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Perceptions of discharge planning needs : A study of discharge planning in the mental health setting

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**PERCEPTIONS OF DISCHARGE PLANNING NEEDS -
A STUDY OF DISCHARGE PLANNING IN THE MENTAL
HEALTH SETTING**

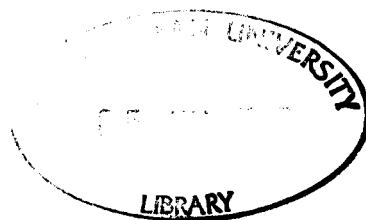
by

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A Thesis Submitted in Partial Fulfilment of the Requirements of the Award of

Master of Nursing
at the School of Nursing, Edith Cowan University

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ABSTRACT

PERCEPTIONS OF DISCHARGE PLANNING NEEDS -

A STUDY OF DISCHARGE PLANNING IN THE MENTAL HEALTH SETTING

Major mental disorder, with prolonged periods of dysfunction that require long term care, is an issue of concern amongst mental health professionals. Although substantial effort and resources are devoted towards returning mentally ill individuals to the community, one of the most distinctive and consistent features of the **persistently mentally ill (PMI)** is their high rate of **readmission to hospital**. Existing studies into **discharge planning** have revealed that a paucity research had been undertaken to determine if this is the case in Western Australia. This study sought to investigate **perceptions** of discharge planning held by patients, carers, nurses and allied health workers involved in discharge preparation in a major metropolitan psychiatric hospital operated by the Health Department of Western Australia. Eighty one subjects were selected from the four principal groups involved in care in this mental health setting, consisting of patients ($n = 21$), carers ($n = 20$), nurses ($n = 22$) and allied health workers ($n = 18$). Perceptions of discharge planning of these subjects were evaluated and compared using the **Discharge Priorities Rating Scale**. Farran, Carr & Maxson's model of **goal congruence** in discharge planning was used to guide this study. Significant differences were found to exist in the perceptions of discharge planning between patients, carers, nurses and allied health workers. Differences in perceptions are seen to have a detrimental effect on the discharge planning process, resulting in unnecessary and frequent **readmission** to hospital and the perpetuation of institutional dependency. Whilst the results of this study can only be applied to similar institutions, the findings are relevant for the persistently mentally ill who have **patterns of frequent readmissions** across the public and private mental health service settings. The results obtained indicate that nurses can facilitate effective discharge planning practices by adopting a more assertive role in the health care team, in communicating patients' and their carers' concerns and promoting a more collaborative approach to care.

DECLARATION

"I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text."

Signature.....

Date.....

12th June 1995

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TABLE OF CONTENTS

| | Page |
|--|------|
| Use of Theses | i |
| Abstract | ii |
| Declaration | iii |
| Acknowledgments | iv |
| Table of Contents | v |
| List of Tables | viii |
| List of Figures | ix |
| Appendix | x |
| | |
| INTRODUCTION | 1 |
| Background to the problem | 2 |
| Significance of the study | 4 |
| Purpose of the study | 7 |
| Research questions | 7 |
| Operational definitions | 8 |
| Structure of the thesis | 9 |
| | |
| LITERATURE REVIEW | 11 |
| Introduction | 11 |
| Mental illness in Australia | 11 |
| Deinstitutionalisation and the persistently mentally ill | 15 |
| Re-admission and the persistently mentally ill | 22 |
| Discharge planning and the persistently mentally ill | 28 |
| Summary | 32 |

| | |
|--|---------------|
| THEORETICAL FRAMEWORK | 34 |
| Introduction | 34 |
| Goal congruity | 34 |
| Goal incongruity | 36 |
| Summary | 39 |
| METHODOLOGY | 40 |
| Introduction | 40 |
| Research Design | 40 |
| Setting | 41 |
| Sample | 41 |
| Instrument | 43 |
| Instrument validity | 43 |
| Instrument reliability | 44 |
| Reliability Analysis | 45 |
| Procedure for data collection | 48 |
| Data collection and analysis | 50 |
| Ethical considerations | 52 |
| Summary | 53 |
| RESULTS | 54 |
| Introduction | 54 |
| Questionnaire responses | 55 |
| Sample characteristics | 56 |
| Evaluation of discharge planning perceptions - group responses | 57 |
| Perceptions relating to the importance of discharge planning | 58 |
| Perceptions relating to community supports | 60 |
| Perceptions relating to living skills | 63 |

| | |
|---|------------|
| Perceptions relating to stress & stress management | 65 |
| Perceptions relating to patient education | 68 |
| Perceptions relating to carer education | 70 |
| Perceptions relating to involvement in discharge planning | 73 |
| Perceptions relating to discharge planning in treatment | 76 |
| Perceptions relating to discharge planning progress | 79 |
| Perceptions relating to effectiveness of discharge planning | 82 |
| Summary | 85 |
| DISCUSSION | 88 |
| Introduction | 88 |
| Evaluation of perceptions in discharge planning | 89 |
| Strategies to promote effective discharge planning | 95 |
| Nursing implications | 99 |
| Unexpected findings | 100 |
| Limitations of this study | 103 |
| Conclusion | 104 |
| REFERENCES | 107 |
| APPENDICES | 115 |

LIST OF TABLES

| | Page |
|---|------|
| Table 1. Reliability analysis of statement clusters | 47 |
| Table 2. Return rates | 55 |
| Table 3. Characteristics of respondents | 56 |
| Table 4. Diagnostic descriptors | 102 |

LIST OF FIGURES

| | Page |
|---|------|
| Figure 1. Theoretical framework - discharge planning goal congruity | 35 |
| Figure 2. Dysfunctional communication - parallel type | 36 |
| Figure 3. Dysfunctional communication - dyadic type | 37 |
| Figure 4. Dysfunctional communication - triadic type | 38 |
| Figure 5. Importance of discharge planning | 59 |
| Figure 6. Community support focus | 61 |
| Figure 7. Life skills development focus | 64 |
| Figure 8. Stress & stress management | 66 |
| Figure 9. Patient education | 68 |
| Figure 10. Carer education | 71 |
| Figure 11. Involvement in discharge planning | 74 |
| Figure 12. Discharge planning in treatment | 76 |
| Figure 13. Evaluation of discharge planning progress | 80 |
| Figure 14. Effectiveness of discharge planning | 83 |
| Figure 15. Observes patterns of discharge planning communication | 90 |

APPENDIX

| | | Page |
|--------------|--|-------------|
| Appendix 1. | Edith Cowan University Letter of Approval to Proceed with Research | 115 |
| Appendix 2. | Hospital Committee for Ethical Review Letter of Request to Proceed with Research | 116 |
| Appendix 3. | Hospital Committee for Ethical Review Letter of Approval to Proceed with Research | 117 |
| Appendix 4. | Supporting Correspondence Chief Nursing Officer, Health Department of W.A. | 118 |
| Appendix 5. | Supporting Correspondence Hospital Coordinator Staff Development/Research | 120 |
| Appendix 6. | Copy of Hospital Circular | 121 |
| Appendix 7. | Discharge Planning Survey Circular | 122 |
| Appendix 8. | Patient Consent Form | 123 |
| Appendix 9. | Discharge Priorities Rating Scale | 124 |
| Appendix 10. | Follow-up Interview Proforma | 133 |

CHAPTER 1. INTRODUCTION

Mental illness is gaining a higher profile in society today, with up to one in every five Australians expected to experience periods of significant disturbance to their psychological well-being at some stage during their lives (Working Group on Mental Health [WGMH], 1994). Psychological compromise may range from brief, isolated episodes of mild anxiety through the myriad of psychiatric disorders, to the severity of life long psychosis. The financial costs to the community of mental illness are immense but the human price is often hidden, less tangible and difficult to evaluate. What is known about Australians with severe mental illness however, is that they experience considerable misunderstanding, stigma and discrimination “on a scale not experienced by any other health service user” (Whiteford, 1992, p.350).

Major mental disorder, with prolonged periods of dysfunction that require long term care, is an issue of great concern amongst mental health professionals. Of those patients with persistent mental illness, the affective disorder group are recognised as having a good prognosis, if given favourable discharge conditions with effective discharge planning practices and follow-up care. Whilst only 6% to 10% of these patients have lifelong episodes of illness, this group contributes up to 40% of all cases of readmission to hospital (Byrne & Varghese, 1988; McEnany, 1990). This research study focuses on examining these patients and their carers, nurses and allied health workers involved in discharge preparation in the mental health setting, and investigates their understanding of discharge planning and what effects their perceptions have with respect to the discharge planning process.

Background to the Problem

The generally accepted description of a mental disorder is that of a “medically diagnosed illness that results in significant impairment of an individual’s cognitive, affective or relational abilities” (WGMH, 1994, p. 7). Accompanying these disturbances to psychological well-being is usually a substantial impairment in day to day living skills and subsequent loss of quality of life. This is true of individuals diagnosed with the major psychiatric disorders of schizophrenia and affective psychoses. These disorders can result in long term debilitation, with gradually increasing levels of dependence on health care services. Characteristics of these disorders include a reluctance to seek out help, the likelihood of admission to a hospital for treatment and a high probability of readmission following relapse of illness (Human Rights & Equal Opportunities Commission [HREOC], 1993; Kaplan & Sadock, 1991; Schizophrenia Australia Foundation [SAF], 1994). Individuals presenting with these features are considered to be chronically or persistently mentally ill [PMI].

Although substantial effort and resources are devoted towards returning mentally ill individuals to the community, one of the most distinctive and consistent features of the PMI is their high rate of readmission to hospital. As a phenomenon, the frequent readmission to hospital of the PMI is not new. This patient group is recognised as one of the greatest contributors to public hospital admissions in the area of mental health care (HREOC, 1993; WGMH., 1994).

The anecdotal **revolving door syndrome** has become a well recognised and phlegmatically accepted feature of chronic mental illness (Sullinger, 1988). Much is known about how and why the PMI **return to hospital**, but little research has been conducted into the factors associated with their **return to the community**. Ensuring the best possible outcome for the patient and the most efficient use of resources are the major objectives of discharge planning, the process used by hospitals to restore individuals to the community. Available evidence (HREOC, 1993; WGMH., 1994) indicates that neither of these objectives are satisfactorily addressed with the PMI.

Since the problem of frequent readmission to hospital among the PMI is not new, the challenge for mental health professionals is to find fresh answers to old mental health problems. For this to be achieved, a greater understanding of the complex issues affecting the chronically mentally ill is required before appropriate strategies can be developed, implemented and evaluated. Research has shown that the mechanism of discharge planning as a process is not necessarily flawed, but rather it is in the **application** of this process that questions are raised (Abramson, 1990; Chafetz, 1988; Kratzer-Worley & Lowery, 1988). Health professionals have knowledge, understanding of and varying degrees of involvement in the discharge planning process, but what of the patients and their informal carers?

Perception, the process by which an individual interprets or makes sense of stimuli (Rawlins, Williams & Beck, 1993), is acknowledged as being influenced by an enormous number of factors (Calicchia, 1981; Whattey & Müller, 1984). As various factors can

influence perceptions of events, it is reasonable to assume that patients, their families and health professionals may all have different viewpoints or perceptions relating to what constitutes mental health treatment and care (Danielson, Hamel-Bisel & Winstead-Fry, 1993). Although considerable research has been conducted into discharge planning, there is a paucity of research that investigates the perceptions that patients and their informal carers have of discharge planning, and what effect their perceptions have on the discharge planning process.

A lack of research in this area poses many questions. What level of knowledge, understanding and involvement in discharge planning do patients and their informal carers have? How important is their role in this process and what effect does this have on the success or failure of treatment? What do they know about discharge planning? Are they actively involved? Do their views converge with those of the professional carers? Do mental health workers consider patients and their informal carers when planning for discharge? What are the perceptions of those involved in the discharge planning process?

Significance of the Study

Research into these issues is essential and has been identified as such by Australia's Human Rights Commissioner, Brian Burdekin, who found that deficits in research in mental health in Australia was evidence of significant discrimination in health care. Burdekin found that the mentally ill were placed "at a disadvantage by depriving them of opportunities to lead more fulfilling and constructive lives than they currently enjoy"

(HREOC, 1993, p.821). In this critical report on the state of mental health care and treatment in Australia, recommendations were made for continuing research into psychiatric treatment, rehabilitation and care services as priority issues, placing emphasis on “evaluating what works, what does not work and why” (p.837).

Boyd & Luetje (1992), in their meta-analysis of published mental health care research between 1988-1992 stated that this type of research is essential, finding that “psychiatric nursing practice and research are still not directed toward this population and the problems associated with long-term mental illness” (p.208). As a scant amount of research exists that relates to the area of assessing perceptions of those involved in discharge planning in the mental health setting, research such as this has benefits for all those involved in the discharge planning process as well as for society in general.

Benefits to Patients: The persistently mentally ill are probably the most disadvantaged group in society today. Apart from bearing the stigma of mental illness, this group is often under-educated, under-skilled and deficient in both social and financial resources. Their views are often neither sought nor much valued when given. They do not attract sympathetic public attention and are considered by health professionals as difficult to treat. As effective discharge planning is crucial if the mental health patient is to be assured of a successful discharge period, it becomes imperative that the issues are examined from the patient’s position and be adequately redressed.

Benefits To Carers: Informal carers or support networks consisting of family and friends are important resources to health care workers and are irreplaceable to the patient. These networks do more than provide support to the patient before and after discharge from hospital, as they also help to reinforce on-going treatment following hospitalisation providing a link between hospital and the community. Better understanding of the issues influencing the readmission of the persistently mentally ill can assist in the development of more effective discharge planning that results in increased periods of remission, helping preserve these networks of support.

Benefits to Nurses: As nursing practice becomes increasingly research based, issues that pose continuing practice problems need to be investigated. Nurses, as the ones most frequently in contact with the patient, occupy a unique position in the health care team and play an important role in communicating patients' concerns with others involved in care. Gaining insight into the understanding that patients and carers have of treatment issues and communicating these to the health care team will assist in consolidating the nurse as an active member of the multidisciplinary team and is consistent with the expanding role of the nurse as a patient advocate. Research such as this makes an appropriate contribution to enhancing research based practice in mental health nursing.

Benefits to the Health Care Team: Effective treatment interventions with subsequent lengthy periods of remission from mental illness are associated with and facilitated by a collaborative approach to care. Factors which impede the delivery of effective mental health care can also have an adverse effect on the multidisciplinary team. Identification

of areas of deficit when planning for discharge in turn, can lead to the development of more effective discharge planning strategies. Introspective examination and evaluation of discharge planning processes and the perceptions of those involved will assist in promoting more appropriate and effective mental health care.

Benefits to Society: As no one in society is immune from the effects of mental illness it is to the benefit of all that appropriate services be available if and when required. As health care costs continue to escalate, it is essential that expenditure in health care and the services provided for the mentally ill be both cost effective and efficient. Mental illness and its enormous impact on society in both human and economic terms is a neglected but nonetheless important area of study. Research such as this will assist in assessing the problem in order that relevant issues can be identified, appropriate responses developed and the overall standards of mental health care improved.

Purpose of the Study

The purpose of this exploratory descriptive study is to examine perceptions of discharge planning as held by patients, carers, nurses and allied health workers, involved in discharge preparation in the mental health setting, and to investigate what effect their perceptions have on the discharge planning process.

Research Questions

In investigating the perceptions of discharge planning held by patients, carers, nurses and allied health workers, this study is directed by the following research questions:

- (i.) What are the perceptions held by patients, carers, nurses and allied health workers of discharge planning?
- (ii.) What, if any, significant differences exist in the perceptions of discharge planning between patients, carers, nurses and allied health workers?
- (iii.) What effects, if any, do differences in the perceptions of discharge planning between patients, carers, nurses and allied health workers have on the discharge planning process?

Operational definitions

For the purpose of this study, the following operational definitions have been adopted:

Allied Health Professional: non-nurses (consultant psychiatrists, psychiatric registrars, social workers, welfare workers, occupational therapists, psychologists, pharmacists & pastoral staff) involved in care in the mental health setting.

Carer: individuals nominated by the patient as being a major social support when either hospitalised or discharged from hospital.

Discharge Planning: the process used in the health care setting designed to return the patient to the community.

Mental Disorder: “a medically diagnosed illness that results in significant impairment of an individual’s cognitive, affective or relational abilities” (WGMH, 1994, p. 7).

Nurse: registered, enrolled or student nurses involved in care in the mental health setting.

Patient: individuals with the psychiatric diagnosis of an affective disorder.

Perception: the process by which an individual interprets or makes sense of stimuli.

Persistent Mental Illness: (or PMI) any of the major psychiatric disorders characterised by prolonged periods of dysfunction in individuals who may require long term care.

Structure of the Thesis

This introductory chapter has provided a background as to the purpose of the research and the research questions directing this study. Chapter two presents a comprehensive review of the literature on the history of and current issues relating to mental illness in Australia, with specific focus on those with persistent mental illness and the factors associated with their readmission to hospital. The theoretical framework chosen to assist in the organisation of this study is described in chapter three. Chapter four presents

details of the research design, the setting and sample chosen for, and methods used in the conduct of the research. A description of the development and application of the instrument used for data collection and the handling of the data are also provided. Ethical aspects of this study are described in this chapter.

The results of the data analysis in response to the each of the research questions, sample characteristics and limitations of this study are presented in chapter five. This chapter consists of a discussion of the results of this analysis in relation to the theoretical framework used to guide this study. Findings will be related the literature on this topic, discussing strategies to promote effective discharge planning practices and subsequent implications to nursing practice. The thesis concludes with a discussion of unexpected findings of, and limitations to this study

CHAPTER 2. LITERATURE REVIEW

Introduction

This chapter consists of a review of the literature relevant to this study, to help develop an understanding of the issues associated with persistent mental illness [PMI]. This review will firstly, discuss the extent of mental illness in Australian society and identify the persistently mentally ill. Secondly, deinstitutionalisation or the movement from institutional to community based mental health care will be described. The third section will examine the issue of readmission to hospital of those with persistent mental illness and establish the link between the cycle of hospital readmission and chronicity. Finally, discussion on discharge planning as it relates to the persistently mentally ill will be presented.

Mental Illness in Australia

Mental health and mental illness are associated issues that are increasingly gaining a higher profile in society today. Attention has been drawn to well publicised problems such as youth suicide, substance use and abuse, anorexia, stress and related disorders, phobias, disorders of mood, schizophrenia, disorders of aging and a variety of other equally important but obscure issues. Mental illness is more openly discussed than has been the case in the past, yet the public is poorly informed and relatively uneducated about mental health (Australian Health Ministers Conference [AHMC], 1992c).

The definition of mental health as accepted by Australian Health Ministers Conference is described as:

the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of cognitive, affective and relational abilities, and the achievement of individual and collective goals consistent with justice (AHMC, 1992b, p. 20).

Mental illness respects no boundaries. Neither race, culture, creed, socioeconomic standing, educational background nor intellectual capacity can afford protection. No-one in society is immune to the problems associated with mental illness and many Australians are impaired in their capacity to enjoy mental health.

In the United Kingdom, it is estimated that as many as 15% of all general practitioner consultations and up to 45% of all people requiring hospital treatment for physical illness have psychological and emotional problems (Brooking, Ritter & Thomas, 1992).

Similarities are found in the United States of America where it is approximated that, at some time during their lives, over 30% of Americans will suffer with mental illness (Kaplan & Sadock, 1991, p.134). The Australian experience, whilst not mirroring this incidence, shows that anywhere between 18.4% (Puckett, 1993) to 20% (WGMH, 1994) of all Australians are likely to be affected by mental illness.

A report on mental illness commissioned by the Australian Health Ministers Advisory Council [AHMAC] established that 2.3 million people or "approximately 20% of the adult population will experience one of seven major mental disorders in a year" (WGMH, 1994, p.17). Raphael (1992) reported similarities in incidence, determining that 20% of adults and 10% to 15% of adolescents are affected by mental illness at any one time. This level of incidence is supported by the HREOC (1993), in its report on the state of mental health services in Australia, finding that "one in five adults have or will develop some form of mental disorder" (p.13), at some stage during their lives.

Where chronic illness is the "leading problem of the industrialised world" (Loomis & Conco, 1991, p.163), the persistently mentally ill could be said to occupy the same position in the area of mental health care. Currently, approximately 5% of all people over 65 years of age require long term mental health care (Australian Institute of Health & Welfare [AIHW], 1994). It is predicted that by 2041, the number of aged Australians will increase, doubling to 5.5 million and representing 22% of the population (Australian Bureau of Statistics [ABS], 1994). With this growing elderly population, it is expected that there will be a corresponding increase in mental disorders related to aging. Until recently, a large component of the mentally ill treated in public psychiatric hospitals consisted of those diagnosed with disorders of aging.

With the movement of the aged out of public psychiatric hospitals, the most significant contributors still requiring long term health care in the public hospital sector, are those patients with the major psychotic illnesses of schizophrenia or affective disorder. It is

estimated that approximately 1.5% of Australians (250,000) suffer from either of the persistent mental illnesses of affective disorders or schizophrenia (HREOC, 1993).

Schizophrenia has a uniform distribution of incidence of 1% of the population (Burrows, Judd & Norman, 1988; Kaplan & Sadock, 1991; SAF, 1994), with this being consistent for both developed and developing countries. Equally, the incidence of affective disorder in the community is also appraised at 1% of the population (Byrne & Varghese, 1988; Kaplan & Sadock, 1991; McEnany, 1990), with established consistency across populations.

It is evident from the literature, that discrepancies exist in the assessment of incidence of these disorders in Australia, with estimates erring on the side of caution. The incidence of these disorders in the community could be under-estimated, with the actual incidence being closer to at least 2% or 330,000 Australians. With Australia's annual population growth rate predicted at approximately 1.02% (ABS, 1994), the problem of mental illness in the community takes on significant proportions both for now and for the future. These groups of disorders are leading problems in the area of mental health care. With up to 40% of all these patients suffering recurrent episodes for which readmission to hospital is required (HREOC, 1994), these groups account for more hospital bed occupancy than all other mental illnesses combined (Health Department of Western Australia [HDWA], 1991).

Without treatment, the prognosis for those diagnosed with schizophrenia is poor, as even given the optimal conditions for treatment and follow up, at least 30% will progress to

chronic dysfunctional features of this disorder and require long-term care (Burrows et al., 1988). The prognosis for those with affective disorder is somewhat better, due to the fact that although 6% to 10% of these patients have lifetime risk, when given ideal treatment conditions, the relapse rate amongst this group is low. Surprisingly, despite there being a much smaller number of these patients having lifelong episodes of illness, this group is seen as contributing almost 40% of all cases of readmission to hospital. The issues relating to this feature revolve around effectiveness of treatment programmes (Byrne & Varghese, 1988; McEnany, 1990).

A diagnosis of a persistent mental illness does not necessarily equate with chronic mental ill health, as many of those who suffer from these disorders will not encounter continuing disabling episodes of illness. However, it is clear from the authoritative sources cited here that significant numbers of Australians will experience recurrent symptoms for which some form of long term care is required. Unfortunately, as the frequency of admission to hospital for this care increases, so does the likelihood for future readmissions and with it, the risk of institutional dependency (Chafetz, 1988; Mulaik, 1992). Dependence on institutions has long been recognised as being detrimental and compounds the problems faced by the persistently mentally ill (Robinson & Pinkey, 1992).

Deinstitutionalisation and the Persistently Mentally Ill

Over the last three decades there has been a deliberate attempt in Western psychiatry to reduce levels of dependency on institutional care (McFadyen, 1992; Miller, 1985). This

approach, referred to as deinstitutionalisation, arose out of more humanistic social policies of the 1960's. The stated goal of deinstitutionalisation "was to release the mentally ill from custodial care in large state institutions to care and rehabilitation in the community" (Kratzer-Worley & Lowery, 1988, p.126). Deinstitutionalisation in favour of community care is seen as progressive (Mulvany, 1994), and the focus in mental health care is now directed towards normalising the persistently mentally ill and treatments of least restriction (Peternelj-Taylor & Hartley, 1993).

In the past ten years, there has been a decrease in the number of public psychiatric institutions across Australia. Between 1985 and 1992, there has been a 43% reduction in public psychiatric hospital beds, down from 12,741 in 1985-86 to 7,266 in 1991-92, with the situation in Western Australia observed to be consistent with this trend (AIHW, 1994). Corresponding with this overall reduction in services, beds and bed days, there has been a 25% drop in the number of people employed in public psychiatric hospitals from 18,730 in 1986 to 14,000 in 1991 (AIHW, 1994, p.149).

As this devolution of psychiatric care and services from hospital centres into the community has been progressively implemented, those with impaired mental health and who require treatment are no longer necessarily hospitalised. During the past decade, with a shift towards community based models of treatment, the number of mentally ill being treated in large mental institutions has declined and the average length of stay of patients in these institutions has decreased (HREOC, 1993). Throughout Australia, as psychiatric in-patient facilities are being reduced in both number and in the range of

services they provide, there has been a corresponding increase in out-patient and community care services (AIHW, 1992; HREOC, 1993; SAF, 1994).

With a shift in services for the provision of care of Australians with aging disorders, from the public to the private sector, there has been a 41% increase in the number of aged nursing homes from 851 in 1985 to 1198 in 1992 (AIHW, 1994, p.155), and this trend is continuing. The reduction of the number of admissions of the aged to psychiatric hospitals and a shift to community care has resulted in a decrease in patients requiring long term care in public mental health treatment facilities. These factors have contributed to the reduced lengths of stay in public psychiatric hospitals.

More recently, increased funding by the Commonwealth Government to mental health issues has been acknowledged as a direct response to the Human Rights and Equal Opportunities Commission (1993) "Inquiry Into The Human Rights Of People With Mental Illness" (Department of Human Services and Health [DHS], 1994, p.1). This additional expenditure is in line with the major recommendations from that report, and increases the amount spent on the provision of mental health treatment, prevention and promotion programmes both for now and in the future.

Under the 1994-95 Federal Budget, a 5 year plan of action has been set out for the development and implementation of new initiatives in the area of mental health treatment and care. These initiatives include:

providing funds to encourage a full range of accessible high quality health and other services appropriate to the needs of people with mental illness;

promoting improved planning and intersectoral linkages at all levels of government and with the private and non-government not-for-profit-sectors;

increasing the emphasis on promotion of mental health and the prevention of mental illness;

taking action to overcome discrimination and barriers to reform and discrimination; and

promoting more effective use of community services workers and the mental health workforce.

(DHS, 1994, p.9)

In recognition of the gradual shift from institutional mental health care to the provision of services and care in the community, an additional \$168.7 million has been allocated in the 1994-95 Budget (DHS, 1994), above and beyond that required for provision of existing services to continue these and other initiatives. Despite these progressive changes and the trend to the majority of patients now receiving community based mental health care, the bulk of the national budget expended in the provision of mental health services in Australia continues to be provided in the area of institutional psychiatry.

The motives and effectiveness behind the move from institutional care have been examined from different viewpoints in the literature and questioned. Brandon's (1987) commentary on patients leaving the British hospital system highlighted several issues. He found from workshop discussions with staff and patients on a long stay unit at a large U.K. hospital, that the PMI on leaving the mental health institution are often placed into a hostel or what is described as an accommodation institution (p.55). Patients are merely transposed from hospital into community institutionalisation where they remain powerless and where dependence on the system is encouraged by authoritarian attitudes and management practices. Brandon found that the PMI lack encouragement to be independent, are not provided with vocational, diversional or recreational activities and are unable to personalise their living environment. Attempts at autonomy are perceived as disruptive and as "making waves" (Brandon, 1987, p.54). Placement out of hospital often is less attractive than hospitalisation and actually contributes to the cycle of readmission. Brandon views changes in the attitudes of health care providers as essential for deinstitutionalisation to be successful and patients' quality of life improved.

Kratzer-Worley & Lowery (1988), in their meta-analysis on the effects of deinstitutionalisation in the US from 1963, viewed the need to establish community care infrastructures as the area for prioritisation in the deinstitutionalisation of the chronically mentally ill. They argue a shared responsibility exists between the community agencies and the institution to "coordinate and cooperate in the care of this client population" (Kratzer-Worley & Lowery, 1988, p.126). What was found however, was that these

groups often operated in isolation, with a clear demarcation between what is hospital and what is community care. They found that this demarcation was an administrative one and related to budgetary rather than clinical considerations. The failure to develop cooperative organisational guidelines with a patient centred focus resulted in services that were inadequate and actually contributed to unnecessary readmissions.

In an ethnographic study involving 50 homeless adults in Los Angeles, Koegel (1992), concluded that failure to take into account socioeconomic circumstances and environmental factors set the PMI up to fail on discharge from hospital and that this was a mitigating factor associated with their return to hospital. On return to hospital, health professionals had a tendency to blame the PMI for the circumstances of their return, when in fact it should be incumbent upon health professionals to rectify “gaps in our understanding” (Koegel, 1992, p.2) of the persistently mentally ill. Koegel reasoned that the moves to deinstitutionalisation have been founded on a poor understanding of the problems of the long term mentally ill and this has resulted in inappropriate health care management policies. He argued that management of this group had been largely influenced by epidemiological and clinical perspectives rather than the humanistic, and that greater effort should be directed towards understanding the problems faced by the PMI from their perspective.

In their commentary on the American movement towards the democratisation of psychiatry, Bassuk and Buckner (1992), agreed with this point of view but also argued that health policy was overly influenced by cynical, budgetary driven political directives.

They insisted that homelessness and the lack of adequate accommodation, as contributing factors in many readmissions of the PMI, are largely ignored as aspects of mental health policy, views that are shared by Gelberg & Linn (1988). In a study conducted in California involving 529 homeless adults across 19 separate sites, Gelberg & Linn found that almost 44% (232) had been receiving treatment for mental illness. Despite their findings that lack of adequate accommodation increases the use of mental health facilities, mental health authorities did not view the provision of adequate accommodation on discharge as a health issue, but took the position that this was a social issue.

Although treatments of least restriction are increasingly favoured, relapse amongst the PMI contributes to as much as 80% of all admissions to hospital (Sullinger, 1988). Whilst deinstitutionalisation is desirable, relapse of illness and subsequent readmission to hospital of the persistently mentally ill (PMI) is a major concern to health professionals, families and patients. This is especially the case for those patients with affective disorder, where the likelihood of a favourable prognosis is high, given adequate treatment and follow-up services. Since deinstitutionalisation is a stated goal in the management of PMI and readmissions perpetuate institutionalisation, it is evident that research that provides information that can be used to reduce the incidence of hospital readmission is worthwhile.

Readmission and the Persistently Mentally Ill

Frequent readmission to hospital of the persistently mentally ill can have enormous social and economic consequences. Mental health and well-being is directly related to the number of and quality of contacts that people have with others (Puckett, 1993). This has a bearing upon everyone's level of mental health and is especially true for those whose mental health has already been compromised. Dislocation from these supportive influences through readmission has a damaging effect on the patient, the family, service providers and the community.

A major US study investigated deinstitutionalisation from the perspective of readmission patterns. This epidemiological study conducted by Casper, Romo & Fasnacht (1991) involved the retrospective audit of admission records over a six year period of 1,456 patients who had been identified as frequent users of inpatient services at five New York State hospitals. The purpose of this study was to identify predictors for readmission of the mentally ill, and whilst casting no light on the reasons behind large numbers of readmissions of the mentally ill, it did identify that frequency of previous admissions to hospital is the one variable consistently identified as the most reliable predictor for readmission. Since frequency of admission to hospital is an indicator of increased likelihood of further admissions, efforts to reduce or prevent readmission can assist in breaking this cycle of events.

Just as frequency of previous hospital admission is the single most reliable predictor for readmission, non-compliance with treatment is the most frequently identified cause of

relapse of illness for which readmission would be required. There is a universal recognition of non-compliance as a problem in the health care setting, with this term being described differently by various authors.

Phillips (1988), acknowledges that "the problem of nonadherence or noncompliance is about as old as medicine" (p.18). This raises the multiple questions of *Why is this so? What is it that makes complying with discharge expectations so difficult? Whose expectations are not being met? Why is this a problem? Why does it persist?* The issue of compliance with discharge plans on return to the community "is a major issue for the chronically mentally ill" (Hochberger & Fisher-James, 1992, p.25). A number of research studies have been conducted investigating reasons for non-compliance.

Mulaik, (1992) found that where patients and health care providers differed with respect to treatment goals and on the importance of various aspects of treatment, the likelihood of compliance was reduced. This study investigated relapse and re-hospitalisation amongst 11 newly readmitted schizophrenics. The subject group consisted of seven men and four women. Assessment consisted of a structured interview using open ended questions with a content analysis of resulting data. The principal focus of this study was to determine barriers to action.

Major barriers to action in respect to non-compliance related to medication education and lack of understanding of medication actions, dosage requirements and side effects. These barriers were influenced by a failure on the part of the care providers to ensure

that patients had a clear understanding of the issues associated with their prescribed medications. Improvement in patient-health provider communication and drug education programmes involving family or other supportive carers were strategies recommended to overcome these barriers.

Coudreaut-Quinn, Emmons & McMorrow (1992), reported that up to 92% of all readmissions amongst multiple admission patients resulted from non-adherence with treatment. Compliance with treatment for those people with persistent mental illness consists primarily of prophylactic drug maintenance. Coudreaut-Quinn et al., investigated the high rate of non-adherence with treatment once the patient left the structured setting of the hospital. Their study based in a 28 bed extended stay unit of a major psychiatric hospital in the US, involved the implementation of a medication education and self administration programme. The purpose of the project was to promote greater compliance amongst the persistently mentally ill when discharged from hospital.

In this programme, the patient was both educated regarding their illness and its management and given greater control over their own care through self administration of medications. Proficiency in administration and assessment of medication knowledge was measured. What was found, in this study, was that even with education and controlled conditions, patients had still misconceptions regarding what is the primary method of management on discharge from hospital. The argument for better communication

between patient and health workers through more effective patient education programmes and ongoing evaluation of patient abilities was emphasised.

This aspect was addressed also by O'Reilly, O'Donovan & Cernovsky (1990), in their study investigating 200 randomly selected, chronically mentally ill patients attending two outpatient centres in Ontario. These patients were surveyed using a forced choice questionnaire format regarding their satisfaction with services. This study extended out from the patients themselves, to include the family of each patient and the community nurse and physician responsible for each patient. Major differences in satisfaction with services were established between these groups. It was reported that health professionals had a propensity to plan treatment and discharge from their own perspectives resulting in a lack of commonality of objectives between the health care team, patients and significant others. Where lack of common understanding existed, failure in treatment compliance often resulted and was a major contributing factor behind the large numbers of readmissions to psychiatric facilities.

Dow, Verdi & Sacco (1991), similarly found, in their study investigating patient communication and knowledge of medications, that conflict in perceptions and expectations had a negative effect on patient satisfaction, treatment compliance and resolution of problems. This US study was conducted using 48 persistently mentally ill patients in a state hospital. Patients were randomly assigned to two groups and assessed using a Health Locus of Control questionnaire, measuring locus of control orientation

regarding health issues. Assessment occurred prior to and following participation in either of a two week communication skills or drug education programme.

The results of this study indicated that patient compliance with medications and interpersonal skills improved significantly following education. Aspects of this study identified that where conflict existed between what the patient expected to gain and what the therapists perceived as benefits from education contributed to misunderstanding and a loss of satisfaction, reduced compliance and limited problem resolution. This study concluded that “specific emphasis was needed on communication in the doctor-patient relationship to produce meaningful change” (Dow et al., p.19).

A study conducted by Ervin, Walcott-McQuigg, Chen & Upshaw (1992), conducted in a community setting, focussed on the measurement of patients’ perceptions of care quality. Interviews were conducted with a purposive sample of 60 patients six weeks following discharge from hospital and after receiving four home visits by community nurses. Subjects were interviewed in their homes and asked to completed a visual analogue scale questionnaire relating to care satisfaction.

This study revealed that while interpersonal factors between patients and doctor were important, the provision of effective health care in the community required participation of not just the patient and professional health worker, but emphasised the value of “participation of family or significant other” (p.30). Inclusion of these carers improved the quality of information communication and reduced the level of health provider

underestimation of patient knowledge need. This is an issue of great concern as it has been established that patients and health care providers “commonly disagree on the nature of health problems, appropriate treatment and expected outcomes” (Ervin et al., 1992, p.27).

Peet & Harvey (1991), concerned that up to 75% of all relapses amongst those with affective disorder related to poor medication compliance, investigated methods to promote compliance. The study involved 60 patients who had been attending a U.K. regional outpatient clinic for a number of years. Patients were randomly selected and randomly allocated to a control group and a treatment group. Treatment consisted of a drug education programme that involved repeated assessment of medication knowledge and follow-up into the community for home evaluations. The pre-education assessment produced surprising results, revealing that patients who had been attending the same clinic for an average of seven years had major misconceptions about their treatment and what was expected of them regarding treatment compliance.

It was established that patients can fit very well in the routine of the system without having any real knowledge of their condition and treatment and that this had gone undetected by health workers who had been in continual contact with these patients. Although the drug education programme itself produced statistically significant improvement in knowledge, recommendations from this study were broad, addressing the need for improved patient, carer and health provider communication.

Keeling, Utz, Shuster & Boyle (1993), in commenting on the diagnostic problem of non-compliance, found that non-compliance is more frequently encountered where a medical model dominates the approach to treatment, as with this approach to care a lesser value is placed on the “client/provider relationship” (p.93). They argue that if a collaborative relationship exists between the patient and all those involved in treatment and care, the issue of non-compliance becomes redundant. If non-compliance is evident, this is indicative that a collaborative arrangement either does not exist or there is a misinterpretation as to whose ideas and expectations are not being met.

While family ties, social networks and community supports are recognised as variables that contribute to the maintenance of individuals in the community (Grosser & Vine, 1991), frequent readmission to hospital can exhaust these resources. If the frequency of re-hospitalisation can be reduced, fragmentation of the family and destruction of support networks can be contained. Research that contributes towards reducing readmission will be instrumental in lessening the costs to patients, families and the community (Burrows et al., 1988; HREOC, 1993). A crucial aspect of treatment that can give rise to non-compliance and eventual return to hospital is in the area of discharge planning.

Discharge Planning and the Persistently Mentally Ill

Lack of adequate preparation in planning the discharge of the chronically mentally ill from hospital to the community has been likened to “throwing puppies on the freeway” (Hochberger & Fisher-James, 1992, p.25). Discharge planning according to the Health Department of Western Australia is the “process of activities that involve the patient (or

carer) and a team of individuals from different disciplines working together to facilitate the transition of that patient from one environment to another” (HDWA, 1992, p.4).

This description does not reflect the concerns expressed by Naylor (1990), which although similar, focuses on the effectiveness of discharge planning, that is, including measuring outcomes. She says, “effective discharge planning is needed to facilitate timely hospital discharge and to find appropriate alternative care needed in order to prevent unnecessary readmissions, maintain health status of patients and lessen the burden of care on the family” (p.330). In other words, satisfying the process discharge planning is not enough and that a relationship exists between the effectiveness of the process and the frequency of readmission to hospital.

Recent studies have cast doubts on the effectiveness of discharge planning. Tierney, Closs, Hunter & MacMillan (1993), in investigating discharge planning for the elderly reported that discharge planning to be consistently inadequate in a variety of settings throughout the previous two decades. Their study contained a meta-analysis of previous studies into discharge planning in the U.K., and identified that the shortcomings in discharge planning related to “poor communication between hospital and the community; lack of assessment and planning for discharge; inadequate notice for discharge; inadequate discussion with patients and their carers; over reliance on informal support or lack of statutory service provision; inattention to the special needs of the most vulnerable and wasted or duplicated visits by community nurses” (Tierney et al., 1993, p.180).

A recent study of public hospitals, commissioned by the Health Department of Western Australia, was critical of discharge planning processes employed in the public sector. This study examined discharge planning practices at four major metropolitan hospitals and consisted of a retrospective audit of 141 patient records, a questionnaire survey of 1227 hospital staff involved in discharge preparation and interview with 9 key nursing and medical or allied health personnel across these sites. It was reported that discharge planning practices in Western Australian hospitals were “largely ineffective” (Williams, 1991, p.1).

Although Williams' study targeted general hospitals, in her report, she also directed comments towards the mental health client, and concluded that conditions were not any more favourable in the mental health setting. An invitation had been extended to those involved in discharge planning in the mental health setting to contribute to this report; however, from all the areas involved in the provision of mental health care in Western Australia, only two responses were elicited (this author being one of these). Despite such a poor level of response, mental health patients were clearly and specifically identified in this report, as being amongst those patient groups considered by health professionals to be “high risk in terms of needing comprehensive discharge planning to effect optimal recovery” (p.30).

Williams' findings were similar to those reported in the study by Tierney et al. (1993), in that the areas of concern she identified related to a lack of a coordinated approach to discharge planning; insufficient warning of discharge; failure to initiate appropriate

discharge resources; poor levels of communication between medical staff, nursing and allied health; poor communication between medical staff and patient and carers; patients and carers being supplied with jargonised and confusing information; poor patient and carer education and guidance; and inadequate or unsuitable follow-up arrangements.

Discharge planning practices in the mental health setting have come under scrutiny from a variety of sectors in recent times. According to the Mental Health Task Force Report “mental health services exist to meet the needs of consumers” (AHMAC, 1990, p.4). Despite this assertion, the available evidence exists that these *consumers* of care have little say in the decisions that are made about them during hospitalisation and prior to discharge. Public statements aired by the Australian Human Rights Commissioner, Brian Burdekin in delivering the annual Walter Murdoch address reinforce the view that “the provision of satisfactory standards of care extends to that care the patient care would reasonably expect to receive in the community” (Burdekin, 1993).

The “Mental Health Statement of Rights and Responsibilities” (AHMC, 1992a), states that, in addition to basic and fundamental human rights, consumers of mental health care and their informal carers have “the right to interact with health care providers particularly in decision making regarding treatment, care and rehabilitation” (p.1). This national policy directive also identifies planning for discharge as part of the treatment process going to endorse that “every person admitted to a mental health facility or community program has the right to adequate discharge planning” (p.9).

In the mental health setting, the purpose of discharge planning is to prepare the patient for return to the community, minimising the occurrence of relapse and prevention of readmission to hospital. For these goals to be achieved, and discharge planning be effective, discharge planning needs to be a deliberate, coordinated process. The goal of this process must be clear and a congruity of purpose amongst those involved in this process is essential. Effective discharge planning benefits patients and their families, decreases healthcare costs, reduces length of stay, prevents the need for rehospitalisation due to complications that arise after discharge and promotes the appropriate use of community resources.

Prolonged discharge periods and reduced frequency of admission are in part measures of successful treatment outcomes achieved through effective discharge planning practices. Despite the benefits described in the promotion of effective discharge planning practices, the available evidence indicates that this is not being achieved in the mental health sector. Limited research has been conducted in Australia at examining issues associated with readmission to hospital of the PMI and there is an established need to investigate this problem and determine what the perceptions of discharge planning of the key groups involved with the patient play in respect to this issue.

Summary

Findings arising out of the studies reported here supported that, whilst effort to provide decent affordable accommodation, improved living standards and better standards of care should be given priority to improve the prospects of those affected by

deinstitutionalisation, efforts should also be directed towards prevention of chronicity, through preserving family structures and social networks. Reduction in the frequency of admission has additional benefits. If family and social supports can be maintained, this in itself will reduce the burden on the mental health care system.

The following chapter will describe a theoretical model that will be used to examine discharge planning in the mental health setting. This model will help identify the dynamics at work between the various groups involved in discharge preparation in the mental health setting and will provide a basis for the interpretation of results for data gathered in this research.

CHAPTER 3. THEORETICAL FRAMEWORK

Introduction

This section describes the theoretical framework that has been adapted for utilisation in this research study. Theoretical frameworks provide “direction and guidance for structuring professional nursing practice, education and research” (Creasia & Parker, 1991, p.5). Use of a theoretical framework facilitates a problem solving approach to the research, assisting in organisation of research questions, determination of research design, selection of subjects and interpretation of results.

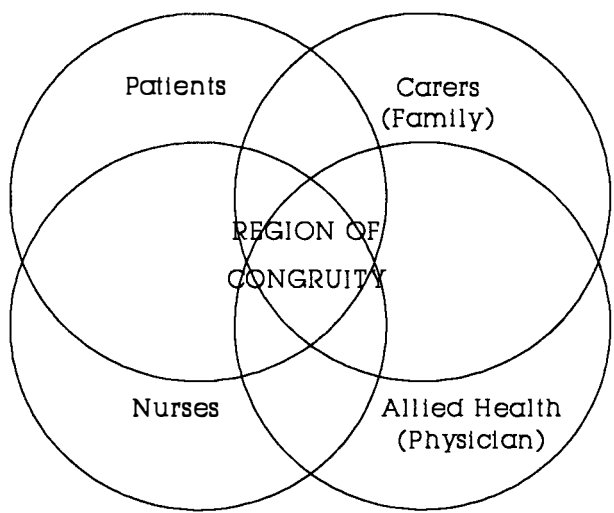
Goal Congruity

Farran, Carr & Maxson (1988) present a model for examining goal setting and expectations in the mental health setting. This model can be used to identify what the, "different players [patient, family, nurse and physician] expect over the course of hospitalisation" (p.159), to examine if a balance or goal congruity exists. Goal congruity is described as the level of agreement that exists between the parties involved in the treatment process.

The model developed by Farran et al., examines for goal congruity between the “patient, family, nurse and physician” (p.161), and has therefore been adapted for this study. As the purpose of this exploratory descriptive study was to examine perceptions of discharge planning as held by those key groups; patients, carers, nurses and allied health, this framework would appear to be the most appropriate choice. Minor adaptation of

this model made it more consistent with the populations under investigation. In this study, the physician category has been modified to include all allied health workers and the family category is also modified to represent any informal carer (Figure 1.). Further, the issue focus is changed from the treatment process to the discharge planning process. This structure clearly illustrates what should be exhibited when there is a balance, common purpose and congruence of understanding in the perceptions of discharge planning by all involved in the discharge planning process.

Figure 1.
Theoretical Framework of Discharge Planning Goal Congruity



(adapted from Farran, Carr & Maxson, 1988, p.161)

All those involved groups are seen to be integrated into the planning process and all parties have an equal opportunity to be involved. Clear lines of communication are

facilitated and congruity of purpose is demonstrated by the representation of a balanced approach to discharge planning. In this model, the likelihood of a favourable discharge prognosis is promoted, as "goal communication patterns are established" (Farran et al., p.164). Where this occurs, treatment outcomes are more likely to be achieved.

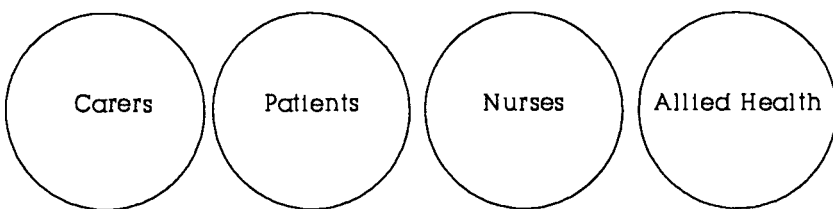
Goal Incongruity

Where imbalance exists in the planning process, communication patterns are described as parallel, dyadic or triadic. Parallel patterns (see Figure 2.) are dysfunctional, reflecting incongruity between all parties involved in the planning process.

Figure 2.

Dysfunctional Communication- Parallel Type

Parallel Communication Process

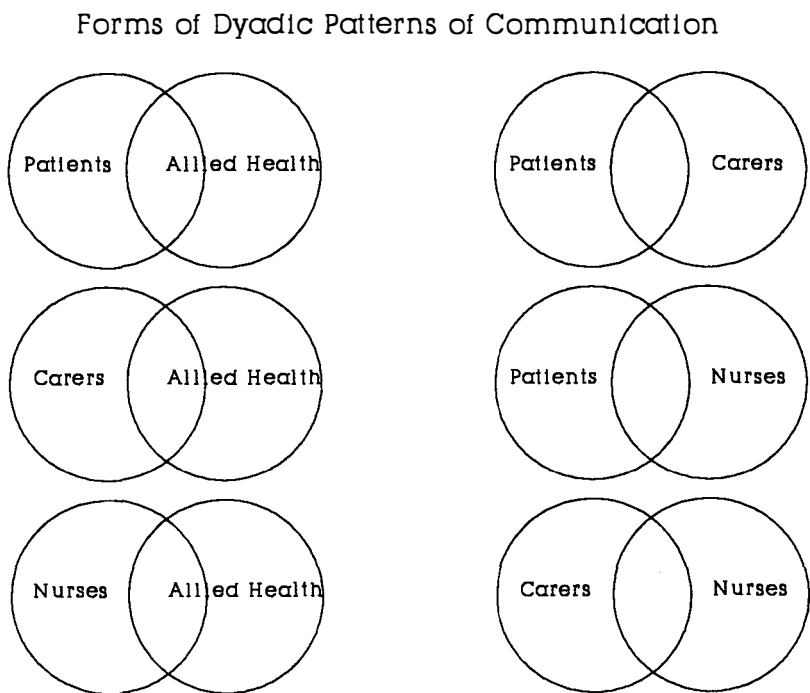


(adapted from Farran, Carr & Maxson, 1988, p.161)

An illustration of this type of communication pattern is where each of the parties has a different understanding of the priority issues in care and arises where assumptions that common understanding exists between interested parties, but no validation occurs to establish this. Dyadic patterns of communication (see Figure 3.), while reflecting some common understanding between pairs, are demonstrations of impaired communication or incongruity. Shared goals may exist between some of the parties in a one-to-one relationship, but there is failure to establish common goals amongst all the parties.

Figure 3.

Dysfunctional Communication - Dyadic Type



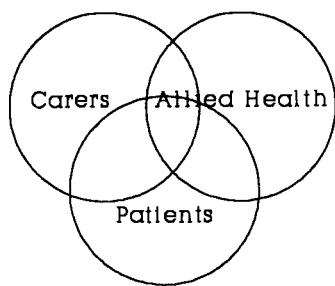
(adapted from Farran, Carr & Maxson, 1988, p162)

Triadic patterns of communication (see Figure 4.), signify that congruity or consensus exists between the majority of parties" (Farran et al., p.163). Whilst on the whole, goal agreement may be established, this pattern is dysfunctional, particularly if the planning issue relates to discharge from hospital and the party alienated from the process is required to contribute in some significant way in ensuring the success of discharge. Triadic patterns of communication are most frequently encountered where the medical model of care predominates.

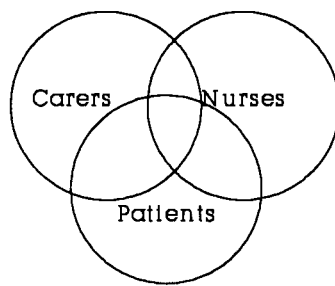
Figure 4.

Dysfunctional Communication - Triadic Type

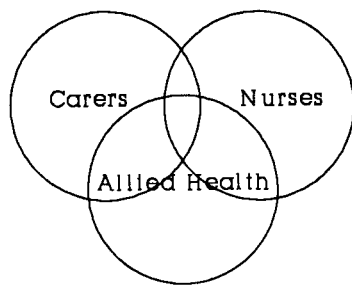
Triadic Communication Process A



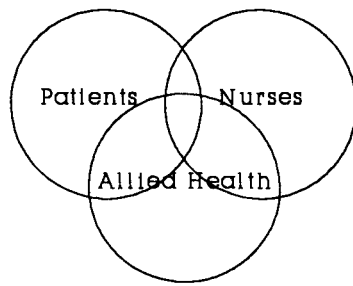
Triadic Communication Process B



Triadic Communication Process C



Triadic Communication Process D



(adapted from Farran, Carr & Maxson, 1988, p.163)

Summary

During the discharge planning period, goal congruity must be established if successful treatment outcomes are to be achieved. The following research uses the theoretical framework described here as a guide to address the research questions for this study. This research study examines perceptions of discharge planning as held by patients, carers, nurses and allied health workers, involved in discharge preparation in the mental health setting, and investigates what effect their perceptions have on the discharge planning process. Results of this study will be examined to determine whether or not goal congruity is established between these groups.

The next chapter details the research design used in the conduct of this study. The setting for the research and the method used for obtaining group samples is described. The development of the instrument used for data collection is discussed and the methods used for data collection and the procedures used for data analysis are outlined. Ethical aspects of this study are also detailed.

CHAPTER 4. METHODOLOGY

Introduction

The purpose of this chapter is to describe the methods and procedures used for the conduct of this research study. This section starts with a description of the research design, followed by an outline of the research setting and sample. Next, the instrument developed for the study is described and the procedure used for data collection summarised. Data collation and methods of data analysis are then described. Ethical considerations are discussed at the end of this section.

Research Design

This study involves the use of an exploratory descriptive research design. This approach is appropriate (Burns & Grove, 1987; Leininger, 1985; Polit & Hungler, 1991), where:

- (i.) little knowledge of the problem exists;
- (ii.) individuals, groups and processes are involved;
- (iii.) poor conceptual background of the problem has been developed;
- (iv.) clarification is required for problems with practice;
- (v.) theoretical models need to be developed.

An added dimension to this study is the use of methodological triangulation, which permits integration of quantitative and qualitative data collection methods, adding strength to the study findings (Cowman, 1993). The use of this strategy is appropriate in

studies such as this where perceptions, ideas and beliefs are being explored and “different viewpoints are likely to produce some elements which do not fit a theory or model” (Jick, 1979, p.609).

Setting

This research was conducted at a major centre for mental health care and treatment in Western Australia. Data relating to perceptions of discharge planning were collected from subjects associated with the three pre-discharge units located within this site. The three units targeted in this study are located immediately adjacent to one another. Each unit is identical in physical structure and the composition of the health care team.

Guiding philosophies for each of these units are consistent with the philosophy of the hospital which includes patient centredness and the provision of quality care. Patient allocation to each of the teams is determined according to a geographic distribution, based on the patient’s residential address therefore, the patient category mix between teams is also similar.

Sample

Purposive sampling was used with a total of one hundred subjects being selected, consisting of twenty five subjects being selected from each of the four target groups. Small sample sizes such as this are suitable where multiple methods and perspectives are used in the evaluation of the issues (Burns & Grove, 1987). As the purpose of the research involved investigation of perceptions of discharge planning as held by those

involved in the discharge process, the groups that the subjects were recruited from and the criteria for inclusion were:

Patient: any person with a psychiatric diagnosis of an affective disorder admitted for treatment to the pre-discharge units of the research site. A history of a least one prior admission was required for inclusion in this research study.

Carer: a person nominated by the patient as a major social support when either hospitalised or discharged from hospital;

Nurse: any nurse (Registered, Enrolled or Student Nurses) involved in the provision of direct nursing care in the target units;

Allied Health Professional: all those (Consultant Psychiatrists, Psychiatric Registrars, Social Workers, Welfare Workers, Occupational Therapists, Psychologists, Pharmacists & Pastoral staff) providing services to the target units.

Once granted approval from the Committee for the conduct of Ethical Research, Edith Cowan University (see Appendix #1), the researcher sought permission to conduct the study from the Hospital Ethics Review Committee (see Appendix #2). Following the granting of approval to proceed with the research (see Appendix #3), the researcher gained access to the research subjects by direct contact with the setting.

Support from nursing services was obtained through telephone contact and personal correspondence. The researcher's pre-existing contacts with the majority of subjects in the units involved in this study assisted in the conduct and facilitated the progress of the research. This research was further supported by the endorsement of senior nursing personnel (see Appendix #4, #5 and 6).

Instrument

The data for this study were obtained by the use of a questionnaire devised by the researcher. A comprehensive and exhaustive search of the literature failed to establish the existence of an instrument specific to this area of knowledge. In order to address the research questions, a questionnaire was developed to assess perceptions held by each group of participants in relationship to various aspects of discharge planning (see Appendix #9). This questionnaire was constructed using the primary factors identified in the literature as the major factors associated with readmission to hospital.

Instrument Validity

Face and content validity of this tool was established by:

- (i.) using items identified within the literature as principal issues associated with hospital re-admission in the construction of the questionnaire items;
- (ii.) review of the questionnaire by experts (nurses, allied health workers, members of carer organisations & ex-patients) known to the researcher.

This review consisted of obtaining comments from representatives of each of these groups, that the questions reflected the topic being researched and that the questionnaire was readable and without ambiguity;

- (iii.) the researcher's own clinical experiences in over 20 years mental health nursing practice and on-going patient contact in the clinical setting.

Instrument Reliability

Reliability of this questionnaire was established via a pilot study conducted prior to the commencement of this research. The pilot study used volunteer subjects who were known to the author and representative of the same groups included in the main study. Four subjects from each of the groups completed this questionnaire. Two weeks later, these same subjects were asked to repeat the exercise. Analysis of the data collected was conducted using *SPSSX[®] for WINDOWS[®]* revealing:

- i. test - retest reliability used Pearson's product moment correlation co-efficient with values of $r = 0.983$ to 0.998 from amongst the four groups. This high correlation of test-retest reliability confirmed stability between the repeated measures.
- ii. internal reliability of test items with Cronbach's alpha coefficient scores around the item clusters ranging from 0.7619 - 1.00 ;

Whilst the samples used in the pilot study were small, this method of instrument development is acceptable in descriptive research, where little is known regarding the topic under investigation (Burns & Grove, 1987) and where specialised groups or subjects are being explored. Further development of the instrument would be required before it could be applied to different settings and the results generalised across different populations. Data collected in this pilot study for the development of the questionnaire were not included in the research study data.

Reliability Analysis

A factor analysis of the questionnaire was conducted using *SPSSX[®] for WINDOWS[®]* and the questions were allocated into 10 subsets or clusters that reflected categorical themes. The factor analysis procedure is the commonly accepted method used when developing instruments that measure variables such as attitudes or perceptions (Burns & Grove, 1987, p.544). This clustering was refined from that undertaken in the pilot study. Reliability of item cluster groups for internal consistency values was re-tested using Cronbach's alpha. Reliability co-efficient values of between .6650 - .9266 were obtained (see Table 1.). A reliability coefficient was not obtained for question cluster 10 (Q.24) as it contained a single item.

The questionnaire contained a short demographic section consisting of five questions followed by a series of 33 statements. A forced choice Likert-type scale requiring a strongly agree to strongly disagree semantic differential response was used. A value of one (1) was assigned for the most positive response up to a value of four (4) for the

most negative response. Forced choice Likert-type scales are desirable where a clear choice between positive and negative responses are required (Burns & Grove, 1987; Polit & Hungler, 1991).

The questionnaire contained an area for comments. The opportunity for comments from the respondents was necessary to establish if there were other issues important to the respondents not covered in the questionnaire. Respondents were also asked to indicate if they were willing to be interviewed. Only those respondents willing to be interviewed were required to identify themselves to the researcher in the appropriate section on the questionnaire.

Table 1.

Reliability Analysis of Statement Clusters

| Question cluster | Question cluster theme | Questionnaire item numbers | Reliability coefficient |
|------------------|--|-----------------------------|-------------------------|
| 1. | Satisfaction with emphasis on access to community supports | 9, 26, 27, 33 | .7141 |
| 2. | Satisfaction with emphasis on developing living skills | 3, 8, 11, 25, 30, 31 | .7348 |
| 3. | Recognition of stress as contributing to re-admissions | 21, 28 | .7587 |
| 4. | Satisfaction with patient education as part of treatment | 14, 16 | .8687 |
| 5. | Satisfaction with carer education as part of treatment | 2, 5, 6 | .7109 |
| 6. | Satisfaction with involvement in discharge planning | 18, 22 | .9266 |
| 7. | Discharge planning an integral and essential part of treatment | 1, 4, 7, 10, 13, 15, 17, 29 | .7825 |
| 8. | Discharge planning an identified component of treatment | 20, 23 | .7841 |
| 9. | Satisfaction with effectiveness of current discharge planning | 12, 32 | .6650 |
| 10. | Discharge planning an unimportant issue | 24 | * |

Procedure for Data Collection

Prior to the distribution of questionnaires and the collection of data, preliminary contact was made with each of the subject groups. This contact consisted of:

- (i.) meeting with nursing and allied health administration on the site and in each of the units to provide an outline of the research project;
- (ii.) distribution by hospital administration of a notice (see Appendix #6) advising all staff of the nature and duration of the project;
- (iii.) informal visits to each of the units to meet with patients and staff to provide information on the project (see Appendix #7), and gain anecdotal information and ideas relating to discharge planning;
- (iv.) formally addressing patient groups and team meetings on each of the units to elicit support.

Following from this preliminary work, one hundred questionnaires were distributed by the researcher amongst the four target groups (twenty five to each group). Respondents were asked to indicate on the questionnaire, if they were willing to participate in a follow-up interview. In all cases free and informed consent was obtained. Potential subjects were canvassed prior to distribution of the questionnaire. In the case of patient participants, a signed consent was obtained from each patient and then approved by the

treating psychiatrist before proceeding with the research. No psychiatrist either sought any information on patients considered for the study nor were there any objections to the inclusion of any patient from whom a signed consent was obtained.

Three respondents from each group were selected on the basis of the types of comments they added to the questionnaire and these were also interviewed as a follow up to the questionnaire. Selection of interviewees was directed to those respondents whose comments introduced new ideas or who provided issues not previously identified within the literature. The purpose of these interviews was to provide a mechanism for checking areas of ambiguity in responses and to permit exploration of the issues. This approach, as a part of the strategy of methodological triangulation was consistent with the conceptual model being used, where an exploration of the expectations or perceptions of those involved in care were being examined. These respondents were thus provided with an opportunity to discuss their perceptions and opinions of discharge planning.

Interviews were conducted utilising a standard question format consisting of a combination of open and closed questions based on the questionnaire itself (See Appendix #10). Focus was directed initially around the comments made by each respondent in their completion of the questionnaire. Interviewees were able to elaborate on these issues and other areas as they wished. Clarification was sought by the researcher on points raised as required. Each interview lasted for approximately one hour, was tape recorded and transcribed into verbatim reports of the interview. All data in this study were collected by the researcher.

Data Collation and Analysis

Prior to analysis, the data were collated, screened and data integrity assessed. As recommended by Tabachnick & Fidell (1989), several measures were used to screen out discrepancies in the data obtained from the responses to the questionnaire. Where missing values were detected scattered throughout the cases and items in the questionnaire responses, mean values for that item were determined from the available data and applied to replace the missing values before the data were analysed. Tabachnick & Fidell (1989) recommend this as method of compensating for missing data without affecting the accuracy of the analysis.

Many missing values were detected in response to item 19 (13 in all), *"I am satisfied that enough priority is placed on locating appropriate accommodation before discharge"*. These missing values were concentrated in the patient and carer categories, with accompanying comments indicative that accommodation was not an issue for many patients who returned to their homes. Reliability analysis with this item deleted changed the reliability coefficient from .7794 to .7825 for cluster group 7. Where items with missing values are not critical to the analysis or are highly correlated with other completed items, deletion of the item is recommended (Tabachnick & Fidell, 1989 p.64). This item was therefore deleted reducing the total number of questionnaire items from 33 to 32.

The first research question - *What are the perceptions held by patients, carers, nurses and allied health workers of discharge planning?* was assessed using the questionnaire (see Appendix #9 - Discharge Priorities Perception Rating Scale), developed for this purpose. This questionnaire provided a means of evaluating perceptions around an established range of issues and permitted respondents the opportunity to identify and address any additional issues that they considered important.

The second research question - *What, if any, significant differences exist in the perceptions of discharge planning between patients, carers, nurses and allied health workers?*, - was investigated through a quantitative analysis of the data using the SPSS® statistical computing package. A oneway analysis of variance (ANOVA) was conducted on the data to detect for statistically significant differences between the groups. Detection of where and between which groups differences existed was achieved using Scheffé's post hoc test using a .05 level of significance.

The third research question - *What effects, if any, do differences in the perceptions of discharge planning perceptions between patients, carers, nurses and allied health workers have on the discharge planning process?* - was addressed through a qualitative analysis of the data. A content analysis of the data was conducted and this consisted of several stages. Comments collected in interview and questionnaire responses were arranged around common themes and issues on the basis of frequency of occurrence with these being enriched with anecdotal comments passed during the data collection. Once organised around common themes, the questionnaires and transcripts of interviews were

examined and re-examined. Organisation of the data in this way allows for the qualitative data to be checked simply (Sandelowski, 1993), and then be used to facilitate corroboration and validation of the inferential analysis of the quantitative data. This utilisation of the methodological triangulation technique has the advantage of strengthening study findings (Cowman, 1993).

Ethical Considerations

Prior to commencing this study, the research proposal was vetted and approved by the Committee for the Conduct of Ethical Research, Edith Cowan University and the Ethical Review Committee of the hospital selected for the study (see Appendix #1, #2 & #3). All participants were fully informed of the purpose and potential benefits of the research and that they were free to withdraw without penalty at any time. The research being non-invasive, was deemed to be risk free.

Respondents to the questionnaire remained anonymous if they chose as there was no obligation to divulge their identity. Only those respondents willing to be interviewed were asked to identify themselves. The identity of these participants was known only to the researcher and in the case of the patient group, the treating psychiatrist who was required to grant permission for patient inclusion (see Appendix #4). This requirement was on the recommendation of the Hospital Research and Ethics Committee as a pre-requisite before permission was given to conduct the study.

All completed questionnaires were held by the researcher and were not made accessible to others. Tapes of interviews were erased once transcribed and interviewees were identifiable only through an allocated code number. The list, completed questionnaires and transcripts of interviews were kept secure and separate. This information continues to be retained securely and in confidence by the researcher. All data gathered for this study is to be destroyed after 5 years by incineration.

Summary

This chapter has described the methods and procedures used in the conduct of this research study. Description has been provided of the setting and the subject groups from which the sample was obtained. The validity and reliability of the instrument developed for data collection was also addressed. Data collection methods were described and the data handling procedures outlined. Finally, ethical considerations in the conduct of the research were discussed.

The following chapter deals with the analysis of the data obtained in this study. These results address each of the research questions. Results of the analysis are presented firstly, by way of a summarisation of the main theme for each section; this is followed by a descriptive and inferential analysis of the data comparing group responses around each of the themes; finally, these analyses are evaluated against interview and questionnaire comments.

CHAPTER 5. RESULTS

Introduction

This chapter deals with the presentation of the results of the analysis of data collected for this study. In investigating perceptions of discharge planning as held by patients, carers, nurses and allied health workers and what effect their perceptions have on the discharge planning process, this study was directed by the following research questions:

- (i.) What are the perceptions held by patients, carers, nurses and allied health workers of discharge planning?
- (ii.) What, if any, significant differences exist in the perceptions of discharge planning between patients, carers, nurses and allied health workers?
- (iii.) What effects, if any, do differences in the perceptions of discharge planning between patients, carers, nurses and allied health workers have on the discharge planning process?

The results from this study are presented as both descriptive and inferential analyses of the quantitative data, in conjunction with a content analysis of the qualitative data arising from transcripts of interviews, questionnaire comments and anecdotal remarks collected in the course of the study. The analysis of the data follows, with a presentation of findings in relation to the stated research questions.

Questionnaire Responses

A total of one hundred questionnaires were distributed between each of the groups.

Eighty-two questionnaires were returned, giving an overall rate of return of 82%. The response rates for the return of these questionnaires (see Table 2.) was high, with nurses having the greatest ($n = 22$), and health professionals the lowest ($n = 18$) rate of return.

Table 2.

Return Rates

| Group | | n | Rate (%) | Overall (%) | % of Total |
|----------|--------|-----|----------|-------------|------------|
| PATIENT | Male | 11 | 52 | 84 | 26 |
| | Female | 10 | 48 | | |
| CARER | Male | 7 | 35 | 80 | 25 |
| | Female | 13 | 65 | | |
| NURSE | Male | 9 | 41 | 88 | 27 |
| | Female | 13 | 59 | | |
| A/HEALTH | Male | 6 | 33 | 72 | 22 |
| | Female | 12 | 67 | | |

Prior to the analysis of the data, one patient questionnaire was discarded reducing the patient group response rate from 88% to 84% ($n = 22$ to $n = 21$). This questionnaire was returned with all item responses marked 2 (agree). Comments accompanying this questionnaire; “Just agree with whatever you are told. There's no point doing anything else.”, indicated incongruity between the questionnaire responses and the accompanying

comments. To preserve the integrity of the data, it was considered acceptable for this questionnaire to be deleted (Tabachnick & Fidell, 1989, p.64).

Sample Characteristics

No uniformity in the distribution of gender (see Table 3.), either overall or between groups, was observed, with the majority of subjects being female ($n = 48$).

Table 3.

Characteristics of Respondents

| Group | | Mean Age (yrs) | Age SD | Mean contact time (yrs) | Yes to Interview |
|----------|--------|-------------------|--------|----------------------------|---------------------|
| PATIENT | Male | 37.3 | 6.37 | 3.8 | 5 |
| | Female | 35.8 | 7.45 | 3.6 | 6 |
| CARER | Male | 35.9 | 5.86 | 3.4 | 3 |
| | Female | 44.9 | 9.63 | 4.6 | 6 |
| NURSE | Male | 37.8 | 8.54 | 6.0 | 3 |
| | Female | 35.0 | 6.32 | 5.8 | 5 |
| A/HEALTH | Male | 46.0 | 7.96 | 6.3 | 3 |
| | Female | 38.0 | 5.68 | 3.3 | 7 |

The subjects showed some similarities in age and length of time associated with the hospital. Subject ages ranged from 18 to 71 years with a mean age of 38.7 years ($SD = 10.4$). The length of time subjects had in contact with the hospital ranged from 1 to 12 years with a mean period of contact of 4.5 years ($SD = 2.9$).

Evaluation of Discharge Planning Perceptions - Group Responses

This study investigated the issue of perceptions of discharge planning held by those involved in discharge preparation in the mental health setting. The first research question - *What are the perceptions held by patients, carers, nurses and allied health workers of discharge planning?* was addressed using the Discharge Priorities Perception Rating Scale (see Appendix #9). This instrument permitted evaluation of perceptions around an established range of issues, and provided respondents the opportunity to identify and address any additional issues that they considered important. The categories consisted of:

- (i.) importance of discharge planning
- (ii.) community supports
- (iii.) living skills
- (iv.) stress
- (v.) patient education
- (vi.) carer education
- (vii.) involvement in discharge planning
- (viii.) discharge planning in treatment
- (ix.) discharge planning progress
- (x.) effectiveness of discharge planning

ANOVA was utilised to examine the data to answer the second research question -

What, if any, significant differences exist in the perceptions of discharge planning between patients, carers, nurses and allied health workers? This procedure detected for statistically significant differences between the groups in their mean responses to these categories. Determination of where and between which groups differences existed was achieved using Scheffé's post hoc test at a .05 level of significance.

Themes and issues identified by way of a content analysis of the written questionnaire responses, interview transcripts and anecdotal comments, was used to corroborate and validate the inferential analysis of the quantitative data. This technique facilitated the exploration of the third research question - *What effects, if any, do differences in the perceptions of discharge planning perceptions between patients, carers, nurses and allied health workers have on the discharge planning process?*

The results will now be presented with firstly, a summarisation of the main theme for each section; this will be followed by a descriptive and inferential analysis of the data comparing group responses around each theme; finally, this analysis will be evaluated against interview and questionnaire comments.

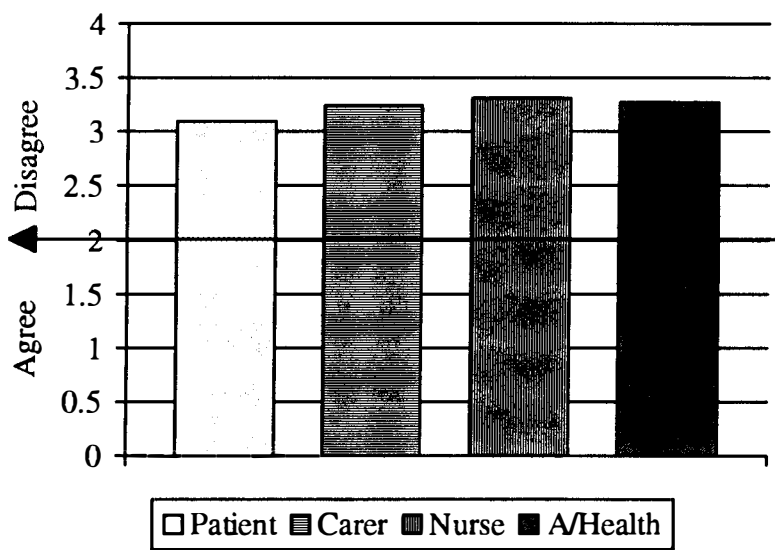
Perceptions Relating to the Importance of Discharge Planning

Item 24 on the questionnaire was a statement that "Discharge planning makes no difference to the success of treatment". This attracted a uniformly disagree to strongly disagree response from all respondents, acknowledging that discharge planning plays an

important part in the return of patients to the community (see Figure 5.). There was universal agreement within and between groups regarding the value of discharge planning and no statistically significant differences, $F (3, 77) = 0.64, p > .05$, were observed between the groups to this statement

Figure 5.

Importance of Discharge Planning



Although agreement existed between all groups regarding the importance of discharge planning, the content analysis revealed that a certain lack of accord existed within and between groups concerning the interpretation of what constituted discharge planning and who should be involved in this process. Patients and carers frequently expressed comments around common themes relating to the importance of being made aware of discharge planning and the desire for greater involvement in the preparation for discharge. Concerns were raised by these groups that they did not have a clear

understanding on when discharge planning commenced and how they could be involved in the process. This concern was typified by one carer who stated

I'm not sure what is meant by discharge planning, but I assume it means that careful consideration is given to the patient's needs before they are discharged from hospital. That would be sensible so I think that it [discharge planning] is very important. I must confess however, that apart from that pamphlet in Admissions, no-one has discussed anything with me or [wife's name] about going home or what will happen before she goes home. No-one has spoken to us about it yet. (Carer 3).

Whilst discharge planning was viewed by all groups as an important part of treatment, a psychiatrist with extensive experience in community psychiatry had an extremely clear understanding and views on treatment and care. This person expressed firmly and succinctly the view that discharge planning was:

Only a part of good psychiatric management. Integrated in/out patient teams, with GPs, support groups, families etc... and adequate housing and rehab options are needed. I wouldn't even call it discharge planning, its just a planned phase of treatment and involves transfer to the community and management in the community (Psychiatrist 1).

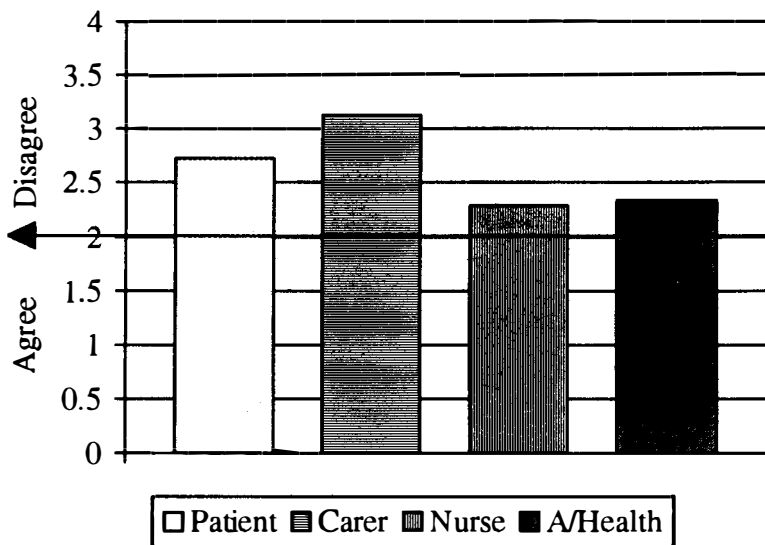
Perceptions Relating to Community Supports

The theme for this question cluster related to perception of the community support focus in the discharge planning process. Mean responses from all groups (see Figure 6.), indicated disagreement between groups. ANOVA detected statistically significant

differences, $F(3, 77) = 19.10, p < .001$, between the groups with Scheffé's post hoc test revealing that the patient and carer groups differed significantly from the nurse and allied health groups. Evident from the content analysis, was that each of the groups had differences in perceptions regarding what are priority issues in community care and where effort should be placed relating to the quality and availability of information on community supports.

Figure 6.

Community Support Focus



Nurses and allied health workers disagreed over their understanding of the types of community supports available. One nurse clinician objected that other health team members refused to share knowledge about community supports and services, complaining that this was a type of job demarcation, stating::

I've had this fool of a man [*reference to Social Worker 2*] on my case a few times because of suggestions I've made regarding several patients who I case manage. I

have assessed these patients both in hospital and the community and have made recommendations regarding their management based on my clinical judgement. It's not that I am unaware of the services they require. I mean, I've worked community in the inner city area. I know what's out there. This turkey hasn't got a clue, but waffles on about *role boundaries, coordination of welfare services, preserving community resources*. What's worse, is that Nursing Admin gets hot under the collar about this when Social Welfare complains. With this arguing about who does what, the patients don't get a fair shake (Nurse 10).

A similar position was reported anecdotally by a psychologist who stated:

Listen. If a social worker can conduct family counselling, I should be able to make referrals to community agencies. I can't see how its going to cause the destruction of community services for me to deal direct with different groups concerning the patients I see. Sure I can go through the appropriate channels, but this always takes more time and doesn't get things done when they need to be done (Psychologist 1).

Although all the mean responses indicated an overall level of dissatisfaction with the emphasis place on developing community supports in the discharge planning process, it was the carer group that expressed most concerning an overall lack of knowledge of what services existed in the community and who complained of the failure of health professionals to suitably inform them. Several carers stated that they had learnt of community resources from other carers and felt that better communication was required between themselves and the health professionals.

I felt my son's behaviour was my fault. I thought I was a bad mother, his illness was my fault. You know. I didn't think that I had done a good enough job in

raising him. I really needed to talk to someone who had gone through this like me. These people in hospital [health workers] don't know what it's like. When I asked about groups that could help, they didn't know much at all. I spoke to another mother in the kiosk, she has a boy with schizophrenia. It was her, she told me about ARAFMI [Association of relatives and friends of the mentally ill]. They've really helped me understand about me and my son. Why couldn't the hospital do that? (Patient 5's Mother).

Written comments, and interviews with patients and carers identified many similar themes that related to a lack of knowledge of community services (both formal and informal). Many respondents from these two groups expressed that they were unsure of the type of follow-up attention that would be provided in the community, that they lacked specific information and felt that there was poor preparation for discharge from hospital.

Perceptions Relating to Life Skills Development Focus

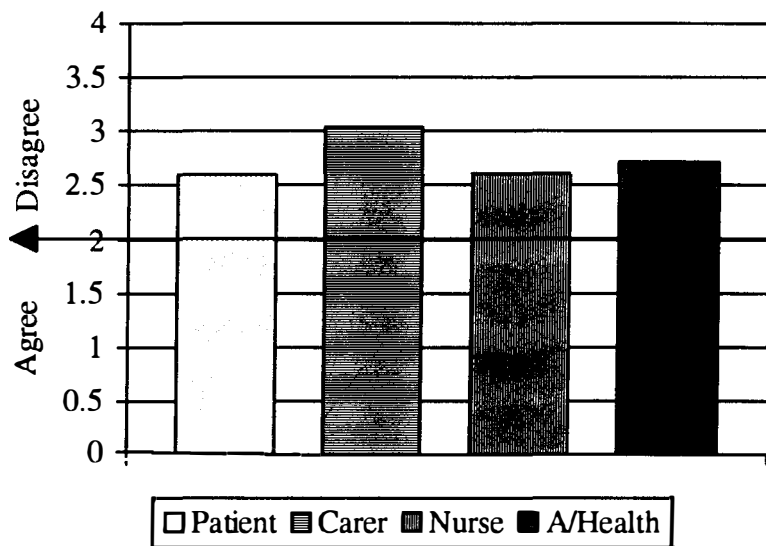
The theme for this category related to perceptions of the emphasis placed in the discharge planning process on developing adequate living skills. Mean responses from all groups (see Figure 7.), showed general dissatisfaction around this issue, with overall agreement between and within the groups regarding the inadequacy of life skill preparation prior to leaving hospital.

Whilst all groups were dissatisfied, the carer group expressed the greatest dissatisfaction, an observation supported by the inferential analysis of the data, with ANOVA revealing statistically significant differences, $F(3, 77) = 7.92$, $p < .001$, between the groups

and Scheffé's post hoc test identifying that the carer group differed significantly from the patient, nurse and allied health groups.

Figure 7.

Life Skills Development Focus



All groups were in agreement that it would be appropriate for discharge planning to focus on developing living skills, but was consensus that existing planning was ineffective in this area. Deficits in the preparation of individuals for return to the community were viewed as major contributing factors in readmission of patients.

Carers were especially at odds with both the nurse and allied health groups regarding the reality basis of life skills preparation. This concern was amplified in the comments of one carer, the husband of one of the patients. He expressed anger and frustration when recounting the experiences of his wife. His expectations were not in keeping with those

that were held by the health care workers. His wife, was in his eyes, being treated like a child and not adequately being prepared for return home. He spoke of a lack of reality in the activities offered by occupational therapy and felt that these in fact added to his wife's loss of self esteem.

My wife can cope and I help out as much as I can, but she's doubting herself so much now. When she was in hospital last time, she was given rehabilitation. What a joke. She complained about sitting around talking about items from the newspaper, doing childish games and going out on walks. She said they went down to the beach one day and it was so obvious they were from the mental hospital that she wouldn't get off the bus. She says that the relaxation groups helped but they were for half an hour twice a week. My wife is an intelligent capable woman. She needs to be involved in real adult type activities, she'd like to gain skills in things like computing - Christ that's what kids are doing and she's doing kids things. I don't think they're real down there. (Patient 7's Husband)

Health workers supported some of the comments raised by the carer group in expressing doubts about the appropriateness of hospital based programmes. Individuals from this group shared the view that patients should be appraised in their home environment to determine their needs and assess their functioning.

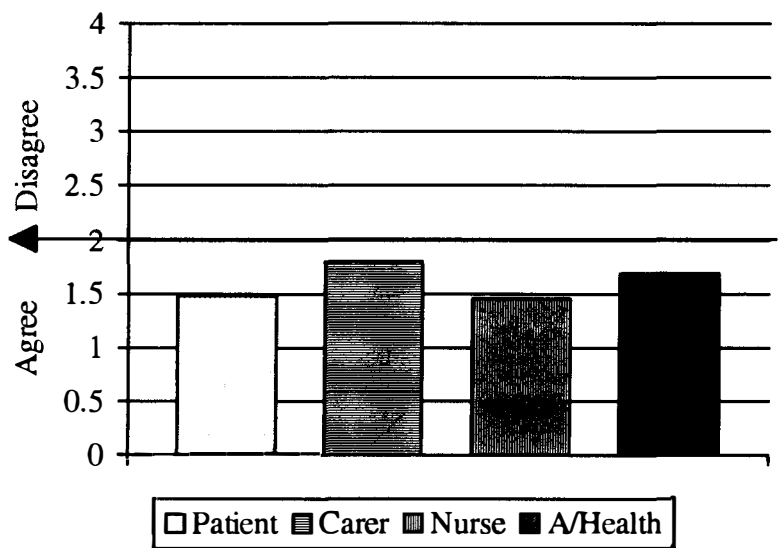
Perceptions Relating to Stress & Stress Management

Perceptions relating to the importance of stress management in the discharge planning process were the main themes covered in this category. All groups were in agreement this in the content analysis of comments from interviews and questionnaire responses, that greater emphasis needed to be placed on stress management. ANOVA revealed no

statistically significant differences, $F (3, 77) = 3.16, p > .05$, between the groups regarding this (see Figure 8.).

Figure 8.

Stress & Stress Management



Themes from the patient and carer groups related to the inadequacy of stress management education provided to patients in hospital prior to discharge. This concern is exemplified by the comments from a patient with an established pattern of frequent readmissions:

Mountains become molehills if you can see around them. When you're stressed, it's the other way around. I've sometimes been so pressured by little things that the big things seem impossible. I'm sure I could handle the big things if someone could let me get past these little fellas. That's when things start to fall apart. I know its happening but I can't do anything to help it. Once I contacted the hospital and they

told me to contact a clinic. I contacted the clinic and they told me I'd have to wait for a week for an appointment. I was readmitted two days later. (Patient 8)

Failure on the part of nurses and allied health workers to recognise needs deficits in patients, frustrated several carers. It seemed to some carers that patient attendance in therapeutic activities was optional and that patients seemed to spend large amounts of time doing nothing. They reported a general acceptance on the part of health workers and nurses in particular that patients were not being given enough encouragement to participate in constructive activities.

If you've got a pre-existing condition which affects your ability to deal with day to day life events, anything outside of the ordinary is a problem. My son is not stupid, but when he's been ill, he needs time and patience just to get by. Because he has difficulty in speaking up for himself, which I'm told is not unusual with mood disorders, he doesn't get to attend those groups which would help him deal with stress. Surely it's the job of the doctors and nurses to recognise this sort of thing, why should it be up to him. (Patient 12's Father)

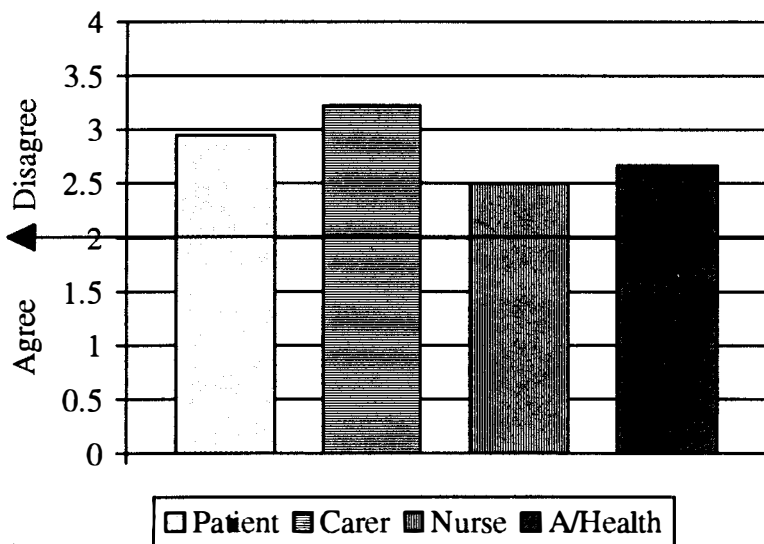
Similar themes were expressed by respondents from the nurse and allied health group, in that little or no effort was directed towards developing appropriate stress management skills in patients and that stress management should have a higher priority in treatment. No specific suggestions were offered as to how this could be achieved, although several respondents suggested that stress management programmes would be more appropriate if offered as part of continuing community care as out-patient treatment rather than a treatment focus prior to discharge from hospital.

Perceptions Relating to Patient Education

The theme for this category related to patient education. All groups were in agreement that education of patients prior to discharge as important, but they were dissatisfied with the education provided to patients whilst in hospital, in particular, their knowledge of their illness and medication education (see Figure 9.). ANOVA discovered statistically significant differences, $F(3, 77) = 5.46, p < .01$, between the groups with Scheffé's post hoc test revealing in this instance, that the carer group differed significantly from the nurse group.

Figure 9.

Patient Education



The issue of patient education was perceived similarly by each of the groups as relating to education of patients about their illness and its treatment. Overall, each of the groups were critical over the level and focus of patient education in hospital, with overall

agreement indicated from the responses that patient education is unsatisfactory. The carer group raised additional concerns that related to safety in the amount of education provided patients with several expressing either explicitly or implicitly that it was dangerous in discharging patients with lethal cocktails of drugs without ensuring adequate medication education

She's got a box full of pills in her bedroom. Some from here, others from the clinic. There's lots of different colours and names that sound like Eastern European countries for all I know. She never seems to know which ones she should be taking and I'm no help cos don't know anything about them. I don't know if her restlessness is her problem coming back or those pills. One of the patients told her that pills can do that, so now I don't know if she should take them or not, I mean er... which is worse. I once asked the doctor about it, you know, should she take them and the doctor got real dirty on me, he was real touchy and I think he thought I was an anti-psychiatry nut. Anyway, it's still not right, they [health workers] should make sure all the family know what's going on (Sister, Patient 3).

While carers viewed nurses as being responsible for medication education for carers and for patients, nurses' views of medication education centred on ensuring compliance in hospital and shifted responsibility to patients and community nurses on discharge from hospital. Several nurses stated that were frustrated in their attempts to establish medication awareness programmes, but in the one area where a family education programme had been commenced, there was support for this type of service.

Occupational therapists were seen by the health care team as having the greatest role in patient education and nurses, surprisingly, despite having the greatest access to patients also affirmed this. A common concern expressed by nurses and allied health workers, was that, regardless of who was responsible for patient education, some mechanism was required to ensure that patients were not only educated, but importantly, that patients were assessed as to their understanding. This was summed up in comments by a social worker:

The doctors and everyone says *Look, I've told them* but I really question whether they tell a patient at a time when they're able to take in that information and to be able to think about it and to be able to come back with some sort of informed impression. I mean, some patients clearly have been told but they're not in a state to be able to absorb the information or really make sense of it. (Social Worker 1)

Perceptions Relating to Carer Education

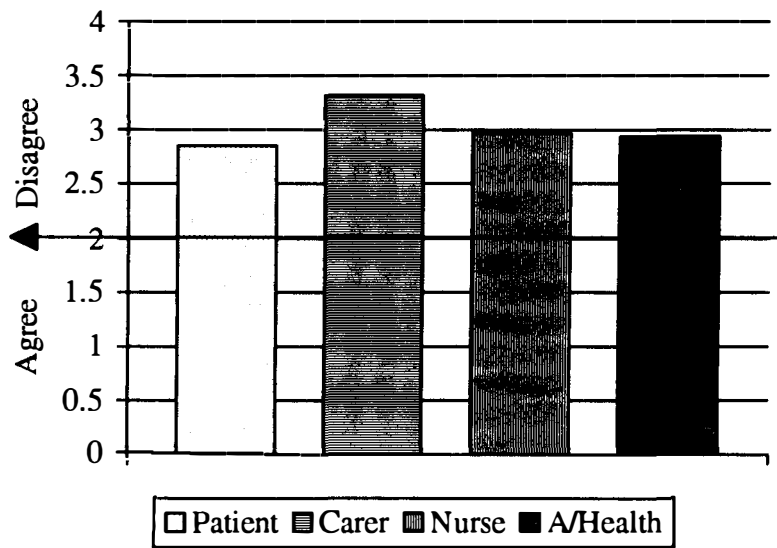
The theme for this category related to carer education in the discharge planning process. ANOVA detected statistically significant differences, $F(3, 77) = 3.72, p < .02$, between the groups with Scheffé's post hoc test revealing that the patient and carer groups differed significantly from one another, and, as with the issue of patient education, all of the groups were dissatisfied with the amount of emphasis placed on this aspect of discharge preparation (see Figure 10.).

Whilst acknowledging the value of carer education, few health professionals and nurses took the time to elaborate on this aspect of discharge planning other than to commend

the role of the carer. Many carers however stated the desire to become more involved in the planning of care and discharge process, and saw education programmes as an opportunity for this to occur, but did not see any opportunity to become more actively involved.

Figure 10.

Carer Education



Many allied health workers respected the important role that carers play in supporting patients once they returned to the community, but did not see the institutional setting as an appropriate location for on-going involvement with the family. This position was supported by a community mental health nurse who saw the role of the community health clinic as being more able to meet needs in this area:

When the patient is hospitalised, this is a period of turmoil for the patient and the family, and the hospital treatment focus is directed towards resolution of this

particular crisis. If community nursing contact can be maintained during this time, then on discharge, issues that contributed to the readmission can be dealt with between clinic staff and the family unit. Continuity of care, the building of trust and long term therapeutic relationships where meaningful activities such as education can occur are important. This depth of care is generally not available within the hospital setting and is best offered in the community clinic (Community Mental Health Nurse 1).

The community nurse tempered this statement by acknowledging this description as an ideal and this did not occur in practice. Constructive comments were offered by a registered nurse who reported on a carer education group that had recently commenced on his unit. This group was scheduled to run for six nights over a period of six weeks with topics being structured e.g. symptom of illness, medication awareness, information about caring for the patient at home and so on. This nurse stated that relatives had been a little reluctant to participate but at the end of the six weeks felt it was worth it. He suggested that similar groups should be provided for the patient.

A respondent from the allied health group expressed some cynicism about the ability of carers to effectively deal with even low level education complaining that despite providing patients and carers with information, that they failed to understand and he found himself constantly having to repeat the exercise, a complaint also identified by other health care workers. This issue was also addressed by a student nurse who commented that he didn't think that either patients or carers were managed appropriately regarding education as they often expressed lack of understanding of even basic issues. The student saw failure to comprehend as a problem owned by the health professionals

and not the patient or carers, exemplifying this by criticising the timing of when information or education is given, stating:

I think a lot of that information is given at the wrong time, even like with patient rights - when a patient arrives in the hospital, they're given a pamphlet with their rights that say *This is what you're entitled to, this is for* you know, but how many of them can really understand. And then they're supposed to hold on to that bit of paper, I really wonder. (Student Nurse 1)

Patient responses to this topic varied. One patient was quite guarded about how much power his daughter might have over him if she became too involved in his care. Another expressed concern about how his mother really needed to understand about his medication:

Perhaps if she could attend the med ed [*medication education*] group too. It might help her 'cos she thinks I'm addicted to these drugs. You know she can really hassle me and well we didn't get on too well at the best of times.....and I can really lose it.....well I think it would help her anyway....(Patient 5)

Perceptions Relating to Involvement in Discharge Planning

This category dealt with perceptions on involvement in the discharge planning process.

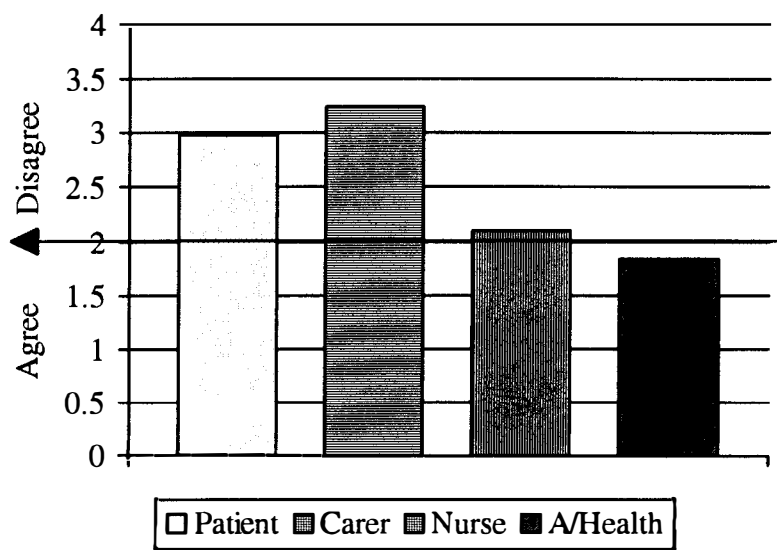
Mean group responses in this category showed some polarisation in the differences between groups (see Figure 11.), with ANOVA revealing statistically significant

differences, $F(3, 77) = 18.74$, $p < .001$, between the groups with Scheffé's post

hoc test revealing that the patient and carer groups differed significantly from the nurse and allied health groups.

Figure 11.

Involvement in Discharge Planning



Overall, nurses and allied health workers indicated satisfaction in response to this issue, in that they had both the opportunity for, and active involvement in the discharge planning process. Some junior nurses dissented, and expressed the desire to be more actively involved in discharge planning for the patient, but felt that organisational needs interfered with their ability to follow-up with patients, this being illustrated one nurse:

I may have spent a considerable time on developing rapport with patients and their families, only to see my efforts wasted by being arbitrarily moved by nursing admin when there is change of roster or if there is a shortage in another unit. This doesn't happen to any other member of the team. They at least have the opportunity to

plan for and gradually pass their patients over when leaving an area. We [nurses] are expendable and our therapeutic relationships are considered unimportant. If this is the case, I suppose you could consider then that the patient needs aren't worth much either (Nurse Clinician 3).

A higher level of involvement was also a priority issue from the viewpoint of patients and carers. Patients wanted to have more say in what happened to them and they frequently expressed feelings of being powerless.

Its really odd. How would you feel? Have you ever had really important things done without being involved? No... er... I mean they [*health workers*]... they are running my life and don't even ask me about it. (Patient 7)

Many carers felt that patients were not given the opportunity to be responsible for themselves whilst in hospital and then were unable to cope on discharge. Often, carers complained that when they attempted to seek greater involvement in the planning of care that they and their wishes were ignored, and they were made to feel as if they were interfering. A common theme expressed by this group was on the amount of consultation they had with allied health workers and how difficult it was to make contact with medical staff and in particular, psychiatrists.

I know that they [*health workers*] are busy, but you wouldn't believe how difficult it is to get a hold of his psychiatrist. This guy only works part-time and is never available. I get messages passed by several different people, you know, from his other doctor and the nurses but it's not good enough. I want to talk about

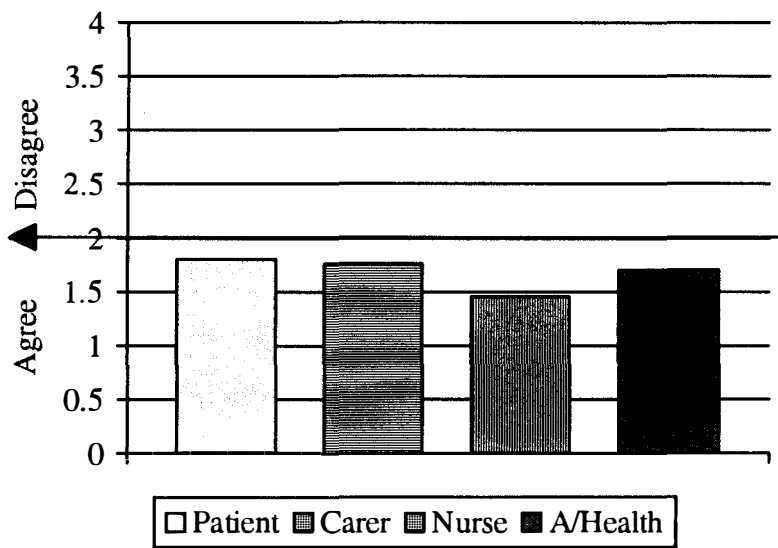
different things with the person in control of [son's name] but it's impossible.
(Carer 7 - Patient 12's father)

Perceptions Relating to Discharge Planning in Treatment

The questions in this group addressed issues associated with the value and place of discharge planning in the treatment process. Agreement existed between all groups (see Figure 12.), in that discharge planning should be an integral and essential part of treatment. ANOVA discovered statistically significant differences, $F(3, 77) = 3.98$, $p < .02$, between the groups with Scheffé's post hoc test revealing that only the patient and carer groups differed significantly from one another.

Figure 12.

Discharge Planning in Treatment



All groups agreed that discharge planning was an important part of hospital treatment and should start on the admission of the patient. Moderately strong levels of agreement were expressed that the process should involve all relevant parties and should help in reducing the number of readmissions to hospital. A degree of incongruity was demonstrated around this issue, as despite accepting that all should be involved in planning, involvement took on a passive meaning. One respondent, a student nurse, verbalised what many other health workers had alluded, stating that the nurses' role in discharge planning was one of *telling* the patient what he/she needed

It [*discharge planning*] has got to be the most important issue in caring for the patient. I mean, what's the point in getting the patient well enough to leave without making sure that he's going to survive in the community. It's our job to ensure that the patient has the best chance. (Student Nurse 1, a second year student).

This person viewed the process as a benign paternalism, with patients and their families looking for direction from the health care team. This paternalistic attitude was prevalent amongst many of the health professionals. Psychiatrist 1 saw discharge planning, not as a separate issue, but as an essential part of treatment. This person that, in practice, this was not a view shared by her colleagues.

It was agreed that factors contributing to hospital admission should be identified and addressed as part of the discharge planning process, but this, according to issues raised by several patients, was not always the case in practice. One patient who had several admissions over a one year period, and who was interviewed recounted her experience.

Each time she was discharged, she returned home where she lived alone with few social contacts. Her access to public transport was limited and she experienced difficulties in attending the regional community mental health centre. She said that she mentioned her concern in hospital to several nurses, the social worker and at home to the community nurse who visited but they showed little interest. She said with some emotion that she felt that she would not last long out of hospital again.

When I was in hospital last time, I didn't know anything about... you know... the aftercare nurse. When I went home, this person... nurse... turned up at my house to check on me. Well he seemed OK. but he didn't know anything about me. He started talking about my injection and I got a bit worried cos I'd stopped them in hospital. He had to use my phone to check with the clinic... he'd been looking at my old record. He gave me a card to visit the clinic to see the doctor there and it was a different doctor to the one I'd seen before but they'd already booked me in and couldn't change it. I felt a bit upset 'cos I trusted the other doctor. (Patient 3)

This patient expressed that she felt the discharge preparation she had received for return to the community lacked emphasis on developing appropriate community resources to assist her on her discharge from hospital and that her concerns had been ignored. Her views were similar to those expressed by others.

Dissenting views were also expressed by the carer group. Their comments focussed around themes such as a failure on the part of nurses and health professionals to adequately consult with them and investigate the issue effectively. One area of concern related to health professionals not seeking corroboration from carers over the accuracy

of patient information relating to readmission to hospital. Carers expressed a fairly uniform view that discharge planning should be given great attention but experience has told them this is not the case. Carers voiced how they experienced great difficulty in obtaining decisions from anyone, angry at the lack of concern about their feelings and overwhelmed by feelings of powerlessness. One experience provided an example:

Discharge planning? What a joke. My son suddenly arrived on my door step with a bag a medicine and no idea what to do. I went to the hospital, I told the nurses and the doctors and the social people that my flat was no good a place for my son to live... he's awake half the night... the neighbours complain... we argue... he threatens me... what do they want me to do. He's my son, I want to help but they [*hospital staff*] think they know everything [*tearful and angry*]. Let them come and live here. (Patient 5's Mother)

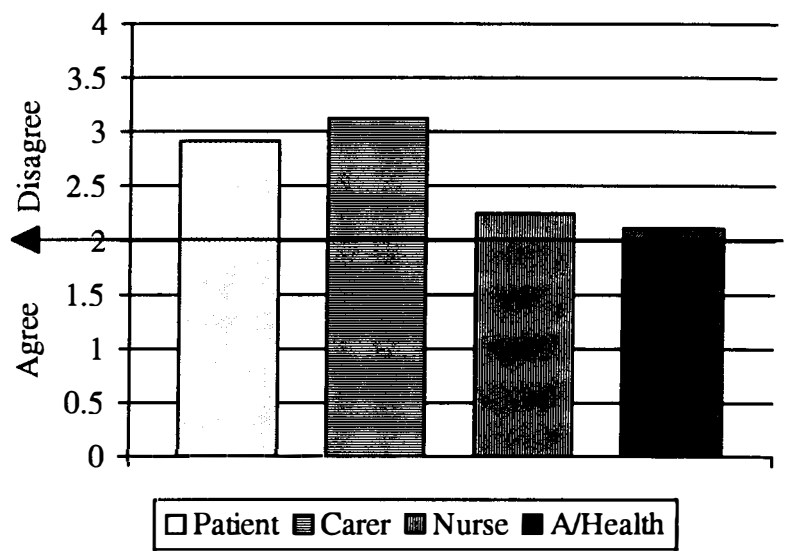
Perceptions Relating to Evaluation of Discharge Planning Progress

The theme for this category related to perceptions of the evaluation of progress in discharge planning in treatment. Patients and carers responses were largely negative around this cluster(see Figure 13.), while nurses and allied health workers expressed more favourable responses. There was a general feeling from these two groups that, although there might be imperfections in the process, that the process was clearly identified as a component of treatment.

ANOVA revealed statistically significant differences, $F(3, 77) = 9.07$, $p < .001$, between the groups with Scheffé's post hoc test revealing that the patient and carer groups differed significantly from the nurse and allied health groups.

Figure 13.

Evaluation of Discharge Planning Progress



Nurses and allied health workers, medical staff in particular, felt that documentation in the notes was evidence of discharge planning as a part of treatment, that team meetings always addressed discharge planning needs of patients and that this constituted an evaluation of progress towards this goal.

One occupational therapist with a total of 10 years experience in the mental health setting dissented from this view and expressed extreme frustration at being unable to carry through with plan of action that had been decided between the team and the patient. Her views were consistent with those of other health care workers and were critical of the medical model of management that predominates in this setting. She complained that decisions are made about the patient without consultation with the

patient and yet the patient is seen at fault for failing to comply with expectations. In describing the following incident, she was exemplifying what has happened to her frequently in her clinical experience.

For example, you find out that following a team meeting that your patient you would be assured would be discharged in two weeks, has been discharged in two days. If at the meeting it has been decided, on clinical grounds, that the person should stay in hospital for two weeks, and that clinical decision is overridden by some form of administrative decision? Sometimes it's pressure for beds, or accommodation, you know, like there are a number of factors, it's not usually one identified [tapers out lost for words]....(Occupational Therapist)

These types of examples were also given by other health professionals. While there was criticism of the medical model, surprisingly, it was a psychiatrist who complained that she was forced to make autocratic decisions because administrative and organisational needs of the hospital overrode her clinical concerns, stating that:

discrepancy between the ideal situation and what actually happens I think, represents the different approaches of the different teams within the hospital. When pressure is on to increase patient throughput, it's often a case of risk assessment. Those patients deemed lowest risk can be managed outside the hospital in clinics (Psychiatrist 2).

Carers perceived a disjointed picture of the evaluation of progress in discharge planning. Comments were critical, that there seemed to be no clear plan of treatment let alone a direction towards discharge. Patients generally expressed feelings of powerlessness, that control of discharge planning was externalised, where they were told what would

occur and then only just before it happened. Comments expressed by patients frequently related to the suddenness in discovering that they were to be discharged from hospital.

The first time I heard about discharge planning was when I was told by [*nurse*] that I would be going home. I had to call [*husband*] and let him know. He was a bit surprised. I mean, I had asked several times about going home but they all said [*health care team*] that it probably wouldn't happen for a while. (Patient 12)

One of the hospital Chaplains expressed considerable concern about this issue. He found himself performing a counselling role for many patients who experienced what he referred to as a “discharge crisis”, agreeing that this example provided by this patient was not an isolated case. The Chaplain also confirmed that he was frustrated in conveying his concerns to the health team responsible for treating patients, as they considered his views as relating only to pastoral care, and as such are given low consideration:

In all my years of dealing with psychiatric patients, it has been a great source of frustration to me that this situation has not changed to any great degree. The chapel being so close to the wards provides a sanctuary and I frequently see many patients who are suddenly faced with the prospect of leaving hospital and this causes them great anxiety. (Chaplain 1).

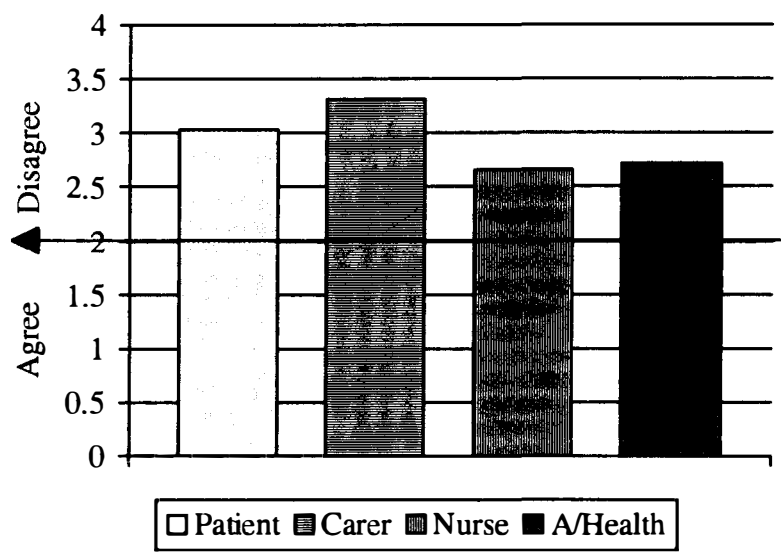
Perceptions Relating to Effectiveness of Discharge Planning

The theme for this category related to perceptions regarding the effectiveness of the existing discharge planning process. The mean response from all groups (see Figure

14.), indicated overwhelming dissatisfaction in this area. ANOVA detected statistically significant differences, $F (3, 77) = 5.19, p < .02$, between the groups with Scheffé's post hoc test revealing that the carer group differed significantly from the nurse and allied health groups.

Figure 14.

Effectiveness of Discharge Planning



Nurses and allied health workers were concerned that discharge planning should be structured and focussed, but conceded this was an ideal. Comments from these groups addressed issues such as failure to communicate, lack of staff continuity, lack of coordination as a whole, administrative difficulties, the influence of external factors, pressure on beds, lack of power of individuals in the team as reasons for their dissatisfaction. These factors were frequently cited as contributing to the ineffectiveness of the discharge planning process as a whole. The extensive written comments from one

social worker were not only critical of discharge planning, but actually attacked almost all the other members in the health care team. These comments were the most frank expression of the undercurrent of dissension that was implicit in many of the questionnaire responses and in particular, the interviews conducted with nurses and allied health workers:

Whilst I as an allied health professional have the necessary mandate to be involved in discharge planning, this is very frequently hindered by medical staff by:- not consulting; not being aware of options; not being aware of time and effort involved in linking clients and resources; clients being discharged prior to any plan being implemented. Unskilled staff making piecemeal referrals without consultation with social work or O.T. who are trained in a process to fully access needs from a systemic perspective which includes client, family and community needs. (Social Worker 2.)

Patients although not satisfied with the discharge planning process, expressed concerns directed towards the length of stay in hospital and the frustration of being unable to plan their lives. Newer patients felt that discharge planning was important but that the professionals should know their jobs, whilst those patients with greater contact preferred not to make waves. Carers were consistent in their criticism of this topic as they had been with all aspects of discharge planning and their concerns were strongly expressed around a unanimous vote of no-confidence in the discharge planning process and practices employed by this hospital.

Summary

This chapter presented the results of the analysis of the data collected in this study. This study sought to investigate perceptions of discharge planning as held by patients, carers, nurses and allied health workers and examine what effect their perceptions had on the discharge planning process. The research questions sought to investigate what perceptions of discharge planning were held, if differences in perceptions existed and how perceptions effected the discharge planning process.

The questionnaire developed for this study provided a means to evaluate perceptions regarding discharge planning as held by patients, carers, nurses and allied health workers, involved in discharge preparation in the mental health setting. A one-way analysis of variance of the mean responses by each group to the ten topic categories detected for statistically significant differences between the groups and Scheffé's post hoc test was used to identify specific area where differences existed. Differences between the groups were amplified using a summary of the main themes arising out of the content analysis of the qualitative data.

Evidence has been provided, in response to the research questions directing this study, that perceptions of discharge planning do in fact vary across the different subject groups. Significant differences were observed in the perceptions that patients, carers, nurses and allied health workers have of discharge planning and the issues involved in this process. These differences in perceptions were identified as being contextual and relating to the role that individuals have in the hospital setting.

Poor communication and limited collaboration within and between the groups was reported, with patients and carers, in particular, complaining of a lack of any constructive influence in the decision making process regarding discharge planning. Ineffective levels of communication and collaboration were reported by health professionals as contributing to the ineffectiveness of discharge planning, resulting in unnecessary readmission of patients to hospital, a feature concurred with by carers and patients.

Conflict between health team members was reported and observed, with this conflict being related to the interdiscipline competition and the medical model of management that predominated in this health care setting. In this model the psychiatrist is perceived as the leader of the team, having a controlling influence on the overall aspects of patient management, and this was viewed negatively by other team members, nurses, patients and carers.

Many of the respondents to this study expressed concern that the services offered in the public mental health system were inadequate, superficial and in the long run contributed to many of the problems faced by the persistently mentally ill. Concern was expressed that too much emphasis was placed on the provision of institutional services from the health provider perspective and not enough focus directed to the return of patients to the community from the carer and patient perspective. Patient centred care was perceived by many respondents from all groups as being subservient to the needs of the institution,

again, being viewed as contributing to poor discharge planning practices. Improved levels of patient advocacy by way of patient centred care was viewed by many as a constructive way of dealing with the perceived deficits in the discharge planning process.

Evident from the analysis of the responses to the questionnaire and the subsequent interviews, was that each of the groups involved in the care of the patient is not necessarily involved in the planning for the discharge of the patient. Patients and carers in particular lack confidence in those providing treatment and care and this lack of involvement in the discharge planning process is viewed as contributing negatively to the effectiveness of the discharge planning process and the unnecessary readmission to hospital of many patients.

The next chapter deals consists of a discussion of the results of this analysis in the context of the theoretical framework used to guide this study. The study findings will be related to the literature on this topic, addressing strategies to promote effective discharge planning practices and the subsequent implications that these have on nursing practice. The thesis concludes with a summary containing a discussion of the research findings, a presentation of unexpected findings and an analysis of the limitations regarding the application of these findings.

CHAPTER 6. DISCUSSION

Introduction

The purpose of this study was to investigate perceptions of discharge planning held by patients, carers, nurses and allied health workers involved in discharge preparation in the mental health setting, and examine what effect their perceptions had with respect to the discharge planning process. This study addressed the questions of:

- (i.) What are the perceptions held by patients, carers, nurses and allied health workers of discharge planning?
- (ii.) What, if any, significant differences exist in the perceptions of discharge planning between patients, carers, nurses and allied health workers?
- (iii.) What effects, if any, do differences in the perceptions of discharge planning between patients, carers, nurses and allied health workers have on the discharge planning process?

Eighty one subjects were selected from the four principal groups involved in care in the mental health setting, consisting of patients ($n = 21$), carers ($n = 20$), nurses ($n = 22$) and allied health workers ($n = 18$). Subjects for this study were obtained from the three pre-discharge units in a major metropolitan psychiatric hospital operated by the Health

Department of Western Australia. The philosophies for each of these units are consistent with the hospital philosophy, which includes patient centredness and the provision of quality care. Perceptions of discharge planning of these subjects were evaluated using an instrument developed for this purpose. Data obtained from the use of this instrument were analysed in respect to the questions guiding this study.

This chapter consists of a discussion of the results of this analysis in relation to the theoretical framework used to guide this study. The study findings will be related to the collective knowledge drawn from the literature on this topic. As the findings from this study increase the understanding in an area of mental health nursing practice that presents with continuing practice problems, strategies to promote effective discharge planning practices and subsequent implications to nursing practice will be addressed. The thesis concludes with a discussion of unexpected findings of and limitations to this study.

Evaluation of Perceptions of Discharge Planning

In examining perceptions of discharge planning as held by those groups involved in care at this major centre of mental health care operated by the Health Department of Western Australia, it was revealed that perceptions relating to discharge planning varied widely between these groups and that statistically significant differences were found to exist in their perceptions of various aspects of discharge planning.

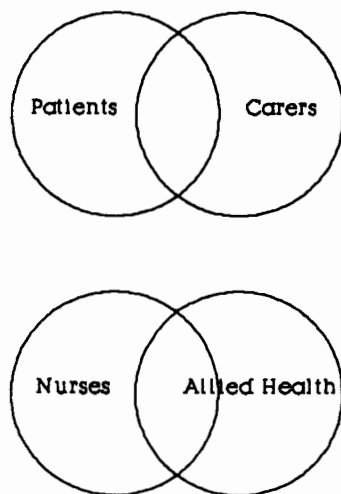
It was clearly determined that patients and carers had distinctly different ideas relating to discharge planning when compared to nurses and allied health workers. These

differences in perceptions observed in this study (see Figure 15.), illustrate what Farran et al., (1988) described as dyadic communication patterns. This along with parallel and triadic types of communication patterns are described as being dysfunctional and indicative of ineffective goal congruency.

Figure 15.

Observed Patterns of Discharge Planning Communication

Dyadic Patterns of Discharge Planning Communication



Dyadic and, to a lesser extent, triadic patterns of communication were observed in this study, between the groups involved in the care of the patient in the mental health setting. An analysis of the data showed that carers and patients, and the nurse and allied health workers formed dyadic patterns of communication around 50 % of the question clusters. According to Farran et al., the identification of these dysfunctional patterns of

communication support the contention that, in this setting, discharge planning practices are impaired and ineffective.

Areas of discord identified in the research undertaken here related primarily to the involvement of patients and carers in the discharge planning process. Where differences in perceptions exist, achievement of goals will be compromised (Abramson, 1990; Ervin et al., 1992; Farran et al., 1988). Goal incongruity in discharge planning in caring for the persistently mentally ill is a measure of failure to adequately prepare this group for return to the community and compromise in this area can result in the patient's premature return to hospital. An increase in frequency of readmission is viewed as contributing to, and perpetuating a cycle of, hospital readmission and eventual institutional dependency (Casper et al., 1991). This phenomena has been reported and identified here, adding further to the evidence of ineffective discharge planning practices.

While it is acknowledged that the involvement of patients and significant others in the planning of treatment, including the discharge process, is considered an essential approach in collaborative discharge planning, findings from this study provide evidence that a collaborative approach was not in existence in this clinical setting. Carers in particular were clearly identified as lacking confidence, involvement in and satisfaction with all aspects of the discharge planning process. Poor communication in the evaluation of progress in planning for discharge between the health care team, and patients and carers was identified as another shared area of concern.

Areas where congruity existed between patients and carers related to dissatisfaction with the amount of involvement in existing discharge planning practices. Conversely, nurse and allied health workers expressed satisfaction in this area. This shared area of concern related to decision making and amount of control in the discharge planning process.

Resistance from health professionals was reported by patients and carers in their attempts to gain greater involvement in discharge planning process. Catherman (1990) encountered reluctance and sometimes hostility on the part of some nurses and other health professionals to adopt a patient centred approach. This phenomena has been described by others (Blalock & Devellis, 1986; Calicchia, 1981; Galasso, 1987; Gantt, Goldstein & Pinsky, 1989; Lang & Mattson, 1985), and has been related to a reluctance to share power. Patients and carers reported similar experiences, where their views were either not sought, under-valued or ignored.

Nurses and allied health workers were perceived as placing greater importance in their own views of patient and carer needs regarding discharge planning. Patient and carers reported experiencing feelings of powerlessness similar to that described by Abramson, (1990), and Burgess & Burns (1990). The patient and carer group also expressed concern and frustration that medical, allied health and nursing staff were often inaccessible and inconsistent in their decisions and approach to treatment and care.

The philosophy of the hospital and units in this study focuses on the delivery of patient centred care. Despite this, patients and carers in this study were critical of the way in which the needs of the institution were placed above their own concerns, a feature also identified and described by others. This incongruity between what is stated and what is

practiced is not unexpected as according to Burnard & Morrison (1991), who have found that patient centred care often conflicts with the organisational requirements of the institution. The satisfaction of organisational needs at the expense of patients was reported by many respondents. This misprioritisation is speculated as a mechanism to avoid personal and professional accountability.

This study found that nursing practice was often prioritised around organisational needs. Porter (1993), also found nursing practice to be frequently directed by organisational rather than patient needs, and that this was evident in areas where the medical model was dominant, and often resulted in a lack of therapeutic interaction between nurses and patients. Lack of therapeutic interaction between patients and nurses was specifically addressed as a complaint raised by carers and the nurses themselves. The medical model of care evident in this setting was viewed as having an adverse effect on patient care, and interfered with effective discharge planning

Psychiatrists were identified by almost all respondents as having the most power and influence in determining the direction of treatment and ultimately, discharge. All groups indicated that it was the psychiatrist who controlled the discharge process. It was surprising therefore to discover that the psychiatrists who responded ($n = 3$) were dissatisfied with the discharge process as it stands. Interestingly, psychiatrists, in their comments and interview, also expressed feelings of powerlessness. They stated they were often faced with meeting the demands placed on them by the institution for a through-put of patients when hospital beds were short.

Despite acknowledging that many patients were being returned to the community to situations which precipitated the admission of the patient, they generally accepted this as necessary, and expected that mental health community services would meet the patient's needs out of hospital. This expectation was unrealistic in light of reports from other members of the health care team, including community mental health nurses, that poor liaison existed between the hospital and community agencies.

Although all groups placed considerable importance on the part that patient and carer education played in contributing to the success of discharge planning, nurse and allied health workers often rationalised away this issue. These groups acknowledged the crucial value of these programmes, but failed to act on ensuring that appropriate education programmes were developed, using organisational difficulties in a form of conditioned ethical response, where what is right is recognised but overlooked in the interests of the common good. This response has been identified and acknowledged as perpetuating ineffective care and treatment practices and is a professional, ethical and legal minefield (Grosser & Vine, 1991; HREOC, 1993; Kapp, 1994; Smith, 1994).

Country carers expressed many concerns not identified by those carers located in the metropolitan area. These concerns made the country carer feel additionally disadvantaged when attempting to deal with the problems of mental illness and an acute lack of support services. Sadly, of those carers located in the metropolitan area, who reported ($n = 3$) that they previously resided in the country and due to the frequency

readmissions of their loved one (husband/child), they had been obliged to move to the city to prevent disintegration of the family. The unique problems faced by those in remote or rural settings have been recognised, and in recent time been partially addressed by the institution of greater numbers of community mental health nurses and the extension of services into country areas (HREOC, 1993). Notwithstanding this, the example cited here is evidence of one of the hidden problems associated with inadequate discharge planning and frequent readmission to hospital.

This study has confirmed that ineffective discharge planning does contribute to unnecessary hospital readmissions. A lack of focus on effective discharge planning and a failure to deal with the effects of these short-comings can have disastrous long term consequences. Strategies that reduce the frequency of readmission to hospital of the persistently mentally ill need be examined, considered and implemented if this situation is to change.

Strategies to Promote Effective Discharge Planning

The ownership of the problem of repeated readmissions is a shared one and requires a collaborative approach for it to be dealt with effectively (Morrison, 1992; Parker, 1993; Peternelj-Taylor, & Hartley, 1993). The literature cites a number of strategies that can be employed to promote a collaborative approach to care which can be used effectively in approaching the complex issues associated with readmission to hospital.

According to Williams (1991), successful discharge planning requires careful organisation and timing. Planning should be dynamic, flexible, continually assessed and responsive to changes in conditions. Ideally there should be a close and early liaison with the patient, care-givers and community support networks. High risk patients should be identified and these patients should be given priority and considerable attention when planning for discharge from hospital. The multidisciplinary team should be coordinated in its approach and committed to ensuring patient satisfaction, with the appropriate and efficient utilisation of resources. Many studies however, indicate that discharge planning is often not a priority of doctors and nurses until the days immediately prior to patient discharge (Brooker, Barrowclough & Tarrier, 1992; Bubela & Galloway, 1990; Nolan, 1989; von Essen & Sjöden, 1993).

Patient education programmes, with clear identification of the patient's understanding of their illness and on-going management plans are described by others as beneficial strategies that can be incorporated in care (Bubela & Galloway, 1990; Buckwalter & Kerfoot, 1982; Hastings, 1989; Hochberger & Fisher-James, 1992; Naylor, 1990; O'Reilly et al, 1990; Peet et al, 1991). Education programmes utilising self-help pre-discharge groups encourage identification of individual problems and sharing of coping strategies have also been described as useful (Hochberger & Fisher-James, 1992; Kelly, Sauter, Tugrul & Weaver, 1990; Kraenzle-Schneider, 1993; Shepherd, 1992).

Buckwalter & Kerfoot (1982) put forward that the most successful kind of teaching in psychiatric - mental health nursing "is that which allows patients to take charge of their

illness and become partners in the treatment process”(p.15). Approaching patient care from this perspective, restores the rights and responsibilities of the patient and encourages participation and investment in the discharge planning process. A collaborative approach to care is increasingly encouraged within nursing and allied health literature (Abramson, 1990; Gardner & Wheeler, 1987; Peplau, 1988; Russell, 1990; Watson, 1985), as the basis for health education campaigns. Peet & Harvey (1991) identified that,

A meta-analysis of health education programmes showed that the most beneficial interventions were those providing an interactive process of learning between patients and health professionals... matching the information with its measured objectives, of tailoring the programme to the socio-educational level of the patients and of personalising treatment schedules to fit the individual routines of patients. (Peet & Harvey, 1991, p. 197)

Case management models are increasingly gaining favour in the management of the long term mentally ill. Consistency in management of patients is gained, with on-going care being provided by the same health care team, (Cronin-Stubbs, 1988; Galasso, 1987; Lang & Mattson, 1985; Lund & Frank, 1991; Leverich, Post & Rostoff, 1990). Care is planned in negotiation with the patient and shared responsibilities begin before admission and continue after discharge (Maurin, 1990; Russell, 1990; Onyett, 1992; Youseff, 1988).

While it is important to ensure that there has been clear identification of all possible variables which contribute to readmission to hospital, it is essential that all those involved

in the care process are also involved in treatment and planning for return to the community. The active involvement of significant others in the patients' lives to construct common goals is seen as an important strategy that is effective in promoting treatment outcomes (Baker, 1989; Chapman, 1991; Buckwalter & Kerfoot, 1982; Goering, Wasylenski, Farkas, Lancee & Ballantyne, 1988; Miller, 1989; Sullinger, 1988).

Research findings (Abramson, 1990; Carr, Farran & Maxson, 1988) have established that increasing patient control of decision making in discharge planning would increase the likelihood of successful post discharge outcomes. This is a highly desirable goal and is consistent with "National Goals, Targets And Strategies For Improving Mental Health" (WGMH, 1994). Also consistent with the WGMH recommendations, is the encouragement and inclusion of the patient and providers of care, including informal carers, to work towards common goals which are mutually defined and agreed upon, an approach advocated by Rosenstock (1988). This collaborative model restores autonomy to the patient and encourages the development of shared responsibilities.

The strategies described here and other similar strategies that can be used to promote compliance have been demonstrated to have varying degrees of success, but none will be wholly effective unless there is congruence of purpose within and between the groups involved in the care process. Without congruity of purpose, and understanding of the needs of mental health patients as they understand the needs, the success of hospital care and on-going discharge plans will be seriously compromised.

Nursing Implications

Implicit in many of the strategies cited here is the requirement for a more active and assertive role on the part of the nurse in the planning of care for the patient. Nurses play an integral part in the health care team structure in the mental health setting. They, as the ones most frequently in contact with patients and their carers, have greater cognisance of the problems experienced by these groups when the patient is discharged from hospital.

Nursing theorists such as Peplau have had a great influence on nursing care in the mental health setting. Peplau (1988), advocates restoring independence to the patient by making them more responsible in their own care, with the nurse acting to facilitate this goal. By communicating patient and carers concerns to, and encouraging their greater involvement with the health care team, the nurse can achieve this goal and assist in promoting a more collaborative approach to care. The collaborative approach restores power to those in the decision making process who are disadvantaged (Keeling et al., 1993), and is consistent with a patient centred approach to care (Peplau, 1987; Peplau, 1988).

Nurses traditionally are adept in communication skills that are supportive, informative and prescriptive. It is clear that many of the faults identified with discharge planning in the mental health setting are a reflection on the passive role played by the nurse in the discharge planning process. Burnard & Morrison (1991), warn that for nurses to become more assertive also requires the development of greater interpersonal skills in

order to be able to interact with others in the health care team with a high level of competency. Nurses tend not to be skilled in interpersonal skills that are catalytic, cathartic and confronting and to operate at this level with patients, carers and allied health professionals requires a “greater investment of self and is emotionally draining” (p.28).

Nurses will be required to make a greater investment in their care of patients before substantial changes can be expected to occur. The persistently mentally ill will continue to present nursing challenges and nurses will be required to grow professionally in order to meet their needs. In meeting the needs of the patient, the nurse has the potential to achieve personal and professional growth and through this, greater professional recognition.

Unexpected Findings

In this study, one psychiatrist reported that he didn't think frequent readmission of the persistently mentally ill was a great problem and cited that out of a total of 1623 of the multiple admissions in 1992 only fifty three patients had more than three admissions to hospital or 3.25% of the total admissions over the 12 month period. When pressed further, given that these patients each had at least three admissions, this psychiatrist was forced to concede that this represented in real turns a minimum of 159 admissions or 9.8% of all admissions (not counting those others with > 1 but < 3 admissions). This example highlighted to the researcher some of the concerns that have been expressed regarding inaccuracies in, and the inadequacy of collection, collation and dissemination

of data relating to mental illness in Australia (AHMC, 1992c; Nutbeam, Wise, Bauman, Harris & Leeder, 1993).

Statistical data on mental health at a national level are practically non-existent and misgivings have been expressed that data on the use of mental health services are inadequate with “no available national data on the incidence of mental disorders or the welfare of mentally ill people in the community” (AIHW, 1994, p.227). Although regional data are available on general incidence of mental illness as well on the material and financial resources devoted to mental health, reporting methods are fragmented and reflect only part of the picture relating to the extent of the problem faced by the community in dealing with mental illness.

The lack of a national mental health database has been identified as the greatest impediment to the development of a national network of preventative psychiatry, and secondary and tertiary mental illness prevention programmes (AHMC, 1992b). It has been proposed that priority be given to the establishment of an Australian Mental Health Epidemiology Network (WGMH, 1994) as an essential element in the development of future policy and services. The experiences of this researcher leads to support for this goal.

A further unexpected coincidental finding, whilst researching for this study, was an example of the haphazard nature of data collection. In the preliminary research of the issues for this study, this author discovered an example reporting discrepancies in the

incidence of a diagnostic category of affective disorder. Manic type affective disorder is one of the most frequently encountered forms of the affective disorder diagnostic category. In Western Australia, it would appear that the incidence of this disorder is under reported.

The Health Department of Western Australia follows the World Health Organisation ICD9 diagnostic classification system. Under this classification system, 296.0 is the coded classification for manic type affective disorder. Psychiatrists at the site of this research study follow the American Psychiatric Association (1987) classification system for psychiatric disorders, known as DSM-III-R. Under DSM-III-R, the code 296.4 is allocated to manic type affective disorder (see Table 4.).

Table 4.

Diagnostic Descriptors

| Code | DSM-III-R Descriptor | ICD9 Descriptor |
|-------|--------------------------------------|---------------------------------------|
| 296.0 | Affective psychosis - single episode | Affective disorder - manic type |
| 296.4 | Affective disorder - manic type | Affective disorder - circular type |
| 296.6 | Affective disorder - mixed type | Affective disorder - unspecified type |

Although a minor discrepancy exists between the descriptors of ICD9 vs DSM-III-R, reporting methods adopted by this major centre of mental health care results in an under reporting of manic type affective disorder (296.0) and corresponding over-reporting of

circular type affective disorder (296.4) respectively. This observed discrepancy, albeit small, does effect the quality of the epidemiological data contributed by Western Australia to the national incidence of mental disorders, and is an illustration of the concerns expressed by AIHW, AHMC and WGMH.

Limitations of this Study

This study examined perceptions of patients, their carers, nurses and allied health workers in relationship to discharge planning, within a large public institutional centre offering mental health care. As such, results of this research may only be generalisable to other similar settings catering to similar patient groups. It is acknowledged that non-traditional institutional environments and private facilities offering similar services report fewer of the problems identified within this study, however the results of this study may prove useful for comparative purposes.

Patient subjects were screened by their treating psychiatrist prior to inclusion in the study. Despite confidentiality of responses being guaranteed, several potential subjects declined the approaches for inclusion in the study for fear of reprisal if they were critical of the hospital and its staff. Anecdotal comments of this type were also made by several of those who agreed to participate.

The forced choice nature of the questionnaire yielded several blank responses. Blank responses are usually an indication the respondent is uncertain. Responses of this nature are difficult to interpret. While the method to compensate for blank responses is

considered acceptable, this may not have been a true reflection of the respondents' intentions.

Many of the patient and carer responses reported in this study are highly subjective and could be interpreted as limitations. These responses although emotive are often fuelled by personal experiences that have influenced their perceptions of events. As von Essen & Sjöden (1993) have stated the objectivity of, "professional opinion is not necessarily more valid than that of the patient" (p.294) and so, the subjective nature of these examples and incidents cannot be devalued or discounted.

Conclusion

This study sought to investigate perceptions of discharge planning as held by patients, carers, nurses and allied health workers and examined what effect their perceptions had on the discharge planning process in the mental health setting. In addressing the research questions that have directed this study, it has been established that significant differences do exist in the perceptions of discharge planning between patients, carers, nurses and allied health workers, and that these differences have a detrimental effect on the discharge planning process.

The major areas where differences in perceptions were identified, and which adversely influence discharge planning were identified regarding:

- (i.) limited collaboration in the discharge planning process, with inequality between the groups in the decision making process resulting in unnecessary readmissions;
- (ii.) impaired communications within and between groups, especially between health professionals and the patient and carer group;
- (iii.) a distinct lack of patient centredness in the approach to care in this setting, with organisational needs having priority over patient needs in respect to discharge planning;
- (iv.) ineffective patient advocacy from health professionals, where the patient is not encouraged to participate in their own care

In the only previous major study into discharge planning in Western Australian hospitals by Williams (1991), the sensitive area of psychiatry had been avoided due to it being fraught with difficulties. Williams (personal correspondence, November 3, 1992) ventured that, in the mental health setting, “anecdotal evidence suggests that discharge planning is less than optimal.... health care workers do not always communicate effectively.... discharge planning is not carried out, resulting in discontinuity of care and often readmission to institutions”.

Williams anticipated that the results of this researcher's study would "demonstrate client dissatisfaction with discharge arrangements". Again, what has been revealed in this study, is that the dissatisfaction with existing discharge planning practices in this mental health setting extends past the patient group and effects all those involved in the discharge planning process. This research study addressed several questions relating to perceptions of discharge planning and the effect of perceptions on discharge planning and indeed found that significant differences existed not just in perceptions between the groups. What has emerged from this study far exceeds what was originally anticipated.

Discharge planning is more than an orchestrated process, and the consequences of ineffective discharge planning practices extract a terrible human toll. Failure to address deficits in discharge planning practices such as those identified within this study continues to place a large number of Australians at risk. This risk is avoidable and therefore unacceptable. Continuance of ineffective discharge planning practices is consignment of the persistently mentally ill to, and acceptance of, what Hochberger & Fisher-James (1992), compared to "throwing puppies on the freeway" (p.25).

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APPENDIX #1.

Edith Cowan University Letter of Approval To Conduct Research



**EDITH COWAN
UNIVERSITY**

PERTH, WESTERN AUSTRALIA
CLAREMONT CAMPUS

Office of Research and Development

Godsworthy Road, Claremont
Western Australia 6010
Telephone: 09 383 0333
Facsimile: 09 383 1196

LETTER OF APPROVAL

Name: Mr. Michael Finn,

Home address: [REDACTED]

Dear Michael,

The Committee for the Conduct of Ethical Research has considered the ethical implications of your research project and I am pleased to advise it has been cleared for implementation.

Yours sincerely,

Eric Graham
Committee for the Conduct of Ethical Research

26th November, 1992

Approval number 92/ H 116

JOONDALUP CAMPUS
Joondalup Drive, Joondalup
Western Australia 6227
Telephone: 09 405 5555

MOUNT LAWLEY CAMPUS
2 Bradford Street, Mount Lawley
Western Australia 6052
Telephone: 09 370 6111

CHURCHLANDS CAMPUS
Pearson Street, Churchlands
Western Australia 6018
Telephone: 09 383 8333

CLAREMONT CAMPUS
Godsworthy Road, Claremont
Western Australia 6010
Telephone: 09 383 0333

BUNBURY CAMPUS
Robertson Drive, Bunbury
Western Australia 8230
Telephone: 097 91 2022

APPENDIX #2.**Application To Conduct Research**

Dr _____, Chairperson,
 Research and Ethics Committee,
 Hospital,
 Road,
 W.A. 6 .

2nd November, 1992.

Dear Dr _____,

I wish to undertake a research project at _____ Hospital. This research will address issues relating to discharge planning and asks for the participation of various subjects, including patients.

Attached is a copy of the research proposal which has been presented to the Committee for the Conduct of Ethical Research (Edith Cowan University). This proposal describes the purpose of the research, as well as the steps which will be taken to ensure protection of patients and confidentiality.

This research is non-invasive and will not impinge upon the treatment of patients in the mental health care setting.

It is my intention to commence the data collection required for this study at the earliest possible occasion, therefore could I please have an early indication with regard to consideration of this request.

Should further information be required, I will endeavour to make this immediately available.

Yours sincerely,

Michael Finn, RMHN, RGN, BHSc (Nursing),

APPENDIX #3.

Hospital Ethics Review Committee Letter of Approval to Conduct Research in Western Australia

Health Department of Western Australia

HOSPITAL

A FULLY ACCREDITED PSYCHIATRIC TEACHING HOSPITAL

Enclures

Mr M. Finn

Dear Mr Finn

Your research proposal entitled 'Discharge needs in the mental health setting - a study of perceptions amongst those involved in care' was discussed by the Hospital Ethics Review Committee at our meeting of 23rd February 1993.

Thank you for subsequently submitting the form for informed consent for those patients who are to be interviewed as part of the research.

On behalf of the committee, I hereby grant you formal approval to proceed with the project.

Yours faithfully

A/Chairman
Hospital Ethics Review Committee

22 March 1993 GJM

APPENDIX #4

Letter of Support for Research

Chief Nursing Officer, Health Department of Western Australia.

Ms Claudette Kelly
 C/o Edith Cowan University
 School of Nursing
 Pearson Street
 CHURCHLANDS 6018

Dear Claudette

RESEARCH PROPOSAL: MICHAEL FINN

I have read, with considerable interest, the research proposal aimed at considering the discharge needs in mental health care settings. As you are aware I spent a year investigating discharge from general health care settings, purposefully avoiding the psychiatric field as it is so fraught with difficulties.

The proposed study is highly relevant to the industry because of the following factors:

1. The national trends to de-institutionalise psychiatric care are progressing and this requires both clients and carers to have comprehensive discharge planning. Anecdotal evidence suggests discharge planning is less than optimal at this time.
2. Western Australia psychiatric services are currently undergoing regionalisation with the view to greater integration of institution and community care. Such moves require clear communication between institution and community health care workers and this is achieved through effective discharge planning. Currently these groups of health care workers do not always communicate effectively, i.e. discharge planning is not carried out, resulting in discontinuity of care and often re-admission to institutions.

The Health Department of WA is cognisant of the difficulties at the workplace and the myriad of factors that influence current practices. The proposed research would be extremely valuable to employers in validating what is currently subjective, anecdotal evidence.

.../2

Timeliness of research is also very important. There are two factors which support the timeliness of this proposal:

1. The Minister for Health has recently requested a survey of patients discharged from psychiatric institutions. I would pre-empt that the results will demonstrate client dissatisfaction with discharge arrangements. Mr Finn's research will assist us in determining staffing factors which can be addressed to overcome some problems.
2. The Minister for Health recently released a policy statement on "Guidelines for Discharge Planning". This document identifies policy framework to be implemented in all hospitals. By the time Mr Finn has conducted his research the policy should have been implemented and once again, his results may assist staff to identify areas needing greater attention.

Thank you for the opportunity to read this proposal. I look forward to reading the results and gaining some insight into staff perceptions that may lead to positive workplace reforms.

Yours sincerely

Susanne Williams
CHIEF NURSING OFFICER

3 November 1992

31103SW4

APPENDIX #5

Letter of Support for Research

Coordinator, Hospital Staff Development/Research

Health Department of Western Australia

Western Australia

HOSPITAL

A FULLY ACCREDITED PSYCHIATRIC TEACHING HOSPITAL

Yours
Cordially
Enclosures

Mr Michael Finn

Dear Michael

I am in receipt of your letter dated 24 November 1992, and read your proposal with interest.

On the basis that [redacted] Hospital approved the conduct of your research, this department will be very pleased to assist you in your study, if you so wish.

Please do not hesitate to contact me for any information you require.

In the meantime, I wish you a happy New Year.

Kind regards

[redacted]

Co-ordinator, Staff Development/Research

2 December 1992

21202RD1/DL

[redacted]

The Health Department of Western Australia-promoting a smoke free environment

APPENDIX #6.**Hospital Circular Advising of Research Project****[REDACTED] HOSPITAL****ADMINISTRATIVE CIRCULAR NO. 53/93 DATE: 18.03.93****APPLICABLE TO: ALL STAFF via:**
Heads of Departments, Supervisors: Support Services
Clinical Nurse Specialists: all Wards**FILE NO. 3.2****SUBJECT: RESEARCH PROJECT - [REDACTED] HOSPITAL**

Mr Michael Finn, Lecturer in Nursing Studies at Edith Cowan University, will be conducting a research project at [REDACTED] Hospital during March and April 1993. This project has university and hospital approval and is directed at examining issues related to discharge planning.

Participation from all those interested in the discharge process will be requested and Mr Finn will be approaching individuals to canvas their support.

Although the research will be conducted in [REDACTED] and [REDACTED] units, all staff are advised that Mr Finn has permission to be on site and are asked to co-operate with him.

Copies of the research proposal are available for viewing on the units involved in the study

[REDACTED]

[REDACTED]
DIRECTOR OF NURSING

18 March 1993
30318WEI/DL

APPENDIX #7.

Discharge Planning Assessment Survey

As part of a research project being conducted for a Masters Degree (Nursing), I will be conducting a study which will examine discharge planning in the mental health setting. The purpose of this study is to look at the different features of discharge, to determine which areas are understood to have most importance when planning for discharge from hospital.

There is no compulsion for you to participate in this study, however, you are invited to submit your ideas on questions such as:

What does discharge planning mean to you?
What are important issues in discharge planning?
What questions would you like to ask about discharge from hospital?
Who is responsible for discharge planning?
What do you know about discharge planning?

These are some topics you might consider but you can add whatever you wish, as the intention is to find *your* views.

All responses will be treated in confidence and there is no need or obligation to identify yourself.

If you have any questions or problems please contact the researcher:

Michael Finn, Lecturer (Nursing Studies),
 Edith Cowan University, Office 3838618
 or contact
 Nursing Reception 3838453 for paging/messages
 Monday to Friday 8:30 - 4:30

Please write your responses on the attached sheet, and upon completion, please place your paper inside the attached envelope and return it to me by placing it or asking ward staff to put it in the hospital internal mail system.

Thank you for your help.

Michael Finn,
 2nd November, 1992.

APPENDIX #8.

Patient Consent Form

I (print name) _____

have had the purpose of the study being conducted by the researcher (Michael Finn) explained to me, and voluntarily agree to being interviewed. I understand that agreement to participate is non-binding and that I may withdraw at any time.

Signature _____

Date _____

Next section to be completed by treating psychiatrist

I (print name) _____

give my permission for the above person, a patient under my care, to participate in this research project.

Signature _____

Date _____

APPENDIX #9.

Discharge Priorities Perception Rating Scale:

As part of a research project being conducted for a Masters Degree (Nursing), I will be conducting a study which will examine discharge planning in the mental health setting. The following questionnaire is designed to measure your response to a range of statements relating to discharge from hospital. These statements address several aspects of discharge planning.

The purpose of this questionnaire is to look at the different features of discharge, to determine which areas are understood to have most importance when planning for discharge from hospital. Those who have the most involvement in hospitalisation - patients, relatives or supportive others, nurses, medical and allied health staff will be asked to participate in this study.

The questionnaire should take between 5 - 10 minutes to complete. All responses will be treated in confidence and there is no need or obligation to identify yourself. Statements contained within this form have been created in such a way as to allow the same questionnaire to be used by the different groups participating in this study. If any problems are encountered in completing this form, please contact the researcher:

Michael Finn, Lecturer (Nursing Studies),
Edith Cowan University, Office 3838618

or contact

Nursing Reception 3838453 for paging/messages
Monday to Friday 8:30 - 4:30

Upon completion of this questionnaire, please place it inside the attached envelope and return it to me by placing or asking ward staff to put it in the hospital internal mail system.

Thank you for your help.

Michael Finn,
2nd November, 1992.

DEMOGRAPHIC INFORMATION

1. Sex

Male ☐ Female ☐

2. Age:

.....Years

3. Role in hospital:

| | | |
|--|--|--|
| Patient <input type="checkbox"/> | Carer <input type="checkbox"/> | Student Nurse <input type="checkbox"/> |
| Nurse <input type="checkbox"/> | Community Nurse <input type="checkbox"/> | Psychiatrist <input type="checkbox"/> |
| Registrar <input type="checkbox"/> | Social Worker <input type="checkbox"/> | Pharmacist <input type="checkbox"/> |
| Psychologist <input type="checkbox"/> | Welfare Officer <input type="checkbox"/> | Chaplain <input type="checkbox"/> |
| Occ Therapist <input type="checkbox"/> | Other (please state)..... | |

4. Length of time associated with hospital:

| | | |
|---------------------------------------|------------------------------------|------------------------------------|
| Under 1 year <input type="checkbox"/> | 1-2 years <input type="checkbox"/> | 2-3 years <input type="checkbox"/> |
| 3-4 years <input type="checkbox"/> | 4-5 years <input type="checkbox"/> | 5-6 years <input type="checkbox"/> |
| 6-7 years <input type="checkbox"/> | 7-8 years <input type="checkbox"/> | 8-9 years <input type="checkbox"/> |

more than 9 years (please state).....

5. Are you willing to be interviewed at a later date?

Yes ☐

No ☐

(COMPLETE NEXT SECTION ONLY IF WILLING TO BE INTERVIEWED)

Name

Contact Address

.....

.....

Phone

In the following questionnaire, please circle the response which best describes your feelings to each statement.

- (1) Discharge planning is an important part of hospital treatment.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (2) I am satisfied that enough importance is placed on providing education to the relatives or concerned others regarding patient illnesses.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (3) I am satisfied that enough importance is placed on developing living skills before discharge.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (4) Discharge planning should include all significant people involved in patient care.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (5) I am satisfied that enough importance is placed on providing information to relatives or concerned others regarding discharge medications, effects and side effects.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (6) I am satisfied that enough importance is placed on providing education relating to the effects of illicit drugs and alcohol on mental illness.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (7) I would like to have more opportunity to be involved in discharge planning.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (8) I am satisfied that enough priority is placed on the involvement of family or concerned others when planning for discharge.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (9) Ties with community support groups are encouraged before patients are discharged from hospital.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (10) Careful discharge planning would reduce the number of admissions to hospital.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (11) I am satisfied that there is enough education for patients in managing finances and budgets before discharge.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (12) I feel confident that the discharge planning process used in this hospital will reduce unnecessary re-admissions.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (13) Discharge planning should begin as soon as possible following admission to hospital.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (14) I am satisfied that enough priority is placed on providing education to patients regarding their illnesses.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (15) Discharge planning should examine those factors responsible for admission to hospital.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (16) I am satisfied that enough priority is placed on providing education to patients regarding medication use, effects and side effects.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (17) Discharge planning should help to reduce those factors responsible for admission to hospital.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (18) I am involved in discharge planning.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (19) I am satisfied that enough priority is placed on locating appropriate accommodation before discharge

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

- (20) Discharge planning is a clearly identified part of the treatment process.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

(21) Difficulty in coping with stress often leads to re-admission to hospital.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

(22) I have the opportunity to be involved in discharge planning.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

(23) Progress towards discharge from hospital is a clearly measured part of treatment.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

(24) Discharge planning makes no difference to the success of treatment.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

(25) I am satisfied that enough priority is placed on the development of stress management skills.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

(26) Information on community support groups is made readily available to patients in this hospital.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

(27) On discharge, patients will be aware of the type of follow up service they will receive in the community.

Strongly Agree *Agree* *Disagree* *Strongly Disagree*

(28) Management of stress is an important living skill.

Strongly Agree

Agree

Disagree

Strongly Disagree

(29) Reduction of factors responsible for admission to hospital is an important part of treatment.

Strongly Agree

Agree

Disagree

Strongly Disagree

(30) Self help groups are a valuable and important community resource.

Strongly Agree

Agree

Disagree

Strongly Disagree

(31) I am satisfied that enough priority is placed on promoting good nutrition and healthy eating habits.

Strongly Agree

Agree

Disagree

Strongly Disagree

(32) I am satisfied that the discharge planning process used in this hospital is effective.

Strongly Agree

Agree

Disagree

Strongly Disagree

(33) I have a good knowledge of the range of support groups available in the community.

Strongly Agree

Agree

Disagree

Strongly Disagree

COMMENTS

This image shows a full page of white paper with horizontal dashed lines, typical of primary-ruled notebook paper. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

APPENDIX #10.

Follow-up Interview Proforma

Subject _____

Code Number _____

Tape Number _____

| | | | | |
|-----------------------|-----|---|----|---|
| Questionnaire sighted | Yes | 0 | No | 0 |
|-----------------------|-----|---|----|---|

Questions to clarify _____

| | | | | |
|----------------------|-----|---|----|---|
| Additional questions | Yes | 0 | No | 0 |
|----------------------|-----|---|----|---|

Comments on paper _____

Special remarks _____
