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Mental Health Care Professionals' Experiences With the Discharge Planning Process and Transitioning Patients Attending Outpatient Clinics Into Community Care

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A B S T R A C T

Background: Health care reform promotes delivery of mental health care in the community. Outpatient mental healthcare professionals (HCPs) are pressured to discharge patients. This study's purpose: to understand the experience and perceptions of mental HCPs with discharge planning and transitioning patients into community care.
Methods: Twelve HCPs participated in semi-structured qualitative interviews.
Findings: Three main categories: engaging in the discharge planning process, making the transition smooth, and guiding values emerged. A conceptual framework was created to explain the phenomenon.
Conclusion: HCPs valued strengthening partnerships and building relationships to ensure smooth transition. Sufficient resources and trust imperative for safe patient discharge.

Current healthcare reform promotes the premise that mental health (MH) care delivery should be primarily based in the community (Federal Provincial Territorial Committee on Health Services, 1995; Ministère de la Santé et Services Sociaux [MSSS], 2005; World Health Organization [WHO], 2009). However, the bulk of patient care in MH continues to be delivered in hospital care rather than being concentrated in primary care (Kates, 2008; MSSS, 2005). The Mental Health Action Plan (Plan d'action en santé mentale - PASM) was developed in Quebec, Canada. The goal of PASM was to ensure that specialized MH resources are used effectively and appropriately (Menear & Poirier, 2011; MSSS, 2005). MH patients in the Canadian healthcare system are expected to be transferred from hospital psychiatric ambulatory care services to primary care services in the community in order to improve their quality of life and recovery. The McGill model of nursing emphasizes that whenever possible people should recover in their own communities because it is there they will continue to develop and live their lives (Gottlieb & Rowat, 1987).

Universal health care coverage in Canada gives all Canadians access to medically necessary health care services (Health Canada, 2014). How health care is organized is determined by the provinces and territories. Quebec is a francophone province in Canada and through its governance structure is responsible for providing health and social services that include hospital centres and community care which includes local community service centres (CLSCs) and general practitioners (GPs) (MSSS, 2014). Hospital centres offer hospital and ambulatory care services while CLSCs offer primary care services. Hospital care offers MH inpatient services for acutely ill patients who are unable to cope at home. The psychiatric ambulatory care services offer many specialized MH services by interdisciplinary MH teams and psychiatrists for patients who live in the community and require complex treatment adjustment. The psychiatric ambulatory care services provide care for patients with a variety of MH disorders including schizophrenia spectrum disorders, mood disorders, personality disorders and substance abuse in regular clinics, day hospitals and evaluation services. The community primary care CLSCs offer many kinds of general services including home care and walk-in clinics for people of all ages and a variety of health conditions. Patients with stabilized MH disorders can be seen in GP's offices and in CLSC MH teams or psychosocial services.

MH disorders affect 1 in 6 people living in Quebec (MSSS, 2005). This study's research setting is an academic quaternary health care centre that offers both inpatient and ambulatory care services. The research setting has reported long waiting lists for new complex patients to be treated in psychiatric ambulatory care services. This is especially important given the provincial government's perception that

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psychiatric ambulatory services were not transferring a sufficient number of MH patients into community care (MSSS, 2005). For the purpose of this study, psychiatric ambulatory care services will hereon be referred to as psychiatric outpatient department (P-OPD), and outpatient department (OPD) will refer to ambulatory services for a variety of health care populations. The PASM report highlighted that care in psychiatric ambulatory services is most appropriate for patients with complex MH disorders who require specialized MH services from psychiatrists and HCPs. Once stabilized, patients are better served in community care by GPs and CLSC services (MSSS, 2005).

HCPs organize the transition of patients through the discharge planning process. Nurses are considered vital to this process (Ali Pirani, 2010) as they work within interdisciplinary MH teams, provide liaison services between health institutions and coordinate care for patients as they transition into community care (Laflamme, 2010). To better understand the phenomena of patients being transferred to community care, an examination of the perspectives and experiences of the HCPs who are involved in transferring these patients is necessary.

LITERATURE REVIEW

The literature about discharge planning in general highlights that there is ambiguity in defining the terms around the discharge planning process and transitional care (Holland & Harris, 2007; Watts & Gardner, 2005). For the purpose of this study, discharge planning is defined as "… an ongoing process that facilitates the discharge of the patient to the appropriate level of care. It involves a multidisciplinary assessment of patient/family needs and coordination of care, services and referrals" (McGinley et al., 1996, p.55). Transitional care refers to a process that includes a range of services and care settings that aims to promote the safe and timely transfer of patients from one care setting to another (Holland & Harris, 2007; Naylor, 2002) and unlike the discharge planning process is not bound by setting borders (Holland & Harris, 2007).

Recommendations for Discharging Patients

In general discharge planning research, the discharge planning process aims to facilitate the transition of a patient from one care environment to another seamlessly (Canadian Health Services Research Foundation [CHSRF], 2011; Champagne, Roy, & Michaud, 2003; Jensen et al., 2010). An integrated review looking at hospital inpatient staff nurses' roles in the discharge planning process of general patients concluded that this process should begin upon admission, use a designated care coordinator, and a discharge protocol (Maramba, Richards, Myers, & Larrabee, 2004). Specific to MH, hospitalized inpatients discharged into the community with overlapping services experienced significantly lower readmission rates, better follow-up attendance and improved satisfaction rates (Jensen et al., 2010; Reynolds et al., 2004). In summary, to achieve a seamless transition for MH populations the literature suggests that planning and collaboration will help to achieve this goal.

Effective communication and collaboration between institutions, providers, patients and their families is essential to the MH discharge planning process. It is vital that these key players work together to accurately transfer information (Champagne et al., 2003; CHSRF, 2011; Fitzpatrick & Dawber, 2008). Collaboration between mental HCPs has been linked to better health outcomes in MH populations (Gilbody, Bower, Fletcher, Richards, & Sutton, 2006) and facilitated the transfer of MH patients into community care (CHSRF, 2011). According to Connolly et al. (2010), HCPs in general can have varying opinions regarding patients' readiness for discharge. Effective communication between HCPs working with general patient populations and their families has been linked to increased user satisfaction (Maramba et al., 2004). Mental HCPs need to conduct the discharge planning process as a team with patients and their families as active participants to facilitate patient transfers into community care (Champagne et al., 2003; Hautala-Jylhä, Nikkonen, & Jylhä, 2006; MSSS, 2005).

The therapeutic relationship between HCPs and patients is the essence of MH care, and strong therapeutic relationships have been linked to improved outcomes in both hospital and community settings in MH populations (Hautala-Jylhä, Nikkonen, & Jylhä, 2005; Masson & Sheeshka, 2009). A transfer into community care ends an established relationship between mental HCPs and patients (Reynolds et al., 2004). Literature emphasizes that the transition from hospital to community care is particularly challenging for MH patients as readmission rates are high and utilization of aftercare is low (Nolan, Bradley, & Brimblecombe, 2011; Steffen, Kösters, Becker, & Puschner, 2009). Little is known about what this transition is like for mental HCPs working in P-OPDs and how their experience may affect the discharge planning process and the transition of patients to community care.

Realities in Practice - Challenges in Discharging Patients

Transitioning MH patients into community care can be a complex process for both patients and HCPs. General challenges in the discharge planning process, for all types of patients, include a lack of time (Watts & Gardner, 2005) and concerns for the adequacy of resources in the community (Masson & Sheeshka, 2009). The post-discharge period is a critical time for all patients (Grant & Pan, 2011; Steffen et al., 2009; van Staa, Jedeloo, van Meeteren, & Latour, 2011). There are potentially more serious consequences for MH patients: high rates of medication non-compliance, relapse (Hui et al., 2013) and increased re-hospitalization (Reynolds et al., 2004). No studies were found that specifically examined the transition of MH patients from P-OPDs into community care. Research highlights that the discharge planning process is critical for MH patients, though the majority of studies examined focused on transferring MH patients from inpatient settings.

Health Care Professionals' Perceptions in P-OPDs

In order to understand the challenges of the discharge planning process for MH patients from P-OPDs into community care, there needs to be an understanding of the HCPs' perceptions. One study examined mental HCPs' and patients' perceptions of what happened during a typical outpatient visit after discharge from hospital and discharge planning was notably absent from the topics discussed (Hautala-Jylhä et al., 2006). Studies have examined mental HCPs' perceptions of the discharge planning process but only in inpatient populations (Hautala-Jylhä et al., 2005; Jones et al., 2009; Ryan-Nicholls & Haggarty, 2007). In conclusion, there was a paucity of literature found on the perceptions of P-OPD HCPs on the transition of patients from P-OPD clinics to community care.

The purpose of this study was to understand the experience of P-OPD HCPs with the discharge planning process and to understand their perceptions about transitioning MH patients into community care in order to facilitate patient transitions. This study asked: (1) What is the experience of mental HCPs during the discharge planning process of transferring patients into community care? (2) What are the mental HCPs' perceptions about transitioning patients from their care into community care? Understanding mental HCPs' views will provide insight that can be used to facilitate the number of patients discharged from P-OPD clinics into community care.

METHODS

Design

In order to obtain a deep, rich description of what HCPs think and feel about the discharge planning process and transitioning MH