INPATIENT MENTAL HEALTH: WHAT HELPS/HINDERS THE TRANSITION INTO
COMMUNITIES?

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Abstract

The transition period is the most vulnerable period for patients transitioning from inpatient units to community settings (Coleman, Pincus, Epstein & Ofedahl, 2015). Patients with mental illness have unique needs and vulnerabilities, therefore increasing the need for improved coordinated transitional discharge plans (Coleman et al., 2015). The purpose of this study was to explore the transition experience of patients' ≥18 years of age who transitioned into the community from an inpatient mental health unit. This study sought to understand the patient's experience of present discharge models from a qualitative perspective. This study addressed a knowledge gap by exploring the consumer survivor's voice. Expectations, the environment, level of planning and emotional and physical well-being were all important factors explored that helped and hindered the successful re-integration of patients living with mental illness into the community.

Dedication

To my dear husband Dean, for always supporting me and believing in me through this journey. In addition, special thanks to my dear son Lachlann, who made an early appearance during the course of my studies and his resilience and charisma have inspired me to persevere through my studies.

Acknowledgements

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE: INTRODUCTION

According to Coleman et al. (2015) the transition period is the most vulnerable period for clients transitioning from inpatient to community settings. Patients with mental illness have unique needs and vulnerabilities, therefore improved coordinated transitional discharge plans are imperative (Coleman et al., 2015). Individuals with mental illness often face challenges re-establishing connections with community supports after long-term hospitalizations (Kidd, Virdee, Mihalakakos, McKinney, Feingold, Collins & Velligan, 2016). Patients who are discharged from hospitals to the community setting are at the greatest risk for re-admission within the first 30 days and the greatest risk of suicide within the first 2 weeks post-discharge (Kidd et al., 2016). Fifty percent of patients with a diagnosis of schizophrenia do not attend their first appointment following discharge (Kidd et al., 2016). Poorly coordinated service and poor communication between inpatient providers and community providers has been identified as a key factor influencing patient's transition experience (Kidd et al., 2016). Poor transition has led to delayed rehabilitation and recovery and the development of poor and unhealthy coping methods (Meleis et al., 2000). Transition "can be understood as a passage, or movement, from one life phase, condition, or status to another, and the process and experience of undergoing a transition can result in a change in perception of health, new meaning, and a sense of control" (Skarsater & William, 2006, p. 2). A successful transition occurs when individuals achieve mastery of the change; as evidenced by absent distress and improved well-being (Kralik, Visentin & Van Loon, 2005).

Relocation trauma is an adverse outcome associated with transition from one facility to another (Farhall, Trauer, Newton & Cheung, 2003). It includes greater incidence of deaths, depression and behavioural difficulties (Farhall et al., 2003). According to Farhall et al. (2003)

"for persons with illnesses or disabilities, relocation stress may exacerbate symptoms and impair functioning…relocation trauma [has] been reported for non-psychiatric elderly patients and patients with cognitive disability" (p. 1022). Trauma in psychiatric populations has rarely been studied for the impacts. However, according to Farhall et al. (2003) successful reintegration has been achieved with adequate preparation and planning, allowing patients to visit communities prior to official discharges, collaboration with families and empowering patients by honouring choice, if possible. Continuity of care and transition preparation can therefore improve the transitional experience for patients (Farhall et al., 2003).

In the 1960s, as a result of deinstitutionalization, there has been a significant emphasis for mental health care services to be shifted into community settings, therefore leading to a reduction in the number of available inpatient hospital beds (Linz & Sturm, 2016). According to Forchuk, Martin, Corring, Sherman, Srivastava, Harerimana & Cheng (2019) patients often fall through the cracks with current discharge models. During the discharge process, interpersonal violence often places patients at risk for re-admissions, increased risk of dying by suicide (Walter, F., Carr, Mok, Antonsen, Pedersen, Appleby & Webb, 2019), engagement with violent incidents or admission to hospitals (Forchuk et al., 2019). Due to inadequate community supports, individuals with severe mental illness become homeless or re-located into prisons (Linz & Sturm, 2016).

The purpose of this study was to explore the transition experience of patients' ≥18 who transitioned into the community from an inpatient mental health unit in Canada. To the author's knowledge, no literature has asked what it is like from the consumer survivors. This study sought to address a gap of what the transition experience is like for patients from the perspective of the patient. Patients who have been hospitalized for at least 14 days but are now living in the community were recruited through Can-Voice, a consumer/survivor peer support agency. The

overall question explored was "what helps/hinders the transition from inpatient mental health care to re-integration within communities?" from the patient's perspective.

Theoretical Perspective

The theoretical perspective that guided this study was Afaf Meleis' Transition Theory. Meleis' Theory focuses on the process of transitioning in illness and immigration. For the purposes of this study, the implications of situational transition were explored. Situational transition focuses on geographical changes and transitions from hospitals (Meleis, 2010). As a result of decreased acute care funding and a shift towards more community-based recovery and rehabilitation, patients with acute and chronic illnesses are discharged much earlier. According to Meleis (2010) "the transition to recovery is somewhat more protracted, and patients need expert and competent care until they complete their recovery transition. When patients and their families are not cared for during these transitions, they experience many complications and possible re-admissions" (p. 1).

Meleis (2010) defines healthy transitions as "a mastery of behaviours, cues, and symbols associated with new roles and identities as non-problematic transitions" (p. 3). Situational transition involves a shift of roles and responsibilities; nurses are in an excellent position to support the transition of roles and responsibilities (Meleis, 2010). Transition refers to the complex interactions between the person and their environment (Meleis, 2010). According to Meleis (2010) there are three phases of the transition experience; entry, passage and exit. The phases have different durations and the phases merge with each other (Meleis, 2010). Although there is a general pattern of the transition experience, it is imperative that nurses assess and collaborate with the patient in planning transitions, as each experience is unique to the individuals experiencing it (Meleis, 2010). Successful transitions contain the following

elements; awareness, engagement, change and difference, time span and critical points and events (Meleis et al., 2000).

Awareness

Meleis et al. (2000) regard that individuals must have some perception or awareness of the transitional experience. Having awareness of the transition experience indicates that a transition is occurring (Meleis et al., 2000). According to Meleis et al. (2000) "an absence of awareness of change could signify that an individual may not have initiated the transition experience." (p. 19). However, Meleis et al. (2000) also regard that there is still a question as to whether or not the patient's or nurse's awareness initiates the transition experience. An additional component of transition is engagement.

Engagement

Engagement refers to the individual's involvement in the transitional experience (Meleis et al., 2000). Examples of engagement include asking questions, utilizing support and engaging in activities to support the transitional experience (Meleis et al., 2000). Awareness and engagement are intrinsically related as one may not occur without the other (Meleis et al., 2000). Change and difference also influences the transitional experience.

Change and Difference

Transition can elicit changes in one's life; however, the changes that are occurring may not directly relate to the transition experience itself (Meleis et al., 2000). "Change may be related to critical or dis-equilibrating events, to disruptions in relationships and routines, or to ideas perceptions, and identities" (Meleis et al., 2000, p. 20). Successful transition is also achieved by

the ability to confront differences within one's life; seeing the world or others differently (Meleis et al., 2000).

Time Span

Time span refers to the time span of the transition experience (Meleis et al., 2000). According to Meleis et al. (2000) some researchers mention that there is an identifiable beginning and ending. However Meleis et al. (2000) argue that time restrictions are not possible in some transition experiences. Different illnesses and individual experiences have different timelines and trajectories, and therefore limiting time may influence successful outcomes (Meleis et al., 2000). Critical points and events are additional components of transitions.

Critical Points and Events

According to Meleis et al. (2000) transitional experiences tend to encompass critical points or events. The critical turning point is when the individual has an increased awareness of changes occurring or increased participation in the transitional experience (Meleis et al., 2000). Furthermore, there were "final critical points, which were characterized by a sense of stabilization in new routines, skills, lifestyles, and self-care activities…a period of uncertainty marked with fluctuation, continuous change, and disruption in reality" (Meleis et al., 2000. p. 21).

Meleis (2010) reports that there are also transition conditions that influence the transition experience inclusive of; meanings, expectations, level of knowledge and skill, the environment, level of planning, and emotional and physical well-being.

Meanings

Each individual has a different perspective of the transition experience, which may be positive, neutral or negative (Meleis, 2010). The more awareness one has regarding a transition experience, the greater the likelihood of a smooth transition. Individuals must seek to understand the transition experience from the patient's perspective in order to provide appropriate resources and supports (Meleis, 2010). The expectations of clients has also been found to be an important transition condition.

Expectations

An individual's expectation of the transition experience also impacts the success of a transition (Meleis, 2010). Individuals experience transition may have unknown or unrealistic expectations of the transition experience (Meleis, 2010). When individuals are provided with the information regarding transition expectations, the associated anxiety and stress is reduced (Meleis, 2010). Level of knowledge/skill is another condition that influences transition.

Level of Knowledge/Skill

An individual's level of knowledge and skill surrounding the transition experience may also impact the success (Meleis, 2010). There is significant research noting the importance of providing adequate knowledge and skill during the transition experience (Meleis, 2010). According to Meleis (2010) "parents of premature infants, chronically ill children, and adult patients and their caregivers need information during the transition from hospital to home or from inpatient to outpatient care" (p. 43). Uncertainty during the transition experience can hinder the success of the transition (Meleis, 2010). Level of knowledge/skill is an important condition that influences transition; however, environment is an equally important factor.

Environment

Another important factor influencing successful transition experiences are the external resources within one's life (Meleis, 2010). Social support from friends, family and/or spouse and support from professionals and peer support groups promote smooth transition experiences (Meleis, 2010). "When support was lacking or communication with professional staff was less than optimal, clients in transition experienced feelings of powerlessness, confusion, frustration and conflict" (Meleis, 2010, p. 43). Open, honest, and clear communication with professionals empowers individuals during the transition experience (Meleis, 2010). The level of planning before and during the transition process is another important condition.

Level of Planning

The success of a transition is influenced by the amount of planning at the beginning and during the transition/discharge process (Meleis, 2010). An identification of the problems, challenges and needs are important components of meaningful planning (Meleis, 2010). Open communication between the patient, support persons and professionals is key to facilitating transition (Meleis, 2010). Emotional and physical well-being are also conditions that influence the transition experience.

Emotional and Physical Well-Being

Emotional distress and stress are common feelings exhibited by individuals transitioning (Meleis, 2010). Specific emotions include "anxiety, insecurity, frustration, depression, apprehension, ambivalence and loneliness" (Meleis, 2010, p. 44). Individuals may also experience role confusion and fear failure during the transition experience and as a result may not assume risks to engage with the transition experience (Meleis, 2010). Individual's physical well-being is another important condition of transition (Meleis, 2010). "When physical

discomfort accompanies transition, it may interfere with the assimilation of new information. Bodily unpredictability may be distressing, whereas energy, bodily predictability, and normal operation facilitate transitions" (Meleis, 2010, p. 45). Therefore, impaired physical functioning influences the success and well-being of transition (Meleis, 2010).

Successful transition occurs when a collaborative relationship develops with the nurse and patient and open information is shared among the circle of care (nurse - patient - informal caregiver [as applicable]) (Meleis et al., 2000). "Knowledge development in nursing should be geared toward the development of nursing therapeutics and not toward understanding the phenomena related to responses to health and illness situations" (Meleis, 2010, p. 3). When nurses understand the phenomena for each individual, they are able to facilitate a more successful transitional discharge.

CHAPTER TWO: LITERATURE REVIEW

The Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest and Medline-Ovid were the electronic databases utilized to conduct a review of the literature. CINAHL was investigated with the search terms 'transition,' 'discharge models,' 'discharge,' and 'mental illness,' from 1998 to 2020. Medline was also searched with similar search terms, 'mental illness,' 'discharge models, 'discharge' and 'transition' from 1998-2020. CINAHL: 252 articles, ProQuest: 152 articles and Medline-Ovid: 265 articles, however many were eliminated because they did not focus on mental health, transitions within mental health or did not meet the inclusion or exclusion criteria of the study. A total of eight articles were utilized to conduct the literature review. The selection criteria utilized in the review of the literature were; mental health patients transitioning from inpatient mental health care, participants > 18 years of age, and papers published within the last twenty years. The exclusion criteria for this study included; articles published prior to 1998 and articles related to children and youth <18 years of age.

Forchuk, Jewell, Schofield, Sircelj & Valledor (1998) completed the "Bridge to Discharge" project in Hamilton, Ontario. This study utilized a participatory action research approach to support individuals with chronic mental illness to re-integrate into communities (Forchuk, Jewell, Schofield, Sircelj & Valledor, 1998). This model was based upon Hildegard Peplau's Theory of Interpersonal Relations. Forchuk, Jewell, Schofield, Sircelj & Valledor (1998) found that overlapping in-patient support during the re-integration experience until the working phase of the therapeutic relationship has been established with the community provider facilitates a more successful transition. Furthermore, the "project improved client's quality and saved taxpayers almost half a million dollars in one year and was supportive of staff's quality of work life" (Forchuk, Jewell, Schofield, Sircelj, & Valledor, 1998, p. 197).

Forchuk, Jewell, Schofield, Sircelj & Valledor (1998) found that each patient's involvement with family varied depending on their situation. However, they found that family relationships can foster an ongoing supportive connection and provide "emotional, social, spiritual, cultural, housing and financial support" (Forchuk, Jewell, Schofield, Sircelj & Valledor, 1998, p. 199) to patients. Transitional experience improved if a healthy family network is encouraged during in-patient hospitalization (Forchuk, Jewell, Schofield, Sircelj & Valledor, 1998).

Forchuk, Jewell, Schofield, Sircelj, & Valledor (1998) found peer support is a complementary support in the transitional experience. Forchuk, Jewell, Schofield, Sircelj, & Valledor (1998) stated that "mental health consumers support and learn from each other through the sharing of experiences and resources within the hospital and then the community" (p. 199). Individuals with mental illness often find the professionals are making the decisions regarding their care; Peer support could empower individuals with mental illness to learn how to make decisions regarding their care as peer supports act as role models to encourage participation in decision-making (Forchuk, Jewell, Schofield, Sircelj & Valledor, 1998). However, Forchuk, Jewell, Schofield, Sircelj & Valledor (1998) also found that individuals transitioning may even just need peer support in the form of a friend to assist the individual to navigate into the community from a patient-perspective and provide the foundation for a social support network.

Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby & Chan's (1998) study "Bridging the Discharge Process: Staff and Client Experiences over Time" reported the qualitative findings from the "Bridge to Discharge Project." This study revealed that peer support was found to be helpful as it gave patients hope for the future. One patient stated, "If [they] can make it, then so can I" (Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby &

Chan, 1998, p. 131). Furthermore, participants reported that peer support also helped with developing skills for activities of daily living such as cooking, transportation, and housing, in addition to the recovery and psychosocial support that they provided (Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby & Chan, 1998). Participants also expressed that having peer support during the recovery and transition experience motivated those clients to want to become peer supporters in the future. "Clients identified themselves as potential helpers for other clients about to be discharged" (Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby & Chan, 1998, p. 132).

This project involved overlapping services from the hospital nurse and community nurse until the therapeutic relationship was established with the community nurse (Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby & Chan, 1998). Fourteen months into the study, thirteen clients had successfully transitioned into the community; 4 of those clients who transitioned no longer required inpatient services (Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby & Chan, 1998). Hope was a theme that emerged from the data; Many clients developed hope to leave the hospital, hope to find employment, hope to enroll into an educational program and hopes to reconnect with family (Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby & Chan, 1998)."The changes over time revealed that clients moved from a dependent role with staff to a more active role" (Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby & Chan, 1998, p. 133) as staff encouraged more of a facilitating role as oppose to a provider role (Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby & Chan, 1998). In addition to cost savings, an improvement in quality of life was also observed among the participants (Forchuk, Schofield, Martin, Sircelj, Woodcox, Valledor, Overby & Chan, 1998).

Forchuk and Reynolds (2001) expanded the understanding of the nurse-client relationship by assessing the interaction between the nurse and the client from the patient's perspective. This study was conducted with the following research question, "how do clients perceive the evolving therapeutic relationship with nurses?" (Forchuk & Reynolds, 2001, p. 46). A qualitative research study in Canada and Scotland was completed in order to answer the research question (Forchuk & Reynolds, 2001). Both countries revealed data consistent with the phases of the nurse-client relationship as described by Peplau (Forchuk & Reynolds, 2001). One participant from the Canadian study regarded, "Well at first I wasn't talking to her too much. I was paying no attention to her I guess. But, then I started to talk to her more about this and that and… [now] about everything" (Forchuk & Reynolds, 2001, p. 47). Therefore, demonstrating the movement towards the working phase of the therapeutic nurse-client relationship (Forchuk & Reynolds, 2001). In the Scottish study, a participant reported, "It is very hard for her to understand me, but she is trying very hard. She's very thoughtful. She doesn't object to my thoughts and tries to understand my feelings and reasons" (Forchuk & Reynolds, 2001, p. 48). This quote again recognizes the need to transition through the stages of the therapeutic relationship, and that nurses must honour respect and trust in order to move beyond the orientation phase to the working phase of the relationship (Forchuk & Reynolds, 2001). Overall, both Canadian and Scottish participants regarded that a critical component to the client's recovery is the establishment and maintenance of therapeutic relationships with nurses (Forchuk & Reynolds, 2001). "Clients wanted nurses to listen, be sensitive to feelings, seek clarification of confused messages, help them to 'anchor' accounts of problems in the personal time and setting of the problem, help them to focus on solutions to problems, and to sound warm and genuine" (Forchuk & Reynolds, 2001, p. 49).

Bernardo & Forchuk (2001) completed a study that reviewed 200 charts of patients who had been discharged from a psychiatric hospital from 1991 - 1995. They found that patients with a previous psychiatric hospital admission were at the greatest risk for re-admission in the future. Poor discharge planning increased the risk of re-admission in the future (Bernardo & Forchuk, 2001). However, more distinctly, nurses often had a different perspective than the client surrounding their illness and reasons for re-admission; "clinicians described worsening of symptoms as acute and episodic, whereas patients reported having ongoing struggles with symptoms, underscores the differences in interpretation of given problems" (Bernardo & Forchuk, 2001, p. 1101). These perceptions and attitudes may impair the nurses' ability to accurately assess and determine nursing interventions tailored to the client's needs, and ultimately place the client at risk for future re-admissions (Bernardo & Forchuk, 2001). This study therefore provides an important learning opportunity for nurses as they engage in the nurse-client relationship to focus more on client-centered care and work through the phases of the nurse-client relationship to identify the client's needs and support them to achieve their identified goals.

Forchuk, Martin, Chan, & Jensen (2005) further supported the importance of the therapeutic relationship when examining the cost and effectiveness of a transitional discharge model in a study titled, "Therapeutic relationships: from psychiatric hospital to community". The transitional discharge model was rooted in Peplau's theory and "assumes that the quality of interpersonal relationships has an influence and impact on quality of life and that a supportive social network will promote less need for expensive interventions such as hospitalization" (p. 557). The objectives of this study was to support individuals with a chronic mental illness with successful discharge into communities (Forchuk et al., 2005). Forchuk et al. (2005) hypothesized

that patients would have (1) an enriched quality of life and (2) reduced health and social service expenditure within the one year period following discharge compared with patients experiencing a standard discharge. In a randomized clinical trial involving four tertiary care hospitals, the researchers found that ongoing support from hospital staff after discharge, until the patient was engaged with the community nurse past the orientation phase of the nurse-client relationship lead to successful transition and reduced re-admission rates. The Transitional Discharge Model also included the component of peer support to aid in the transitional process (Forchuk, et al., 2005). "The provision of peer support has been shown to improve several areas of quality of life, such as satisfaction with living situation, personal safety and financial management" (Forchuk et al., p. 557). Consumer/survivors volunteered to provide peer support to individuals transitioning from inpatient mental health services. Peer volunteers "provided friendship, provided understanding, taught community living skills and encouraged current clients in making the transition from psychiatric hospital to community" (Forchuk et al., 2005, p. 560). The result was a $12 million (CDN) savings for the intervention group of less than 200 people and improved quality of life with regards to social relations (Forchuk et al., 2005).

Coatsworth-Puspoky, Forchuk & Ward-Griffin (2006) conducted an ethnographic study that examined how clients described peer support relationships and what circumstances help or hinder peer support relationships. The purpose of this study was to answering the following questions: (1) how do participants define the development of the peer support relationship? (2) What dynamics influence the peer support relationship? (Coatsworth-Puspoky et al., 2006). Coatsworth-Puspoky et al. (2006) described two types of peer support relationships; the "developing [peer support relationships], we have to be to each other what we're not getting elsewhere…and the tenuous [peer support relationships], you'd think because they go through it

they're understanding people, but that's not necessarily true" (p. 493). One participant described a positive experience with peer support relationships:

> It's just that they [mainstream friends didn't understand it [my mental illness] and they
> didn't want to deal with it. But my peers…they've always been there, my good ones,
> friends…My Mom is an angel. She really doesn't understand; she can't help me when
> I'm in my depressions - that's where my peer support comes in…but friends that are
> peer support friends have stuck with me all the way through.
>
> (Coatsworth-Puspoky et al., 2006, p. 495).

However, another participant described a negative, tenuous experience with regards to peer support:

> Isn't anybody there allowed to talk to anybody else with problems? That's what they're
> discouraging, they're saying, don't do that…what's the organization for if it's not there
> to help people - who have problems - to back 'em up? Like it's just not there…Well it
> should be. And they're saying more or less that you're not allowed to do that…I don't
> understand it. I really don't.
>
> (Coatsworth-Puspoky et al., 2006, p. 495).

This study explored how the relationships that develop between patients and peer support progress through the phases that Peplau describes for the establishment of a nurse-client relationship. This study captured how these relationships flourished, however also described circumstances in which the relationship dwindled (Coatsworth-Puspoky et al., 2006). A common theme in the development or deterioration of the peer support relationship, as resonated in Peplau's theory was the ability to establish trust (Coatsworth-Puspoky et al., 2006).

Jensen, Forchuk, Seymour, Chapman, Witcher & Davis' (2009) study generated data regarding the transition experience from an acute care psychiatric ward located at a community hospital in a small town/rural Ontario, Canada. Discharge planning was provided by the community service that was responsible for post discharge follow-up. This resulted in a 40% reduction in the annual readmission rate. All participants reported receiving professional outpatient services and peer support at 6 months post discharge (Jensen et al., 2009).

Kidd, et al. (2016) completed a study to explore the use of a 'Welcome Basket' coupled with peer support during the transition from an inpatient hospitalization to discharge within communities. Twenty-three adults 18 years of age and older were recruited with a major mental illness, primarily psychosis, who had been hospitalized for at least month. Participants had a meeting with a peer support worker two weeks prior to discharge from the hospital where they determined the participant's interests and needs (Kidd et al., 2016). Furthermore, a 'Welcome Basket' was developed to include patient-specific identified items such as "staple supplies, plants, coupons for stores nearby the client's residence, and comfort items within a modest budget (up to $50/basket)" (Kidd et al., 2016, p. 3). The 'Welcome Basket' was administered along with Cognitive Adaptation Training (CAT) interventions (Kidd et al., 2016). Common CAT interventions included accessing and developing an agenda with the participant, activities of daily living, task orientation, organization of the participant's residence and prompting the use of clocks (Kidd et al., 2016). An additional budget of $50 was devoted to providing CAT supplies (Kidd et al., 2016). Furthermore, the peer support worker collaborated with the participant to develop a plan such as a tour in their neighborhood to explore resources within their community and empower them to develop confidence in accessing resources within the community in which they live (Kidd et al., 2016). The visits typically occurred on a weekly basis

within the first 4 weeks following discharge from the hospital to the community (Kidd et al., 2016). According to Kidd et al. (2016) the lived experience that peer support workers shared was highly valued by the participants. "Along with increased hope, participants described feeling understood, supported in a way that did not feel like a clinical support, and feeling better about themselves and their potential as a result" (Kidd et al., 2016, p. 5). In addition, Kidd et al. (2016) found that participants voiced decreased anxiety during the transitional period. Participants also discussed the practicality of the items that were contained within the 'Welcome Basket' to aid in their transition back into communities (Kidd et al., 2016).

Taube-Schiff, Mehak, Ferreira, Kalim, Ungar & Mills (2018) conducted a study to determine the effectiveness of a hospital day program during the transitional discharge period within a Canadian Hospital. Taube-Schiff et al. (2018) hypothesized that participants would exhibit improvement in symptom degree, quality of life, functional status and emotional regulation. One-hundred and ninety-six participants who were accessing services at the North York General Hospital Day Program were evaluated (Taube-Schiff et al., 2018). When comparing participants who completed versus those who did not complete the day program, there were no differences at time of admission between the two (Taube-Schiff et al., 2018). However, the level of symptomatology after completing the hospital day program demonstrated improvements in all symptom measures except for the Emotional Regulation Questionnaire (ERQ) suppression scale (Taube-Schiff et al., 2018). The ERQ contains 10 measurements and evaluates both expressive suppression and cognitive reappraisal (Taube-Schiff et al., 2018). There were significant improvements in psychopathology and disability, quality of life and reappraisal to regulate emotions (Taube-Schiff et al., 2018). Finally, measures of symptomatology, anxiety, depression, quality of life and functional status were significantly

influenced by the use of reappraisal, the emotional regulation strategy (Taube-Schiff et al., 2018). Therefore, supporting the hypothesis that participants would demonstrate improvements in symptom degree, quality of life, functional status and emotional regulation following partial hospitalization (Taube-Schiff et al., 2018).

A recent study conducted by Lam, Li, Anderson, Shariff & Forchuk (2019) explored the median length of stay, 30 day and 1 year rate of re-admissions and emergency visits after discharge from a psychiatric unit before and after the implementation of the Transitional Discharge Model (TDM). The TDM involves support from a primary hospital provider during the transitional period until the establishment of a therapeutic relationship with the community provider, coupled with peer support (Lam et al., 2019). Hospital administrative data were reviewed for participants' ≥18 years spanning a five-year period (Lam et al., 2019). The results revealed there was a significant change in median length of stay after implementation of the TDM in acute care units. However, there were no significant differences in median length of stay for participants discharged from tertiary units (Lam et al., 2019). Lam et al. (2019) believe the reasons in which there were significant differences in the discharge of participants discharged from an acute care unit was because participants admitted to an acute unit are often hospitalized for a shorter period of time, therefore limiting the amount of time away from their community environment (Lam et al., 2019). Early implementation of the TDM in tertiary, chronic mental health settings, would allow for an improved transitional experience as consistent provider supports and peer supports could be established prior to discharge (Lam et al., 2019).

Forchuk, Martin, Corring, Sherman, Srivastava, Harerimana & Cheng (2019) completed a study utilizing participatory action research (PAR) design to explore the implementation of the Transitional Discharge Model (TDM) at nine different hospitals across Ontario. The purpose of

this study was to examine the financial savings of the implementation of the TDM across nine hospitals within Ontario (Forchuk, et al., 2019). Data were gathered from 370 participants spanning the ages of 18-85 years by means of interviews with the participants at discharge, key stakeholders and records derived from health care administration (Forchuk, et al., 2019). The effectiveness of the implementation of the TDM were determined by comparing the cost of the intervention to health care expenditure differences such as decreases to emergency room visits, total number of re-admissions and total length of stay (Forchuk, et al., 2019). Forchuk et al. (2019) determined there were a decrease in the length of stay at both 4 months and 8 months post-implementation of the TDM. This reduction in length of stay contributed to a significant savings when considering the cost of an inpatient admission per day (Forchuk, et al., 2019). Forchuk, et al. (2019) calculated a cost savings of $9,114 per discharge after the implementation of the TDM at 8 months. However, it was noted that there were differences in the implementation of the TDM for acute versus tertiary participants – which may not reveal ineffectiveness of the TDM, but rather suggests future exploration of the different types of care (Forchuk et al., 2019). Forchuk et al. (2019) determined that the implementation of the TDM across provincial hospitals could generate substantial savings and in turn improve the discharge process for patients.

The review of the literature shows that for the period up to 2020, there is a small body of Canadian research in this area. The principal investigator focused on a review of Canadian research because the healthcare system is different in Canada. Work outside of Canada would not inform practice within Canada in the same manner. According to the review of the literature, the transition experience is improved when a healthy network of family support and peer support are encouraged during in-patient hospitalization (Forchuk, Jewell, Schofield, Sircelj & Valledor,

1998). Furthermore, the literature reveals that a critical component to the patient's recovery is the establishment and maintenance of therapeutic relationships with nurses (Forchuk & Reynolds, 2001). In addition, access to partial hospitalization programs offer patients improvements in symptom degree, quality of life, functional status and emotional regulation (Taube-Schiff et al., 2018). Many studies focus heavily on the relationships that exist within the transition experience and the resources to support managing symptoms. Gaps remain in the understanding of other resources and supports that can promote healthy transitions from the perspective of the patient. According to the College of Nurses of Ontario (2006) client-centered care involves "actively including the client as a partner in care because the client is the expert on his/her life, and identifying the client's goals, wishes and preferences" (p. 6) should be the foundation of care planning. To the author's knowledge, previous literature has not inquired with the experts, the patients with lived experience, what the transition period is like for them. Therefore, this study sought to address a research question that has not been explored yet.

CHAPTER FOUR: METHOD

The research question and objectives of this study stem from the theoretical perspective; Afaf Meleis' Transition Theory. The research method utilized in this study was qualitative interpretive description research that used a content analysis approach (Assarroudi, Nabavi, Armat, Ebadi & Vaismoradi, 2018). Qualitative content analysis is the systematic process of coding data to identify themes and patterns (Assarroudi et al., 2018). The purpose of this study was to determine what helps/hinders the transition from inpatient mental healthcare in Ontario to re-integration within communities from the perspective of the patient. To the author's knowledge, no literature has inquired with the experts, the patients with lived experience, what the transition period is like for them. Ethical approval was obtained from the Research Ethics Board (REB) at York University. Participation in the study was voluntary and informed consent was obtained from all participants. The participants were informed that their decision not to participate, and decision to withdraw at any time during the course of the study would not impact the nature of their relationship with the researcher, York University or Can-Voice.

Participant Selection

Can-Voice is a non-profit charitable organization located in London, Ontario, that serves the needs of individuals living with mental illness through an array of member activities. Can-Voice is located within a mixed urban and rural setting, served by a regional hospital. The organization strives to offer social support and education to consumer/survivors of the mental health system, focusing on recovery and wellness and community education surrounding mental illness (Can-Voice, 2019). All individuals employed at Can-Voice have lived experience with mental illness. The organizational goals include providing a safe, supportive, accessible space for consumer survivors of mental health services and programs that assist individuals in accessing

resources for improved quality of life (Can-Voice, 2019). Permission was obtained to conduct research at Can-Voice from the Executive Director (see Appendix A).

The inclusion criteria for this study were participants ≥18 years, admitted as an inpatient at a hospital for at least 14 days, able to read and speak in English, and able to give informed consent. The study's exclusion criteria were the presence of psychosis, current suicidal ideation and/or inability to give informed consent. The consent form was provided to the participants and they were offered an opportunity to address any questions with regards to the study (see Appendix B) (CNO, 2017).

Participant Recruitment

A flyer was created and distributed at Can-Voice (see Appendix C). The flyer was written at the grade four level to ensure all individuals were able to review the flyer and voluntarily participate in the study. The principal investigator's full name, institutional address and email were made available on the flyer therefore allowing multiple means for the participants to contact the researcher and express their interest in participating in the study. The Executive Director at Can-Voice assisted the Principal Investigator with participant recruitment.

Sample

Purposeful sampling were utilized in order to gain an understanding of the transition experience from the perspective of the participants (Streubert & Carpenter, 2011). Participants were recruited using the purposeful sampling techniques of convenience and snowball sampling (Streubert & Carpenter, 2011). The rationale for selecting this sampling method was that it allowed early participants to refer other participants whom they felt may be interested in participating in the study. The initial participants were recruited by means of a flyer at Can-Voice (see Appendix C). All clients at Can-Voice had access to the flyer in the day room. The

sample consisted of 13 participants who have experienced a transition from inpatient mental health care to the community. However, 1 participant withdrew prior to the completion of the interview. Thematic saturation occurred at 12 interviews; at which point recruitment stopped (Ando, Cousins & Young, 2014). Semi-structured interviews were conducted with 12 participants between February – March 2019. Open-ended questions were developed from the research question and Meleis' Theory (see Appendix D).

Trustworthiness

According to Guba & Lincoln's (1985) Operational Techniques researchers should be mindful of the following when engaging in research: credibility, dependability, confirmability and transferability (Streubert & Carpenter, 2011). The principal investigator engaged in techniques to ensure credibility of findings such as prolonged engagement with content and validating experience with participants during the course of the interviews. Furthermore, dependability was maintained by inquiring with self how dependable the results were. Dependability is established once credibility is achieved (Streubert & Carpenter, 2011). The principal investigator engaged in confirmability by engaging in an audit trail of the research process by recording data over time that another researcher could follow (Streubert & Carpenter, 2011). Finally, transferability was explored by examining the probability that results are meaningful to individuals in similar journeys. This is achieved by a review of findings by potential users (Streubert & Carpenter, 2011).

Rigor

Ensuring rigor is confirming exploration to ensure participant's experience is accurately depicted in the research. Burns′ (1989) criteria were utilized to ensure rigor in the data collection

procedures. The Principal Investigator ensured adherence to the following standards: (1) descriptive vividness, (2) methodological congruence, (3) analytical preciseness, (4) theoretical connectedness, and (5) heuristic relevance (Burns, 1988). In order to ensure adherence to descriptive vividness, the researcher clearly stated the location of the interviews, participant descriptions, and steps taken by the researcher to allow the readers to experience the stories from a personal level (Burns, 1989). Furthermore, observational, methodological and personal notes were kept by the Principal Investigator and the data were transcribed verbatim by the Principal Investigator (Burns, 1989). Methodological congruence was maintained by ensuring rigorous documentation of the study′s purpose, phenomenon of interest, research question, sample and setting, ethical procedures, methods, analysis and potential implications for practice (Burns, 1989). Procedural rigor is an important aspect that was maintained by describing the steps that were taken during the data collection procedures to arrive with accurate and concise data (Burns, 1989). Furthermore, the Principal Investigator engaged in the art of ″bracketing,′ to reflect upon personal values, beliefs, and judgments prior to engaging in the research process in order to prevent the inadvertent introduction of bias into the data collection and analysis processes (Burns, 1989). Although the duration of the interviews had been approximated, there was no strict adherence to the timing of the interviews, in order to ensure quality data collection that captured the human experience (Burns, 1989). Furthermore, ethical rigor was ensured by obtaining the written consent of the participants to ensure the participant′s rights were honoured during the study (Burns, 1989). A final aspect to ensure methodological congruence is auditability, which was maintained by providing justification for procedural steps and delineating how themes were discovered from the data (Burns, 1989). Another important aspect to ensuring

rigor, is analytical preciseness. This was maintained by comparing the themes against the data to

ensure coherence and true representation of the participant′s voices (Burns, 1989). Theoretical

connectedness, another important criterion, was upheld by incorporating the voices of the

participants and maintaining theoretical principles in the development of the themes. Lastly,

heuristic relevance was maintained as the individual′s life experiences and relevance to nursing

practice was explored. Furthermore, present data surrounding the phenomenon of interest was

explored (Burns, 1989). Following the dissemination of the findings, the potential clinical

practice implications were described (Burns, 1989).

Data Collection

The data were collected by the principal investigator February 9 – March 27, 2019. The

principal investigator has clinical experience working with individuals with mental illness within

acute and complex care and the justice system. Semi-structured interviews were conducted

stemming from the objectives of this study in order to ensure the participant had the opportunity

to verbalize all of their experiences (see Appendix D). The interviews lasted an average of 1

hour. The audiotapes were transcribed verbatim. Observational notes were collected that

captured significant events; including non-verbal communication such as body language.

Participant's transcriptions were coded and therefore identity was protected in the dissemination

of the research findings to ensure the protection of privacy. All printed material have been stored

in a locked filing cabinet behind a locked door (Streubert & Carpenter, 2011). A copy of the

signed consent form was provided to the participants.

Demographic information was collected to generate a description of the participants (see

Table 1) including age, socio-economic status, place of birth, source of income, living situation,

sex and financial sources (see Appendix E). Participant's mental health history was self-reported

(see Figure 1). This enabled the principal investigator to account for the potential differences in

participant's experiences related to different diagnoses, age, living situation and admissions

rates.

Table 1. Participant Demographics

| Characteristic	Values
Sex:	
Male	5
Female	7
Unspecified Sex	0
Age:	
Mean ± Standard Deviation	58.4 ± 9.4
Median	59
Mode	53, 54, 64
Living Situation:	
Home with Family	2
Group Home	4
Subsidized Housing	1
Alone	5
Financial Sources:	
Workplace Safety & Insurance Board (WSIB)	1
Ontario Disability Support Program (ODSP)	10
Canada Pension Plan (CPP) & Old Age Security	1
Relationship Status:	
Married/Common-law	3
Single	5
Separated	2
Widowed	1
Not Listed	1
Level of Education Completed:	
Elementary School	2
High School	3
University or College	7
Length of Stay in Hospital:	
14 Days	2
21 Days	1
1 Month	6
1.5 Months	1
3 Months	1
>1 Year	1
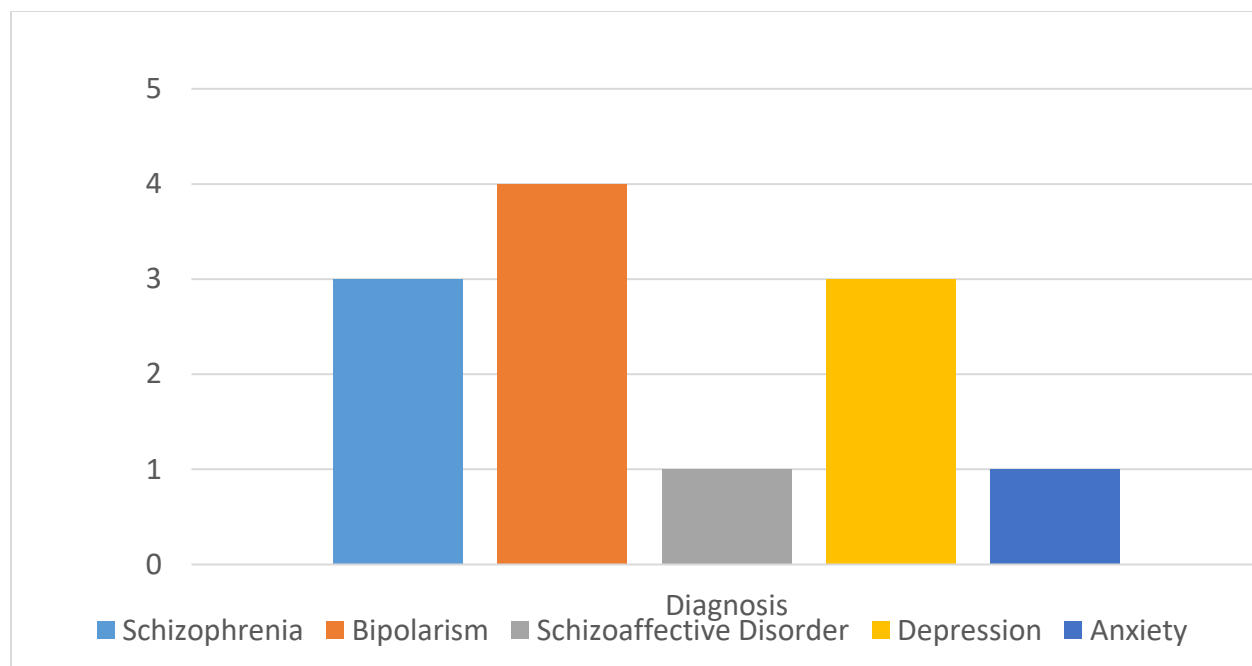
Figure 1. Participant Diagnoses

Thematic Analysis

Qualitative interpretive description research using a content analysis approach was

utilized to conduct thematic analysis of the 12 transcribed interviews (Assarroudi, et al., 2018).

The first phase included the preparation phase where the author became familiarized with the

content to acquire general skills, selected the appropriate sampling method, followed by a

consideration of both manifest and latent content and the development of an interview guide

(Assarroudi et al., 2018). Next, the author conducted and transcribed the interviews and specified

the units of analysis (field notes) and became immersed with the interviews by reading and re-

reading the transcribed data to extract meaning (Assarroudi et al., 2018). Next, the author

progressed through the organization phase where main categories were determined from the

previous related work and theoretical definitions were made (Assarroudi et al., 2018).

Furthermore, rules were made for coding the data, samples were derived for each category, and

the data were analyzed (Assarroudi et al., 2018). Inductive abstraction of categories from the

preliminary codes were then completed and links were made between main categories and

generic categories (Assarroudi et al., 2018). Finally, the author progressed through the reporting

phase by including the results and progression through directed qualitative content analysis

(Assouradi et al., 2018). NVivo 12 Pro was utilized to facilitate the thematic analysis of the 12

transcribed interviews.

Operational definitions were created for each of Meleis (2010) transition conditions;

meanings, expectations, level of knowledge and skill, the environment, level of planning and

emotional and physical well-being (Hsieu & Shannon, 2005). All transcripts were reviewed, and

text were highlighted where it referred to the transition conditions (Hsieu & Shannon, 2005). All

transcripts were coded with the categories initially described and any text that could not be coded

into one of the categories was placed into a new category that described the experience (Hsieu &

Shannon, 2005). Finally, the researcher examined the extent in which Meleis (2010) theory

accurately depicted the transition conditions of the participants of this study (Hsieu & Shannon

& 2005).

CHAPTER FIVE: RESULTS

Of the 12 participants, seven participants were female and five participants were male. The mean age was 58.4±9.4 years. Participants self-reported a number of mental illnesses, specifically three participants reported a diagnosis of schizophrenia, four with bipolarism, one with schizoaffective disorder, three with depression and one with anxiety (see Table 1). All of the participants had been admitted as an inpatient at a hospital for at least 14 days. The participant's length of stay in the hospital ranged from 14 – 365 days, with the average admission period of 60.7 days.

Of the 12 interviews, the environment was the most frequently referenced category, which was further subcategorized into peer support, family support and the therapeutic nurse-client relationship. Level of planning was another frequently referenced category, which was subcategorized into discharge planning/crisis planning, community passes, partial hospitalization and outpatient supports. Finally, the last category described was emotional and physical well-being.

Category I: Meanings

Participants did not discuss the meanings associated with the transition experience (Meleis, et al., 2000).

Category II: Expectations

Individuals experiencing transition may have unknown or unrealistic expectations of the transition experience (Meleis, 2010). When individuals are provided with the information regarding transition expectations, the associated anxiety and stress is reduced (Meleis, 2010).

One participant spoke about his experience in relation to unknown factors; he reported the health care team were dismissive and never really empowered him to engage in his recovery journey:

> It was like I was looking for something and even in the community, I was involved in this stuff and they just basically, you know, said 'I don't think we could help you, because you just don't seem ready.' I mean, a lot of people told me that I wasn't ready… I said well, what do you want me to do to show you I'm ready? And they said, 'when you're ready, you're ready.' So there wasn't any help at all – there was no help…And anyway I'm glad I got out of there – Participant 007.

When patients have clear expectations regarding the transition experience, they can be actively involved in the transition experience (Meleis, 2010). Collaboration among all team members including the patient and the family member during the transition process can assist in reducing stress and anxiety (Meleis, 2010).

Category III: Level of Knowledge and Skill

Participants discussed the importance of increasing individual's level of knowledge and skill surrounding the transition experience (Meleis, et al., 2000). Most notably, knowing who to turn to within the community, how to access services and follow-up with a psychiatrist and additional aftercare. "The first time [I was discharged] I was just handed papers and 'away you go.'" – Participant 011. Participants compared discharge planning to physical health discharge planning and argued that discharged planning from a physical health ailment is more streamlined and suggested improvement to current discharge planning models within mental health care:

> Yah, that happened when I had my stroke, you know. When I was leaving, they said, 'okay, you can't do this, this and this, but you can do this, this and this and this. And you're going to go for warfarin testing, and you know, you know they gave me a whole

pamphlet and yata yata yata.' But when I was getting ready to leave from the ward

[referring to her discharge from the mental health ward], I didn't get any of that, you

know. So I would have preferred some kind of aftercare plan. Like a discharge plan. And

follow-up, like aftercare, you know - Participant 010.

This emphasizes the importance of increasing individual's knowledge and skill, and

subsequently reducing uncertainties to aid in a smoother transition (Meleis, et al., 2000).

Category IV: The Environment

The environment refers to the external resources within one's life (Meleis, et al., 2000).

Social support from friends, family and/or the patient's spouse and support from professionals

and peer support groups promotes smoother discharge experiences (Meleis, 2010). Many

participants regarded that the development of a peer support relationship founded in trust and

respect is fundamental prior to the establishment of support. The participants suggested that the

development or deterioration of peer support relationships is contingent upon the establishment

of trust within the relationship. Many participants spoke about the importance of establishing

connections with formal and informal peer supports.

Participants described how it takes time to establish trust within the professional peer

support relationship. One participant suggests that the establishment of the peer support

relationship can lead to improved self-esteem:

Oh, I felt good about it. It took me awhile to [ha-ha], for [her] to give her two [cents] – to

get through to me. Because I, I just felt. I just felt like I was always just thinking someone

else who would just pull the rug out from beneath me. So I was anxious because someone

was going to play a prank on me. Yes, without question, my esteem level, if I have to use

that term, low self-esteem, most definitely [improved with peer support]" – Participant 007.

Another participant describes how peer support sheds light on the lived experience and offers a firsthand perspective, "with people that were going through the same things or similar things that I was going through. Understood me [peer support]" – Participant 004.

Participants who engaged in peer support described the experience as rewarding as it enables them to apply their skills in managing mental illness to empower others in their experiences:

No, I don't think so. I will say, that I'm not embarrassed – nor proud of my past. But I've used it as a learning tool to help others – that's my goal in life now is to educate, educate and educate on mental health. Because I've had it so bad that I want to make it easier for others – Participant 009.

Participants who have delivered peer support to patients described it as rewarding as they supported others on their journey with mental illness. "It was rewarding. When you make a difference in somebody's life, and you see them years later on a bus, and they say, 'you saved my life,' it's, holy cow, you know" – Participant 008.

One participant discussed peer support with reference to golf; he regarded how significant it is to have peer support to assist you with navigating the mental health care system and during the transition experience:

I wrote this down in regards to peer support in theory with golf. It's like you're going to a new golf course that you've never played before, right? So you wanted to see the pro, but

the pro was busy. So I went out and I joined these three guys, and I shot my first shot. So my next shot, this guy walks up to me and actually knew golfing, and said, 'you know there's water in front of the green?' I said, no you can't see it from here. But, 'we know that there's water in front of the green.' And I said jeese, thank-you very much, I would've hit this. So I hit another club and it got over the water and got it on the green. Otherwise, I would've hit my last club and ended up in the water. So they helped me with dangerous situations, I guess…So, if you know what to look out for, sometimes you don't need a Psychiatrist or a golf pro to get you through, but it's good to have both – Participant 005.

Finally, participants describe shortages among formal supports and indicate the significance of having a formal peer support during the hospital transition period to support and empower them when making decisions. "So if there were peer support in the hospital that would be awesome. I don't know if there is. But you need someone like that coming in, you need a worker for that person, a buddy with the person who can do a lot of stuff for them. Think - I dunno if think for them – but think with them" – Participant 004.

Participants described the significance of the establishment of relationships with informal peer support persons as it improves the person's comfort level. This suggests that honouring space and time is imperative as the individual learns to trust the peer support person. "Uhm comfortable with where you're at, being who you are at whatever stage you are at. And that lack of judgement and freedom of expression and uhm, uh comfortableness with each other and uhm supporting each other" - Participant 004. This participant further mentions that peer support was pivotal in the development and progression of healing as they transitioned from the hospital to the community:

And uhm I came out and I was better, I could. But I was all mixed up when I went in and uhm was just attacked and uh so I had a lot of healing to go through and I needed a lot of support - a lot of support – Participant 004.

Informal peer support relationships led to the development of networks of support within the Willow Creek House (Can-Voice Group Home), which suggests that informal peer support relationships are required beyond the transition period. "And so there's a network kind of at home that's happening. And there's a network here at Can-Voice and I know Willow Creek so I am connected here" – Participant 004.

Another participant discusses the importance of informal peer support on an ongoing basis to provide ongoing support and encouragement in a non-threatening environment, which promotes more open, honest sharing:

When you're going through challenges – you need friends. And even if it's just to sit over a cup of coffee. The best groups [I will] run are when I take the people from Can-Voice to Tim Hortons, and we'll just sit and have a coffee and we'll talk. And I'd do that at the men's shelter, I'd just before I left, have coffee and discussion and they would uhm come in, and everybody felt better when they left, because it was not threatening, and I was one of them, and we just 'talked,' you know – Participant 008.

Another participant also mentions the importance of having multiple forms of peer support during the transition between the hospital and the community and suggests the longer you have been hospitalized, the greater the support is required:

As much supports as you can gather around you would be good. Because it's hard to

make that step on your own if you've been in the hospital. I was only in there for two

weeks, but I'm thinking about the people who've been in there for long periods of time.

And they're faced with a new situation – Participant 004.

Many participants spoke about the stigma that exists within peer support programs,

among workers and staff. Participants reported that health care professionals often do not

appreciate the significant influence they make on the transition experience. "We used to joke

around like we'd sit there waiting, like they kept saying, they just never took us seriously. Like

what possible thing would a person that's gone through it know?" – Participant 007.

Other participants report that stigma exists among peer support workers from the lens of

the patients, as they are reportedly often afraid to confide in peer support workers for fear of

negatively influencing their mental health. They report feeling as if individuals with mental

illness are too unwell so they are hesitant to confide in them for support:

Uhm, and if I have bipolar…I am just as capable of somebody else to lean on. Like, they

can, you know. My, one of my AA [Alcoholics Anonymous] sponsors that I help; she

was like, 'well if you have bipolar, I don't want to call you, because it might be one of

your bad days.' And I said, sweetie, let me take care of that, you know. Let me take care

of that because, you know, uh I reach out when I need to, you know – Participant 010.

One participant emphasized the importance of knowing when you are well versus unwell

in order to offer peer support. They stress the importance of differentiating between self-

identified mental wellness versus illness:

And I can take care of myself enough that I can help other people when I am taking care of myself, you know. If I am not taking care of myself, I won't be able to help other people. But I know myself well enough to take care of myself, you know – Participant 010.

Many participants discussed the important of having family supports during the transition period. However, some participants expressed significant ambivalence surrounding informing family members of their mental illness for fear of stigma:

I kept to myself and I, and I didn't share with them more with uh with my family or anyone really until it all came crashing down…Because of the fear of being judged and looked down on and uh things along that line – Participant 004.

Other participants discussed the importance of including family supports during the discharge planning so that they are actively involved in the process prior to the day of discharge:

This is a family problem, not just my problem. And uhm, prepared my children and my husband, that I was coming back home. And uhm that, you know you have to be understanding that it's going to take me awhile to adjust to the new environment – Participant 008.

One participant spoke about the stigma amongst health care providers that led to further isolation as they collaborated with her family and did not involve her in the discharge planning. "I don't know – stigma, perhaps? And of course, when they did talk to my husband, well 'she's lazy, she's crazy, this and that…' and they tend to take his side of things, and didn't even get my view on anything" – Participant 008. Another participant discussed how not involving her

husband in the transitional period was significant because her husband knows how she is when she is well versus unwell and is an essential support for her when managing her mental illness:

> Uhm, and the hospital, let me think, when I left, what was great about when I left is one thing, that is really great in my life is having [my husband]. Because he knows what it's like to have a mental illness. And he knows what it's like when my mental illness is on the, is like happening [crisis]. He knows when I'm in a low cycle. He knows when I am in a high cycle – Participant 010.

One participant also spoke about the need for more integrated couple's therapy when preparing to transition back home after an admission to a hospital to improve understanding and the reduction of stigma:

> I would like to have seen more uh couples support in some way. But then he would have to participate and be willing - and he wasn't willing. He saw it all as 'hogwash' …that is typical rural community thinking, that you know, you're 'insane' if you have a mental health issue – Participant 008.

This participant discussed how the rural setting and societal stigma influenced the way in which her husband viewed and supported her mental illness when she transitioned back home after discharge from the hospital.

Another participant spoke about the realization that she needed extra support when she was discharged from the hospital, so she moved in with her parents to embrace greater family support:

> When I got stronger I moved into my parent's. Which people could look as a step backwards, but it really isn't – it's a step forward for me personally. Because on my own,

I was struggling, but I have support around me - and I need support around me –
Participant 004.

Another participant spoke about the significant role his family support played when
contemplating dying by suicide:

I was going to commit suicide by medication; over-medicating. And uh I just got to the
point where I, uh, I hit rock bottom and I needed - and I reached out for help. So I got an
appointment to see the Psychiatrist. And the day that I went to see the Psychiatrist was
the day that I was feeling really suicidal. I was up the night before, and if it wasn't for my
daughter being up with me, I would've done it that night [died by suicide] – Participant
001.

Many participants discussed the limited involvement of their family members during the
discharge planning despite the significant role that they all play in offering family support during
the periods of wellness and illness. However, several participants discussed the role of the
therapeutic nurse-client relationship and the influence on helping/hindering the transitional
experience.

Participants spoke about the positive influences of the therapeutic nurse-client
relationship on their transition experience. Participants reported that a positive, consistent
therapeutic nurse-client relationship was pivotal in supporting them to transition back into the
community once discharged from the hospital. One participant discussed how through the
establishment of trust with one nurse significantly influenced his ability to open up about his
mental illness:

I sat down and [she] looked at me and said, uh, uh 'how are you doing?' And I just broke down and I cried like a baby – because it seemed she was the first person that asked me, 'are you okay?' Or maybe it was [her] ability, or her voice, or her tone of voice or the cadence of her voice. What it was – it hit a nerve and I – now I cry like a baby... [Laughs] God [tearing up a bit]. But before, I was very stoic – Participant 007.

The same participant discusses how the establishment of this relationship with previous emergency visits and hospital admissions may have influenced his recovery journey from an earlier time in his life:

What would've helped is a 'person' or somebody like [her] that would've asked me. I felt like I was being condemned all the time. Or that somebody thought I was uhm you know that I was 'faking it,' or something…like I didn't have anything better to do then go into an emergency ward… [Laughs]. Like, yes - I think I'll go right now – Participant 007.

Another participant spoke about the significance of establishing trust and maintaining commitments during the transition period when planning for discharge:

I went to the hospital one time and I was feeling suicidal – like I wanted to get admitted to the hospital. But they wouldn't let me…So they didn't have any room and they didn't think it was a good idea – so what they did is they got the CMHA [Canadian Mental Health Association] team manager, brought her to the hospital, and I spoke with her that night and she said, 'I will put you on the list to get a worker right away.' And we got a cab home – they paid for the cab home. And then I got a worker within 2 weeks – Participant 010.

Several of the participants discussed the significance of having a transitional nurse who consistently followed them into the community and whom they established and maintained a relationship with to support them while living in the community. "Uhm yah, that one I was assigned a CMHA Transition Worker and he was really great. That lasted four or five months with him and uh he really helped a lot" – Participant 011.

Participants discussed how the visits with the consistent provider enabled them to assess how they were coping living within the community, detecting deterioration, and establishing early intervention:

> I stayed in the shelter for 9 months and then I went into an apartment on my own, but I was still followed in the community by my caseworker…Which helped, that was tremendous. Because she would come in and, well she'd look around, and you know, she'd discreetly uhm, 'is the house clean, and is she presentable,' and uhm she'd find that there'd be cookies that I've made. And so she got to assess me, you know" – Participant 008.

Another participant discussed the importance of having a nurse come to assist them with maintaining their coping skills and adherence to their prescribed medications. "Coping and medications. They help me with my morning meds. They come every day to remind me to take my morning meds and evening meds...I'm not very good at self-medicating; I have to be medicated - I have to be reminded" - Participant 002.

Although several participants embraced positive therapeutic nurse-client relationships and discussed the significant role they played in maintaining their wellness during the transition period, several participants spoke about negative experiences within the nurse-client relationship, perpetuated by pervasive stigma that influenced their transition experience:

Yah, I uh was in the hospital and I must say god bless everybody, but there were times when I didn't feel I was treated like I would've liked to. I, I felt like I was being diagnosed all the time. Uhm, I dunno, I was just, I guess I'm a difficult person to deal with…So I'm in the hospital and I dunno for some reason I just took it all in and I see some people getting, I dunno, treated not well, you know. And that's my opinion – Participant 007.

Another participant reflected on her experience with difficulties opening up to nurses and the health care team about her mental illness for fear of being stigmatized and labelled. "And terrified to know how, what to do for fear of anything I said or did was going to be interpreted as being 'crazy'" – Participant 008. Some participants even felt they had to convince nurses and the health care team to believe them about their experiences with trauma. "Because finally, people were believing me. I'm saying to the Doctors and everything, 'I'm being abused,' and nobody listened – nobody" – Participant 008. Another participant reported concerns of feeling like they were not heard or not having concerns addressed when reporting how they felt to the nurses. "Uhm, I would, I would tell them how I felt and they would just kind of pass it off kind of thing like would just 'oh well,' you know. 'Don't worry about it.'" – Participant 006.

The environment contained many elements that participants reported has a significant influence on their transition experience. The inclusion of informal and formal peer supports during the transition experience increased participant's comfort level. Many participants also discussed the importance of including family supports during the transition process. Both positive and negative therapeutic relationships were discussed among the participants. Participants reported that a positive, consistent therapeutic nurse-client relationship was pivotal in supporting the transition back into the community once discharged from the hospital. Negative

nurse-client relationships perpetuated by societal constructed stigma was described by participants as having a significant impact on the transition experience.

Category V: Level of Planning

Several participants addressed the importance of transitional discharge planning. Discharge planning involves analyzing factors that ease the transition into community settings; the hospital cannot be viewed as a wall or means to an end - the two must overlap:

> We did do that in the actual uhm, in the, you know, as one of the assignments while we were in the hospital; like a crisis plan. Uhm, but uhm, like a discharge plan – that would have been nice. And it would have been nice if I could have come back to the hospital like say once a month, you know for like a, like aftercare you know, like a follow-up – Participant 010.

Another participant spoke about how many discharges it took prior to receiving the appropriate transitional support to re-integrate within the community. "I think uhm the first few times I was in the hospital – were not good. The first two times. The last two or three times I had more support on the way out then I did before." – Participant 011.

One participant mentioned that hospitalization influences their ability to cope with activities of daily living. They stressed the importance of continuing to engage in activities of daily living such as paying bills and making phone calls while in the hospital because it is easily forgotten during the transition back home depending on the length of the hospital admission:

> And you want to, because it's like giving up, so you're just letting somebody else take over. But my family wouldn't let me do that either. Like they used to bring my bills in. And I'd have to use the pay phone to pay my bills – Participant 009.

Almost all participants discussed the importance of maintaining connectedness with the community during hospitalizations through authorized leave of absences or 'passes'. One participant discussed their experience of seamless transition as a result of weekend to discharge passes. "Uhm it was, it was pretty simple uhm because I had gone on uhm you know like the weekends I had gone out on the weekends, and I'd had gone out on the stays, like the [passes]." – Participant 011. Several of the participants discussed how the weekend passes played a significant role in their successful transition:

> So uhm, uhm when the Doctor was ready to discharge me, I went, I went to uh, well I used to get uh weekend passes and I'd go to my sister's – she had a house…because then uhm I got to see what it was like on my own. When I went to my sister's, I had her company, it was her home – it wasn't mine. So then when I got to go home, uhm, on a pass, I could get used to being at home – Participant 009.

The same participant emphasized the significance passes had on their ability to maintain self-care and comfort while engaging with the community:

> Yah, but usually you lose your ability to look after yourself in hospital. Especially if you're in there for any length of time. But if you get passes, you get used to your home, and used to the people around it, and used to the community. So I, I strongly suggest pass – Participant 009.

This participant mentioned that remaining in the hospital for prolonged periods of time leads to significant dependency on others:

> But yah, a lot of that you do yourself. Like you get…it's like getting into a rut – it's more comfortable to sit back and let everyone take over. But you can't do that, you have to

keep being independent. Keep being out in the community, so you get used to everything

again – Participant 009.

Although several participants discussed the significant impact passes had on successful

transition into communities, they discussed the barriers faced when having medications

dispensed in preparation for weekend passes:

Like the nurses would fill all the orders and all the paperwork was done the day before.

Pharmacy should have enough people and they should be on the ball looking at reading

stuff, reading charts, see oh this patient needs their meds and they're leaving at this time

– Participant 001.

Intermittent community passes and weekend passes prior to discharge were regarded by

participants as leading to improved transitional experiences. However, some participants

discussed that weekend passes alone to discharge were not enough to aid in the smooth transition

and suggested additional supports such as transitional units. Many participants discussed that a

gap remains between the hospital and the community and that after prolonged hospitalizations,

there needs to be a transitional discharge unit or partial hospitalization program. One participant

spoke about their experience staying on a day surgery unit off the mental health unit at night due

to a hospital surge during their admission:

They had me uhm staying, they had me staying during, sleeping in like the day surgery

part of the hospital. Like after supper, I would go up there and stay, uhm it was really

crowded in the hospital, you know. And so uhm me and so uhm me and this one other

girl, maybe two other people, uhm would go up there after supper around 8 o'clock and

we would stay there for the evening – Participant 010.

This participant discusses the importance of having a transition unit off the mental health unit prior to an official discharge; she regards this transitional period was critical in her successful transition back into the community:

> No, I liked the way that happened - I really did. I really liked the transition from the actual unit to like the day surgery unit. Because it helped me. First of all, it was very quiet at night. And it was wasn't as 'crazy,' as the ward is. And uhm it also helped me get used to what it would be like at home. So that was a really positive thing, you know, being up in day surgery for about, I think it was about a week before I left. Like at least during the week it was. Not on the weekends, because I think I was like at home for the weekend – Participant 008.

Several participants discussed the gap that exists within the community once released from the hospital. For many participants, they mentioned inadequate follow-up during the transition period. **"**Yah, released like people who are homeless, they're released back into the community and there's nothing there - and they don't have supports" –Participant 001.

Participants also discussed the impact of pervasive stigma that exists within the community; societal labelling of mental illness as 'crazy' de-personalizes their experiences and tarnishes their recovery journey:

> Better education within the community. I mean for me to be viewed as 'crazy.' I mean yah there were some stupid things I did, I admit that. But I was trying to cope the best way I knew how. I used to cut and self-abuse, because I hurt so bad inside – I needed a release. So I would injure myself and that was viewed as 'bad,' of course, I get that. But it was viewed more like, 'crazy.' You know like, instead of saying, 'she's hurting,' you know, we better ship her, send her back – Participant 008.

Another participant discussed the importance of ensuring adequate housing support during the transition period in order to prevent homelessness. "Places like Can-Voice [Willow Creek House] helped me out. If it hadn't been for Can-Voice I wouldn't have a home. And I'd be in an institution or the Salvation Army [Hostel for the Homeless]" – Participant 002.

One participant reported that access to follow-up outpatient programs played a significant role in their successful transition, offering supports from multiple disciplines to manage their mental illness within the community:

> It was run by social workers and nurses. I think one was a social worker and one was a nurse. Uhm, and uh it lasted once. Twice a week for 6 weeks and it was really good…Oh, that changed my life, honestly, uhm they had a Pharmacist from the hospital come in and explain how the medications worked, how to take them, and that you only get a 30% boost in your mood from the medications, the rest is what you do – Participant 011.

This same participant reported that there are significant shortages in follow-up groups post-discharge. The participant advocated for improved access to universally funded non-pharmacological approaches to managing mental illness such as Cognitive Behavioural Therapy (CBT):

> So I found, that going into the group situations after the hospital transition – oh that was also referred to as the CBT Group for Depression and I had one for anxiety. I didn't like the depression one. The CBT group has changed my life. The CBT groups are amazing – Participant 011.

The same participant discussed the significance of engaging in CBT outpatient programs in order to learn how to manage their mental illness and future crises:

They built you up to being able to be there – stabilization and stuff like that. It was, that CBT group changed my life. I have had only one or two bouts of depression since then because CBT has taught me that when I hear one of those thoughts that says something 'crazy,' to go nah, 'no we're not doing that. I'm not listening to that. I am not entertaining that thought – and I just kick it out of my head' - Participant 011.

Several participants reported there is an increased need for improved transitional discharge planning. Emotional and physical well-being was described as an equally important component influencing the transitional experience.

Category VI: Emotional and Physical Well-Being

"Anxiety, insecurity, frustration, depression, apprehension, ambivalence and loneliness" are emotions that individuals facing transition may experience during the transitional period (Meleis, 2010). One participant describes feeling insecure with their mental health diagnosis and that it serves as a barrier to seeking treatment and recovery:

Well at first, I thought [there is] nothing wrong with me, and what's going on. And uh I couldn't believe that there was something wrong with me because everything seemed normal, but it's not. Like [I am] hearing voices that [were not] there and no one else could hear them – Participant 002.

Another participant describes struggling alone, which influenced her ability to assume risks and engage with the transition experience. "And uh I was struggling because I was struggling inside [because] I was just trying to keep things together…Because of the fear of being judged and looked down on and uh things along that line" – Participant 004.

Another participant describes the experience of depression during hospitalization and transition and how it consumes them to the point that they do not understand what is going on:

> I have to admit that when I go into the hospital, I don't really know what's going on. My depression gets so bad that I don't remember going in, I don't remember meeting people. I don't remember talking and who's talking first. Four weeks later or whatever, somebody in there will go, 'well yah, you're looking a lot better.' And I'll say really, how did you know that? And they'll say, "I was there when they brought you in" – Participant 011.

The emotional distress that individuals experience during the transitional period can influence their ability to fully engage with the transition experience.

CHAPTER FIVE: DISCUSSION

This study explored factors during the transitional discharge period that can help or hinder patients' successful re-integration into communities from the perspective of the patient. To the author's knowledge, previous literature has not inquired with the experts, the patients with lived experience, what the transition period is like for them. Therefore, this study addressed a research question that had not been explored yet and adds to what is known about the discharge experience. Participants discussed how their expectations of the transition experience influenced their stress and anxiety (Meleis, et al., 2000). The environment was the most frequently referenced category, which was further subcategorized into peer support, family support and the therapeutic nurse-client relationship. Level of planning was another frequently referenced category, which was subcategorized into discharge planning/crisis planning, community passes, a transitional unit and outpatient supports. Finally, the last category described was emotional and physical well-being. Interestingly, participants did not discuss the meanings associated with the transition experience (Meleis, et al., 2000). The new knowledge learned from this study offers different perspectives concerning the discharge process for patients living with mental illness from the perspective of the patient.

This study explored the relationship between patients, peer support, and the influence of these relationships on their transitional discharge. This study supported the findings of Coatsworth-Puspoky, et al. (2006) suggesting that there are circumstances in which these relationships flourish, however also circumstances in which the relationships deteriorate. A common theme in the development or deterioration of the peer support relationship, as resonated in Peplau's theory was the ability to establish trust (Coatsworth-Puspoky, et al., 2006). This study also revealed that patients who experience positive, helping relationships with peer support

workers experience more successful transitions into communities following discharge. However participants also revealed the negative, tenuous experiences that hindered their successful transition within communities. Furthermore, this study revealed that there are formal and informal means of peer support accessed by patients. Participants described the importance of accessing both formal and informal peer supports in order to ensure a balance in accessing the support they need in the moment.

This study also supported reports in the literature that pervasive socially constructed stigma significantly influences many individual's comfort in sharing their mental illness and hospitalization with family members. However, many participants described a period of acute crisis where they needed to access family supports; some described this as a negative experience and others described it as a positive experience that led them to the appropriate family supports to re-integrate into the community. Participants consistently reported that a health family network of support needs to be established during in-patient hospitalizations and the transitional discharge period in order to support individuals to experience recovery and wellness within the community. Despite this recommendation, many participants described inconsistencies in involving family members; many described that they felt the family was the only one consulted in isolation of the person experiencing the mental illness or they felt the collateral perspective of the family was not taken into consideration and not involved in the discharge process. This is consistent with Forchuk, et al.'s (1998) findings that family relationships foster ongoing supportive connection and provide "emotional, social, spiritual, cultural, housing and financial support" (p. 199). Many participants described the significance of including family members as they are the ones who will support the individual to transition into the community and recognize and support them when they need to re-access services with regards to their mental illness in the

future since they know their baseline. According to Lam et al. (2019) patients in transition experience significant barriers to meeting basic needs. Consistent family supports during this transitional period can support patients to bridge the gap between the mental health setting and the broader community (Bromage, Kriegel, Williamson, Maclean & Rowe, 2017).

This study also revealed the influence of both positive and negative nurse-client relationships on the patient's transitional experience. A positive, consistent therapeutic nurse-client relationship was pivotal in supporting participants to transition back into the community once discharged from the hospital. This reinforces the findings of Lam et al. (2019) who found that ongoing support from hospital to community staff, until the patient has engaged with the community nurse past the orientation phase of the nurse-client relationship lead to successful transition and reduced re-admission rates. Many participants described positive nurse-client relationships within their successful discharge back into the community. This further supports Peplau's theory and "assumes that the quality of interpersonal relationships has an influence and impact on quality of life and that a supportive social network will promote less need for expensive interventions such as hospitalization" (Forchuk, et al., 2005)

Almost all participants reflected on circumstances where they engaged in negative interactions within the nurse-client relationship that hindered their transitional experience. This further emphasizes that negative nurse-client relationships where patients are unable to progress into the working phase of the relationship may hinder successful transition into the community. This is consistent with the findings of Bernardo & Forchuk (2001) where it was discovered that nurses' often have different perspectives than the client surrounding their illness and reasons for re-admission; patients often express concerns struggling with prolonged symptoms, whereas healthcare providers refer to the symptoms as intermittent. This creates dissonance in healthcare

provider's perception of patient's ongoing struggles with symptoms (Bernardo & Forchuk, 2001). These perceptions and attitudes may impair the nurses' ability to accurately assess and determine nursing interventions tailored to the patient's needs, and ultimately place the client at risk for future re-admissions (Bernardo & Forchuk, 2001). This reinforces the significance of Peplau's theory application to clinical practice to ensure bracketing is maintained in order to collaborate with patients experiencing mental illness to learn from their perspective what would aid in a successful transition back into the community, as there is no cookie cutter approach that is applicable to all patients living with mental illness. Improved, coordinated transitional care for those with mental illness, leads to improved functioning, patient experience and quality of life and a reduction in the incidence of patient death (Cleverley, 2017).

Furthermore, this study revealed factors that lead to a transitional discharge, recognizing that the hospital discharge is not a wall, but rather a waterfall pouring into the community experience. Many participants described multiple periods of transition prior to accessing the resources they needed in order to ensure a smooth transition from the hospital to the community. According to Kidd et al. (2016) the transition period from the hospital to the community is a precarious time in which the availability of resources and services has an impact on the patient's recovery journey. An important study finding was the importance of crisis planning for discharge. Most notably, knowing who to turn to within the community, how to access services and follow-up with a Psychiatrist and additional aftercare. According to Kidd et al. (2016) patients with mental illness experience difficulties re-establishing connections within the community; inpatient and outpatient health care providers often do not communicate plans of care (Kidd et al., 2016). Poorly coordinated transition between inpatient and outpatient care providers places patients at significant risk of re-admission rates within the first month following

discharge and the greatest risk of suicide within the first two weeks following discharge (Kidd et al., 2016). Highly-structured inpatient programs differ drastically from outpatient services (Kidd et al., 2016).

This study also revealed the significance participants place on authorized leaves of absence or community 'passes' and most notably the weekend-to-discharge community passes, which demonstrates a patient's readiness for transition. Participants described this pass as an opportunity to examine what factors and supports they currently have and an opportunity to explore outstanding resources prior to a formal discharge - from the patient's perspective. Authorized leaves of absence or 'passes' offer the patient an opportunity to demonstrate to their clinical team their ability to exhibit coping skills, manage their mental health symptoms and level of aggression for prescribed periods of time prior to discharge (Barlow & Sickens, 2018). Barlow & Sickens (2018) report that inpatient admissions disrupt family and social connections through environmental separation. According to Barlow & Sickens (2018) upon a review of current literature, authorized leaves of absence require further research on the direct impact as a therapeutic intervention as there is currently limited information available on the decisions surrounding leave of absence practices. Another important finding was the significant gap that still exists within the community for accessing universally funded non-pharmacological approaches to managing mental illness such as Cognitive Behavioural Therapy (CBT). Outpatient accessibility of CBT is limited, despite evidence suggesting CBT is the hallmark therapy for mental illnesses such as anxiety (Wolitzky-Taylor, Chung, Arch, Grossman, Fenwick, Lengnick-Hall & Miranda, 2019). This evidence suggests an exploration of more available and accessible forms of publicly-funded outpatient CBT. According to Taube-Schiff (2018) inclusion interventions such as Dialectical Behavioural Therapy (DBT) in partial

hospitalization programs may improve effectiveness of outpatient interventions and reduce costly inpatient admissions.

The theoretical perspective that guided this study was Afaf Meleis' Transition Theory. Situational transition was explored, focusing on transitions from hospitals (Meleis, 2010). Complications and re-admissions are reduced when patients and their families are supported by competent health care providers during the recovery transition (Meleis, 2010). This study revealed that there are multiple relationships; peer support, family relationships and the nurse-client relationship that influence the transition experience. Participants discussed the factors leading to either a positive, successful transition or a complicated transition experience leading to re-admissions to the hospital.

Meleis (2010) defines healthy transitions as "a mastery of behaviours, cues, and symbols associated with new roles and identities as non-problematic transitions" (p. 3). Situational transition involves a shift of roles and responsibilities; nurses are in an excellent position to support the transition of roles and responsibilities (Meleis, 2010). Transition refers to the complex interactions between the person and their environment (Meleis, 2010). This study supported the theory that the complex interactions among different relationships within the person's environment influence their success in transition. According to Meleis (2010) there are three phases of the transition experience; entry, passage and exit. The phases have different durations and the phases merge with each other (Meleis, 2010). During the course of the study, participants did not discuss the different phases of the transition experience. However, participants did describe the transition conditions that influence the transition journey as described by Meleis (2010): expectations, level of knowledge and skill, and the environment, level of planning and emotional and physical well-being. Although the categories of meaning

was not discussed among the participants, the other important categories were discussed among the sample group. Level of expectation for the transition experience influenced the experience of stress and anxiety. The environment were discussed by participants with regards to peer support, family support and therapeutic nurse-client relationships. Level of planning also influenced the transition experience, which was discussed with reference to discharge planning/crisis planning, community passes, partial hospitalization programs and outpatient supports. Finally, emotional and physical well-being was discussed with reference to emotional distress and stress among participants during the transition period. Therefore, demonstrating that Meleis' (2010) theory is applicable to situational transition for this study, however more markedly with regards to the participant's environment during the transition period. According to Meleis (2010) the transition is a unique experience and thus patients should be consulted with individually to determine the most appropriate planning for their transition back to communities. This was reflective of the participant's experience within this research study as many participants criticized the 'one-size-fits all' framework and argued that a more individualized-approach to discharge planning must occur to ensure smooth transitional discharge experiences.

Limitations

Bias is inherent in any research. According to Bergdahl & Bertero (2014) a theory is a structured, organized means in which to define a dimension. A potential bias in the utilization of a theory is through categorizing the data in accordance with themes (Bergdahl & Bertero, 2014). This may leave out any data that does not fit the theoretical model. A homogeneous sample in one location means there may be differences in the sample which were not captured in this group due to a number of factors. There may be different experiences for new immigrants, different ethnicities or those that do not speak English. This study sought to address a gap of what the transition experience is like for patients from the perspective of the patient. It is difficult to access the mental health consumer survivor's voice and the Principal Investigator needed to get access to participants, this is why a site was chosen where it was practical to access participants willing to share their experience.

The mean age for the sample size was 58.4 ± 9.4 years; different age groups may reveal different challenges and/or barriers that individuals face throughout the transition process. In addition, the study was conducted at a consumer/survivor agency; the participants attend the same program, therefore they are more like each other than people who are not members of Can-Voice. A limitation of the convenience and snowballing technique is that it may encourage recruitment of participants from similar backgrounds (Streubert & Carpenter, 2011). Other patients at other organizations who have experienced a transition from inpatient to outpatient settings may experience transitions differently. Patients who are not involved with organizations may offer important context surrounding their transition experience. Therefore, the researcher suggests a replication and expansion of this study to broader sites such as hospitals and communities to explore different ages and populations. Future research may offer a different

perspective by means of an alternative method and/or sampling technique which may yield different results. This is a qualitative study; we cannot generalize qualitative results. We can however transfer results to similar groups.

Clinical Practice Implications

There are two main implications for clinical practice: the environment and level of planning. The participants expressed the imperativeness of involving peer support in their plan of care, especially during the transition process. Furthermore, the participants have highlighted the significance of involving family within the discharge process to optimize re-integration and allow for success in their recovery journey. Nurses and health care team members can apply this to the clinical setting by recruiting individuals with lived experience within acute and chronic care settings, in addition to ensuring peer support during the transition to the community. Nurses and other health care providers can also engage with family members, involve them with patient's care planning, and discharge planning. Nurses and health care providers need to increase their awareness on the deleterious impact of a negative nurse-patient relationship. Establishing and maintaining therapeutic relationships with patients ensures the focus remains therapeutic, and ultimately enhances the patient's recovery and subsequently supports a smoother transition back into communities.

Participants also highlighted the importance of the level of planning during the transition period. Improved coordination, conceptualizing transition differently and ways to ensure continuous support aids in a smoother transition into communities. Specifically, several of the participants expressed the significant role authorized leave of absences or 'passes', particularly weekend-to-discharge passes had on their successful re-integration within communities. With increasing constraints on acute hospital beds, many acute mental health units have shifted away

from weekend passes because the thought is often 'if they are well enough to go on a weekend pass, then they are well enough to be discharged.' However, participants in this study have highlighted that the weekend passes enabled them to review current resources and supports within the community in which they live and offered them the opportunity to strengthen resources within the community by returning to the hospital prior to discharge and discussing these concerns with their health care team.

Some participants regard that long-term admissions often create dependency on health care providers and encourages institutionalization (Glasby & Lester, 2004). Delays in discharge due to inadequate establishment of resources in communities leads to further constraints on the health care system and makes it more challenging for individuals to successfully re-integrate into communities (Costa, Poss, Peirce & Hirdes, 2012). This encourages nurses and health care providers to consider alternative settings to care for patients – such as more person-centered services where care is needed rather than profession-centered. More community settings to empower individuals with mental illness to thrive within their communities, rather than encouraging dependency and institutionalization (Hudson, 2016). One participant even suggested a community transition unit or partial hospitalization program that empowers patients to draw upon their personal coping skills, while also ensuring the availability of professional services.

Therefore, in order to encourage a transitional discharge versus a discharge as an event, healthcare team members need to start planning for discharge at the start of an admission and take into consideration all factors of planning to support an individual to transition into the community successfully and ultimately reduce re-admission into acute and complex care units. This also includes consideration of the therapeutic uses of passes and encouraging access to authorized leave of absences for a few days prior to officially discharging patients. Transitional planning through

regularly scheduled interdisciplinary team review meetings that include the patient and family members where appropriate should be encouraged in mental health care as practiced in acute medical hospitals. This will enable all inter-disciplinary team members to consider all of the factors that will help and/or hinder an individual patient's transition journey.

Recommendations for Education

Throughout this study, several participants have indicated the stigma and 'othering' that they experience from healthcare providers impacts their transition experience. To date, many College and University Undergraduate nursing programs do not have a full course and clinical dedicated to mental health care. Much of the stigma that exists among society is often related to ignorance. "It is estimated that one in five Canadians will develop at least one psychiatric or behavioural disorder in their lifetime, with depression the most prevalent across age groups, social class, and cultures" (Canadian Association of Schools of Nursing, 2015, p. 3). Therefore, based on this research, the author recommends at minimum one full semester of coursework and clinical placement related to mental health care in an effort to improve future nurses understanding of mental illness and recovery and encourage future nurses to embark on career paths in mental health nursing.

Recommendations for Future Research

Given that participants in this study have indicated insightful pieces of the transition journey that would have been helpful and unhelpful, it would be important to consider further research exploring transition from the perspective of the patient. Future research may offer a different perspective by means of an alternative methodology and/or sampling technique which may yield different results. The principal investigator suggests replicating this study with other groups and in other geographical areas with other age groups, ethnicities and languages.

It would be interesting to explore what the difference is like for patients in Toronto versus London. It would be important to note that the differences between diagnoses and the transition experience were not explored in this study. There may be a question to what the difference is between diagnoses and experience by examining different variables. Future research comparing similarities and/or differences with psychiatric diagnoses is recommended to explore through the completion of a quantitative study.

The author would suggest exploring additional methodologies such as a mixed method longitudinal design whereby participant's transition journey could be explored over time with follow-up interviews based on their journey. It might also be helpful to consider comparing different organizations that engage in transitional discharge planning with those who do not have transitional discharge planning. The principal investigator suggests an experimental study comparing one ward that has a transitional discharge plan and one ward that does not and compare the experience of transition between the two groups.

The author also suggests examining transitional discharge in other aspects of mental health care such within forensic mental health settings since these areas may have similar and/or different challenges and barriers. Questions such as "what supports do patients transitioning from the forensic mental health system identify as important to their re-integration within communities?" may enhance health care provider's understanding of how to best support successful transitions with this vulnerable population.

It is important to consider future knowledge mobilization. Participants voiced the significance passes and partial hospitalizations have on their transition experience. The question then becomes: how do we get professionals to change practice? Supports make a difference and discharge starts at the time of admission – yet this is not reflected in practice yet. Inconsistencies

remain across organizations to support a transitional discharge plan for patients experiencing mental illness. Further inquiry into these areas may elicit further recommendations for clinical practice.

Conclusion

This study addressed a knowledge gap by exploring the consumer survivor's voice. Successful re-integration within communities involves the complex interplay of many factors to ensure the patient accesses a network of support. Expectations, the environment, level of planning and emotional and physical well-being were all important factors explored that helped and hindered the successful re-integration of patients living with mental illness into the community. Recognition and application of these factors in the discharge planning process and partnering 'with' patients to determine how to best support those during the transition period will enhance patients' recovery journey. One participant summarized her transition journey; "Yah, you know, you can't have all the stuff in one pocket. Because sometimes that pocket will be empty – so you have to go into another pocket to get another idea" – Participant 005.

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Appendix A
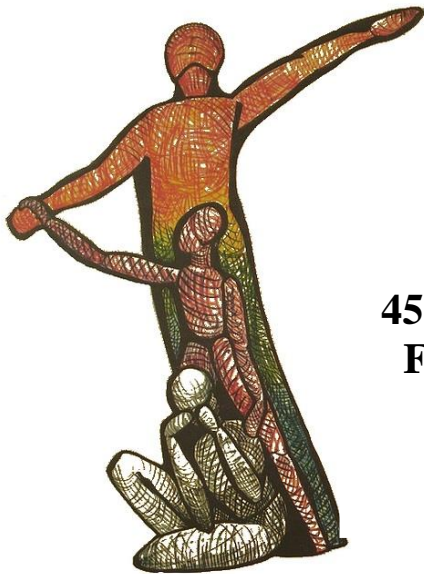
CAN-VOICE

**Consumer/Survivor
Community Support Services
450 Spruce Street London, ON N5W 4P3
Fax: 519-434-1048 Phone: 519-434-8303
www.canvoice.org
canvoice@gtn.net**

December 19, 2018

York University Master of Science in Nursing Thesis Study for Jennifer Arthur

To whom it may concern:

It is my pleasure to offer Jennifer Anderson, RN, B. Sc. N., permission to work with several of our members who have lived experience with the mental health system. Can-Voice has a long history of doing research with Universities and Colleges to assist in understanding and awareness of the issues of our members. Research gives us the up to date information about where things are at a given point in time.

We look forward to working with Jennifer Arthur and your University with her recent Masters work.

If you have any questions or concerns please feel free to contact me at the above number or e-mail.

Sincerely,

Betty Edwards, M. Ed., AAMFT
Executive Director of Can-Voice

Appendix B

Informed Consent Form

Study name

"Inpatient Mental Health: What Helps/Hinders the Transition into Communities?"

Researchers

Researcher Name: Jennifer Anderson, RN, B.S.c.N

Masters in Nursing Candidate

Graduate Program in Nursing

Master of Science in Nursing Program

Research Supervisor: Elsabeth Jensen, RN, BA, PhD; Associate Professor, School of Nursing

Purpose of research

This research study will examine the transition experience for participants who have been discharged from inpatient mental health care at Can-Voice.

What you will be asked to do in the research

If I volunteer to participate in this study, I will be interviewed for approximately 1hour by a nurse researcher to learn about my transition experience from inpatient mental health care. The interview will occur within a private room at Can-Voice.

Risks and discomforts

There are no known risks in participating in this study. However, the interview questions may cause participants to experience emotions, embarrassment, and/or misinterpretation (Vivar, 2007).

Benefits of the research and benefits to you

I understand that my participation in this study may increase my awareness of my experiences through self-reflection. My participation may also help others who have had similar experiences.

Voluntary participation

Your participation in the research is completely voluntary and you may choose to stop participating at any time. Your decision not to continue participating will not influence the nature of your relationship with the researchers or with staff of York University or Can-Voice now or in the future.

Withdrawal from the study

You may stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event that you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality

Data will be collected by typed notes and audio tapes. I understand that all data collected will be held confidential. When transcripts are transcribed they will be de-identified. Within one to two years the electronic version will be deleted. The de-identified transcripts will be kept for five years on a USB key in a locked filing cabinet behind a locked door, and then destroyed. Names and identifiable information will be removed within presentations and publications. Confidentiality will be provided to the fullest extent possible by law.

Questions about the research?

I understand that if I have any questions regarding the research I may contact Jennifer Anderson, Principal Investigator, School of Nursing, York University, at any point during the study.

This research is approved by the Human Participants Review Sub-Committee; York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University.

Legal rights and signatures

Legal Rights and Signatures: I _____, consent to participate in the study: "Inpatient Mental Health: What Helps/Hinders the Transition into Communities?" Conducted by Jennifer Anderson. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

☐ I do not consent to the use of audio tape recording as a part of the data collection

procedure, but I wish to participate in the study

Signature _____ **Date** _____

Participant Name

Signature _____ **Date** _____

Jennifer Anderson

(York University, 2015).

Appendix C

**PARTICIPANTS NEEDED FOR
RESEARCH IN MENTAL HEALTH TRANSITIONS**

Are you a client who has transitioned from inpatient care?

We are looking for volunteers (18 years of age and over) to take part in a study to understand
What Helps/Hinders the transition into Communities

You will be asked to participate in questionnaires and interviews.
Interviews will be conducted in a private room at Can-Voice.
The interviews are predicted to last approximately 1hour.

The benefits of participating in this study is the opportunity to contribute to improved mental
health transition for future clients.

For more information about this study, or to volunteer for this study,
Please contact:
Jennifer Anderson
Master of Science in Nursing Student,
York University

(Zennaro, 2017)

This study has been reviewed by and received ethics clearance

By the York University Research Ethics Board

Appendix D

Interview Guideline

Tell me about your experience moving from the hospital to the community?

Was it a positive, negative or challenging experience? In what ways? How do you access

services?

Is there anything that you would have hoped they had done differently with your discharge?

Who Supports you? Do you live alone, have a partner, etc.?

Do you live far from home? What is home to you?

How long was it before you accessed Can-Voice after discharge ?

How long was your last admission?

Where are you transitioning to? Independent housing, shared housing, etc.?

What funding sources do you use?

Is there anything else you would like to add?

Probing

How could they have been better prepared for discharge by the hospital?

Appendix E

Inpatient Mental Health: What Helps/Hinders the Transition into Communities?

Demographic Questionnaire

Date:

Gender:

☐ Female   ☐ Male   ☐ Other

Age (in years): _____

Date of Birth (dd/mm/yy): _____

Relationship Status:

☐ Single

☐ Separated

☐ Widowed

☐ Married/Common Law

☐ Not listed

Level of Education:

☐ Elementary School

☐ High School

☐ College/University

Mental Illness History: _____

_____

Any current financial Sources? ☐ ODSP ☐ Ontario Works ☐ Employment

☐ Other _____ if so, specify _____

Current living Situation? _____

_____

First encounter with the mental health system? _____

_____

Number of mental health admissions? _____

When you were last hospitalized? _____

Length of stay in the hospital in weeks? Months?

_____

How long have you been attending Can-Voice? Months? Years? _____

How long have you been in the community? _____