What prevents Readmission?
Service user perspectives on what helps prevent readmission to mental health hospitals

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Abstract

A series of interviews was carried out by a community recovery team in an inner-city area of the United Kingdom to discover what its services users believe helps prevent readmission to mental hospital. The aim was to increase understanding of service user perspectives of readmission and give insight into ways to reduce readmission rates. A qualitative thematic analysis method was used to analyse the data following a series of semi-structured interviews with service users. The results showed the value of developed social support networks, medication concordance and non-use of drugs/alcohol in service user perspectives. The conclusions were that community rehabilitation teams need to consider service user's understandings of hospital and its role in their lives when developing interventions.

Keywords: Recovery; Service Users

Declaration of Interest: None

Introduction:

Readmission to hospital and its costs both human and financial have become key concerns in Complex Care provision. Psychosis is one of the leading top ten causes of admission to hospitals across England (Pillay & Moncrieff, 2011). Reducing readmission has therefore become central for Rehabilitation teams working in the community with clients diagnosed with psychotic conditions. However, there is only limited literature that explores the service user perspective on what causes admission and what can work to keep service users well without need for hospital treatment. This paper describes a Counsellng-Psychology-led project conducted in an inner city area, by one NHS community team to interview its clients to ask them what helps them to stay well out of hospital and what can sometimes lead to readmission.

Relevant literature

Bowers (2005) highlighted the trend in recent years for a focus on community care and the resultant loss of focus on inpatient admissions. The emphasis on being cared for in the community has seen a decrease in available funding of NHS psychiatric beds (Pillay & Moncrieff, 2011).

There is a relatively modest literature base concerning the individual reasons for hospital admission particularly from a service user perspective. Zhang, Harvey and Andrew (2011) found frequent admission, risk to self and others and alcohol intoxication to be among the strongest predictors. The same authors suggested that good quality of care following an inpatient discharge is linked to lower readmission rates in the future.

Other past research studies have suggested a number of factors that can lead to multiple psychiatric admissions. For example, some studies have proposed that age, gender and length of stay in hospital are predictors of psychiatric readmission (Yussuf et al., 2008; Vogel, 1997). Hunt et al. (2009) suggested that homelessness, patients 'at risk' of violence and with suicidal ideation as well as high rates of seclusion were also determining factors of multiple admissions into hospital. Although suicidality and non-compliance with medication have both been proposed as common predictors of readmission (Kent, 1994; Rittmannsberger et al (2004)), there are studies that contradict these findings. Yussuf (2008) found that non-compliance was not predictive of multiple admissions into hospital and Lyons (1997) noted that suicidal patients were less likely to be readmitted. Olfson et al. (2011) also found an increased risk of admission with substance abuse. Additionally, studies have shown that there is positive relationship between socioeconomic deprivation and readmissions (Dekker, 1997). Cotton et al. (2007) found the strongest and most consistent predictor of hospital admissions to be measured by how well the patient engaged in the initial assessment. The authors also found that the risk to others and difficulty managing one's own home to be strong predictors of hospital admission.

There seems to be a likelihood of longer hospital stays for clients with psychosis living in London compared with the rest of the UK (Thompson et al. 2004). Patients with psychosis also occupy a larger number of beds compared to other disorders. Pillay and Moncrieff (2011) found that the average number of day beds for patients living with psychosis over a one year period to be 108, compared to 42 for mood disorders.

In terms of the drive to reduce hospital admissions and to maintain clients' well being in the community, there are findings that suggest that financial pressures that realign mental health resources to community settings can shift the role of inpatient admissions (Vigod et al., 2013). Vigod et al also pointed out that inpatient admission is viewed as a period for stabilisation rather as a way of facilitating complete recovery. They further suggested that incomplete recovery during inpatient admissions can place individuals at risk for subsequent admission. In contrast, Lyons (1997) did not find evidence to suggest that 'premature discharge' was related to high readmission rates and therefore concluded that there was no association between readmission and patient outcome (for example; incomplete recovery or premature discharge).

With regard to maintaining well-being within the community, various interventions that can minimise multiple readmissions into hospital have been proposed. Silva et al. (2009) suggested the importance of community psychosocial support services in preventing multiple psychiatric admissions. Additionally, other studies have recommended psycho-education for both clients and their families, identification of early symptoms of relapse, application of immediate and appropriate measures, and adequate record-keeping by health institutes as ways of reducing hospital readmissions (Yussuf et al., 2008). Hunt et al., (2009) pointed out that 'there is need to ensure that all staff have knowledge and understanding of health networks available to achieve positive patient outcomes and minimise readmission and relapse rates'.

In summary, psychiatric readmission seems not only to reflect the quality of inpatient care but also the continuity of care in the community (Vigod et al., 2013).

Community-care and Recovery

In recent years there has been a major shift in long-term mental health and particularly psychosis are viewed. People labelled with diagnoses such as schizophrenia have been able to challenge the traditional notion that they will not make good progress through their experiences and achieve recovery (Bellack 2006). Recovery in this context looks above and beyond any symptoms and is based in understanding and recognising that psychotic experience can have an impact on many areas of life including self esteem, relationships with family and friends, social engagement and the experience of social stigma.

The concept of recovery has become a central tenet of mental health planning in recent history and one of the clear objectives (and assumptions) of the recent implementation framework is that 'people with mental health problems will recover' (No Health Without Mental Health 2012). There is therefore a drive for all services to be working in a recovery-focussed way.

Studies have noted 'a marked preference by patients for community rather than hospital residence' (Thornicroft, Bebbington and Leff, 2005), a theme identified across re-provision literature (Newton et al, 2000; Leff, 2000; de Girolamo and Bassi, 2004). Hallam and Trieman (2001) found that service-users responded to environments which were less restrictive and offered a less clinical environment.

Defining recovery can be difficult. Studies such as that of Liberman et al, (2002) suggest that in order to be considered recovered a person must sustain adequate functioning for an extended period of two years. They propose that recovery can be achieved with presenting mild to moderate symptoms still in place. They also note the importance of normal functioning in a range of important life skills, which includes activities such as work, engaging in social relationships, living independently and taking responsibility for oneself.

However, most recovery criteria, including Liberman et al.'s (2002), choose to attempt to reach an objective assessment of recovery and do not consider the service users' subjective appraisal of their own functioning or whether they are satisfied with their life. Varying subjective feelings personal to the service user may exist, such as (for example), whether they are distressed by residual symptoms, frustration with any inability they feel to achieve their ambitions and hopelessness about the future (Bellack, 2006) which an objective account may fail to consider.

Other literature sources, such as Service Users' own writings and creative reflections on their experience, for example those recorded in Psychosis, Stories of Recovery and Hope (Cordle et al 2011), begin to provide a different sort of resource for understanding experiences of psychosis, including readmission.

Accordingly the interviews described here were actively seeking to explore the subjective service user experience of readmission.

The project

Service users, all of whom experienced severe and enduring mental health issues and were under the care of a Psychosis community team in South East London, were invited to participate in interviews to express their views about hospital admission, about what they found worked to keep them well and what sometimes led to readmission. A sample relevant for a qualitative piece of work (eight in total) were interviewed from two different categories: those who had experienced recent admission to hospital (in the past two years) and those who experienced several admissions longer ago (more than five years) but had remained well without need for readmission in recent years. Two interview schedules were prepared with the focus of both being to understand more about what admission to (mental) hospital means for the client and to think about what has been useful in that experience and what can be done to help reduce readmission in future. A Thematic Analysis was undertaken to analyse the data generated and a series of themes extrapolated.

Some clinical judgement was used in the selection of clients: would they be able to cope with an interview? Would

they find the questions manageable? before informed consent was obtained from each service-user who chose to participate. Being able to participate in a meaningful discussion about the survey was used as an indication of the service users' ability to give informed consent, and take part in the interview. Those that agreed and were able to take part participated in a structured interview carried out by the authors in a setting agreed with the individual participant (usually at the participants' residential home). In some instances the interview was conducted over more than one session, depending on the Service User's needs. Due to participant characteristics, the interview was kept relatively short and the language straightforward. Each question had two parts: the prompt (such as 'In your opinion, what led to your last admission?' Or 'Recently you have not needed readmission. Why do you think that is?') and an open follow-up ('Can you please tell me more about this'). A conversational approach was taken throughout the interviews intended to encourage participants to speak naturally and express their full opinions. There was also an open section at the end of the interview where participants could express any other feelings or thoughts they might have on the subject.

Questions that were addressed included:

- What works to keep you well?

- What elements of your care plan work best for you?

- What could have been done to prevent you needing readmission?

- What can the the community team do better to reduce need for readmission in the future?

Table 1: showing demographic information for participants

Thematic Analysis was employed to evaluate the qualitative data.
Survey participants

Ethnicities	Black British
	White British
	Caribbean
	Turkish Cypriot
	Irish
Clinical Diagnoses	Schizophrenia (F20)
	Paranoid Schizophrenia (F20.0)
	Other Schizophrenia (F20.8)

Results

Several themes and sub-themes emerged from the interviews. One overarching theme seemed to revolve around whether the need for readmission was driven by internal or external factors. Both were considered significant by the participants and thoughtfully reviewed. Another key theme seemed to be the perception of hospital and how it was held in mind by the participants. A third overarching theme spoke to the importance of family and/or support networks in the readmission process. Under these broad headings it was possible to link subthemes that threw light on how readmission was experienced and understood by participants.

Theme 1: Power/control/awareness

The sense of whether they had power to control admission was mentioned as significant for participants. Comments such as '(I was) being forced'; 'I deteriorated' suggest a lack of agency or choice around the experience, and of the experience of readmission being driven by external factors (and perhaps being experienced as punitive). However, there was a general sense of clients in Group One (recent readmission) having some say over what was happening. Responses to the question of what led to readmission included: 'smoking cannabis'; 'because I was too busy with other people and not looking after myself'.

There was also a theme emerging from Group One of admission having been avoidable. The question 'What might have helped you to avoid needing to go to hospital?' brought comments like: 'Taking my meds'; '(having) someone from care community team to speak to', 'Having someone come to talk to me'.

This sense that changes to circumstances might help to avoid admission was also reflected in Group Two (no recent readmission). From this group there emerged a list of choices that might be made around possible ways to stay well which included: taking medication; talking about problems; eating well/healthy eating; hobbies or activities such as yoga, swimming or line dancing; smoking; avoiding alcohol; cleanliness; attending groups or college; listening to music and watching television.

This list (somewhat reflected by Group One also) suggests an understanding of wellness and Recovery, and a knowledge of what works to keep someone out of hospital.

Theme 2: Relationship to/perception of hospital

The theme of agency linked to the actual experience and perception of admission to hospital. A general sub-theme of hospital being something to be avoided emerged across both groups. Comments such as 'I reckon hospital is bad news'; 'I felt ashamed (on readmission)'; 'I felt like a failure'; 'I think it is a case of they not liking me, put me in. They tried hurting me'; '(I felt) like my freedom has been taken away from me'; '(it was a) claustrophobic space. I didn't like it because I was restrained a lot', all seem to reflect a negative view of hospital and readmission and of hospital as restrictive. There were also traces of stigma (shame) and personal guilt (failure) in these comments. However, there were also positive views of hospital. Questions around the experience of hospital elicited responses such as 'comfortable and assured. Happy to be back. Protected'; 'I was happy because I had time to myself'.

There was also mention of the value of 'Meeting other patients who were going through the same similar sort of things' and this sense of being part of a community of fellows seemed significant.

Perhaps inevitably the ordinary day-to-day realities of hospital life were remembered as important. The quality of the food was mentioned by several participants as were the routines, garden breaks, being checked on by staff, the importance of activities.

Theme 3: Relationship with medication

Medication emerged as important for several participants when considering readmission and their relationship with their medication regime seemed significant for them. This was in both directions: medication was important and necessary for staying well but also at times felt as if it was out of the participant's control, as if they felt it hard to refuse and therefore to have full control over their own regime.

Theme 4: Social system

The other overarching theme concerned the importance of family or the system within which the person was living while in the community. Group One participants made comments around what led to readmission or might have helped such as: 'family issues such as mum not being well'. 'maybe (it would have helped) having a third person to come and talk to me and my family'; 'I felt I was being picked on and bullied by residents and staff'; 'staff were not there for me'. These comments seem to highlight the need for a positive and listening environment around the

client. Group Two also reflected the importance of a caring 'system' around the client with comments such as: 'family helps me out'; 'family helps me keep well and out of hospital; 'conversation with staff when I'm not feeling too good or unwell'; 'staff helps keeping me out of hospital'; 'talking to people like my care co-ordinator or the doctor or the staff (is helpful)'.

A sub-theme within the social system theme was around the risks of (street) drug or alcohol use. There seemed to be links being made by participants between social networks and drug use that highlighted readmission being more likely following use of drugs and alcohol.

Discussion

The perception of hospital perhaps reflects on where services are at present: hospital is discouraged as a way of treating mental health problems and clients are discouraged from seeing it as a useful or positive part of their care. Therefore it is only when all other options have been tried and have not been effective that hospital is considered. Perhaps inevitably therefore hospital is perceived by clients as a last resort and has negative connotations of failure or shame attached.

The role of medication echoes Rittmannsberger et al (2004) and their finding that non-compliance with prescribed medication leads to increased likelihood of hospitalisation. For instance one participant stated: 'Take my medication without fail' as a way that s/he stays well and avoids need for readmission.

The importance of family and social systems was strongly highlighted by the survey and this seems to reflect wider research in this area. The Silva et al. (2009) study for example suggests the importance of community psychosocial support services in preventing multiple psychiatric admissions. It can be easy to underestimate the significance of systemic issues with this client group and to see family or social networks (particularly friendship groups) as less key. However this survey seems to challenge that view.

The subtheme around the risks of substance abuse and links to readmission resonates with Olfson et al. (2011) who found an increased risk of admission with substance abuse. Again this seems to be part of the wider theme of social networks and their significance for the individual. Clients with severe and enduring mental health issues are often vulnerable and can be victims of drug dealers etc. The need for a social network that is supportive and positive but which does not leave a person too open to this sort of exploitation seems to be the ideal. How community services can support a client in developing such a network is one of the challenges of this work.

Conclusion

The aim of this study was to capture service-user perspectives on readmission to (mental) hospital. The very fact that avoidance of readmission is in part what drove the decision to conduct such a survey perhaps creates a context for client experience. Certainly the themes that emerged seemed to reflect this: hospital is a problematic experience (one set about with stigma and shame) and to be avoided (rather than simply one option within a treatment package).

Ways to avoid readmission seemed clear: take medication; avoid substance abuse; stay active; talk to people; stay in touch with family or support systems; and remain in control of choices and decision-making as far as possible.

At times the very restrictiveness of hospital was in some ways perceived as a virtue as it can provide a safe space with access to other people in the same situation.

This seemed to reflect previous (limited) research in service user experience of readmission and perhaps gives some sense of the directions that community care might go in future. Certainly if Recovery is to remain a priority and the realities of economic pressures taken into account, continued consideration of how to reduce readmission and facilitate better community provision of care will be necessary.

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