupational therapist attached to the ward”. “We stay in bed, sleep or walking up and down most of the time”. Indeed, these comments were later confirmed with the ward staff; stating that because one of the acute inpatient wards was closing down there were difficulties with recruitment of staff from the therapy professions.

All participants agreed (consensus) that they needed a structured plan and an objective to work towards and more personal one-to-one session in hospital to achieve this. “We need a structured plan and objectives so that we know what is happening and more personal one to one sessions with our nurses”.

4.25.3. Nurse/Patient Relationship

There followed a discussion of what is needed in the community in order to keep patients out of hospital and enable them to live successfully.

A female participant (F1) talked about the frequency of her CPN visits. Immediately following discharge, the support was felt to be satisfactory. “I need more support from my care co-ordinator; had CPN that was good but then it changed to a social worker; I was not happy with the support, initially she visited me 2-3 times a week, then once a week then every three months”. Another female (F4) patient supported the views commenting; “In general I feel we need more aftercare follow up care, that’s why people revolve”; these views were endorsed by four more patients, two males and two more females; stating that the care co-ordinators visits became less frequent- tailing off to once a week once a fortnight, then to every 3 months. There was an agreement by all participants that they need more support and more visits by
the CPNs. They felt this period (following recent discharge from hospital) is crucial, as this is when they become de-motivated and need others (staff) to support and encourage them.

One female participant (F2) commented and all other participants agreed that they need 24 hour support; “we need night support; 24 hour support before it's too late and no matter of who you see it's too late. You end up in hospital”. A male participant (M3) however, acknowledged that they need more resources commenting; “at every review your CPN should be present, they are rarely there, it's essential. They need more resources to enable the CPN to spend more quality time with their clients”. All participants felt that having a plan and set objectives after every visit would help them to structure their life. There was an agreement amongst all subjects that they need more structure and more support, both, in hospital as well as in the community. Two participants a female (F4) and a male (M1) commented however, that this depended on the relationship they had with their key worker, whether or not their objectives are discussed and their needs are met.

A discussion then proceeded on the relationship with their key worker. Initially three participants, one male and two females reported that their contact with their care co-ordinator is limited; the male subject (M5) commented; “particularly, if our illness takes over and we relapse we need more contact, more visits and more support from our CPN". The female participant (F2) stated; “the CPN comes, ask you how you are and that’s it". Another female (F4) commented; “one to one contact with staff is poor, we don’t get individual counseling”. All patients agreed with the above statements and six participants felt that when they get better this is due to their medication and not to any nursing interventions.
4.25.4. Purpose and Meaningfulness

The discussion continued with the researcher asking the participants, what could be done to stop them from keep coming back into hospital. A male participant (M5) and a female (F3) stated that their level of motivation drops as the illness takes over; and “we need somebody to push and motivate us”. “Once we become patients our meaning and purpose become less”. Another female (F1) confirmed “I don’t have any purpose and meaning in my life”. One male participant (M3) summed it up as, “our days are always the same one rolling into the other. Walking around purposeless, smoking and going to bed.

There isn’t much of a daily plan in our lives”. When asked by the researcher if they could suggest anything to improve their quality of life many participants suggested voluntary work, swimming, going to the gym, yoga classes, music and art as some activities which might help to give them more meaning and purpose. One male participant (M3) suggested “....a specific support group, I feel that in general I would be able to cope better”. Another male (M5) reported that sometimes he goes out and it helps but “at times you get fed up, we don’t do a lot....". However, as male participant (M4) commented “relapse and readmission becomes a vicious circle and loose confidence and motivation to do anything in the community”. A further female subject (F4) suggested that staff should try and motivate them instead of patients having to ask for their support. “This would prevent I think a lot of relapse”.

4.25.5. Social Isolation

When the researcher asked the participants to discuss the factors responsible for their relapse, there was an agreement by all participants that being socially isolated and the lack of social support play a big part in their relapse. A male participant (M4) stated; “social isolation takes away our confidence, we stop attending out
patients and so it becomes a vicious circle and we relapse back into our illness”. A
demale participant (F2) reported; “sometimes you don’t feel like seeing anybody. I
leave it too late and no matter whom you see then it’s too late. You end up in
hospital”.

Another male participant (M1) (and four others agreed) stated that they need
support especially at night because “that’s when it gets most lonely”. There was a
consensus that friendship networks are important for keeping them out of hospital.
A male participant (M5) talked about attending an ex patient club, five days a week;
“occasionally I find it helpful but not all the time, especially when other patients talk
about their problems”. Two further patients (M3 and F2) agreed that attending the
ex patients club at times can be stressful as they have to listen to other’s problems
and can’t escape from them. However, a female (F3) commented that sometimes
it’s nice to meet other patients, because they are “friendly they are your true friends”.
A male patient (M2) agreed, commenting ” my friends (ex psychiatric patients
leaving in the same hostel) are really important they’ve stopped me committing
suicide a number of times, they have phoned the CPN they are really helpful in
crisis”. There was a consensus that sometimes friends are important in keeping
them out of hospital.

4.25.6. Stigma and labelling

When participants were asked to describe how it felt for them to be in need of
psychiatric services participants did not find having to attend day hospital and Out
Patients appointments as very positive. They saw it as a re-enforcer of their “status
of being psychiatric patients”. One female participant (F2) stated; “I don’t like day
hospital or outpatient appointments. They remind me of being a psychiatric patient;
it reminds me that sometime I will have to come back into the unit and never
escaping the stigma and label. It feels like I’ve never been out”".
Three participants, two male (M1, M2) and a female (F3) agreed that also it is a disruption to other normalizing things they are doing, having to change their daily routine in order to attend hospital appointments. A female participant (F4) reported that “living in the local area you always meet people you know from hospital, like ex patients and staff members. They always remind you of who you are”. Another male participant (M3) observed; “I have a label and a diagnosis at times it feels that's all I've got”. As commented by another female (F3) “we feel like patients and we look like patients” and a male participant (M1) “you can't escape from your illness, and another male participant (M2) “I have been given a variety of diagnoses, ...I also have drug and alcohol problems and I have been kicked out of the A&E many times”. The participants' feelings of low self-esteem and rejection by society are reflected in a female participant's (F3) statement; “sometimes you need a fresh start somewhere else, where nobody knows you”. The views and experiences of the participants suggest that being a “psychiatric patient” affects their self-perception undermine their self-confidence and their quality of life. Indeed, according to Kaminski et al (1999) labeling and stigma associated with mental illness have a major adverse impact on the quality of life of psychiatric patients.

2.25.7. Struggling for Control

The discussion continued with the researcher asking the participants to describe their feelings when they are re-admitted into hospital. A male participant (M1) stated that coming back into hospital gives him “a feeling of complete defeat”. All participants expressed feelings of “failure, disheartening, and loss of control”. Six patients expressed feelings of “anger and frustration as their illness takes over”. A female participant (F1) reported “we are treated like children we loose control”. One male participant (M2) stated “I feel guilty when I am admitted because I also have drink problems; I do it to myself. There are far more deserving people out there that
need to be here rather than me”. Another male patient (M5) reported “before admission I feel desperate, self-harming, my illness is causing me lots of problems”. However, the same participant stated “sometimes we feel relief; we are happy to leave it all to the staff, we don’t want control, we like to cop out” whilst another male (M4) agreed saying “we don’t want to make decisions when we are not feeling well”. Nevertheless it was recognized by all patients that staff have all the control, and make all the decisions; a male patient (M1) stated; “staff have all the control, we don’t take part in our care plan or the decisions about our treatment; staff make all the decisions, our opinions don’t matter”. A female (F4) agreed saying “....we don’t feel empowered or in control of our care plan”. However, there was a consensus amongst the group, despite some benefits of being in hospital participants wished to remain away from hospital.

Generally, participants feel that they do not have control over their lives. They are not empowered in and out of hospital and feel that their involvement is only a token. Participants expressed their concerns regarding the future changes of the acute services and the transfer of the acute in-patient beds in one site of the Trust. This would mean patients will lose social contacts with their visitor’s, family and friends. As they will have to travel further a field, hence creating difficulties for them with transport etc. Although they participated in meetings regarding the closure, this was stated by three participants to be a waste of time, as their opinions were not considered in the final decision. According to them, “higher authorities made the decision, we are powerless” confirming the views of all participants in the group that when it comes to making decisions their opinion is not valued, and their attendance at meetings is only tokenistic.
4.26. Summary of Key Findings

- Patients feel that they are not adequately prepared for discharge. This finding confirms the findings of patients' views during study (a) phase II. The review of nursing and medical records in phase III, also indicates that there is very little evidence of patient preparation for discharge.

- They feel they need more support in the community, such as more intensive input from CPNS, and more structure and plan in their life.

- They feel they need more meaning and purpose in their life.

- Social isolation and lack of friendships is reported as key to their relapse. This is supported by the subjects during the face to face interview in phase II, where patients identify social isolation as important reason for their relapse and hence hospital readmission.

- Stigma and "labeling" undermine patients self image and confidence.

- The price of becoming an "RD patient" is loosing control over their lives.
4.27. PHASE IV: FOCUS GROUP INTERVIEW WITH STAFF (STUDY B)

4.27.1. Introduction

This study reports the second part of the focus group interview with staff (study b); gathering data directly concerning their opinions and perspectives regarding similar issues explored during study (a). Such as, reasons for patients relapse and readmissions, discharge preparation and community support; and to substantiate, and reinforce the findings of the previous studies of the research.

4.27.2. The Aim of the Study

- Within a group setting to obtain staff views and perspectives regarding the relapse and readmission of RD patients

4.27.3. The Objectives of the Study

- Within a group setting, to establish staffs perspectives on patient discharge preparation, and discharge care plan
- To obtain staffs views regarding patient community support and aftercare
- To identify staffs views regarding professional practice

4.27.4. The Sample

Four staff working in the acute inpatient unit (within the same team) agreed to participate in the interview. The sample was purposive one male and three female and comprised of a ward manager, an acting deputy team leader, and two staff nurses.
Their psychiatric experience ranged from four to over 20 years. As the interview was conducted during the hand over period there was a total of ten staff on duty. Two staff had escort duties (accompanying patients to various departments) two staff were carrying out observations and two staff had to remain on the ward within the clinical environment.

4.28. The Interview

The discussion with staff began immediately following the patients' interview, taking place in a quiet room, away from the clinical area. The researcher explained the purpose of the interview, assured confidentiality and anonymity of the data and sought consent from staff to participate in the study. The aim of the interview was to elicit information regarding staff's perspectives, beliefs, values, behaviours and perceptions and discover meaning (Hirschman 1986) of the revolving door phenomenon. The interview was conducted according to an interview schedule (appendix 7) consisting of five main open ended questions. The main questions were often complemented by more specific questions aimed at further exploration and clarification of relevant issues. During the process of the interview participants were able to express their feelings and perceptions within a trusting atmosphere created by a relaxed environment.

A tape recorded was not used to record information as staff felt that its use could compromise the patients' confidentiality; furthermore staff felt that the use of a tape would hinder their responses and spontaneity. The interview lasted approximately one and half hours.
4.29. **Description of the Tools (Interview Schedule - Appendix 7)**

The interview schedule consists of five main open ended questions predetermined by the researcher designed to elicit specific information on;

- Reasons for relapse and readmission of RD patients (Legitimate and illegitimate)
- Staff perceptions and feelings regarding patient readmission
- Community support and resources available
- Professional practice
4.30. THE FINDINGS

4.30.1. Themes

The following themes emerged:

1. Reasons for relapse and readmission (Legitimate and illegitimate)
2. Perceptions and feelings regarding patient readmission
3. Community support and resources
4. Professional practice

4.30.2. Reasons for Relapse and Re-admission (Legitimate and illegitimate)

The interview begun with the question of what nurses perceive to be reasons for patients relapse and re-admission. They cited several reasons for patient relapse and re-admission including both illegitimate and legitimate; some members suggested that patients feign illness in order to get readmitted. A male participant (M1) commented “they know what to say and how to present their symptoms in order to come back in. For example, I can’t cope I am going to hang myself unless I came back in”. A female (F2) agreed saying “I believe that patients feel that they have the right to be here, a lot don’t need to be in here but they learn the behaviours and symptoms and signs to help them get readmitted. For example, a well-known user always gets admitted through a 136 section” (Police section)”. Another female (F1) commented; “I feel that they feel safe here, and can escape from their problems. I believe some don’t need an acute bed, and could be managed in the community”. A third female (F3) felt that; “people return to hospital because it is a safe haven for them. They feel the security of the walls and it’s an environment they know best".
Other reasons cited by nurses included the patients’ inability to cope with their lives. A female participant (F1) reported; “people also return due to the nature of their illness they have a psychiatric episode, and some do not have the coping mechanisms and strategies to stay in the community they relapse and so return to hospital”. Another female (F2) suggested that RD patients “lack coping strategies- they can’t face the family, so they pretend they are ill, it’s a form of escapism”. A male participant (M1) stated that patients who keep coming back into hospital are mainly patients on section and those usually who stop taking their medication, once they are discharged home. “….they feel well and so think that they do not need medication, therefore become unwell again”. The same participant suggested that non-compliance with medication “particularly anti-psychotic drugs, is very common with female patients due to side effects such as gaining weight”.

Further reasons suggested were about the patients’ life style and circles of friends particularly with the younger age group of patients between the ages of 20-40 years: a male participant (M1) observed “it is the life style they lead, many have alcohol and drug problems and so it becomes a kind of culture, a world that they live in”, adding that “75% have drug and alcohol problems as it helps to numb their reality”. A female participant (F2) agreed saying; “it is the friendship circles they live in, especially the young ones, mixing with friends that drink and take drugs, because of their medication they do not see the risks and before you know it they are back in hospital. I feel it is the features of drug and alcohol problems”. The male participant added that some patients on private insurance can claim money and get paid when they come into hospital.

However, nurses acknowledge that for most patients, are usually legitimate reasons behind their frequent readmissions; as a female participant (F1) observed; “especially the people over 50 years of age are genuinely ill and relapse because of the nature of
their illness. We will not stop these patients ever coming in. It is a frightening experience. I believe it’s their illness and they will keep coming back”. All participants agreed that the majority of patients are genuinely ill and that they will need re-admission from time to time; indeed, a female participant (F4) asserted “I feel that in general there are those who are genuinely ill and there are those that abuse the system. They are in the minority though”. However even though patients need to be admitted there are some especially those who come under section that think they shouldn’t be in hospital. As a female (F1) and a male (M1) nurses observed “the nature of their admission, they have been sectioned, they have their freedom taken from them”. “They are keen to leave because their freedom is taken way”.

Another female (F3) commented that often RD patients are difficult to engage with various programmes in the community, “because of their illness, it is often difficult to engage them in the community e.g. with the CPA, the CPN and peers and they lack friendships”.

4.30.3. Staff Perceptions and Feelings Regarding Patients Re-admissions

The researcher continued the discussion asking staff to express their feelings regarding patients repeated admissions. There was a consensus amongst the group. A summary of their comments highlights their feelings of frustration, anger, despair and defeat, sadness, and loss of control. A female participant (F1) stated; “I wonder why, what has made them come back. At the same time I feel frustrated. We put watertight discharge plans in place and so I wonder why the system is falling down in the community”.

189
Another female (F2) member cited; “It’s very repetitive. You feel frustrated and you feel that some patients’ sabotage everything you put in place, so no matter what is done some just will not take up the support or help needed in order for them to remain in the community”. A third female (F3) agreed saying “it is very sad when you see the same patients coming back again; I feel demoralized, helpless”. The male participant (M1) commented “sometimes we feel angry; we don’t have any control, because of the nature of their illness the housing association will not tolerate them and will chuck them out”.

The discussion was then diverted towards their frustration regarding RD patients inappropriately occupying acute beds, known as “bed blockers”; a female (F1) stated; “many nursing homes will not take them, they cannot cope with such clients and they are also bad for business and so such patient's become bed blockers in our system”. Another female (F3) reported “there is nowhere suitable in the community; there is no accommodation for them. Whenever there is a problem in the nursing home, residential home they are sent back here in hospital blocking our beds”. The male nurse (M1) agreed saying “many don't need an acute bed but because of all these factors we don't therefore have enough acute beds for those they need them”. However he observed that “although under a 136, the police would bring them in regardless if there is a lack of beds and so sometimes patients have to sleep the night in the seclusion room, which is far from ideal”. A female participant (F3) added; “Yes I feel that the police don’t always use the sectioning appropriately, I think that clients do not want repeat admission to this ward (intensive care unit), they feel locked up”.

4.30.4. Community Support and Resources

The discussion then focused around resources in the community and what is needed in the community in order to keep patients out of hospital. All participants agreed that more support from social services, manpower, outreach services, more support workers, an Out of Hours team and more community psychiatric nurses with smaller case loads, are needed. The following quotations reflect their comments: A female participant (F2) commented; “I feel that social services should be more supportive, and do more for the clients in the community”. A male nurse (M1) reported “particularly as the population is growing, caseloads for community staff are massive, they need more resources”. Another female (F3) said “more resources are essential as soon as a client disengages, you loose them. Yes, for example, community centers, the patient will not turn up for their depot injection, when they make their mind up to disengage that’s it”. The male participant (M1) agreed “there isn't enough support for them to check that the patient is attending crucial services to prevent relapse” a female nurse (F3) reported “there needs to be more support workers”. Another female participant (F1) observed “there is assertive outreach but it is such a small team, you will always have revolving door patients because there aren’t enough resources” and the male nurse (M1) stated “there needs to be more safe houses and intensive outreach teams”.

4.30.5. Professional Practice

When nurses were asked to give examples and reasons of why some RD patients have not been re-admitted for long periods of time, participants attributed these to the different practices and approaches of the consultants and their teams. According to their views, some consultants are at retiring age and they seem unwilling to take risks
especially if there is a threat of suicide, hence they would admit patients straight away. Whereas, new younger consultants are more willing to take risks and would carry out a full assessment, before admission.

A female participant (F2) reported; “I think it depends on the catchment area, the consultant and team in the area. Old consultants will bring patients in as a place of safety but sometimes this is not a place of safety. The seclusion room will be used as a bed with the door open”. A male (M1) and a female participant (F1) agreed saying respectively “yes if you have a consultant that is nearing retirement they have a different attitude than the younger newer consultants with regard to their attitude and methods of practice towards their work” and “yes approaches are different, before when there was a threat of suicide the patients were admitted straight away, now the new consultants will do a full assessment before admitting to an inpatient unit”.

When participants were asked to expand on other professional practices such as the patients’ discharge care planning two females (F2 and F1) commented; “Due to financial resources, many therefore have to be discharged without adequate plans in place, although sometimes patients will say that they want to be discharged early” and “Discharge is subject to planning, clients from the intensive care unit go through to the 'open side' before discharge”.

192
4.30.6. Summary of Key Findings

Staff cited the following reasons for patients' readmission into hospital:

- Lack of coping strategies and a form of escapism (confirmed by patients during the focus group interview that when they are admitted "it's a relief, and like to cop out of everything)
- Non-compliance with medication (RD patients in face to face interview of phase II, admit poor compliance with medication)
- Life style of substance misuse
- Lack of friendships (sustained by patients during the focus group interview)
- Severity of illness
- When patients are re-admitted staff reported of feeling frustrated, angry, defeated and desperate (patients in focus group interview reported similar feelings).
- Staff cited more support and resources such as social support, intensive outreach work, more CPNs, are needed in the community in order to maintain patients in the community (patients in focus group interview confirm these views).
- A change in attitude of the admitting clinicians is reported as crucial in helping to reduce patient re-admission.
5.1. DISCUSSION OF THE FINDINGS

5.1.1 Introduction

The discussion adopts an integrated approach drawing concurrently from the findings of all six studies within the four phases of the research, as shown in diagram 1; where appropriate cross-references within and across studies are made. The discussion takes place within the context of the ISOP (Individual-Social-Organisational-Professional) multi-dimensional theoretical framework (Diagram 2) aiming to increase theoretical knowledge and understanding; although it is acknowledged that the dimensions and elements of the framework are independent these are interrelated and there may be overlaps between them, though the discourse and arguments follows a process which fits best within the framework.

The principal aims of the study were to investigate, through the computerised patient data, the associations between the frequency of re-admissions (dependent variable) and the socio-demographic details (gender, age, and marital status- independent variables) and clinical characteristics (diagnosis, level of CPA, legal status, number of outpatients appointments and number of day care places-independent variables) of the revolving door patients (RD), and to compare similarities and diversities with the Non-RD group.

Moreover, using a semi-structured interview schedule through a face to face interview the research sets out to establish patients and their named nurses' views about the reasons of RD patients repeat relapses and re-admissions; to identify patients and nurses perspectives on the care patients received during their admission and discharge phase and to make comparisons between the responses of
the RD and Non-RD groups and their named nurses. Further, the research aimed to identify the process of discharge planning and follow up and after care of RD patients through the examination of RD patients medical and nursing records; and finally, it explores patients and nurses own perspectives of reasons for patient relapse and readmission, discharge preparation, care plan and community support by means of focus group interviews with patients and staff. In light of the discussion the theoretical framework is evaluated and modified to consider a more flexible and interactive approach as shown in diagram 3 p228. The discussion is drawn to a conclusion by bringing together the research aims and objectives, the research findings and the arguments generated within the context of the theoretical framework.

Diagram 1: The Four Phases and Six Studies of the Research
5.1.2. The ISOP Multi-dimensional Theoretical Framework

The literature highlights that the "revolving door" phenomenon is influenced by a combination of many factors. Drawing from earlier research on severe mental illness and re-admissions four main dimensions were integrated to construct the ISOP framework (diagram 2); the Individual- the Social- the Organisational- and the Professional (as discussed in chapter two). Each dimension comprises of various elements.

Diagram 2: The ISOP Multi-dimensional Theoretical Framework
5.2. THE DISCUSSION

5.2.1. The Individual Dimension

5.2.2. Definitions of “Revolving Door” (RD) Patient and Perceptions of Being Ill

The definition of the “Revolving Door” patient in this research arises from the interaction of a wide range of characteristics of patients related to the underlying severity of their illness and their frequent and sometimes long utilisation of inpatient psychiatric services; having 3 to 9 re-admissions over a period of 24 months, being male and young (mean age=33.96) and having a diagnosis of schizophrenia and other related psychotic disorders and affective disorders; in addition being older (mean age=37) and female with a diagnosis of personality disorder. Furthermore, needing care and rehabilitation constitute key features of RD patients. It could be argued that these defining characteristics are broad; however, there is no agreement or no one definition in the literature of the “revolving door” concept. Nevertheless, the term “revolving door” is the most consistently used in the literature (Haywood et al 1995, Kustrup 1995, Korkeila et al 1998, Saarento et al 2000) although the expression “recidivists” is interchangeably used by many researchers. Even though, each researcher (Woogh 1986, Rabinowitz et al 1995, Glazer et al 1996, Vogel et al 1997, Tomasson et al 1998) uses their own criteria to define the concept, albeit the common denominator is the frequency of patients’ re-admissions.

However, the perception of the “revolving door” label denotes a connotation of a “difficult” patient and therefore this influences their care and management. In the focus group interview with staff, nurses’ conceptualisation of the RD phenomenon is frequently reflected in their expressed stress, desperation, frustration and disappointment of having to care for patients who keep coming back and forth into
hospital. "We don't know what to do with them", "there are those that abuse the system" "they lack coping strategies", "it is difficult to engage people in the community with their CPA and they don't turn up for their appointments". Kelly and May (1982) using an interactionist approach in their study of the nursing role, identified a theoretical framework for conceptualising "good" and "bad" patients. They argued that the concepts of bad and good are not so much about the patients but about the nurses' opinions of them. According to this framework, the professionals ascribe a sense of "worthiness" of care and during this process, labelling might take place such as the "revolving door" label. It could be argued that this framework is useful in the current study whereby patients, being active recipients of care, may accept and internalise the label of "revolving door" with profound consequences; thus the label becoming a self-fulfilling prophecy; "I am a revolving door patient I have no option but to come back into hospital" and thereby influencing patients' relationships with their nurses. The nurses' frustration over the lack of effective care is often vented as hostility, holding patients responsible for their readmissions; "they know what to do, exactly what to say in order to get readmitted, they don't need to be here". The "revolving door" label, further heightening an affective response from nurses, categorising these patients "bad" and "difficult" and hence managing them according to their label. However, educating and teaching nurses may shed further light about the RD phenomenon, encouraging them to avoid labelling patients and treating them with more empathy, understanding and moral support.

Defining the "revolving door" concept from the outset of this research however, it has been useful in explaining the phenomenon through the ISOP theoretical framework; determining the parameters of the study by establishing time limits, keeping the consistency of terminology throughout the research and clarifying the study's scope and direction.
This research reveals that data from the face to face semi-structured interviews with named nurses (phase II), and data from the focus group interviews with nurses (phase IV) are often conflicting regarding participants opinions about the reasons of patients re-admissions. Named nurses (face to face semi-structured interviews) felt that patients needed to be admitted because of the severity of their psychiatric symptoms such as suicidal thoughts and depression, psychosis, paranoid and delusional ideas and aggressive behaviour. Indeed, previous studies of clinical correlates of admissions (Rabinowitz et al 1995) found that delusions, aggressive behaviour, suicidal tendencies, and higher levels of danger to self or others (Swett 1995) were a good measure of predictors of which patients were likely to be readmitted into hospital. These findings are also consistent with Swett's (1995) Hull's et al (1996) and Hurst's (2000) studies, who found that the degree of suicidal ideas, risk of harm to self or others, self neglect and psychotic symptoms were associated with multiple re-admissions.

In the same study (face to face interviews with named nurses) on two occasions where nurses felt that patient admission could have been prevented, the problem was located with the health care system, suggesting inadequate community care and follow-up and insufficient assessment and support, therefore absolving the individual patient from blame; indeed, the DoH (1998) highlights the "failures in providing continuity of care" following discharge from hospital. For many patients who are discharged community adjustment requires a follow through with medically required aftercare (Fenton 2000).

On the other hand, nurses during the focus group interview (study (b) phase IV) perceive that some patients feign illness in order to be readmitted to a place of safety; commenting that mentally ill people “learn the system” “they know how to present themselves during assessments and they know which routes to take in order to get re-admitted”. Moreover nurses suggest that some patients claim insurance
money once they are in hospital. They further comment that patients use the hospital as a safe haven, escaping from their problems. According to the same nurses many patients should not be readmitted and should be managed in the community. The nurses' perspectives are verified by some patients, during the focus group interview (study (a) phase IV); expressing relief and happiness when they are in hospital that staff, take over the responsibility of their care. A male patient even discloses feelings of guilt because of his additional alcohol problems, which he reports as self inducing and occupying a bed that may be “needed by someone more deserving” than him.

Both nurses’ and patients comments reflect the sick role theory as suggested by Parsons (1952), Radley (1994) and Christopoulos (2001), arguing that being in hospital legitimises individuals sickness and lets them off from their social responsibilities and obligations. This theory however, also suggests that individuals who appear to feign sickness or abuse the sick role and straining social resources for their own secondary gains are shunned by society (Christopoulos 2001). Although, the sick role theory only partly explains the need for patient readmission. The question of why some patients despite of having the option to remain in the community choose to be admitted into hospital requires further investigation. A great deal of empirical evidence shows lack of patient involvement in their care and decision making (Lowry 1998 and Valimaki et al 1998). Psychiatric treatment, rehabilitation and care do not empower, nor enhances patients' opportunities, freedom, and self direction (Stineman 2001). This argument is reflected in a named nurse’s response, suggesting that the patient is constantly readmitted because he "lacks confidence and self esteem and he is institutionalised". Indeed, as Marshall (1996) and Price (1996) argue patients with severe mental illness find it difficult to survive in the community therefore the institution provides a place of sanctuary for them.
During the focus group interview with patients, the RD subjects complain of lack of purpose, low self-esteem and meaninglessness in their life. The findings are supported by Repper and Brooker (1998) arguing that people with severe mental illness and long term problems are unlikely to show marked improvement or skills following treatment and support. A study by Chan et al (2004) substantiates further these findings; they indicate that patients with increasing number of hospitalisations showed decreased satisfaction with life enjoyment and meaningfulness of life.

Even though, participants in the current study (focus group interview with patients) suggest ways of improving their lives such as doing voluntary work, going swimming and the gym, enrolling in yoga, music and art classes, they also note that their level of motivation is not sustained “we often need nurses to push and motivate us “and as a consequence their quality of life decreases, they live in poor conditions and therefore they may need frequent re-admissions. People with severe mental illness may lack the desire and motivation to make any changes in their lives; as patients report during the focus group interview; “once we become patients our meaning and purpose becomes less”. Indeed, Perkins and Repper (1996) argue that mental health problems cause massive disruption in many aspects of patients functioning. Nurses in the current study (focus group interview) confirm that it is often difficult to engage patients with their care and treatment programmes in the community; the patients’ experience of personal and social difficulties interferes with their conduct and functioning and hence the label of mental illness and the adoption of the sick role may be used appropriately in order to gain access into inpatient facilities.

5.2.3. Demographic Characteristics as Predictors for Patient Readmission (Gender and Age)

Previous studies suggest that demographic characteristics such as age, and gender, play a key part in the frequency of patients’ re-admissions, although the association
between gender and multiple re-admissions is not consistent throughout the various research papers. The two studies within the current research (phase I-computerised data and semi-structured face to face interview with patients in phase II) reveal respectively that there is an almost equal distribution of Non-RD male (n=328/50.2%) and Non-RD female (n=326/49.8%) patients, and Non-RD men (n=2) and Non-RD women (n=2). However whilst the computerised data study shows that there are significantly more females (n=172/60.4%) than males (n=113/39.6%) amongst the RD group the findings of the exploratory face to face semi-structured interviews study are divergent; they show that there is a higher number of RD male to female participants with a ratio of 4:1. The computerised data further suggest that females in general have higher readmission rates (mean number of admission=2.24) than males (M=1.93) and that RD females have more re-admissions (M=4.03) than their RD male counterparts (M=3.75). Although these results are contrary to Korkeila’s (1998) study suggesting that male patients have more re-admissions than females, nevertheless, they are confirmatory of Vogel et al (1997), Geller (1998), and Daniels et al (1998) findings; highlighting that women have more re-admissions than men, albeit it varies across diagnostic groups. While other researchers (Swett 1995) found no differences in rates of re-admissions between males and females.

In studying the association between rates of readmission and age, the computerised data show that RD patients are younger (Mean age=35.9) than Non-RD patients (Mean age=39.8). The study showed a significant difference between age and readmission; the younger the patients the more frequently they are likely to be readmitted. The data reveal that the majority of RD patients (n=116/41%) with re-admissions cluster within the 25-36 years of age group. Second are clusters amongst those in the age group of 17-25 (n=58/20%) followed by the 36-45 years old (n= 49/18%); then by the 46-55 age groups (n=34/11%), followed by the 56-65 years
old (n=19/6%). Those over the age of 66 years had the least re-admissions (n=9/3%).

Indeed the results of many previous studies confirm these findings; Woogh (1986), Kustrup (1987), Sanguineti et al (1996), Geller (1998), Korkeila (1998), Saarento et al (2000) report that RD patients are more likely to be younger than patients with only one re-admission. The most represented age group within the current study is the 26-35 cohort constituting 41% of the entire research sample (N=939). Korkeila (1998), Sanguineti et al (1996) and Heggestad et al (2001) also showed that patients in the 25-34 age groups were more likely to return to hospital quicker than patients in the older age category. Examining the relationship between age and gender this study reports that male RD patients comprise the youngest group of the entire sample with a mean age of 33.96. This is in line with Fernando et al (1990) study revealing that the majority of their sample was male with a mean age of 33.6 years. It also compares with Lelliott’s et al (1995) study observing that the men in their cohort study were significantly younger than the women.

The exploratory face to face interview with patients (phase II, study a) within the current research indicates however, that RD patients are older (Mean age=48.33) than Non-RD patients (Mean age=45.2). Even though the sample size is too small for comparisons and generalisations it is supported by Sullivan et al (1995) suggesting that patients with multiple admissions were older than those with single admissions.

5.2.4. Clinical Characteristics as Predictors of Patient Readmission

Previous research reveals that clinical variables such as diagnosis are very important factors in predicting hospital re-admissions. This study (computerised data) reveals that the majority of patients admitted into hospital have a diagnosis of affective
disorder (n=426) and schizophrenia (n=286). These findings are complemented by the data of the face to face semi-structured interviews with patients and also the data of the focus group interviews with patients; the studies identify that most participants had a diagnosis of affective disorders and schizophrenia. The results are further substantiated by previous research such as those of Woogh (1986), Sanguineti et al (1996), Vogel et al (1997) and Daniels et al (1998), observing the principle diagnoses to be psychotic, affective disorders and substance related disorders.

However, when comparing the RD group with the Non-RD group of patients in this study (computerised data) there are more male patients (42%) with schizophrenia in the RD group than the Non-RD (34%) group, and significantly more female patients (28%) with personality disorders in the RD group than the Non-RD group (7%). Rabinowitz et al (1995) in a longitudinal study of a sample of 2220 psychiatric patients comparing an RD with a Non-RD group attempted to predict RD individuals at first admission. Patients with schizophrenia were the largest diagnostic RD group, although the length of time since first admission and consequent re-admissions was not clear. Moreover patients with schizophrenia not only were re-admitted more often but also more rapidly (Korkeila et al 1998) than patients with other mental health disorders. Furthermore, nurses in the current study (the focus group interview) state lack of coping strategies and difficulty in engaging patients in the community because of the severity of their illness as key reasons for patients re-admissions. Factors associated with an increased risk of readmission by other studies (Lyons et al 1997) found that the severity of psychotic symptoms leading to an impairment of self-care were clinical predictors of re-admissions.

Another significant finding of the current study (computerised data) is that patients with a diagnosis of personality disorder are re-admitted more frequently than any other diagnostic group with a mean number of 3.28 re-admissions, followed by patients with a diagnosis of schizophrenia (M=2.27 admissions) then affective
disorders (M=1.83). Patients with neurotic and behavioural disorders have the lowest rate of re-admissions (M=1.61). Kastrup (1988) and Geller (1998) report similar findings within their studies; suggesting that patients with frequent re-admissions are often diagnosed with psychotic and personality disorders. Breeze and Repper (1998) in a focus group interview with nurses report the nurses observations regarding patients with personality disorder, multiple diagnoses, and enduring mental health problems; as being the most difficult and challenging to treat, they don’t seek or accept help they don’t get better within the set time limits and therefore they are always being readmitted.

Although the current study indicates that female patients with personality disorder and male patients with schizophrenia have the highest risk of readmission, the majority of studies support the notion that patients with schizophrenia or psychotic disorder have more frequent re-admissions than patients with other diagnoses, albeit these studies do not differentiate between gender and diagnosis. Fenton et al (1998) stipulate that mental illness such as schizophrenia and bipolar disorder are often recurrent with exacerbation and remissions superimposed on varying degrees of prolonged disability. Heggestad et al (2001) suggest that patients with more severe illness such as schizophrenia were found to have the highest probability of readmission.

5.2.5. Compliance with Medication

Within the context of the current research (exploratory face to face semi-structured interviews with patients, face to face semi-structured interviews with nurses and focus group interview with staff) patients and staff across studies are in agreement citing non-compliance with medication, as a major factor of patient relapse and readmission. However there is no evidence indicating that patient education takes place. Patients rate the information received regarding medication as either poor or
very poor. Further, the review of medical and nursing records in phase III also shows that very little or no advice/information regarding medication and side effects is given to the patient. Even though, Parker et al (1995), Wyatt et al (1997) and Wallace et al (1999) during a client satisfaction survey and interviews regarding care and services, found that patients rate the information and explanation given about medications amongst the most helpful actions.

In this study (exploratory face to face semi-structured interviews with patients) when participants were asked to rate their compliance with medication, only two out of five RD patients admitted full compliance. In contrast all four Non-RD patients report full compliance. During the named nurses’ face to face semi-structured interview and during the focus group interviews with nurses' participants verify the patients’ responses. Furthermore, staff report that many patients stop taking their medication, “because they feel well and they think they don’t need it” or because of the side effects of putting on weight. Indeed, this is supported by previous research (Sullivan et al 1995) identifying a rate of non compliance 8.18 times greater amongst their RD group than the comparison group. Vogel et al (1997) also found that medication non-compliance is a well known problem amongst the severely mentally ill, linked to medication side effects (one of them putting on weight); in addition this problem is related to the lack of insight into their illness, and the use of oral rather than depot medication (Sullivan et al 1995). Haywood et al (1995) and Fenton (2000) argue that the most important determinant of successful community maintenance is medication compliance. Fenton demonstrates that compliance therapy based on motivational interviewing of 4-6 sessions of behavioural interventions prior to patients' discharge is very effective in improving medication compliance with relapsed patients, although no single approach is likely to work for all patients.

During the focus group interview with patients (Phase IV) the participants observe that they "get better because of their medication and not due to any nursing
interventions”. Sullivan et al (1995) study supports the current research’s data; they found that even though medication compliance is poor, 66% of patients in their study had thought that overall their medication was “very helpful” in their illness. The results of Wyatt’s et al (1997) study suggest that at least for the group of patients with schizophrenia early treatment with anti-psychotic medication decreases the immediate morbidity associated with schizophrenia and reduces hospital readmissions.

5.2.6. Life Style of Drug/Alcohol Misuse

Nurses during the focus group interview (phase IV) attributed younger (between 20-40 years) patients’ lifestyle and friendship circles of drug and alcohol misuse as significant factors for patients relapse. Although patients with a primary diagnosis of drugs and alcohol misuse were excluded from this study, a patient participant with multiple diagnoses stated that he had several re-admissions because of his drugs and alcohol problems. A study by Higgins et al (1999) supports the above comments, suggesting that an increasing number of hospital admissions are due to those patients with an associated drug or alcohol problem especially among young men aged between 18-25 years. Sullivan et al (1995) further report in their study that the rate of alcohol abuse was 3.3% higher amongst RD patients than within their comparison group. Haywood et al (1995) concluded that beside non-compliance with medication, alcohol and drug problems were the most important factors related to high rates of readmission.
5.3. The Social Dimension

5.3.1. Social Networks and Friendships as Buffers Against Relapse

Exploring the factors associated with relapse and patient re-admission the current research data across studies and phases (exploratory face to face semi-structured interviews with patients and named nurses and focus group interviews with patients and named nurses) suggest a general agreement; amongst other factors, patients cite social isolation, lack of social support and lack of close friendships and loneliness as having a major influence on their relapse and re-admissions. Repper and Brooker (1998) substantiate these findings stipulating that such factors are frequently accorded priority by the patients themselves. Loneliness and dissatisfaction with life are highly correlated and has been suggested that feelings of loneliness increase during periods of mental illness (Lauder et al 2004). Comments during the focus group interview with patients like “social isolation takes away our confidence, we stop attending out patients and therefore we relapse and go back into hospital; it’s a vicious circle”, and “we need support especially at night because that’s when it gets most lonely”, reflect the desolation, hopelessness and desperation that patients with severe mental health problems endure in the community. Further in this research, patients’ data are confirmed by the nurses responses (focus group interview) stating lack of friendships and social isolation as key reasons for patients frequent hospitalisations. A study by Vogel et al (1997) report amongst other factors, living alone and loneliness as precipitants of hospital re-admissions. A further study by Swett (1995) argues that the lack of “significant others” in the life of patients’, are contributory factors to readmission.

Subjects during the exploratory face to face semi-structured interviews and patients during the focus group interviews cite family members, friends, ex-psychiatric patients, drop in centres, the patients’ club house and their local church as their
social contacts and sources of social support. In particular some patients appreciate the friendliness they find in the patients' club reporting; "sometimes it's nice to meet other patients because they are your true friends". "Friends-ex psychiatric patients-have stopped me from committing suicide a number of times", "our friends are important in keeping us out of hospital, they phone the CPN, they are really helpful in crises". Delaney (1998) argues that places like the clubhouse setting, providing human interaction and kindness, hope and inclusion in a relaxed atmosphere, could validate patients feelings of worthiness; furthermore through the provision of productive activity and psychosocial support such as education, developing hobbies and providing "transitional" job opportunities for patients, the effects of these interactions even though unmeasurable can have a substantial impact on patients' well being, thus reducing the number of their re-admissions.

Other participants however, (focus group interview with patients) with low stress and coping threshold question the helpfulness of ex patients clubs reporting; "occasionally I find it helpful but not all the time. Especially when other patients talk about their problems and we can't escape from them". Indeed, many patients find it stressful of having to listen to others' problems. In general findings show that social support through social networks and friendships is significantly related to the mental health and well being of individuals (McCulloch 1995).

5.3.2. The Role of the Family in the Care of RD Patients

Nurses in the focus group interview believe that some patients "can't face what is going on in the family they can't cope with various family situations" and therefore are admitted into hospital. Indeed, according to Leff and Vaughn (1985) high expressed emotion in families of people with schizophrenia and other severe mental health problems could be an important determinant of patient relapse and readmission. An RD patient during the exploratory face to face interview cited a "strained relationship"
with his parents as a factor contributing to his relapse and hospital re-admission. Bowers (1997) explains that many patients because of their illness sever their relationships with their families and their children. Family research studies suggest that unresolved problems with the family and family rejection may increase the level of stress in the environment and hence increase the probability of patient relapse (Sullivan et al 1995). Whereas long term family intervention has been repeatedly demonstrated to improve the outcomes of patients with severe mental illness (Dixon and Lehman 1995). Supportive families (characterised by low EE) on the other hand are crucial in preventing patient readmission. All Non-RD patients (exploratory face to face interview with patients) mentioned their families as their source of support; with a female participant citing “my husband is very good to me; he supports me”. As Brewin et al (1991) argue certain interactions between family members and patients can either improve or worsen their mental health. A variety of psychosocial interventions designed to reduce levels of EE are now used in mental health care settings aiming to decrease the emotional stress within the family and consequently the rate of patient relapse and hospital readmission (Mari et al 1997).

5.3.3. Marital and Employment Status as Provision of Social Support

The marital status can be a useful proxy of social support for the individual providing a link between psychiatric patients and re-admissions. Indeed, the current research study highlights the significant correlation between marital status and re-admissions. Both studies the computerised data and the exploratory face to face interview with patients are in agreement regarding the data of marital status of patients. The marital status of 71 cases of the computerised data was missing. The study shows that 590/68% patients (293 male and 297 female) of the entire sample are single, divorced and widowed whilst only 168/32% are married. When considering the marital status of the two groups there is a significant difference between the RD and
Non-RD groups; whilst the single and separated divorced and widowed status is outstanding in the RD group (216/76%) within the Non-RD group only 374/42% are single, divorced, separated and widowed. When comparing men and women in the RD group there are significantly more RD women that are single, divorced, separated and widowed (119/56%) than RD men (97/44%). Swett's (1995) and Sanguineti's et al (1998) studies support the current research findings; in their studies of predictive factors of early readmission they found that being single, divorced, separated or widowed contributed to patients' re-admissions. Research on marriage (Sherbourne 1990, Rokach et al 2002) stipulate that being married operates as a protective factor against loneliness, leads to a better functioning and greater well being and therefore acts as a buffer against relapse and re-hospitalisation.

However, other researchers, for example Geller (1998) and Heggestad et al (2001) have not shown statistically significant differences between marital status and gender or marital status and frequency of re-admissions. Although a study by Bowers (1997) of 30 non-psychotic patients reports that some patients had difficulties in their marital relationships, and their psychiatric problems caused the marriage to come under threat, the sample is too small for generalisation of their results.

Regarding employment status the current study (exploratory face to face interview with patients) reveals that the majority of RD patients are unemployed; a finding supported by other studies demonstrating that patients with multiple re-admissions are often unemployed. The majority of studies indicate that unemployment is a good indicator of readmission rates amongst patients with severe mental illness (Kammerling et al 1993). Postrado et al (1995) found that only 25% of their sample with severe mental health problems had been in employment. In a study by Ward et al (1998) of inpatient mental health services the authors found that 95% of patients they interviewed were unemployed. In another study by Sullivan et al (1995) three quarters of the revolving door patients they questioned were unemployed. In a study
of community psychiatric nurses case loads by Bowers (1997), he found that whenever patients manage to get a job, this was mainly temporary work, part-time, of low status and low pay with little chance of career and financial progress. Albeit, many people with severe mental health problems are unable to work in open employment in the present job market as few employers would provide support or accommodate their social disability (Repper et al 1998). However, according to Johnstone et al (2000) these findings are not surprising, as by default revolving door patients are frequently hospitalised, they spend longer in hospital, they lack social networks, their competence and skills are reduced and they are often incapacitated by the severity of their illness; hence they become unable to sustain regular employment.

5.3.4. Stigma as a Prelude to Patient Re-admission

Participants in the current study (focus group interview with patients-study (a) phase IV) expressed their feelings of dehumanisation, stating that once they become psychiatric patients they possess only a “label” and a “diagnosis”. Even when they are discharged from hospital they are never free from the fact that they are in need of psychiatric services, an issue resented by some patients observing; “I don’t like the day hospital or out patients appointments. They remind me of being a psychiatric patient. They remind me of having to come into the unit, therefore never escaping the stigma and label”. Patients further report perceptions of altered self-image, low self confidence and decrease in their quality of life. “We feel like patients and we look like patients”, “living in the local area you always meet people you know from hospital like ex-patients and staff”, “we can’t escape from our illness”. Indeed living with mental illness can have a profound effect on ones’ self esteem. The person’s experience of their illness is often manifested and identified by others through labelling of their “deviant behaviour” which has negative social connotations and
stigma (Christopoulos 2001). According to Kaminski et al (1999) and Chan et al (2004) labelling and stigmatising associated with mental illness have a major adverse impact on the quality of life of the individuals concerned. A large population survey indicates that public attitudes to mental illness and specifically to schizophrenia are negative with many believing that patients with schizophrenia and other severe mental illness are dangerous and unpredictable (Johnson et al 2001).

Ward et al (1998) assert that stigmatising psychiatric illness is a central factor in the social exclusion of which continues to be experienced by severely mentally ill people. This is certainly reflected in the subjects' responses of the current study, wishing for a “fresh start somewhere else where nobody knows them”. Indeed, Goffman (1962) argues that long hospitalisation leads to difficulties for patients to re-enter the “real world”. He asserts that deviance is a socially constructed phenomenon created in order to label those individuals who do not fit in with social norms. Public stigmatisation of being a psychiatric patient leads to little or no chance of employment, nor financial security, or development of social networks and friendships; hence escalating into a process of isolation, loneliness and desolation and consequently to further relapses and re-admissions.

Although the literature suggests that patients are stigmatised the current research shows that nurses also feel stigmatised. Nurses responses in the focus group interviews display some of the characteristics described by Goffman (1962) such as; anxiety, bewilderment, frustration, anger, incompetence and defensiveness. Some of these comments are; “I feel frustrated and wonder why they are back, why the system is failing in the community”, “we feel that some patients sabotage everything we put in place”, “it’s very sad when you see the same patients coming back in; I feel demoralised and helpless, sometimes we feel angry, we don’t have any control".
However, it could be argued that as a consequence of being stigmatised, nurses also stigmatise the patients as revealed through their comments and attitudes during the focus group interview; "many nursing homes will not take them (RD patients) they cannot cope with such clients they are bad for business, and so they become bed blockers in our system". "Whenever there is a problem in the nursing home, residential home they are sent back here blocking our beds". Indeed, caring for people with severe mental illness, labelled as “difficult patients” can be very stressful for nurses, and so they tend to avoid them and become less supportive of them (Breeze et al 1998).

5.4. The Organisational Dimension

5.4.1. Re-admission as a Required Option Treatment for the Revolving Door Patient

The current study (computerised data- phase I) identified that 285 (30.4%) of the total sample of 939 admissions, constitutes re-admissions ranging from 3-9 hospitalisations over a period of 24 months. This is in line with other studies (Sanguinetti et al 1996, Kee et al 1998) stipulating that hospital re-admissions account for 22% to 37% of all admissions. It is important to note that although the number of re-admissions is relatively small (one third of the total admissions) nevertheless these patients demand significant inpatient resources; substantiated by other researchers’ (Korkeila et al 1998) arguing that a small but significant number of patients are constantly readmitted and use the majority of health and social care service resources. However, the process of de-institutionalisation and the resulting tendency to reduce the duration of admissions because of the drastic decrease in the number of hospital beds are considered to be important factors of the increase in the rates of re-admissions (Munizza et al 1993) and the increased bed occupancy levels.
Earlier research (Swett 1995, Korkeila et al 1998) suggests that the number of previous re-admissions is a strong predictor of future hospitalisations.

Regarding the question of whether patients need to be readmitted into inpatient facilities, nurses' responses during the face to face semi-structured interviews and nurses' responses during the focus group interview appear to be divergent and mixed; whilst nurses in the former study report that patients needed to be admitted and nothing could be done to prevent readmission, nurses in the latter study query the need of re-hospitalisation for some RD patients. Their comments reflect their doubts; “a well known user always gets admitted through a 136 section”, “those patients that keep coming back are those who stop taking their medication”, “I believe that patients feel they have the right to be here whilst a lot of them don’t need to be here” “I believe they don’t need an acute bed and could be managed in the community”.

On the other hand during the focus group interview, nurses express their views that a small number of patients would always relapse and require readmission into the hospital “due to the nature of their illness, especially those patients over 50 who genuinely relapse from time to time”. Indeed research by Sederer et al (1995) and Sullivan et al (995) indicates that a significant proportion of people with severe mental illness have frequent relapses and inpatient re-admissions, with a figure as high as 75% of patients with schizophrenia relapsing after one year and 87% after two years of hospital discharge (Weiden et al 1995).

When nurses during the focus group interview were asked to give examples of patients who were not readmitted but were successfully treated in the community they attributed the success to different practices of consultants; “older age consultants will bring patients in as a place of safety; “yes if a consultant is near
retirement age they have a different attitude than the younger newer consultants; they will not admit straight away but they will do an assessment first”.

RD patients who repeatedly get readmitted however, challenge nurses' competencies and question the effectiveness of their care; indeed, earlier research suggests that the frequency of re-admissions indicates failure of the previous admission (Swett 1995).

5.4.2. Length of Stay (LOS) in Inpatient Facilities as a Predictor of Patient Re-admission

The results of the current study (computerised data), suggest that whilst some patients stay zero days over a period of two years others virtually live in hospital with a LOS of 618 days. It is important to note that whereas the cumulative LOS of the current study is based on two years, the LOS reported in some studies is based on one year whilst in others the time of LOS is not stipulated. Secondly, as LOS data are not normally distributed the median, and lower and upper bound limits were also calculated. Stevens et al (2003) suggest that there are many confounding effects of interrelated factors in the measurement of LOS, for example the frequency of re-admissions; hence the first admission is one way of describing inpatient LOS. However, this results in an underestimation of the individual actual LOS.

The mean LOS of the entire sample in this study is 38.82 days and the median is 20 days with a mean lower bound of 34.72 and a mean upper bound of 42.91; A study by Stevens et al (2001) report a similar cumulative mean of psychiatric LOS of 39.5 days in Germany. However the time length is not clear in their study. When considering the two samples in the current study the mean LOS of Non-RD patients is 37.22 days, the lower bound is 32.72 and the upper bound is 41.72 days. The mean LOS of the RD group is 42.48 days, the mean lower bound is 33.8 and the
mean upper bound is 51.17 days. The Independent T-Test however, shows no significant difference between the mean LOS of the two samples. Although females (mean LOS=39.76) have longer LOS than males (mean LOS =37.76) there is no significant difference between gender and LOS, albeit Daniels et al (1998) also found that females tend to stay in hospital longer than males.

Nevertheless, the total average stay of the RD group in this study is almost three times higher than the total average (mean LOS =18.5 days) indicated by the studies of Swett, (1995), Geller et al (1998) (mean LOS=18.8 days) and Sloan et al (1999) (mean LOS=16.63 days). On the other hand the LOS of RD patients in the current study is much lower compared to the LOS of Wards et al (1998) study showing a mean LOS of 98 days; although their high LOS is accounted for by several patients who had been resident on the ward for several years. Similarly in the current study the high mean LOS could be further explained by placing patients in different categories; 321/34% of patients stay over the nationally recommended standard of 30 days. 92/10% of patients LOS is more than 90 days, of which 24/3% patients LOS is over 200 days and 15/1% patients LOS is more than 300 days.

When comparing LOS and diagnosis the computerised data show a significant difference (P=0.0001) between patients with schizophrenia (mean LOS=59.66 days) and patients with affective disorders (mean LOS=32.76), personality disorders (mean LOS=30.34) and neurotic and behavioural disorders (mean LOS=16.95). The study by Ward et al (1998) substantiate these findings reporting that 78% of patients with a diagnosis of schizophrenia and psychotic illness in their study stayed longer in hospital than any other diagnostic group.

Heggestad et al (2001) argue that the LOS at individual and hospital level has been used as an indicator for re-admissions in many studies although with conflicting results. Whilst Korkeila et al (1998) found a positive correlation between LOS and
the risk of readmission and LOS and rapid re-hospitalisation, Johnstone et al (2000) assert that the lengths of stay in hospital for people with serious mental illness have reduced drastically.

In Korkeila's study (1998) a cumulative LOS of 3-6 months was associated with a higher risk of multiple re-admissions compared to a cumulative LOS of less than one month. A study by Appleby et al (1993) revealed that shorter LOS yielded more frequent admissions than longer LOS. Indeed, Johnstone et al (1999) in their systematic review of several studies found that a reduced LOS is cited as one of the reasons for the emergence of the "revolving door" phenomenon.

The literature reveals that there is no conclusive evidence between the different variables and LOS although the current study and Ward's et al study (1998) indicate a significant difference related to the diagnosis of schizophrenia. However, it could be argued that longer LOS imply the need for treatment over a longer period of time, consequently leading to further dependency on inpatient services and thus more re-admissions.

5.4.3. Cost of Inpatient Care

Frequency of re-admissions and LOS are widely becoming indicators for hospital performance often used as measures of resource care (Stevens et al 2003). High re-admissions rates result in higher costs and diminished quality of life (Kee et al 1998). In this study direct costs of psychiatric care are strongly related to patients' length of stay. Direct costs correspond to spending for treatment and rehabilitation. Long inpatient care regarding direct and indirect costs are exceedingly high. In this organisation the direct costs of the acute inpatient services in the financial year of April 2002 totalled £4,770,881 (£9,541,762 for two years) representing approximately 60% of the total patient care. Fenton et al (1998) argue that care for patients with
severe mental illness accounts for the use of nearly half of the mental health resources with the largest proportion spend on acute inpatient care. Johnstone et al (1999) stipulate that 80% of the total costs in mental health are used by inpatient services. The total number admitted into acute inpatient services over a 24 month period over the period of April 2000-April 2002 was approximately 1000 patients. Of those 285 (30%) had 3-9 re-admissions. Thus the annual cost of multiple-episode "revolving door" patients create a significant concern for the organisation regarding financial and human resources and for the clinicians regarding treatment and care interventions as well as having training and education implications for the staff working in the inpatient services and the community.

5.4.4. Quality of Care in the Inpatient Setting

Acute inpatient psychiatric care forms part of the comprehensive overall health service with the expectation of substantial patient improvement within a reasonably short-term period of treatment (Cleary et al 2003). In the current study (exploratory face to face interview with patients) most RD and Non-RD patients agree that either all or some of their needs and expectations were met and that the co-ordination of their care was good or satisfactory. However regarding the overall experience of their hospital stay it is observed that RD and Non-RD patients' opinions are in opposition; in general Non-RD patients are satisfied with the care they received, their contact with their named nurse, and their involvement with their care plan; this is also reflected by their positive attitude that they would be willing to be admitted to the same ward if they needed similar treatment in the future. Even though some patients report that information they received was poor and did not know their named nurse.

Similarly nurses' responses (face to face semi-structured interviews with named nurses) are confirmatory to the responses of the Non-RD patients; in the nurses' opinion the co-ordination of care is excellent, they are quite satisfied with the
standard of care they provide, and they report the level of patient involvement in their care to be either good or excellent. Cleary's et al (2003) study also showed patient positive feedback regarding patients overall experience of mental health nursing and 59% of their patients indicated that they would like to return to the same unit if necessary in the future.

However, when RD participants were asked about their satisfaction with inpatient care and their involvement in their care plan the majority stated dissatisfaction. According to Kee et al (1998) as pressures to reduce high costs rises, this may compromise the quality of inpatient care. Indeed, inadequate care during hospitalisation is amongst the causes cited in previous studies for patient re-admissions (Wallace et al 1999). The majority of RD patients during the exploratory face to face semi-structured interview reported that they would not be willing to return to the same unit if they needed to in the future. Although, the researcher recognises that the question of whether patients would be willing to return to the same ward is of a sensitive nature, perhaps it could be asked after they were discharged from hospital. Indeed, in a study by Gardner et al (1999) the authors found that when they interviewed clients whilst inpatients whether they needed hospitalisation, 52% of participants who said that they did not need it, when they were re-interviewed after discharge they agreed that in retrospect, they had needed it.

Nonetheless, it is important to note, that when reviewing the patients medical and nursing records (phase III), it was observed that subsequent to the index admission, other care plans were not signed by patients, suggesting that indeed RD patients are not involved in the planning of their care. These data are further substantiated by the responses of RD patients during the focus group interview (study (a) phase IV) asserting that they are often left to their own devices, “most of the time walking around on the ward, smoking, staying in bed or sleeping”; hence their days becoming “meaningless one rolling into the other”; “there are no therapies or treatments
available to us due to lack of support staff such as occupational therapists and psychologists”.

The results of studies of Higgins et al (1999) and Hurst (2000) agree with the current research; reporting that nurses comment on an increase in administrative duties to the detriment of nursing care, due to limited access to secretarial or information technology support, and moreover, most of their activities focus on resolving crises of the minority of severely ill patients, often neglecting the majority of other patients. Nurses in the current study affirm (focus group interview) that there were difficulties with recruiting support staff (occupational therapists and psychologists) due to the future closing down of the inpatient unit in one site of the Trust. Previous research (Wallace et al 1999) found that inactivity and lack of stimulation in inpatient settings was a major concern for patients in their study as this affected their mood and orientation. Indeed, Hurst (2000) suggests that nurses speak of a dilemma of operating in a custodial rather than a therapeutic approach to care.

Furthermore, Heggestad et al (2001) found that discharging patients from wards with relatively low access to therapists increase the risk of early readmission. Thus it could be argued that the quality and intensity of care, and patient satisfaction with their involvement and high access to therapists during inpatient episodes may have a preventative effect on future re-admissions. These findings are confirmed by Cleary et al (2003) where involvement in treatment and decision making, scored low in their patient satisfaction survey.

5.4.5. Community Care and Patient Readmission

The current results (exploratory face to face semi-structured interview with patients and the review of medical and nursing records in phase III) reveal that there are no consistent treatment programmes directly related to pre-discharge and relapse
prevention. Although it is argued that the immediate post-discharge phase carries a high risk of relapse and it is very important that patients are successfully engaged in treatment programmes to reduce relapse rates (Bergen et al 1998). The National Service Framework (DOH 1999) and the NHS Plan (DOH 2000) propose substantial changes in the mental health services; shifting the focus of care in the community and developing further the various service management frameworks. It is further noted that early discharge and inadequate care following discharge are cited as causes of re-admission (Kee et al 1998).

Although, participants during the patients' focus group (study (a), phase IV) admit that the support they receive from their CPNs following discharge is quite intensive initially, 2-3 times a week, it then subsides to once a week, then to once a fortnight and then it becomes even less frequent-once every three months. Albeit, according to the patients this period (few months after discharge) is the most crucial for them; when their motivation is at a low level and thus needing encouragement and professional help to keep them from back-sliding. Indeed, the DOH (1998) highlights the "failures" in providing continuity of care following discharge from hospital and emphasises the role of psychiatric nurses in discharge planning and requests health authorities to review their discharge procedures.

In this study the patients' views are consistent with the nurses' observations; during the focus group interview with staff (phase IV study (b)) in order to keep patients out of hospital, the nurses recommend added support from social services, more outreach services, extra community psychiatric nurses with smaller case loads and they suggest that care co-ordinators should have more frequent contact with RD patients. Some of their comments include; "social services should be more supportive and do more for the clients in the community" "the patient population is growing caseloads of community nurses are massive, they need more resources" "because of lack of support clients disengage with services and then you loose
them”. Indeed, Ford et al (2002) during their development of a framework of assertive community framework for the severely mentally ill recommend a caseload of no more than 12 patients per worker to enable enhanced therapeutic relationships to develop, provide flexibility with the client group and to increase staffs’ understanding of problems and to further engage patients in more timely interventions.

However, whilst it is recommended that treatment packages/programmes should be geared towards patient self care and independence, it could be argued that the same treatment programmes foster patient dependence (especially revolving door patients who are already heavily dependent) either on the health service systems such as Intensive Outreach Services, Out of Hours Help lines, 24 hour support services, out patients and day care services, or on the professionals themselves. Nevertheless, both patients and nurses (focus group interview with patients and focus group interview with nurses) mention that access to 24 hour services would prevent patients hospital re-admission. Some patient’s views reflects the situation of resource shortages “we need night support. We need 24 hour support before it’s too late and no matter who you see it’s too late. We end up back in hospital” “the CPNs need more resources when we have a CPA review they are rarely there”. Flanigan et al (1994) affirms these views; they found in their study of reasons for acute hospital admissions that accessibility to high supervision hostels, with staff available 24 hours, has prevented hospital admission in many cases. Meddings et al (2000) assert that having a comprehensive range of interventions, a team approach and manageable case loads would enable effective delivery of community care.

Further data from the focus interview with patients (study (a) phase IV) suggest that RD patients need more intensive support from their care co-ordinators, with a clear structure and objectives but this according to patients depends upon their relationship with them; further suggesting that one to one contact with their care co-
ordinator is limited, and very often this relationship is at a superficial level. Indeed, Hurst (2000) argues that the success of the relationship largely depends upon the nurses psychotherapeutic and interpersonal skills.

The community is now recognised as the preferred setting for mental health care. Indeed this option is also much preferred by patients as revealed in the literature (Nocon and Qureshi 1996) and by the results of this study (focus group interview study (a) phase IV); a patient consensus shows that they prefer to stay out of hospital into the community; even though the debate of how to best care for people in the community continues. Fenton (2000) argues that many patients who are discharged require community adjustment and a follow through with medically required aftercare. One of the most consistent research findings is that assertive community care reduces the demand for readmission of patients with severe mental illness. A review of randomised controlled trials of assertive community treatment (ACT) by Lockwood (2000) concluded that ACT is clinically effective in managing the care of severely mentally ill in the community. If correctly targeted on high users of inpatient care it can substantially reduce the costs of hospital care whilst improving outcome and patient satisfaction.

5.4.6. Out Patients Appointments/Day Care Places

During the last few decades the number of beds in psychiatric hospitals has decreased notably and hospitalisation has been replaced by day or out patient services (Thornicroft and Bebbington 1989). The findings of the current study (phase I-computerised data) are consistent with the findings of other studies (Saraento et al 1995, Korkeila et al 1995, and Korkeila et al 1998); indicating that increased aftercare arrangements such as outpatient appointments and day care places had an increased effect on hospital re-admissions. This study highlights that RD patients
had significantly more out patients (M=11.16) and day care placements (89.8) than Non-RD patients (M=7.9 out patients and M=61 day care places).

Certainly, the previous and the current study suggest that generic psychiatric outpatient care arranged through the CMHTs does not seem to have essentially the necessary effect of decreasing the need for hospitalisation. Perhaps what is needed, for the RD patients are more specialised and targeted interventions such as intensive outreach and early intervention work programmes. Appleby et al (1993) even suggest that for a small number of severely mentally ill, longer or more frequent hospitalisation is more appropriate than out patient appointments and day care places.

The current study highlights that female RD patients receive significantly more out patients appointments (M=13) and more day care places (M=106) than any other sub-sample including their RD male counterparts. Furthermore this study demonstrates that patients with a diagnosis of personality disorder receive more out patient appointments (M=10.5) and more day care places (M=88.8) than any other diagnostic group. Previous research (Hull et al 1996) also found that patients with personality disorder make more intensive use of psychiatric services including accident and emergency visits, hospitalisations and out patient appointments and day care places than any other diagnostic group.

5.5. The Professional Dimension

5.5.1. Nurses Role in the Discharge Planning and the Care Programme Approach (CPA)

Despite the introduction of the Care Programme Approach ensuring a more systematic process to discharge planning and aftercare (Johnson et al 2001), the findings of the current research indicate that very little preparation takes place during
the patients discharge phase. Even though, the computerised data show that of those registered (N=759) on the CPA the majority are on enhanced level. The same data further indicate a significant difference between the level of CPA and the number of patient admissions. Whilst 211/78% of RD patients are on enhanced CPA, in comparison 303/62% of Non-RD patients are on enhanced level.

Even though the majority (514/68%) of patients are on enhanced CPA the study reveals some anomalies in the data within the various phases. Most RD and Non-RD patients (exploratory face to face semi-structured interview with patients), did not know the date of their discharge, and did not meet with their care co-ordinator to discuss their community needs. Even though in 10 of 13 patients’ records (review of medical and nursing records in phase III), the name of the care co-ordinator was documented. Furthermore, RD patients (study (a) phase II) and specifically those detained under the MHA reveal more dissatisfaction with their discharge plan and preparation than Non-RD and informal patients. The computerised data however, reveal no differences between RD and Non RD groups regarding their legal status showing that the majority of patients are admitted informally. Wallace et al (1999) study confirms the above results reporting negative comments regarding patients’ discharge planning; for example patients in their study, were discharged with no prior preparation at all.

The findings are consistent with the findings of the review of nursing and medical records (phase III), showing that there was only evidence in 4 of 13 records that patients readiness for discharge was assessed, evidence in 6 of 13 records that patients community needs and evidence in 4 of 13 records that potential risk factors were assessed. There was evidence in only 1 record that patients’ expectations of community support were assessed prior to discharge. These findings are in agreement with the data of the focus group interview with patients; participants report that they did not find the pre-discharge groups particularly helpful in enabling them to
apply their skills in real situations. Indeed the White Paper, MHS, Modern, Sound and Supportive, (DOH 1998) reports that many patients who were discharged did not have the necessary skills to live outside the "institution".

However, the findings are contrary to nurses responses in the face to face semi-structured interview with named nurses; 5 of 6 nurses report that patients were adequately prepared and 5 of 6 nurses state that patients were ready for discharge. When examining the medical and nursing records (phase III) there was a date recorded in 8 of 13 records, and a discharge summary and copy of a letter sent to the patients GP in 10 of 13 cases. In addition the destination address and living circumstances in the community were identified in 11 and 12 records respectively. But, only five records show patient involvement in their discharge plan, only 4 records demonstrate carer involvement (even though the carer was identified in 7 of 13 cases) only 5 records illustrate any evidence of discharge preparation programmes and astonishingly there was evidence in only 1 record regarding a relapse plan for patients. Furthermore, during the focus group interview with staff, nurses admitted that patients are frequently discharged without appropriate discharge planning due to pressure of beds and the demand on inpatient resources; even though earlier in the same interview nurses said that they have put in place the most “water tight” discharge plans for patients. The findings are supported by Higgins et al (1999) and Hurst (2000) reporting that in their studies nurses referred to a predicament between discharging patients before they are fully recovered and the pressure to free beds. A circular by the DOH (1998) on hospital discharges however, requests health authorities to review their discharge procedures.

Further anomalies identified in phase III (review of medical and nursing patients' records) with discharge planning include; patient care pathway from discharge to follow up and aftercare is difficult to track from patients' CPA documents as there are no clear links between patient assessments (many forms of assessments exist,
carried out by various professionals such as nurses, doctors, occupational therapists, social workers) and admission, discharge and after care plans. There seems to be a significant lack of baseline information regarding patients' community needs, the support needed, and the frequency of CPN visits required. Within the patients medical and nursing records there are several care plans; the first being carried out during the index admission and other subsequent care plans one for each patient re-admission; with all subsequent care plans been similar or identical to the index care plan, however bearing no signature of the patient. It is not clear though, whether subsequent care plans are merely copies of the index plans, therefore an assumption can be made that patients are not involved in their care, or whether patients refuse to sign their care plans even though they have been involved.

The study (face to face semi-structured interviews with patients) further suggests that neither the patients nor their families are prepared for discharge. The date of patients discharge was sometimes decided only one or two days before and sometimes on the same day following the ward round. This may explain the reason of why some patients were not aware of the date and also why their community needs had not been discussed with their care co-ordinator. Wallace et al (1999) report grave concerns from patients relatives, reporting of some families receiving phone calls (the day of the patients discharge) telling them that the patient was being discharged, whilst families did not feel ready to receive them.

Higgins et al (1999) and Hurst (2000) argue that discharge planning involves the co-ordination of services and resources, patient education, provision of care, consultation and communication with other professionals and agencies and with the patients, their carers and families. Indeed, discharge planning includes activities that facilitate the transition of patients from one setting to another. Adequate and appropriate discharge planning and satisfaction of patients with their involvement with the care plan may help to reduce their hospital re-admissions.
5.5.2. Nurse Patient Relationships

Regarding patients relationships with their named nurses there are differences of opinion between RD and Non-RD patients (exploratory face to face interview with patients). While only one RD patient rate their relationship with their named nurse and other staff as very good and one as satisfactory, the majority of Non-RD patients rate their relationship with nurses and other staff as very good. Two RD patients and two Non-RD state that their named nurse was able to listen and understand their problems; nevertheless, the majority of RD and Non-RD patients highly praised the empathic qualities of nurses. This finding is supported by the studies of Wallace et al (1999) and Cleary et al (2003), indicating that patients appreciate the kindness, friendliness and professionalism of nurses.

Although the data regarding the views of RD patients (exploratory face to face semi-structured interview with patients and focus group interview with patients) emphasise the difficulties in securing adequate time with their named nurse or care co-ordinator. Patients complain of insufficient time with their named nurse/care co-ordinator and the lack of individual counselling. Two female patients state; “the CPN comes asks you how you are and that's it” “one to one contact with staff is very poor, we don't get individual counselling”. Higgins et al (1999) findings are in agreement with the current study reporting that patients had only passing relationships with nurses who seemed to spend most of their time in the office talking on the phone, writing, or dealing with unexpected situations. Indeed, in a study by Hurst (2000) the author found that in recent years there had been a significant decrease in the time that G grade (-23%) and F grade (-2%) nurses spend in direct contact with patients. Furthermore a study by Sainsbury Trust/MHA Commission (1998) found very little interaction between patients and their nurses.
It is argued that professionals must become more responsive to patients' needs, and must offer patients the opportunity to become more involved with their care and participate in decisions affecting their care (Wallace et al. 1999). Indeed, patients are individuals and their opinions must be valued, furthermore they are now more aware about treatment options and costs and their involvement should be used more effectively to promote their mental health, quality of life and furthermore increase their satisfaction with treatment and services (Ryles 1999).

Responding to individual needs and treating patients with dignity, respect and confidentiality is crucial to their recovery; trusting long-term relationships and open communication between patients and professionals are very important care elements in promoting patients' independence and autonomy and hence reducing their need for inpatient admission.

5.5.3. Struggling for Power and Control

The current study highlights the struggle for power and control between staff and patients; in phase IV, during the focus group interview, RD patients report of feeling completely defeated and disempowered when they are readmitted into hospital. According to many participants they become overwhelmed by feelings of failure; reporting that nurses belittle them and sometimes “treat them like children”. Consequently, they become depended on them who (nurses) then adopt the role of parents. Hence it is often left to the professionals to make all the decisions regarding patients' care and treatment. Indeed, the review of medical and nursing records (phase III) verifies this perception indicating very little evidence of patient involvement in their own care. It is interesting to note that in the same study (focus group interview with patients) conversely patients report a sense of relief about their hospitalisation and about staff taking responsibility of their care. Patients comments such as feeling safe in hospital, not having to make decisions and letting staff to take
control, highlights their inequality and dependence on staff and the system. Though the UKCC code of Professional Conduct for Nursing (UKCC 1996) clearly states that the practitioner will accept a role as an advocate on behalf of the patient. Nevertheless, even though participants state that they like to withdraw from any decisions, in general they feel marginalised and are dissatisfied with the lack of control over their lives. With this in mind the potential for conflict is quite high. Indeed, patients complain that although they participate in meetings their opinions and views are not considered in the final decisions regarding their treatment and the running of services. There is growing research evidence that the perception of personal control plays a crucial role in the health and well being of individuals, particularly for psychiatric patients where independence and freedom are often overridden by professionals even though Lowry (1998) and Valimaki et al (1998) argue that the opinions of people with severe mental illness are largely ignored; thus they play a minor role in their own care and treatment.

Likewise and not at all surprisingly nurses during the focus group interview also express feelings of frustration, anger, disappointment and defeat, often blaming patients of sabotaging everything they put in place to help them. Indeed revolving door patients present nurses with many challenges, thus inevitably affecting the nurse/patient interaction and patient care. According to Swett (1995) inpatient readmission particularly when it occurs within a relatively short time following the patient’s previous discharge is often seen as a failure of the earlier admission. Re-hospitalisation is seen as a failure by both patients and staff; they both feel that they have no control over the events of readmission. Hence the current study suggests a degree of ambiguity within the concept of power and control.

In a qualitative study by Breeze and Repper (1998) mental health nurses cited the following criteria as defining characteristics of a “difficult patient”; long term mental health problems, detained under the MHA, multiple and complex needs, does not
respond to intervention, disruptive, aggressive, violent, self harm, and “misplaced” on an acute ward. Undeniably, RD patients often fit these criteria because of their re-admission, the severity of their diagnosis, their demands on services, and detention under the MHA. Therefore, Breeze and Repper (1998) suggest that a “difficult” patient present a challenge to nurse’s competence and control. In reality however, patients also have no control over their admission to hospital neither their care nor treatment. In effect, a negative cycle is set up whereby both nurses and patients struggle for control and hence colluding in a self-perpetuating system which very often fails to provide adequate or appropriate care.

Equal relationships involve mutual trust and respect, participation, commitment and support, carried out within a caring nurturing environment that encourages honesty, genuineness and open communication (Ryles 1999). Indeed, this practice may help in the shifting of the balance of power and control and may help to reduce the conflict within the relationship between nurses and patients. This process may restore the helplessness, frustration and meaninglessness that both patients and staff express regarding multiple re-admissions and it may help to reduce the frequency of this negative cycle of repetitive hospitalisations.

5.5.4. Information/Advice Received

While RD patients in the current study (exploratory face to face interview with patients-phase II) rate the information regarding their medication, the various services, their condition and treatment as poor or very poor, Non-RD patients are more satisfied with the information they received from staff. Nurses also during their face to face semi-structured interviews rate the information given to patients as either very good or excellent. Nonetheless, the review of medical and nursing records (phase III) supports the responses of the RD patients interviews; when the RD patients records were examined, no evidence to support that information on
medication, who to contact in an emergency or what the patient should do during a crisis is given to patients. Cleary et al (2003) during a patient satisfaction survey also highlight that the lowest mean ratings were received regarding the information given to patients about their rights, and regarding the information regarding the hospital services which they were admitted.

However, earlier research suggests that information-giving alone is not adequate to achieve behaviour change (Hunt et al 2001). Indeed, lifestyle behaviours are influenced by many internal and external factors and these might be deeply ingrained. Simply giving information regarding health will not initiate sufficient motivation and confidence for people, especially people with severe mental illness, to change their lifestyle. Enabling someone to change, means thinking about what changes need to be made from the patients perspective based on partnership and joined decision between professionals and patients (Hunt et al 2001).

5.6. “Fittingness” of the ISOP Multi-dimensional Theoretical Framework

The ISOP multi-dimensional theoretical framework was developed from the review of the literature of what other researchers believe and argue about the revolving door phenomenon. Constructing the theoretical framework however, proved challenging in many ways; whether the framework matches the theoretical context of the current research, whether the generated data fit within the framework and whether it can propose a solution to the research problem.

Reflecting on the “goodness of fit” of the framework many strengths have been identified: The framework adopts a multi-dimensional approach providing a theoretical background drawn from a diverse plethora of factors explaining the RD phenomenon; the approach of the framework is integrated leading from one dimension into the other; the framework helps to clarify and specify precise areas of
where existing ideas within the literature of the revolving door phenomenon fit; it further suggests a new perspective on existing ideas, and the dimensions and various elements provide a step by step guide to the discussion of the findings.

However although the strengths of the framework have been established, following discussion of the findings and how the data relate to each dimension and the various elements and how the framework fits into the field of knowledge, the following questions were posed;

- How do the various dimensions of the framework relate to one another?
- What fits and what does not fit within the framework?
- What modifications if any need to be made to enhance better understanding of the “revolving door” phenomenon?
- Through the modified framework what solutions can be proposed towards solving the revolving door phenomenon?

Albeit, the four dimensions of the framework are interrelated, they act independently, hence restricting the free flow of the discussion from one element in one dimension into another element in another dimension. For example, within the Individual dimension the perception of being ill, overlaps with the sick role and the rejection and stigma by society within the Social dimension. Furthermore the issue of drug and alcohol misuse in the individual dimension overlaps with the Social dimension as substance misuse is considered a social problem (Storch 1993). Similarly, although the LOS associated with bed utilisation and costs constitutes an organisational issue, according to Geller (1993) the consequences of prolonged inpatient LOS (isolating patients from their social networks), initiate maladaptive processes in the patient, (institutionalisation) hence, these issues are more appropriately explored within the Social dimension.
Furthermore, depending on the perspective (for example the various service frameworks and treatment, out patients community care, assertive outreach, and discharge planning) whilst discussion of the systems may be appropriately considered within the parameters of the Organisational, the discourse of the quality of the interactions and the effectiveness of treatment may be better examined within the Professional dimension.

Therefore, in light of the evaluation of the framework the following modifications are proposed: that it is reconstructed to consider a more flexible, fluid and interactive approach taking into account the continuity of the dimensions as shown in diagram 3 below. The new framework attempts to provide a more holistic and fuller picture of the individual and their experience of their illness (Shaw 1999); the RD phenomenon and the experience of illness according to this framework is related to a number of factors which are dynamic, changing over time depending on the personal experience and circumstances of the individual; thus these changing variables (elements) influence the framework's structure.

Diagram 3: The Modified Multi-dimensional Theoretical Framework
5.7. The Theoretical and Practical Implications of the Research Viewed Through the Modified Framework

The findings of this study have very important theoretical and practical implications; when a patient with a high risk re-admission potential is referred to or admitted into the psychiatric services, the patient can be managed in a holistic process within the context of the multi-dimensional interactive framework.

The research through the analysis and synthesis of the data from the various studies suggests that the frequency of RD patients’ re-admissions occurs as a result of a series of interrelated and complementary factors which can be explained through the continuum and dynamic interaction of the Individual, the Social, the Organisational and the Professional dimensions of the ISOP theoretical framework.

When developing and identifying the level of specific services required it is useful to understand the theoretical underpinning of the revolving door phenomenon; from a clinical and managerial point of view it is important to be able to predict which patients are likely to be readmitted.

As regards to the diagnosis and number of re-admissions the current research study differentiates between gender and diagnosis; being male with a diagnosis of schizophrenia and being female with a diagnosis of personality disorder are strongly associated with the RD phenomenon; in addition, the study further suggests several factors, which, when combined yield significant risks of readmission; being young, single, unemployed, characterised by medication non-compliance, leading a lifestyle of drug and alcohol misuse, being socially isolated, labelled mentally ill, stigmatised by society and being in receipt of frequent outpatient appointments and day care places.
The framework provides a theoretical foundation to be utilised by clinicians and managers. This research study proposes four principles to guide the treatment and management of the RD patient; assessment and planning, discharge care planning, education and advocacy (shown in diagram 4).

Diagram 4: A Holistic and Interactive Process of Managing High Risk Patients

5.8. Assessment and Planning

5.8.1. Risk Assessment tool

There is an urgent need to develop more assertive approaches in identifying and reaching people with severe mental illness. The data identifying the various characteristics of RD patients could form a foundation for the development of a specific risk assessment tool to be utilised by managers and clinicians for screening the potential risk of re-admission of first admission patients. Such information is a means of developing targeted clinical interventions of early prevention and relapse programs, focusing on timely referral to the early intervention teams; enabling
clinicians to create an appropriate framework of care specific to those individuals' needs thus stopping a potential cycle of re-admissions;

5.8.2. Care Protocols, Policies, Strategies

Through the Organisational dimension of the ISOP framework the current study purports a strong correlation between the failure of the organisation to provide adequate and appropriate care and the frequency of patients readmission; inadequate inpatient care, long cumulative LOS in inpatient facilities, frequent but ineffective attendance of outpatient and day care places and insufficient community support and follow up may foster patients dependency on health and social care services. Priorities should be identified regarding the care and management of these people and specific care protocols, policies and strategies representing their interests should be developed and allocation of resources should be targeted to meet their needs. Hence this problem suggests the need for more effective therapeutic strategies within and outside the hospital to prevent relapses in patients with severe mental illness.

5.8.3. Developing a Specific Data Base for Monitoring the RD Patient

Studies on bed utilisation reveal that a small but significant group of people use a disproportionate vast amount of resources (Geller 1993, Semke and Hanig 1995). Developing a specific data base to identify patients with frequent re-admissions and ongoing monitoring of their LOS is very important; those with zero as well as those with exceedingly long LOS should be identified; setting up a monitoring and management meeting once a month to discuss patients from all community teams, their patterns of hospital use, and their allocation and referrals to specialist treatment programs thus reducing rates of readmission and high bed utilisation; it will also help managers to focus their direction of support and resources.
5.8.4. Community Care

The current study found that RD patients complain about the insufficient time and low frequency of CPN visits; furthermore they are dissatisfied with the interaction with their care co-ordinators and of not having adequate quality time with their Community Psychiatric Nurses (CPNs). CPNs have been continuously encouraged to focus their efforts on patients with severe mental illness (Bowers 1997); however these people present major challenges to the professionals caring for them (Gourney 1995) especially when the CPNs cover large case loads. Clinically focused assertive care with small case loads (10-15) of clients covering the entire spectrum of patients with severe and enduring mental illness, should become a priority, not an option. Having a small case load would enable CPNs to spend more time with their clients, providing psychotherapeutic support and individual counselling. Although, this alternative may be expensive, research shows that inpatient care is even more expensive. Patients should be allocated a specific care co-ordinator to whom patients can relate, and the care provided should be more holistic and intensive based on the Assertive Outreach framework. The provision of adequate and comprehensive assertive outreach services, and targeted and effective community interventions and support, including 24 hour coverage, aspiring to engage and maintain contact with the RD patient with the aim of avoiding admission is a great challenge to health and social care organisations and staff. However, the NHS Plan (DOH 2000) states that assertive outreach services should be available throughout the country.

5.9. Discharge Planning

5.9.1. Pre-discharge Planning

The current study highlights the inadequacy of pre-discharge preparation, and the lack of involvement of patients and their carers in the discharge plan. Clearly patient
discharge care planning is an issue that needs to be addressed. Pre-discharge assessment of patient readiness for discharge, assessment of community and aftercare needs, identification of support and resources required and an appropriate discharge and aftercare care plan and targeted timely interventions may prevent further patient relapses and therefore may stop further re-admissions reducing the NHS costs.

The pre-discharge plan should be initiated as early as possible during the first week of the patient's admission. An estimated length of stay for each patient (≤30 days) should be planned during their CPA case review. Whilst focusing on patient's discharge needs, treatment during hospitalisation aiming to provide support and maintaining an optimistic level of functioning should be an important prerequisite for preventing patient relapse.

5.9.2. The Discharge Plan Must be Comprehensive

The discharge plan must be comprehensive, identifying the patients' needs and limitations. Although the discharge plan is the responsibility of the patient care co-ordinator, structured multi-professional assessments and systematic interventions and multi-agency input to meet the needs of each individual patient should be developed. The patient and if necessary their carer must be actively involved; whilst it is crucial that the patients understand their plan (Geller 1993), nurses working with the multi-disciplinary team must recognise the needs and limitations of RD patients and design a plan that addresses their long term community needs. Nurses should be encouraging patients to anticipate and plan for potential adverse events (e.g. reluctance to take medication, unwillingness to attend outpatients, stressful situations, availability of telephone service in patients' home, access to CPN, what to do in a crisis situation and who to contact in an emergency).
5.9.3. The Discharge Plan Must be Consistent

Discharge planning is an integral part of the patients’ treatment and should involve the co-ordination of services and resources, patient education, provision of care, and consultation with other disciplines and agencies, also including the patient, their family and carers. Expertise in all these is a pre-requisite for effective patient discharge. The plans should be reviewed regularly at scheduled patient case conferences to which the multi-disciplinary team including the patient, their relatives and significant others should be invited and encouraged to participate. The discharge plan must be consistent and monitored across the various treatment sites (e.g. out patients, day care, specialist services). Although the plan needs to be flexible, and dynamic to meet the patients changing needs, expectations and behaviours.

5.9.4. The Discharge Plan Must be Enforceable

During the current study the review of medical and nursing patients records revealed that discharge care plans are not utilised to their full potential of providing assessment, and monitoring of treatment and care for the patients; Discharged care plans must be endorsed by everyone involved in the care of the patient. Close liaison and clear lines of communication between inpatient, and community services, between carers, relatives, the patient and professionals involved in the care of the individual are crucial. Various members of the team should follow up patients and their families to monitor the implementation of discharge goals and objectives, the patients and families coping strategies, and ensure their understanding and compliance with the course of treatment.
5.10. Education

5.10.1. Quality of Care

Improving the quality of care is of prime concern to clinicians, managers, and educators (DOH 1998). The current research and previous studies note that nurses spend most of their time in dealing with administrative duties to the detriment of their patients (Sullivan 1998, Higgins 1999, Hurst 2000, Cleary et al 2003). Furthermore, it is argued that nurses in inpatient settings use interventions that are inappropriate and ineffective (for example, custodial routine and ritualised care); therefore nurses should try and create an environment which promotes an intensive client contact and form more meaningful relationships with patients. Keeping patients occupied does not necessarily require input from highly skilled nurses (Higgins 1999); trained support workers could help to take the pressure off nurses time. Reflective practice and evaluation would enable nurses to challenge and change their current practice.

5.10.2. Education and Awareness of Nurses of the RD Phenomenon

The study revealed that patients with severe mental health problems and staff caring for them encounter many struggles; due to frequent re-admissions, the stress, anxiety and frustration experienced by both patients and staff have been highlighted through the various phases of the research. Through the study's interactive dimensions of the framework, education and awareness of staff to increase their knowledge and understanding of the reasons of frequent re-admissions are crucial to the prevention and management of the revolving door patient.

Early identification of factors leading to readmission will help staff to prospectively address them during the admission phase of patient, and will help staff to put in place important preventive intervention programs, such as, patient and staff education on relapse prevention, planning and intensive support for patients;
Continuing education for nurses regarding effective communication, particularly with persons experiencing severe stress, emotional problems, discharge planning, effective response to a crisis call, assessment of patients discharge needs, and recognising and reporting signs of relapse.

The area of medication compliance, monitoring and early recognition of side effects is vitally important (Gourney 1994) in improving long term outcomes of the RD patient. It is essential therefore that nurses are trained in the management of medication and early detection of side effects. This may help to break the cycle of frequent hospital admissions and reduce the rates of hospitalisations.

5.10.3. Patient Education

From a clinical point of view the findings of the present study point to the importance of the care and support systems for the severely mentally ill. The framework of care and support of patients should be directed towards coping with their illness, recognising early signs of relapse and, increasing their understanding, knowledge and responsibility towards their illness. Further the results of the study point to the importance of care and support systems focused on interventions which make it possible for patients to increase not only their comprehensibility and manageability but also the perception of self control and meaningfulness in their lives thus increasing their quality of life. Specific educational programmes including provision of information about the illness and its treatment, prompts or reminders, positive reinforcement and social support plans should be at the centre of meeting the needs of these individuals.

The current study found that patients are not adequately equipped with daily living skills or given enough information regarding their illness, medication and health services. Research highlights that educating and teaching patients regarding their
daily activities, treatment goals and objectives, and recognising early warning signs and teaching them to seek early treatment will significantly reduce the number of their re-admission (Axelrod and Wetzler 1989, Johnson 2001). Indeed, clear goals and objectives should be set for each patient, and the individual strengths of each patient should be assessed and utilised in helping them to reach their treatment goals. Furthermore, activity therapies treatment programs provide patients with therapeutic activities that are necessary to help patients reach and maintain the level of functioning needed for re-entry into the community. These must be tailored made to the needs of each individual patient in order to enhance their quality of life.

Medication non-compliance has been cited in the literature and the patients and staff of the current study as an important factor contributing to patient relapse. Therefore medication education regarding its use and side effects, blood tests to assess the therapeutic level and strategies to improve compliance, regular supervision and monitoring should form key elements of patient education.

5.10.4. Public Education and Raising Awareness of Mental illnesses

Through the Social dimension of the framework this research identified that patients feel stigmatised. Negative evaluations of the quality of care patients receive during their inpatient stay, their reluctance to attend out patients and day care places reflect the perceived negative attitudes of staff and the public misconception towards mental illness. As a result many people are not receiving the care they need.

For those who work directly with people who have mental illness and those who struggle with both the illness and its labels confronting the issues surrounding psychiatric labels is a step breaking down those stereotypes. Moving patients, from oppression into a realm of awareness and wellness; for health care workers, helping them to address their perceptions, attitudes and clinical practice. Education of the
public to enhance their knowledge and awareness of mental illnesses may help to reduce the stigma and hence accept patients more readily into the community. The Royal College of Psychiatrists under the chairmanship of Professor Crisp in 2001 (RCP 2001) has led a series of campaigns aiming to increase awareness of the concept of mental illness and reduce the stigma and discrimination associated with it; the campaign, through posters, booklets, availability of resources, information and advice postulate three ways in changing society’s negative perceptions and attitudes:

I. Through public education, reducing ignorance and prejudice about mental illness
II. By implementing anti-discrimination measures so that affected people can take their proper place in society
III. By improving the therapeutic services available and ensuring that treatment programmes are carried out in partnership with the individual and their families and an adequately resourced team.

Implementing this challenging practical campaign in mental health trusts would help to reduce stigma and discrimination and reduce the damaging effects of negative attitudes towards mental illness; it would consequently decrease social isolation and increase patients confidence and self-esteem, thus reducing the patients’ frequent need for hospitalisation.

5.11. Advocacy

5.11.1. Establishing networks within various community agencies

Through the Social dimension the current study further identifies that factors such as loneliness and isolation from society, being single, the lack of a “significant other”, unemployment, the lack of friendships and social networks, the family relationships (whether they belong to a high or low EE families) and the stigma and rejection
suffered for being mentally ill are major contributory factors to their relapse and frequent hospitalisations. Because of the severity of their symptoms their frequent re-admissions and prolonged hospital stays RD patients are unable to sustain friendships and relationships with the “normal” population.

As part of this research the study proposes that a tangible social support “friendship/advocacy group” is developed (facilitated by the researcher and a CPN)) for a group of six RD patients referred by the CMHTs. The group will meet once a fortnight for 1-2 hours for at least 4 months to provide friendship, advocacy and support to those individuals feeling particularly vulnerable; other themes for exploration will emerge from patients’ perspectives and concerns. The group will be informal and friendly with the aim of supporting individuals who are feeling stigmatised, lonely, isolated and friendless. Furthermore, the group will act as an advocate to those individuals who require help in presenting their views in different situations. The group will be evaluated at the end of the four months, with the aim of continuing if it is found to be effective in reducing the rate of readmissions.

5.11.2. Community Living Skills Training

The research identified that the majority of the RD patients have difficulty in forming close secure and stable relationships with other people. Intensive community living skills training to patients over a long period of time is crucial for patients with problems of low self-esteem and motivation (Shaw 1999). This training should be providing skills ranging from forming relationships and friendships to more practical applications of obtaining accommodation and social security benefits, reaffirming their self worth. The training should further be focusing on problem solving and minimising the over dependence of patients on health and social care services.
5.12. Limitations of the Study and Suggestions for Further Research

- As with any study there are a number of limitations identified within this research. Although the sample (N=939) was quite large the study was carried out only in one Trust. However as the Trust is a result of a merger of three previous Trusts with various models of service, different policies and procedures and covering a diverse and large geographical area, the results may be generalizable to other Trusts.

- Previous studies strongly suggest that there is a significant correlation between alcohol/drug abuse and frequency of patient readmission. The current study did not obtain information regarding these aspects which may constitute a limitation of the research. Furthermore, the employment status of revolving door patients was unavailable from the current hospital administration system; It is recommended that future similar studies of revolving door subjects include data for analysis on the employment status of patients (obtained through other means) and on patients with dual diagnosis (secondary diagnosis of substance misuse).

- The sample size studied during the exploratory face to face interview with patients and with named nurses and during the focus group interview with patients and with staff was small and therefore their responses may have limited generalizability. However, the data generated depth and richness and the findings of this study can be utilised as a basis for future research to investigate further RD patients and nurses views regarding inpatient care and discharge planning, with a larger sample including a control group of Non-RD patients for comparisons.

- From the data obtained through the Trust computerised system some important variables might have been missed. It is suggested for further research to prospectively investigate specific issues of social support, networks and
friendships of RD patients to identify additional related factors associated with their relapse and readmission.

- Research shows that Assertive Community Treatment (ACT) is an effective method of reducing the frequency of re-admissions. It is recommended in the future to investigate a sample of RD patients in receipt of ACT and compare with a control group not in receipt of ACT to establish its impact on the frequency of hospital admissions.

- Stigma and discrimination have been highlighted as key factors contributing to patient relapse and readmission. It is suggested for further investigation to conduct a survey examining the attitudes of health care professionals working closely with RD patients and to explore the public's perceptions towards patients with severe mental illness.

- Appropriate and adequate discharge planning has been identified as crucial in the prevention of patient re-admission. It is recommended to carry out a content analysis of the discharge care plans of RD patients to establish the process of discharge planning and identify what staff, consider as key aspects in discharge planning. To determine whether there are differences in aspects of discharge planning care of the revolving door patients and a comparison group of Non-RD patients.

- Research indicates an association between high rates of out patient appointments and day care places and frequency of re-admissions, questioning the quality of interactions during out patient appointments and day care placements. Hence it is suggested to investigate the nature and content of interactions in out patients' clinics and contact with staff using a naturalistic (direct observation) research methodology.
5.13. Strengths of the Current Research Study

- The strength of the methodology of the study is worthy of a mention. The research study adopted a mixed method using both quantitative and qualitative approaches. Data were collected from various sources including the Trust administration system, the patients' medical and nursing records and the patients and staff; data from each study were cross referenced with each other and synthesised across the four phases of the research, to confirm, support and validate the findings, thus strengthening the overall validity of the study.

- The use of an anonymous established computerised data base allowed for the entire targeted adult patient population to be studied; using a large sample of registered male and female patients from 17 to 80 years of age and including various diagnoses. Hence, the risks of a biased sample were avoided and the information obtained was accurate. The use of the number of admission data as a measure provided a readily quantifiable stable criterion of which comparisons between two groups of patients (RD and Non-RD) were made.

- The exploratory face to face semi-structured interview and focus group interview with patients and staff offered participants the opportunity to be treated as individuals as they shared their experiences, explored their feelings, and made known their priorities; it also strengthens the validity of the research as it recognises the experience and knowledge of participants, which were sought directly. By allowing patients to define their concerns during the interviews an attempt was made to humanise their experience of hospitalisation.

- The calculation and measurement of costs regarding the research sample adds further strength to the computerised data and to the entire research project.
Although each study in this research presents a unique perspective the data were synthesised and discussed within the context of the ISOP multi-dimensional theoretical framework. Through the framework many factors regarding the individual, social, organisational and professional dimensions constituting significant influences to patients frequent hospital re-admissions have been explored, further enhancing the understanding of the revolving door phenomenon.

5.14. Contribution of the Current Study to the Body of Knowledge

There is no existing theory in the literature that explains the “revolving door” phenomenon. Furthermore there is no consensus of the defining elements of the revolving door profile and reasons for frequent re-admissions. Various authors cite or suggest different factors as contributory to patient’ relapse and re-admission;

Therefore, the current study proposes a multi-dimensional interactive theoretical framework (ISOP) constructed through the various suppositions regarding the characteristics and reasons of RD patients frequent re-admissions. The theoretical framework offers more than a medical perspective integrating individual, social, psychological and organizational factors in order to fully explore the complexities of the RD phenomenon. Thus, the framework provides conjectural explanations contributing to a deeper understanding adding significantly to the comprehensives of the RD phenomenon, initiating further the advancement of the theoretical perspectives of the framework.

Previous literature identified a broad spectrum of inconsistent defining features of the revolving door patients; the current study however, clearly shows that being male, single, with a diagnosis of schizophrenia age around 24-36 (M=33.9)
constitutes a high risk of frequent readmissions. Furthermore this study reveals (a finding not reported elsewhere) that being female, single, separated/divorced or widowed, with a diagnosis of personality disorder, and a median age of 34 years and being in greater receipt of outpatient appointments and day care places than any other group in the sample constitute predictive characteristics of the revolving door patient.

- The importance of identifying risk factors of re-admission has been emphasised throughout the literature. The findings of the current study provide a foundation on which a RD patient predictive risk assessment tool can be developed and used in clinical settings; indicating the likelihood of patient readmission and hence providing the means for clinicians and managers to put preventative strategies in place for high risk individuals; thereby, enabling the discontinuity of the cycle of re-admissions.

- In addition this study acknowledges that labelling and stigmatizing patients with severe mental illness may further reinforce their “psychiatric status” and develop a social need to adopt the “sick role” thereby legitimizing their illness and further encouraging a vicious cycle of re-admissions.
6.1. SUMMARY AND CONCLUSIONS

Revolving door patients have a long history of mental illness and treatment that has not been effective in keeping them out of inpatient psychiatric units. Several studies suggest that patients with frequent re-admissions constitute between 15-30% of the total admissions into acute inpatient settings. In-patient re-admissions in the current study account for approximately 30% of the total admissions of patients with severe mental health problems, constituting a significant number of patients’ utilising nearly half of the mental health resources and contributing considerably to the health care costs. This study recognises that labelling patients as RD might influence the perceptions of staff and patients alike with negative consequences; staff may perceive patients as difficult and hence treat and care for them accordingly. Patients may internalise the term and this may be used as a “self-fulfilling prophecy”. Invariably, nurse/patient relationships would be affected. On the other hand, assigning a definition to a key concept may be useful in conceptualising the research problem, guiding the inquiry and setting the parameters of the research study.

The association between the revolving door phenomenon and the various demographic, clinical, socio-economic, organizational and professional variables has been recognized in the current study and the previous research literature. This research, through the analysis and synthesis of interrelated data from six studies underpinned by the ISOP multi-dimensional theoretical framework, argues that repeated hospital re-admissions occur due to the dynamic interaction of the various elements of the four dimensions.
Hence the current study purports that the revolving door phenomenon emerged as a product of the patients individual characteristics; the function of their symptoms and the degree of the severity of their illness; moreover, the adoption of the sick role by individuals unable to cope with the demands and stresses of everyday life plays a significant and powerful role in the way patients with severe mental illness are treated, their prognosis, the course of their illness and their patterns of hospital re-admissions.

The study further suggests, that unemployment, the lack of friendships and social networks, lack of significant others, loneliness, the family relationships (whether they belong to a high or low EE families) and the way mentally ill people are accepted or rejected by society, discrimination and stigma (indeed this is reflected by the responses of participants during the focus group interview with patients commenting that they feel rejected and stigmatized by society and only consider other patients as their “true friends”) created by the de-institutionalization policies originated in the 1960s are contributory factors to patients relapse and readmission. The research also maintains that high rates of re-admissions are the defaults of the organization because of inadequate or inappropriate care, poor follow up and lack of community support.

Professional issues such as inadequate or inappropriate discharge planning, nurses and patient interaction and an imbalance of power and control between patients and staff are also stipulated in this research as factors contributing to the creation of the revolving door phenomenon. Therefore the phenomenon creating a major concern for the politicians, the managers and the clinicians causing problems related to bed utilization, resources and high costs, the quality and effectiveness of care, and professional and educational issues. To the patients and to their families the revolving door issue manifests strong influences on the stress level, the personal lifestyle, and the quality of life for the individuals; it affects the assessment, course and
outcome of patients' illness as well as their responses to treatment and consequently their need for frequent re-admissions.

The current research through the interaction of the elements of the ISOP multi-dimensional theoretical framework proposes a new and innovative approach (Assessment and Planning, Discharge Planning, Education and Advocacy) to the treatment and management of the revolving door patient that has both theoretical and practical significance; the framework provides an integrated inpatient and community service approach providing psycho-social, medical/nursing and organizational care, necessary to help the RD patients reach the level of functioning needed to sustain them in community settings; such as, understanding the RD phenomenon, early identification of the high risk relapse and re-admission patients, developing specific programs, focusing on timely referral to the early intervention teams and appropriate and adequate discharge planning and support; furthermore supporting and educating staff, patients, their families and the public regarding the RD phenomenon, and how to cope with the stress and stigma that this phenomenon causes; for the patients how to develop social skills, and enhance their social circles, and how to acquire better compliance with medication and treatment. Increasing their self-esteem confidence and quality of their life thus helping to break the cycle of frequent hospital admissions, reducing bed occupancy rates and decreasing the prevalence of hospitalizations.

The current study through the proposal of the ISOP interactive multi-dimensional theoretical framework offers a deeper understanding and adds significantly to the comprehensives of the RD phenomenon, would contribute towards the reduction of the NHS costs and provides additional evidence to the body of research knowledge. Hence this innovative approach may help to stop or decrease a potential cycle of re-admissions and may assist managers and clinicians to focus their direction of support and resources more appropriately and effectively.
## REVOLVING DOOR PATIENT SEMI-STRUCTURED INTERVIEW SCHEDULE

**DATA TO BE OBTAINED THROUGH FACE TO FACE INTERVIEW WITH THE PATIENT**

### SECTION A: ADMISSION DETAILS

<table>
<thead>
<tr>
<th>Patient ID: ..................</th>
<th>Mental Health Act...............</th>
<th>Patient’s named nurse ID...............</th>
</tr>
</thead>
</table>

**Diagnosis........................................**

**Number of re-admissions in the last two years........................................**

**Reasons for last admission:**

- ................................................................................................................................
- ................................................................................................................................
- ................................................................................................................................

### SECTION B: DEMOGRAPHIC DETAILS

<table>
<thead>
<tr>
<th>Age..............</th>
</tr>
</thead>
</table>

| Gender: | Male [ ] | Female [ ] |

<table>
<thead>
<tr>
<th>Marital Status:</th>
</tr>
</thead>
</table>

- Married [ ]
- Single [ ]
- Co-habiting [ ]
- Separated [ ]

- Divorced [ ]
- Widowed [ ]
- Other [ ]

<table>
<thead>
<tr>
<th>Employment Status</th>
</tr>
</thead>
</table>

- Employed [ ]
- Unemployed [ ]
- Homemaker [ ]
- Retired [ ]

- Student [ ]
- Other [ ]

<table>
<thead>
<tr>
<th>Ethnic Group:</th>
</tr>
</thead>
</table>

- White [ ]
- Black Caribbean [ ]
- Black African [ ]
- Black Other [ ]

- Indian [ ]
- Bangladeshi [ ]
- Chinese [ ]
- Other [ ]

<table>
<thead>
<tr>
<th>Living Circumstances</th>
</tr>
</thead>
</table>

- Living Alone [ ]
- Living with others [ ]
## SECTION C: IN-PATIENT CARE - PERCEPTIONS ON CARE RECEIVED

How would you rate the following aspects of your care?

<table>
<thead>
<tr>
<th>Care Items:</th>
<th>Very poor</th>
<th>Poor</th>
<th>Satisfactory</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-ordination of your care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your involvement in your care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact with your named nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathic qualities of nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to treatment/therapies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Information Items:                 |           |      |              |           |           |
| Advice/information given to you    |           |      |              |           |           |
| on medication (Including side effects) |       |      |              |           |           |
| Information on your treatment      |           |      |              |           |           |
| Information on your illness        |           |      |              |           |           |
| Information on services/facilities |           |      |              |           |           |

| Environment Items:                 |           |      |              |           |           |
| Environment of the ward            |           |      |              |           |           |
| (including safety, décor etc)      |           |      |              |           |           |

Do you comply with medication and or other treatments/programmes?
- Always
- Most times
- Sometimes
- Never

Please comment if the answer is sometimes or never

In your opinion did the care you received matched your needs/expectations?

If answer is none please comment:

How satisfied are you with the level of your involvement in your care plan?
- Extremely dissatisfied
- Dissatisfied
- Very satisfied
- Very dissatisfied
- Satisfied
- Extremely satisfied
Is there anything specific in your care that you appreciated most?
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
Is there anything specific in your care that you appreciated least?
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

SECTION D: DISCHARGE CARE PLAN

Do you know the date of your discharge?    Yes [ ] No [ ]

Have you discussed your discharge plan and community needs with your named nurse or care co-ordinator?    Yes [ ] No [ ]

If the answer is No, please comment
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Do you think you were adequately prepared for discharge?    Yes [ ] No [ ]

In your opinion does the discharge plan meet your needs?    Yes all [ ] Yes some [ ] None [ ]

If answer is None please comment:
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

In preparation of your discharge have you attended/participated in any programmes? Please comment:
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

After you are discharged from hospital have you been referred to any professionals or services? Please comment:
........................................................................................................................................
........................................................................................................................................
In your opinion were you ready for discharge? Yes ☐ No ☐
If the answer is no, please comment:

...........................................................................................................................................
...........................................................................................................................................

Overall how satisfied are you with your discharge plan/involvement in your plan?

Very dissatisfied ☐ Quite dissatisfied ☐
Dissatisfied ☐ Satisfied ☐
Quite satisfied ☐ Very satisfied ☐

Would you be willing to return to the same ward if you needed similar treatment in the future? Yes ☐ No ☐

Would you recommend the same ward to a family member or friend if they needed similar treatment in the future? Yes ☐ No ☐

Please comment:
...........................................................................................................................................
...........................................................................................................................................

SECTION E: SOCIAL NETWORKS/ SUPPORT
Are you in regular contact/do you meet with any of the following?
Family members ☐ Friends ☐ ex- psychiatric patients ☐
Other please specify .............................. ☐ None of the above ☐

Do you receive support from any of the following?
Family members ☐ Friends ☐
Ex psychiatric patients ☐ Drop-in Centre ☐
Home Help ☐ Other please specify .............................. ☐
None of the above ☐

Do you have any further comments regarding any of the above questions or your care in general?
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................

Thank you for participating in the study
Praxoulla Rameshwar, Clinical Governance
Team Leader
Appendix 2

NAMED NURSES SEMI-STRUCTURED INTERVIEW SCHEDULE

DATA TO BE OBTAINED THROUGH FACE TO FACE INTERVIEW WITH THE NAMED NURSES

SECTION A: DEMOGRAPHIC DETAILS

Named nurse ID: .................  Patient ID: .................

Age: .........................

Job Title: .................................................................

Gender:  Male  Female  ☐  ☐

Length of time in present position: ..................................................

Courses attended since nurse qualification:
........................................................................................................
........................................................................................................
........................................................................................................

SECTION B: PATIENT ADMISSION DETAILS

In your opinion what were the contributory factors to your patients’ relapse?
........................................................................................................
........................................................................................................
........................................................................................................

In your opinion could admission have been prevented?  Yes  ☐  No  ☐

If the answer is Yes please explain:
........................................................................................................
........................................................................................................
........................................................................................................
SECTION C: IN-PATIENT CARE - PERCEPTIONS ON CARE RECEIVED

How would you rate the following aspects of your patient care?

<table>
<thead>
<tr>
<th>Care Items:</th>
<th>Very poor</th>
<th>Poor</th>
<th>Satisfactory</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard of patient care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-ordination of patient's care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient involvement in their care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse/patient relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to treatment/therapies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information Items:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice/information given to patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>on medication (Including side effects)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information on patient treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information on their illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information on services/facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward environment:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment (including safety Décor, etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does your patient comply with medication and or other treatments/programmes?

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please comment if the answer is sometimes or never

..................................................................................................................................
..................................................................................................................................
..................................................................................................................................

In your opinion does the care plan meet the patient’s needs?

<table>
<thead>
<tr>
<th>If answer is None, please comment:</th>
<th>Yes all</th>
<th>Yes some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

260
SECTION D: DISCHARGE CARE PLAN

Do you think your patient was adequately prepared for discharged?
Yes [ ] No [ ]

If the answer is No, please comment
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................

In your opinion was your patient ready for discharge?
Yes [ ] No [ ]

If the answer is No, please comment
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................

In your opinion does the discharge plan matches the patient’s needs?
Yes all [ ] Yes some [ ] None [ ]

If the answer is None, please comment:
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................

Overall how satisfied are you with the patient’s discharge plan and preparation for discharge?
Extremely dissatisfied [ ] Very dissatisfied [ ]
Dissatisfied [ ] Satisfied [ ]
Very satisfied [ ] Extremely satisfied [ ]

If you needed treatment in the future yourself would you be willing to be admitted to the same ward? Yes [ ] No [ ]

Would you recommend the service to a family member or friend? Yes [ ] No [ ]

Please comment:
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................

Do you have any further comments regarding any of the above questions or any items of patients care in general?
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................
.................................................................................................................................

Thank you for participating in the study
Praxoulla Rameshwar, Clinical Governance Team Leader
CONSENT FORM

Dear Participant

I am undertaking a study regarding your views and satisfaction with care and your discharge plan.

Your responses will be collected through a semi-structured questionnaire developed by the researcher, Praxoulla Rameshwar Clinical Governance Team Leader.

The results of the study will provide us with valuable information which will enable us to identify strengths and weaknesses in your care, make recommendations for improvements and plan and put in place training programmes for staff working in the trust.

Your responses to the questionnaire and any other information gathered through the course of research is confidential and will be anonymised by not entering your name and assigning a code to the questionnaire known only to the researcher.

The information you provide us will not be used in any way other than the purpose of research.

I confirm that I have understood the purpose of the study, as explained to me by the researchers.

I understand that my participation is voluntary and have the right to withdraw at any time.

If I do not participate in the study my care will not be affected.

I agree to take part in this study.

Participant name............................... Signature............................

Researcher name......................... Signature..........................

Date...........................................
CONSENT FORM

Dear Participant

I am undertaking a study regarding your views and satisfaction regarding patients care and discharge plan.

Your responses will be collected through a semi-structured questionnaire developed by the researcher, Praxoulla Rameshwar Clinical Governance Team Leader.

The results of the study will provide us with valuable information which will enable us to identify strengths and weaknesses in patient care, make recommendations for improvements and plan and put in place training programmes for staff working in the trust.

Your responses to the questionnaire and any other information gathered through the course of research is confidential and will be anonymised by not entering your name and assigning a code to the questionnaire known only to the researcher.

The information you provide us will not be used in any way other than the purpose of research.

I confirm that I have understood the purpose of the study, as explained to me by the researcher(s).

I understand that my participation is voluntary and have the right to withdraw at any time.

I agree to take part in this study.

Participant name............................. Signature............................

Researcher name......................... Signature..........................

Date.................................................
<table>
<thead>
<tr>
<th>Area of Evidence</th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge date clearly stated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge summary and copy of letter to GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of multi-professional involvement in DP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of patient involvement in DP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of carer involvement in patient's DP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of patient discharge preparation programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relapse plan for patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of assessment of patient's readiness for discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of pre-discharge assessment and potential risk factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of pre-discharge assessment of patient's community needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of patient's expectations of community support and after care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Destination address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care co-ordinator identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer/relative identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial issues/concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living circumstances identified (e.g. patient living alone)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out Patient Appointment dates, and who to see</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of CPN visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other professionals involved in patient’s care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services involved in patient’s care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Details of attendance at day centre, day hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice on medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice on what to do in crisis.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice on who to contact in emergency</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Question schedule, written notes and themes from the patients’ focus group

Key: Q=question M=Male F=Female

<table>
<thead>
<tr>
<th>Q.1</th>
<th>Theme one</th>
<th>Discharge interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M1</td>
<td>I don’t feel prepared. I attend the groups- “coping with anxiety” and “coping with depression” but don’t find them useful</td>
</tr>
<tr>
<td></td>
<td>M2</td>
<td>Found them childish</td>
</tr>
<tr>
<td></td>
<td>F1</td>
<td>They are childish!</td>
</tr>
<tr>
<td></td>
<td>F2</td>
<td>They are patronising and trivial</td>
</tr>
<tr>
<td></td>
<td>M1</td>
<td>In the community these groups don’t help us with our problems</td>
</tr>
<tr>
<td></td>
<td>F2</td>
<td>We can’t apply the skills we learn in situations outside the hospital</td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>These programmes can only help us in the short term, but not in the long term. We are not able to apply the skills we learn in real situations</td>
</tr>
<tr>
<td></td>
<td>F3</td>
<td>I am going home on leave this W/E (as part of discharge preparation) but don’t feel ready for it; the nurses say I have to go</td>
</tr>
<tr>
<td></td>
<td>M4</td>
<td>There is nothing happening on the ward. We don’t have a psychologist or occupational therapist attached to the ward</td>
</tr>
<tr>
<td></td>
<td>F2</td>
<td>We stay in bed, sleep, or walking up and down most of the time</td>
</tr>
<tr>
<td></td>
<td>M1, F2, and all patients</td>
<td>We need a structured plan and objectives so that we know what is happening and more personal one to one sessions with our nurses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q.2</th>
<th>Theme two</th>
<th>Community support and nurse patient relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F1</td>
<td>I need more support from my care co-ordinator- had CPN who used to visit me once a week that was good but then changed to a social worker- I was not happy with the support. Initially she visited me 2-3 times a week, then once a week then every three months</td>
</tr>
<tr>
<td></td>
<td>F4</td>
<td>In general I feel that we need more aftercare, follow up care, that’s why people revolve</td>
</tr>
<tr>
<td></td>
<td>All patients</td>
<td>Visits become less after the first couple of months following our discharge-tailing off to once a week, once a fortnight, then to every three months</td>
</tr>
<tr>
<td></td>
<td>All patients</td>
<td>The period following our discharge is crucial-we become de-motivated; this is the time that we need intensive support from the staff</td>
</tr>
<tr>
<td></td>
<td>F2</td>
<td>Need night support-24 hour support before it’s too late I leave it too late and no matter of who you see it’s too late. You end up in hospital</td>
</tr>
<tr>
<td></td>
<td>M5</td>
<td>Particularly if our illness takes over and we relapse again We need more support and more visits from the CPNs</td>
</tr>
<tr>
<td></td>
<td>M3</td>
<td>At every review your CPN should be present, they are rarely there, it’s essential. They need more resources to enable CPN to spend more quality time with their clients</td>
</tr>
<tr>
<td></td>
<td>All patients</td>
<td>Having more structure and objectives and having a plan both in hospital and the community would help us cope better-structure our lives</td>
</tr>
<tr>
<td></td>
<td>F4</td>
<td>It depends on our relationship with our care co-ordinator. Sometimes our objectives are not discussed-there is no time-and our needs are not met.</td>
</tr>
<tr>
<td></td>
<td>M1</td>
<td>The doctor is supportive although I realise it depends on who you have. I would</td>
</tr>
<tr>
<td>Theme three</td>
<td>Purpose/meaningfulness/motivation/engagement</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>M5</td>
<td>Our level of motivation drops as our illness takes over.</td>
<td></td>
</tr>
<tr>
<td>F3</td>
<td>We need someone to push and motivate us. Once we become “patients” our meaning and purpose become less</td>
<td></td>
</tr>
<tr>
<td>F1</td>
<td>I don’t have any purpose and meaning in my life</td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td>The days are always the same; one rolling into the other, walking around purposeless, smoking and going to bed; there isn’t much of a daily plan in our lives</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>We need leisure activities such as music, art, going to the gym, swimming, yoga</td>
<td></td>
</tr>
<tr>
<td>F4</td>
<td>Doing some voluntary work, swimming, going to the gym would give me more purpose</td>
<td></td>
</tr>
<tr>
<td>F2</td>
<td>Having more stimulation in the community e.g. arts and crafts and hobbies</td>
<td></td>
</tr>
<tr>
<td>F4</td>
<td>Having a hobby and sustaining the hobby, working for charity may help. But this is not kept up.</td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td>If I had the opportunity say once a month to attend a specific support group I feel that in general I would be able to cope better</td>
<td></td>
</tr>
<tr>
<td>M5</td>
<td>Sometimes I do go out, (ex patients club, shopping etc) sometimes it helps but at times you get fed up, we don’t do a lot. There is nothing to do at weekends. There isn’t a lot of meaning in my life</td>
<td></td>
</tr>
<tr>
<td>M4</td>
<td>Relapse and readmission becomes a vicious circle and loose confidence and motivation to do anything in the community</td>
<td></td>
</tr>
<tr>
<td>F4</td>
<td>You have to ask for support rather than them trying to motivate you which would prevent I think a lot of relapse</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme four</th>
<th>Social isolation/social network/support/friendships</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>Being socially isolated plays a big part in our relapse. Having friendships and networks is important to keep you from relapsing</td>
</tr>
<tr>
<td>M4</td>
<td>Social isolation takes away our confidence, we stop attending out patients and so it becomes a vicious circle and we relapse back into our illness</td>
</tr>
<tr>
<td>F2</td>
<td>Sometimes you don’t feel like seeing anybody. I leave it too late and no matter whom you see then it’s too late. You end up in hospital</td>
</tr>
<tr>
<td>F3</td>
<td>Yes sometimes you don’t feel like seeing anybody</td>
</tr>
<tr>
<td>F1</td>
<td>I isolate myself and don’t have contact with other people</td>
</tr>
<tr>
<td>M1(+4)</td>
<td>I need support during the night because that’s when it gets most lonely</td>
</tr>
<tr>
<td>M5</td>
<td>I attend the ex-patients club five days a week. Occasionally I find it helpful but not all the time. Especially when other patients talk about their problems</td>
</tr>
<tr>
<td>M3</td>
<td>We sit around smoking and listening to others problems; we can’t escape from it</td>
</tr>
<tr>
<td>F2</td>
<td>Yes I have schizophrenia, I have my own problems and I don’t want to hear about everyone else’s different kinds</td>
</tr>
<tr>
<td>F3</td>
<td>But sometimes is nice to meet other patients, because they are friendly they are your true friends</td>
</tr>
</tbody>
</table>
| M2         | My friends are really important they’ve stopped me committing suicide a number
of times. They have phoned the CPN, they are really helpful in a crisis

All patients

Yes it is important to have friends- sometimes they keep you out of hospital

Q.5 How does it feel to be in need of psychiatric services?

Theme five Stigma/labelling

F2 I don’t like attending day hospital or OPA-they remind me of being a psychiatric patient; it reminds me that some time I will have to come back into the unit and never escaping the stigma and label; it feels like I never been out

M1, M2, F3 Having to attend OPA disrupts our daily routine; having to stop what we are doing to attend OPA

F4 I live in a local area where you always meet people you know from hospital like ex-patients and staff. They always remind you of who you are.

M3 I have a label and a diagnosis at times it feels that’s all I’ve got

F3 Yes we look like patients and we feel like patients

M1 You can’t escape from your illness

M2 I have been given a variety of diagnoses; schizophrenia, personality disorder, ………multiple, but I also have drug and alcohol problems which makes things very difficult. I have been in hospital many times and have been kicked out of the A&E loads

F3 Sometimes you need a fresh start somewhere else, where nobody knows you.

Q.6 How do you feel when you have to be re-admitted into hospital?

Theme six Struggling for control

M1 Having to come back into the hospital gives me a feeling of complete defeat

All patients A feeling of loss of control, failure, dishearten

Six patients We often feel angry and frustrated as our illness takes over

F1 We are treated like children-we loose control

M2 I feel guilty when I am admitted because I also have drink problems; I do it to myself; there are far more deserving people out there that need to be here rather than me

M5 Before admission I feel desperate-self harming, my illness is causing me lots of problems

M5 Sometimes we feel relief; we are happy to leave it all to the staff-we don’t want control, we like to cop out.

M4 We don’t want to have to make decisions when we are not feeling well

M3 When you relapse you feel a sense of anger, it’s the illness again

All patients Despite the benefits of being in hospital our choice is to stay out of hospital

M1 Staff, have all the control; we don’t take part in our care plan or the decisions about our treatment. Staff make all the decisions, our opinion doesn’t matter

F4 I like to have more control in the community; we don’t feel empowered or in control of our care plans

All patients We have been told that there are going to be changes in the acute inpatient services, all services being transferred to one site; we are not happy about that, we attended meetings but our opinion has not been considered

Three patients Attending these meetings was a waste of time as “higher authorities” made the decision; we are powerless

All patients Our relatives and friends will not be able to visit us as often as before because of the greater distance
### Question schedule, written notes and themes from the nurses’ focus group

**Key:** Q=question M=male F=female

<table>
<thead>
<tr>
<th>Q.1</th>
<th>In your opinion what are the reasons of revolving door patients relapse and re-admission?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme one</strong></td>
<td>Reasons for relapse and re-admission</td>
</tr>
<tr>
<td><strong>M1:</strong></td>
<td>They know what to say, and how to present their symptoms in order to come back in. For example, 'I can't cope I'm going to hang myself unless I come back in'.</td>
</tr>
<tr>
<td><strong>F2:</strong></td>
<td>Yes, I believe that patients feel that they have the right to be here, a lot don't need to be in here but they learn the behaviours and symptoms and signs to help them be re-admitted. For example, a well-known user always gets admitted through a 136 section&quot; (Police section)</td>
</tr>
<tr>
<td><strong>F1:</strong></td>
<td>I feel that they feel safe here and can escape from their problems. I believe some don't need an acute bed, and could be managed in the community.</td>
</tr>
<tr>
<td><strong>F3:</strong></td>
<td>People return to hospital because it is a safe haven for them. They feel the security of the walls and it's an environment they know best</td>
</tr>
<tr>
<td><strong>M1:</strong></td>
<td>I feel that they feel safe here and can escape from their problems. I believe some don't need an acute bed, and could be managed in the community.</td>
</tr>
<tr>
<td><strong>F2:</strong></td>
<td>People return to hospital because it is a safe haven for them. They feel the security of the walls and it's an environment they know best</td>
</tr>
<tr>
<td><strong>F1:</strong></td>
<td>I feel that people also return due to the nature of their illness, they have a psychiatric episode, and some do not have the coping mechanisms and strategies to stay in the community, they relapse and so return to hospital.</td>
</tr>
<tr>
<td><strong>F2:</strong></td>
<td>RD patients lack coping strategies- they can't face the family, so they pretend they are ill, it's a form of escapism</td>
</tr>
<tr>
<td><strong>M1:</strong></td>
<td>Mostly we see formal admission to the ward (sectioned etc), usually due to non-compliance of medication, when they are discharged home, they feel well and so think that they do not need medication, therefore become unwell again. Females usually stop taking their medication in particular anti-psychotic drugs due to the side effects such as gaining weight).</td>
</tr>
<tr>
<td><strong>F1:</strong></td>
<td>Yes, they are more figures conscious.</td>
</tr>
<tr>
<td><strong>M1:</strong></td>
<td>Yes, 75% have drug and alcohol problems, it helps numb their reality. We have patients on private insurance and they can claim money every time they come in</td>
</tr>
<tr>
<td><strong>F2:</strong></td>
<td>It is the friendship circles they live in, especially the young ones, mixing with friends that drink and take drugs, because of their medication they do not see the risks and before you know it they are back in hospital. I feel it is the features of drug and alcohol problems</td>
</tr>
<tr>
<td><strong>F3:</strong></td>
<td>I think this is more typical of the younger people, the under 40's who have more repeat admissions.</td>
</tr>
<tr>
<td><strong>F1:</strong></td>
<td>Especially the people over 50 years of age are genuinely ill and relapse because of the nature of their illness. We will not stop these patients ever coming in. It is a frightening experience. I believe it's their illness and they will keep coming back</td>
</tr>
<tr>
<td><strong>F4:</strong></td>
<td>I feel that in general there are those who are genuinely ill and there are those that abuse the system, they are in the minority though.</td>
</tr>
<tr>
<td><strong>F1:</strong></td>
<td>Yes I feel that the majority should be here.</td>
</tr>
<tr>
<td><strong>M1:</strong></td>
<td>Although the majority of patients feel that they shouldn't be in here</td>
</tr>
<tr>
<td><strong>F1:</strong></td>
<td>The nature of their admission, they have been sectioned, they have their freedom taken from them.</td>
</tr>
<tr>
<td><strong>M1:</strong></td>
<td>Those who have been sectioned are always keen to leave because they feel...</td>
</tr>
</tbody>
</table>
that their freedom has been taken away

F3: Because of their illness it is difficult to engage people in the community e.g. with the CPA, their CPN and peers

Q.2 How do you feel when certain patients are constantly re-admitted?

<table>
<thead>
<tr>
<th>Theme two</th>
<th>Perceptions and feeling regarding patient readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1:</td>
<td>I wonder why, what has made them come back. At the same time I feel frustrated. We put watertight discharge plans in place and so I wonder why the system is falling down in the community, but I do feel that some patients’ sabotage everything so no matter what is done some just will not take up the support or help needed in order for them to remain in the community.</td>
</tr>
<tr>
<td>F2:</td>
<td>Its very repetitive, I feel frustrated, I do feel that some patients’ sabotage everything so no matter what is done some just will not take up the support or help needed in order for them to remain in the community.</td>
</tr>
<tr>
<td>F3:</td>
<td>It is very sad when you see the same patients coming back again; I feel demoralised, helpless. We can’t do anything about it</td>
</tr>
<tr>
<td>M1:</td>
<td>Sometimes we feel angry; we don’t have any control, because of the nature of their illness the housing association will not tolerate them and will chuck them out.</td>
</tr>
<tr>
<td>F1:</td>
<td>Many nursing homes will not take them, they cannot cope with such clients and they are also bad business and so such patient’s become bed blockers in our system.</td>
</tr>
<tr>
<td>F2:</td>
<td>Yes we have lots of bed blockers.</td>
</tr>
<tr>
<td>F3:</td>
<td>There is nowhere suitable in the community; there is no accommodation for them. And, whenever there is a problem in the nursing home, residential home they are sent back here in hospital blocking our beds. Yes, this means that they do not have stability and appropriate accommodation</td>
</tr>
<tr>
<td>M1:</td>
<td>Many don’t need an acute bed but because of all these factors we don’t therefore have enough acute beds for those they need them. But if they come in on 136, the police will bring them in regardless of the bed situation, and so sometimes patients have to sleep the night in the seclusion room (with the door open) which is far from ideal</td>
</tr>
<tr>
<td>F3:</td>
<td>Yes I feel that the police don’t always use the sectioning appropriately, I think that clients do not want repeat admission to this ward (intensive care unit), they feel locked up</td>
</tr>
</tbody>
</table>

Q.3 What resources are needed in the community in order to keep patients out of hospital?

<table>
<thead>
<tr>
<th>Theme three</th>
<th>Community support and resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>F2:</td>
<td>I feel that social services should be more supportive, and do more for the clients in the community.</td>
</tr>
<tr>
<td>M1:</td>
<td>yes particularly as the population is growing, caseloads for community staff are massive, they need more resources</td>
</tr>
<tr>
<td>F3:</td>
<td>More resources are essential as soon as a client disengages, you loose them.</td>
</tr>
<tr>
<td>F3:</td>
<td>Yes, for example, community centres, the patient will not turn up for their depot injection, when they make their mind up to disengage that’s it.</td>
</tr>
<tr>
<td>M1:</td>
<td>There isn’t enough support for them to check that the patient is attending crucial services to prevent relapse.</td>
</tr>
<tr>
<td>F3:</td>
<td>There needs to be more support workers.</td>
</tr>
</tbody>
</table>
| F1:         | There is assertive outreach but it is such a small team, you will always have
<table>
<thead>
<tr>
<th>Theme four</th>
<th>Professional practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1:</td>
<td>There needs to be more safe houses and intensive outreach teams</td>
</tr>
<tr>
<td>Q.4</td>
<td>Can you think of some previous RD patients (as an example) that have not been admitted for some time; what has been done for these patients in order to keep them out of hospital?</td>
</tr>
<tr>
<td>F1:</td>
<td>There are a few patients that used to be admitted 2-3 times a year and I haven't seen them for ages, something positive must be being done for those patients.</td>
</tr>
<tr>
<td>F2:</td>
<td>I think it depends on the catchment area, the consultant and team in the area. Old consultants will bring patients in as a place of safety but sometimes this is not a place of safety. The seclusion room will be used as a bed with the door open</td>
</tr>
<tr>
<td>M1:</td>
<td>Yes if you have a consultant that is nearing retirement they have a different attitude than the younger newer consultants with regard to their attitude and methods of practice towards their work.</td>
</tr>
<tr>
<td>F1:</td>
<td>Yes approaches are different. Before when there was a threat of suicide the patients were admitted straight away, now the new consultants will do a full assessment before admitting to an inpatient unit.</td>
</tr>
<tr>
<td>F1:</td>
<td>Discharge is subject to planning, clients from the intensive care unit go through to the 'open side' before discharge.</td>
</tr>
<tr>
<td>F2:</td>
<td>Due to financial resources, many therefore have to be discharged without adequate plans in place, although sometimes patients will say that they want to be discharged early</td>
</tr>
</tbody>
</table>
REFERENCES


Airdoos N (1991) Use and effectiveness of psychiatric care plans, *JAN*, 16(2) 177-181


Bliss DZ (2001) Mixed or mixed up methods? (Editorial) Nursing Research, Vol 50 (6) 331


Corner J (1991) In search of more complete answers to research questions. Quantitative versus qualitative research methods: is there a way forward? *Journal of Advanced Nursing*, 16, 718-727


Department of Health (1989a) **Building Bridges. A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people**, DOH

Department of Health (1989b) **Discharge of Patients from Hospital.** London, DOH

Department of Health (1993) **Legal Powers on the Care of Mentally Ill People in the Community**, HMSO, London


Department of Health (1997) **Quality in the New NHS**, DOH

Department of Health (1998a) **Policy Research Programme**, DOH

Department of Health (1998b) **Modernising Mental Health Service; Safe Sound and Supportive**, DOH

Department of Health (1999) **National Service Framework for Mental Health**: London the stationery office

Department of Health (2000) **The NHS Plan**: London the Stationery Office

Department of Health (2002) **Mental Health Policy Implementation Guide: Community** Mental Health Teams, DOH


Henwood KL and Pidgeon NF (1992) Qualitative research and psychological theorising. *British Journal of Psychology*, 83, 97-111


Jackson S, Stevenson C (1998) the gift of time from the friendly professional, *Nursing Times*, Vol., 12(51) 31-33)


Kitzinger J (1995) *Qualitative research: introducing focus groups*. British Medical Journal, vol 311 (7000) p299-302


Marshall J (1996) Good but could be better, Nursing Times, vol., 92(7) 59


Miles M B and Huberman A M (1994) Qualitative Data Analysis. *A Sourcebook of New Methods*, Sage Publ, Beverly Hills California


Morse J (1990) Approaches to qualitative-quantitative methodological triangulation. *Nursing Research*, 40 (1) 120-123
Muliak J (992) Non compliance with medication regimens in severely and persistently mentally ill schizophrenics. *Issues in Mental Health Nursing*, 13, 219-237

Munhall P L (1982) Nursing philosophy and nursing research: in apposition or opposition? *Nursing Research* 31(3) 176-181

Munhall P L (1989) Philosophical pondering on qualitative research methods in nursing. *Nursing Science Quarterly* 2(1) 20-28


National Health Service Executive (1996) *24 Hour Nursing Care For People With Severe And Enduring Mental Health Problems*, NHSE Leeds.


Parker BA (1993) Living with mental illness: the family as care giver. *Journal of Psychosocial Nursing*, 31(3) 19-21


Parsons T (1952) *The Social System*; Chicago: Free Press


Royal College of Nursing (1997) *Ethics Related to Research in Nursing.* RCN

Royal College of Psychiatrists (1988) *Psychiatric beds and resources; factors influencing bed use and service planning,* Royal College of Psychiatrists


Sandelowski M (2000) Focus on research methods. Combining qualitative and quantitative sampling, data collection, and analysis techniques in mixed method studies. *Research in Nursing and Health*, 23 (3) 246-255


Scheff TJ (196) *Being Mentally Ill: A Sociological theory*. Aldine, Chicago


Seeman M (1999) Gender Differences in Psychopathology, from *Celebrating International Women’s Day Conference Paper*


Society Guardian (February 2001) Stigma of mental illness, *Society Guardian*


Storch DD (1993) Drug use by day patients, *Hospital and Community Psychiatry, Vol.*, 44(7) 690


Tanzman B (1993) An overview of surveys of mental health consumers’ preferences for housing and support services. *Hospital and Community Psychiatry*, 44, 450-455


Zolik E and Lantz E (1968) Hospital return rates and pre-release referrals. *Archives of General Psychiatry* 18:712-717