



<http://www.diva-portal.org>

This is the published version of a paper published in *International journal of nursing & clinical practices*.

Citation for the original published paper (version of record):

Sebergsen, K., Norberg, A., Talseth, A-G. (2016)

"I Want to Go Home, but I Need to Stay": The Transition to become Ready for Discharge from Acute Psychiatric Wards, as Narrated by Persons Who Experienced Acute Psychotic Illness.

International journal of nursing & clinical practices, 3: 3:IJNCP-179

<http://dx.doi.org/10.15344/2394-4978/2016/179>

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Permanent link to this version:

<http://urn.kb.se/resolve?urn=urn:nbn:se:umu:diva-127084>

"I Want to Go Home, but I Need to Stay": The Transition to become Ready for Discharge from Acute Psychiatric Wards, as Narrated by Persons Who Experienced Acute Psychotic Illness

Karina Sebergesen^{1,2*}, Astrid Norberg² and Anne-Grethe Talseth¹

¹Department of Health and Care Sciences, Faculty of Health Sciences, UiT The Arctic University of Norway, N-9037 Tromsø, Norway.

²Division of Mental Health and Substance Abuse, University Hospital of North Norway, N-9291 Tromsø, Norway

³Department of Nursing, Umea University, SE-90187 Umea, Sweden. Palliative Research Center, Ersta Sköndal University College, SE-10061 Stockholm, Sweden

Abstract

Background: Discharge planning for persons with psychotic illness who are admitted to acute psychiatric wards is critical for decreasing the well-known risk of new phases of psychosis and early readmissions after discharge from the ward. There is limited knowledge about admitted persons' experience of their readiness for discharge from acute psychiatric wards. This study aims to describe and understand how persons with psychotic illness experience to become ready for discharge during their stay on an acute psychiatric ward.

Method: During their hospital stay, 12 persons who recently had acute psychotic illness were interviewed about their experiences related to their upcoming discharge. The recorded interviews were transcribed and content analysed.

Results: The results describe the participants experienced three phases of transition to become ready for discharge after their acute psychosis had decreased: 1) Being affected by wounds following acute psychotic illness, 2) Being in need for strength to feel better before discharge, and 3) Being ready for discharge.

Conclusion: This experiential knowledge informs the transitional care that mental health nurses provide to persons during the discharge process. In addition to developing plans for discharge and for further mental health care in the community together with persons in care, nurses must seriously consider persons' mental health care needs following psychosis to support the best of outcome of the transition to become ready for discharge.

Background

In most Western countries, persons who experience acute psychotic illness and whose acute care needs are not sufficiently met by community mental health care services, are offered short-term mental health care in acute psychiatric wards [1] to provide safety and security and decrease their psychotic symptoms and enhance their health [2]. In Norway, the specialist physician or psychologist in psychiatry, who is responsible for the person's inpatient mental health care, makes the decision about the discharge from acute psychiatric ward in cooperation with mental health personnel and the person in care. The basement for the decision before the discharge includes considering that the person's acute psychotic symptoms have decreased, and further that the person's medical, social and mental health care needs will be met in the community after discharge [3]. In the early period after psychosis, persons' vulnerability to the risk of experiencing new phases of psychosis is heightened [4]. To reduce this risk, clinical guidelines recommend community mental health care adjusted to each person's care needs following discharge [3,5]. From this perspective, the planning of the person's discharge from the acute psychiatric ward and his/her further mental health care in the community acknowledges and mirrors in national guidelines that recommend personal mental health care plans [6,7]. A person's discharge from an acute psychiatric ward to home is viewed as a transition [8, 9], and the discharge plan is an important component of the transition between the different care settings [10].

Before persons are discharged from acute psychiatric wards, nurses must provide transitional mental health care, including discharge planning [11]. Discharge planning requires nurses to make

Publication History:

Received: February 09, 2016

Accepted: April 09, 2016

Published: April 11, 2016

Keywords:

Content analysis, Discharge planning, Mental health nursing care, Psychosis

multifaceted decisions and the discharge planning is considered a method, a function, a solution [12] and an approach to accessing how each person in care views discharge [11]. Furthermore, it is an indicator of quality of care after hospital discharge [10]. This means that nurses who provide the discharge planning must consider and adjust a person's needs in terms of care and medical services, housing, finances and plans for immediate care if a new acute psychotic illness occurs at home. Furthermore, transitional care on the ward includes decisions about when and how the discharge will occur, and it is provided by nurses on the ward in partnership with the person in care, his/her significant others and community mental health nurses [11]. Mental health nurses' transitional care is critical to supporting and improving persons' engagement in follow-up treatment and care plans supported by community mental health nurses at home [13,14].

Given that mental health care in acute psychiatric wards tends to be short term [1], the time available for the mental health nurses and the person in care to plan and prepare for discharge from acute psychiatric wards is limited [9,15]. Below, we view previous research papers on how persons in acute mental health inpatient psychiatric wards?

***Corresponding Author:** Karina Sebergesen, Department of Health and Care Sciences, Faculty of Health Sciences, UiT The Arctic University of Norway, N-9037 Tromsø, Norway.; E-mail: karina.sebergesen@unn.no

Citation: Sebergesen K, Norberg A, Talseth AG (2016) "I Want to Go Home, but I Need to Stay": The Transition to become Ready for Discharge from Acute Psychiatric Wards, as Narrated by Persons Who Experienced Acute Psychotic Illness. Int J Nurs Clin Pract 3: 179. doi: <http://dx.doi.org/10.15344/2394-4978/2016/179>

Copyright: © 2016 Sebergesen. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Some research has reported that following discharge from acute psychiatric wards, persons are at risk of experiencing negative outcomes. The results of a review study showed that persons' risks of increased psychiatric symptoms and early readmissions were related to their vulnerability linked to homelessness, poor housing facilities, broken appointments or non-cooperation with community mental health care, and noncompliance with recommended medication. Furthermore, suicide attempts, suicide and violence increased significantly in the first month after persons were discharged from the hospital [16]. Loch's [16] findings address and illustrate, on the one hand, persons' need for further support and mental health care after discharge and, on the other hand, the potential for nurses' transitional care to minimize the risks of increased psychotic symptoms and early readmissions. As Noteworthy et al. [17] thoroughly described, mental health nurses' care may bridge the gap in the quality of different mental health care settings.

Qualitative studies have reported persons' experiences with hospital discharge. One interview study found that nurses did not consider persons' opinions about the timing of discharge, for example, discharge before the weekend when community mental health care services are less available and the risk of loneliness and of misusing alcohol and drugs increases for some persons [18]. In a review study, Glasby and Lester [19] reported poor timing in terms of both delayed and early discharge of persons in care. Persons in care wished that nurses provided specific information about their needs after discharge, such as where they could go and whom they could contact if a new crisis occurred after discharge [18]. Another study showed that nurses' discharge planning was mostly positive but that some areas should be improved. Persons wished that nurses better prepared them for discharge by introducing them to peers who had experienced discharges from acute psychiatric wards so that they could receive more information about health problems that may occur, medication treatment and the prevention of mental illness relapses [20]. Manuel et al. [21] explored the discharge experiences of women with severe mental illness after a long-term stay in psychiatric institutions and reported that these women were concerned that the community mental health care would be insufficient to meet their needs of safety, security and support in entering social relationships with other people. Gerson and Rose [22] reported similar results, and found that persons with severe mental illness were unsure whether community mental health nurses care could meet their illness-related needs and needs of support in daily activities.

Several quantitative studies evaluated the effect of transitional care interventions and discharge planning. A statistical study [23] focused on pre-discharge planning in hospitals, including recommendations for post-discharge care in the community. This study did not find significant decrease in persons' psychotic symptoms or rates of readmissions to the hospital or an increase in their quality of life. Two review studies examined pre-discharge transitional care interventions, including discharge plans, appointments for further care, and cooperation with the person in care and his/her family, nurses on the ward and personnel in community care settings [24,25]. These approaches improved persons' mental health and were cost effective for the mental health care services [24,25]. Other studies described that transitional care that included the establishment of relationships between community mental health nurses and persons in care before discharge shortened the persons' length of hospital stay, increased their daily functioning and quality of life after discharge, and decreased their hospital readmissions [13,14]. Persons in care who also participated

in education about coping with psychosis reported an increased ability to engage in self-care after discharge [26]. Researchers utilised questionnaire tool (RDQ) to measure persons' readiness for discharge from acute psychiatric wards following severe mental illness. The results showed that the tool helped psychiatrists make decisions about discharge based on persons' ability to engage in daily activities and to control their aggression, impulsivity and risk of suicide [27].

Our literature review shows that discharge planning characterized by cooperation between the person in care, his/her family members and the mental health personnel in the hospital and community decreased the risks of psychotic illness and early hospital readmissions. Some researchers used qualitative methodology and focused on the persons' experiences of poor timing of discharge and lack of attention to their opinions about timing, and to their other wishes, needs and personal circumstances such as housing, finances and knowledge of who to contact during crisis. A study conducted by Potkin et al. [27] reported persons' readiness for discharge based on a tool measuring their mental health status before discharge. We identified no studies on persons' experience of becoming ready for discharge from acute psychiatric wards following an acute psychotic illness. The attention to and knowledge of how persons in care experience becoming ready for discharge remains limited in mental health nursing research.

Mental health nurses have the responsibility of providing transitional care by planning the discharge and care adjusted to persons' needs and ensuring that the discharge is as smooth, safe and secure as possible to decrease persons' risks of experiencing new phases of psychotic illness (cf. [11, 28]). We reflected on the following question: how do persons' experience and describe the process of becoming ready for discharge from acute psychiatric wards? We designed a study to access persons on acute psychiatric wards who recently experienced an acute psychotic illness to narrate their experiences of becoming ready for discharge from the ward.

The aim of this study is to explore, describe, and understand how persons' experience becoming ready for discharge from acute psychiatric wards, as narrated by persons who recently suffered from an acute psychotic illness.

Methods

Study design

Given the aim of this study, we employed a qualitative, explorative and descriptive study design. To access persons' experiences of becoming ready for discharge from acute psychiatric wards following psychotic illness, we conducted qualitative interviews [29]. A qualitative content analysis, which allows describing the manifest content of the persons' narrated experiences, was performed and interpretations of the underlying meaning of the results, subcategories and categories, were conducted [30]. Content analysis is well suited to analyse multifaceted, sensitive and important phenomena in nursing, especially when there is limited knowledge about the topic explored [31].

Ethics

The Regional Committee for Medical and Health Research Ethics (2012/1319) approved the study, and the research followed ethical principles for research [32]. The participants received information

about the study, the purpose of the study and the interviews in both written and oral forms. Furthermore, they received information about that their participation was voluntary, the presentation of the results would ensure their confidentiality and anonymity, and they had the right to withdraw from the study at any time before the analysis of the data started without explanation and with no consequences to their treatment and care. Then, the participants signed the informed consent form to participate.

Informed consent is a cornerstone in health care research. Interviews with a person in acute inpatient mental health care raise ethical challenges and special concerns regarding the person's vulnerability and ability to provide informed consent [33, 34]. We ensured that the persons who were approached about participation obtained adequate information about the research study and had the opportunity to ask questions to better understand the information and the impact of participation (cf. [34, 35]). To avoid possible risks of evoking bad memories that the person may strive to cope with alone following the interview, the local project contact person on each ward contacted the participants after the interviews to ensure that their primary nurse on ward was meeting their needs. No participants reported experiencing bad memories after participating in the interviews. At the time of data collection, the current authors were not employed in the acute psychiatric wards.

Setting

In Norway, the national mental health service is organised in three service levels: the first level is the community mental health service including general physicians and mental health care services in each municipality; the second level is community mental health centres with mental health care wards and acute ambulatory services; and the third level is psychiatric wards in general hospital, including acute psychiatric wards who are responsible for the emergency short-term mental health services to persons with acute mental illness with complex care needs [4,36]. In Norway, the acute psychiatric wards provide the intensive care to persons experiencing acute psychotic illness (cf. [36]). The mean length of stay in acute psychiatric wards for persons admitted with acute mental illness is 9, 5 days in Norway, and persons with schizophrenic psychosis and affective psychosis have longer stays on ward, with a mean of 10 days [36].

We conducted this study in four acute psychiatric wards in two hospitals located in mid-sized cities. These wards provide services to people in large geographical areas, implying long distances between the admitted persons' home and the hospitals. Acute mental health care is conducted by the nursing staffs, which includes enrolled nurses, nursing assistants, mental health nurses and registered nurses. Multi-professional teams on the ward, plan for discharge in cooperation with the person in care, his/her family members and local mental health professionals. According to the law, persons in care have the right to be involved in the planning of their mental health care and to include their family members in this planning [37]. In Norway, the nurses on ward have to ensure before the discharge that the person in care has a home to come to, and if not, nurses have to cooperate with the community service which is responsible for housing facilities to homeless persons [38].

Recruitment

The participants were purposively recruited from the population of persons admitted to acute psychiatric wards. The participant selection criteria in this study were as follows: being acutely admitted to the

ward, having severe mental illness, displaying a decrease in acute symptoms and exhibiting the ability to narrate experiences about the process of discharge from acute psychiatric wards.

In cooperation with the physician and the nurse in charge of each ward, a local project contact selected 20 admitted adults, provided them with verbal and written information about the study and requested their participation. Of these 20 persons, 14 signed the informed consent for participation. Two persons discharged from the ward before the interviews were arranged, and six persons did not provide their informed consent for participation. Before the interviews began, the first author KS invited each participant to meet her and to obtain further information about the study. KS met two participants before the interviews face-to-face, and scheduled an interview appointment with them during this meeting. KS contacted the other participants via telephone to schedule the interview appointments.

Participants

Eight women and four men aged from 18 to 64 years participated in the study. Eight of the participants lived with partners or other family members, and four of them lived alone. Eight of them had children and grandchildren. The participants reported that they had experienced psychotic symptoms for two to 40 years and had received the diagnosis of psychosis during previous hospital stays. This time they were admitted to the experience of a phase of acute psychotic illness. Eight of the participants informed being involuntarily admitted to the wards and was formal patients under the Norwegian Mental Health Care Act; in other words, they had to remain in hospital care for a set period to undergo assessment by mental health personnel and/or to receive treatment (cf. [39]). The person's formal status under the Mental Health Care Act [39] is considered by specified criteria by specialist physicians or psychologists in psychiatry during the person's stay on ward. The purpose is to evaluate the person's state of mental health to limit the length of the status as a formal inpatient [39].

Interviews

At the point of time for the interviews, the participants had been admitted the acute psychiatric ward since one to about eight weeks. Only KS and the participant were present during the interview, which was conducted in a quiet room that was in the hospital but outside the ward. First, KS informed the participants that she was not in possession of any of their personal or medical information. Then, the interviewer and the interviewee engaged in introductions. KS repeated information about the study and described the interview and the interviewer's role and responsibility during the interview. The participant asked the interviewer questions, such as whether they could take breaks during the interview. This study focused on the participants' experiences of their upcoming discharge from the acute psychiatric ward. They were encouraged to speak freely about their feelings, thoughts, worries and wishes in relation to the discharge. The interviewer asked additional questions, such as "What do you mean? What happened? Could you please describe how you felt in more detail?" Multifaceted narratives concerning participants' experiences in regards to their readiness for discharge from the acute psychiatric ward emerged during the audio-recorded interviews, which lasted from 50 to 90 minutes. KS transcribed the audio-recorded interviews. The twelfth interview did not reveal any new information on the studied topic; therefore, the researcher did not conduct further interviews (cf. [40]).

Content analysis

We performed a qualitative content analysis of the interview text in a stepwise manner [30]. In the first step, we read and re-read the interview text regarding the participants' discharge experiences with an open mind to gain a sense of the whole text. Based on this reading, we understood the participants' descriptions of their discharge to message: "I want to go home, but I need to stay". In the second step, we identified meaning units in the text, of words, sentences or paragraphs containing aspects related to each other in terms of content and context [30]. The meaning units were condensed and labelled with codes relevant to the study's aim. We discussed the coding thoroughly to identify codes that covered the content of the meaning units. In the third step of the analysis, we created categories. A category answers the question "what?" and mainly describes the manifest content of a text [30]. In this step, we examined how the coded meaning units described the discharge; the participants' wish to go home, and their need to stay on the ward. We compared, contrasted and collected the coded meaning units into different sub-categories until we reached a consensus about the constructed subcategories and categories (Table 1). With the aim of understanding the participants' experiences, we conducted the final and fourth step of the analysis, i.e., the interpretation of the underlying meaning linking the subcategories and categories. We interpreted the participants' experiences of becoming ready for discharges a transition. Inspired by Afaf Meleis and research colleagues [8,41,42], we used the perspective of the experienced transitions in a person's illness and health to interpret and reflect on the underlying meaning of the subcategories and categories formulated as a theme. The theme, answering the question of how the participants experienced to become ready for discharge from an acute psychiatric ward, we formulated as follows: Being in transition to become ready for discharge from acute psychiatric wards. Table 2 shows the theme, categories and subcategories.

Meaning unit	Condensed meaning unit	Sub-category	Category
I can return home when I am able to be a mother, a grandmother, a wife and can sit in my living room and enjoy a good cup of coffee or maybe a glass of wine (12).	Describes feeling better when able to be what the homely social roles and daily life requires.	Noticing signs of feeling better	Ready for discharge
I have a special nurse, nurse B, at home and we have regular contact. She comes to me and she knows my family, my serious complaints and my critical psychotic illness. (...) She was the one who asked the local mental health ward for an open door and free bed for me. (...) I can go there, anytime I need to. This has saved me (1).	Describes the importance of the special nurse's care to cope with the severe mental illness, also in critical phases.	Being confident in the ability of living home	

Table 1: Examples from the content analysis.

Theme	Being in transition to become ready for discharge from acute psychiatric wards		
Categories	Being affected by wounds following acute psychotic illness	Being in need for strength to feel better before discharge	Being ready for discharge
Sub-categories	Being physically wounded Being mentally wounded Being in wounded relationships with family members	Needing time on ward Needing time at home	Noticing signs of feeling better Being confident in the ability of living home

Table 2: Theme, categories and subcategories.

Results

The results of being in transition to become ready for discharge from acute psychiatric wards describe the participants' experienced changes in their psychotic illness and in their mental health care needs during a period of time. This period is limited from the point in time when the participants' acute psychotic illness symptoms decreased and they stated that they were not ready for discharge to the point in time when the participants expressed their readiness for discharge. The participants described the changes they experienced during this time from being psychotic ill to feeling better characterized by an unstable and insecure movement in transition phases. Persons' descriptions of the transition occurring during the discharge process inform us of how persons in care in an acute psychiatric ward define becoming ready for discharge.

We present the results, illustrated in Table 2, below and use quotations from the different interviews, labelled from number 1 to 12, to verify the results.

Being affected by wounds following acute psychotic illness

After the acute psychotic illness diminished, the participants felt wounded physically, mentally and in their relationship with their family members. At the same time, the nurses on ward actualized the participants' discharge from the acute psychiatric ward. The participants expressed that they wanted to go home but were anxious about being discharged prematurely because they still needed nurses' care on the ward to feel better.

Being physically wounded

The participants reported that they had physical wounds from the acute psychotic illness. Their body felt as though it had been beaten up; their muscles ached and felt fragile and stiff; and they were tired and exhausted. They had trouble in getting out of bed in the morning, their appetite for food was reduced, and they were too weak to engage in activities. Furthermore, some of them felt sick. It seems as though some nurses did not take note of participants' physical health. The participants felt stressed and frightened that nurses would discharge them before they felt better and had the ability to perform daily

activities at home. Other nurses sensed and understood participants' physical health problems and supported and encouraged them to maintain daily routines, to eat and drink and to go outside in the fresh air. These nurses informed the participants about discharge planning but waited to engage them in the planning. One participant described how nurses encouraged her to eat and drink, as follows:

I was ill and I could not eat. (...)The nurses were attentive and kind. They supported me patiently to eat and drink. They brought me food and explained that I did not have to eat much, just a little, but enough to become better (6).

Being mentally wounded

The participants described that the acute psychotic illness had left mental wounds, stating that the psychosis was as directly under their skin and only covered with an easily broken film. Participant's expressed doubt about being their ordinary self again, and some participants even checked in the mirror or questioned nurses to determine if their faces had changed. They described bad memories from psychosis, such as hallucinating voices that threatened them, and from the pre-psychosis period, such as evoked memories of violence. They expressed painful and shameful memories of their own behaviour during psychosis, such as disrespecting family members and nurses. The participants were anxious about the possibility of becoming acutely psychotically ill again and struggled to forget and control their memories. Some mental health nurses were sensitive to and understanding of the participants' mental wounds, inviting the participants to open up and talk with the nurses. One participant described this experience as follows:

These memories are difficult to share, and it is a choice if you are going to or not. (...)Nurse A, who I related to and I opened up to, knows what is going on in my world. (...) She understands what I am saying. Sometimes, I have to explain some extra. She asks, I explain, I explain and she asks in a two-way communication. (...) This helped me to get better (2).

Being in wounded relationships with family members

The participants described feeling guilty about their behaviour towards their family members during the acute psychotic illness, such as their use of threatening words and irresponsible actions. Participants feared that they had harmed or scared their family, especially their children, and wondered if their family members could trust them again. They attempted to restore their relationships and reconcile with their family during telephone calls or family members' visits to the wards. The participants appreciated nurses who helped them contact their families and invite them to the hospital. The nurses supported and guided the participants in addressing problems in conversations with their families when the participants experienced feelings of chaos and difficulties in sharing their opinions with family members. The participants also stated that contact with family members without support from nurses was a lonely responsibility, causing the participants mental distress and, in some cases, reducing their vitality for life. One participant described her thoughts about her contact with her children as follows:

I am afraid this illness has harmed and frightened my children. I know they need to talk about this. However, I cannot talk with them alone about everything; it will frighten them, you know, such as I told you about my longing for death (10).

Being in need for strength to feel better before discharge

After the participants experienced a decrease in their acute psychotic symptoms, they described their need to stay on the ward for a longer period and to visit home before discharge to gain strength to feel better before discharge.

Needing time on the ward

The participants stated that they felt weak, feared becoming acutely psychotically ill again and needed more time on the ward to feel better physically, mentally and socially before discharge. They explained their weakness, stating that they still cried and became anxious, frustrated or suspicious easily. The participants wanted to feel safer and more secure before discharge, for example, by receiving more information about their new medical treatment, and help to socialize with other persons on the ward before returning home. The participants felt safer because they were on the ward and knew that they could reach the nurses day and night and receive help with situations that they could not cope with alone. They stated that their influence on the timing of discharge was limited and that it was difficult to argue with the nurses. The participants understood nurses' demands to provide short-term care and that other persons needed inpatient mental health care as well. They stated that some nurses did not understand their need for a longer stay on the ward. One participant articulated this need as follows:

My opinion is that the patients need to influence the time for the stay on ward based on how they feel. The hospital personnel decide the stay based on what they think is right, but the hospital personnel do not always know the truth. Therefore, time is an important factor in patients' recovery, but this is difficult to argue and "to sell" to the nurses. When you do, it feels as though you do not want to go home (3).

Needing time at home

The participants expressed their longing for to go home and limitations in their ability to cope with home life. Participants expressed the following limitations in coping with everyday life: feeling too weak to be a responsible parent; to take care of children and to be a partner; to perform household chores such as shopping, preparing meals, and cleaning the house; and to find solutions to life problems such as problems regarding finances. Some nurses understood the participants' personal life situation and helped them visit home, for shorter or longer periods, to meet their family. These home visits were critical to the participants' feeling of improved health and allowed them to evaluate how they could cope with everyday life. The home visits were a basic fundament for the participants to determine when they were ready for discharge. It was difficult for the participants to articulate when and how they felt better and their readiness for discharge, as one of them expressed:

"It is a change, like a threshold you have to pass. Then, you know!" (3).

Being ready for discharge

The participants stated that they were ready for discharge when they noticed well-known signs of feeling better and were confident about the mental health care they would receive at home.

Noticing signs of feeling better

The participants described feeling a sense of relief when they noticed signs of feeling better and that their state of health was similar to that before the psychotic illness occurred. They recognized themselves again, their wellbeing increased and they felt better as demonstrated by more stable emotions, expressions of love and happiness with life and the ability to care for others. The participants' descriptions of their everyday life and health widely varied; some coped with symptoms such as hearing voices during daily living and others expressed that they had no symptoms but experienced anxiety about the acute psychosis returning. They looked forward to returning home, spending time alone or with their loved ones, and engaging in activities that they had longed for, such as drinking coffee in the morning or taking a walk outdoors. They described the ability to concentrate on activities, work and studies and the feeling of being a whole person and ready for discharge. One participant articulated this ability as follows:

I can return home when I am able to be a mother, a grandmother, a wife and can sit in my living room and enjoy a good cup of coffee or maybe a glass of wine (12).

Being confident in the ability of living home

The participants reported that the psychotic illness affected them in various ways. They explained their feared their needs of assistance from mental health care professionals in the days, weeks and months following discharge would be too complex for nurses at home to meet. These needs included assistance managing daily activities, having a trusted person to talk with, addressing daily problems, keeping appointments to follow up the medication treatment, and having knowledge of how to react if they needed immediate care in phases of acute psychosis. The participants also expressed the need for support to become better from psychotic illness. With these needs of support and care, the participants wanted to meet or at least know the name of the nurse contact at home before discharge to ease the contact with the nurse when they returned home. Some nurses understood that participants felt safer and more secure when they received these details before their discharge from the wards. Participants reported that it was important for the nurses on the ward to understand the participants' views of mental health care at home. One participant expressed this view as follows:

I have a special nurse, nurse B, at home and we have regular contact. She comes to my home, and she knows my family, my serious complaints and my critical psychotic illness. (...) She was the one who asked the local mental health ward for an open door and free bed for me. (...) I can go there anytime I need to. This has saved me (1).

Discussion

Psychoses are viewed as severe, fluid and changeable mental illnesses [4]. The mental health care in the different care settings intends to follow and adjust to persons' changing care needs during phases of acute psychotic illness [28]. The nurses plan the discharge in cooperation with the persons in care, their family members and local mental health professionals intending to ensure the discharge as smooth, safe and secure as possible.

The aim of our study is to explore, describe, and understand how persons experience becoming ready for discharge from acute

psychiatric wards based on the narratives of persons who recently suffered from acute psychotic illness. The participants' narratives represent their unique way of articulating their experiences about discharge from acute psychiatric wards. The participants' narratives about their psychotic illness and the mental health care they received differ according to personal circumstances, and earlier experience with illness and care, and including when they narrate and to whom [43]. We do not know the details of the interactions between the nurses and the participants during the discharge process; however, we know how the participants described the transition to become ready for discharge from the acute psychiatric ward.

The results of our study show that being in transition to become ready for discharge involves movement between three different phases of the transition: being affected by wounds following acute psychotic illness, being in need for strength to feel better before discharge, and being ready for discharge. Transition is defined as a passage or movement from one state, condition or place to another [41]. The concept of transition in nursing includes developmental, situational, health-illness and organizational transitions [8]. Persons experience transitions caused by a change decided by others, such as a discharge from hospital to home, and by a change in their health during a period of illness [42]. Nurses have special concern for transitions pertaining to a person's health and illness [42] because such transitions are mostly beyond a person's control. For each person, an illness and health transition is a personal, complex and diverse experience characterized by discontinuity in his/her life span. In other words, the person moves between fairly stable states of illness and health, which involve instability, insecurity and worries that their illness and health will worsen or the future will be unpredictable. A nurse's responsibility is to provide opportunities to enhance a person's health and decrease his/her risk for illness, even though the complexity of a person's needs may challenge a nurse to better understand and provide care to meet these care needs [42].

Our results address that mental health nurses should understand, care for and care about participants' needs during the time of transition to become ready for discharge. We discuss our results in light of previous research and the concept of transition in nursing described by Chick and Meleis [41] and Meleis et al. [42].

Our results show that after the acute psychotic illness had diminished, the participants experienced wounds that affected their health. When nurses initiated the plan to discharge participants from acute psychiatric wards, the participants expressed both their wish to go home and their need to stay on the ward because they needed to feel better before leaving. These results correspond with those of previous studies reporting that persons want to adjust the timing of discharge based on their experience of the illness, care needs and social needs related to their personal circumstances [18, 19, 21]. In addition, our results show that the participants' awareness of the transition was related to their experience of the changes in their acute psychotic illness and insight about their need of mental health nursing care on the ward before the discharge. The participants' awareness of being in a state of transition seems to elicit hope related to becoming better and returning home when ready. This finding corresponds to Chick and Meleis's [41] finding that a person's awareness of being in transition is critical to their experience of the transition and for the outcome of the transition.

Being in transition to become ready for discharge brings attention to the phase of time after the acute psychotic illness has decreased. The participants expressed suffering and vulnerability related to

physical and mental wounds and fragile or broken relationships with family members. Previous research has also highlighted the phase of time following acute psychotic illness as critical, demonstrating that the risk of new phases of psychosis increases during this time [4,9,16]. Furthermore, the risk of new phases of psychosis can decrease when nurses and persons in care plan the discharge and community care together to ensure the continuation of care at home [24-26].

The participants in our study did not primarily focus on their risk of new psychosis; rather, they focused on their suffering from the wounds following acute psychotic illness, which differs in time and quality from their suffering from acute psychotic symptoms. The suffering from the wounds, which are described as marks left on their bodies following the psychotic symptoms, occurs after the acute psychotic symptoms had decreased. The participants expressed their silent suffering as sickness, tiredness, bad memories and disconnectedness from their loved ones. These wounds are difficult to articulate, and the participants attempted to express their care needs to the mental health nurses. Similar to Meleis et al. [42], we understand the expression of wounds following acute psychotic illness as a person's response to his/her experienced changes in the psychotic illness, which may be observable or unobservable and viewed as functional or dysfunctional by mental health nurses. These personal expressions are not random, and nurses must address these expressions to ensure that the person in care experiences the best outcome of the transition. Nurses' care can enhance persons' health and reconnect persons in transition with family members they feel safe with following disruption in the relationships (cf. [42]).

Researchers have reported that the time that a person experiences illness differs from the time of disease as determined by the physician through observable signs of the disease [43, 44]. Thus, a person can suffer from an illness long before the disease is diagnosed based on observed objective signs [43], and an illness can continue after the disease even if the disease is cured and the objective signs of the disease are no longer observable [44]. In our study, it seems that participants' acute psychosis is cured or diminished; however, the participants continue to suffer from the psychotic illness. Mental health nurses are educated and trained to sense symptoms, observe signs of acute mental illness, provide the best care to decrease symptoms and suffering and provide sensitive, attentive and adjusted care based on the persons' need for both closeness and distance when receiving care (cf. [45,46]). Some nurses in this study noticed and understood the participants' silent expressions of suffering from the wounds following the acute psychotic illness, which differ from expressions of suffering from acute psychotic symptoms, and met the participants' mental health care needs. Such care was critical for the participants in this phase of transition to feel better.

The participants described the need to feel better before discharge. They expressed that their sense of self and emotions were unstable and that their health was too poor and limited to cope with daily life at home. Other researchers have described that some persons with severe mental illness report care needs that are too serious and complex for community mental health nurses to sufficiently meet them [19, 22]. Furthermore, Manuel et al. [21] described persons' pre-discharge worries about community mental health nurses' availability and ability to meet their safety, security and social support needs. Our results show that participants know that they need to feel better before discharge as a fundament to cope with daily life at home. The participants stated that they required more time on the ward to feel better and that frequent visits home allowed them to evaluate the

strength that they would need to engage in daily living and reconnect with family. This result is reminiscent of the transitional discharge model described by Reynolds et al. [13] and Forchuc et al. [14]. This model focuses on bridging the relationships between nurses in the hospital care and the community care settings, which increases persons' safety before discharge from the hospital. However, our results report that participants were aware of their need for additional time, on the ward and at home, to feel better. In other words, they were aware that they must be in a state of health to be discharged from the hospital and to cope with the daily living at home. According to Meleis et al. [42], transitions may challenge a change in persons' self-concept and self-esteem, which some persons in care expressed as distress, irritability or anxiety. The participants in our study expressed frustration to the mental health nurses who did not understand their need for more time on the ward and time at home to become better before discharge. Our results show that the participants' wish for more time on the ward was based on both available day and night nursing care on ward and visits home, which seem to give the participants the strength needed to feel better and better able to cope at home. The participants articulated their need of time for transition, as a threshold to pass to become ready for discharge.

Our results show also that the participants' need more time on ward; even if nurses' discharge planning intends to ensure the continuity between the hospital care and the community care for each person after discharge (cf. [11]). It seems that the participants' stays on ward were too short for relieving their psychotic illness after the acute psychotic symptoms had decreased, and they did not feel ready for discharge. This may address their needs of safety, security and to be cared for in the specialised mental health inpatient care provided by nurses present day and night (cf. [28,47]). Other authors have also reported that persons with severe mental illness express feeling unsafe and insecure before discharge about if the community mental health care can meet their care needs [9,20-22]. Community mental health service that is provided by appointments primarily at daytime seems at this period of time after the acute psychotic illness not to be sufficient to the participants' needs of safety to manage their daily life at home.

Transition is characterized by its entry, passage and exit [41]. The participants in our study described being ready for discharge when the intense and overwhelming acute psychotic symptoms decreased (cf. [47]) and when they noticed and recognized the well-known signs of feeling better, such as the same state of health as before the acute psychotic illness occurred. For the participants, feeling better represents familiarity with their state of health and social abilities and confidence to live at home with the help and support of community mental health nurses. Our results are significantly different from the results reported by Potkins et al. [27], who described a tool for psychiatrist to measure persons' statements related to symptoms of psychosis to assess their mental health status and their readiness for discharge. Our results are in line with Fenwick's [48] definition of readiness for discharge as a balance between a person's physical, mental and social resources and limitations in support at home. Other nursing researchers have reported similar results in studies investigating readiness for hospital discharge following heart, hip or cancer surgery [49-51]. These studies highlight that persons' readiness for discharge relies on feeling safe in terms of the nurses' knowledge and information about the persons' illness, risks and care needs; the need for medical equipment after surgery; and further safe and secure community nursing care. These results partially correspond to the results of our study.

According to Meleis et al. [42], transitions represent adaptations to a new state of health, life, or environment and the perception that one has the ability to live with the illness. Nurses must understand the transitions between illness and health as opportunities to enhance persons' health and decrease risks of illness and vulnerabilities during these transitions [42]. Our results show that participants express awareness of their readiness for discharge from acute psychiatric wards. Their awareness is based on feeling better and feeling safe and secure in regards to their psychotic illness, to their need for care from the community mental health nurses to cope with daily life at home with family members and the need be observed and understood as ill to receive support and care if new phases of acute psychosis occur.

Our results describe how the participants experienced being in transition to become ready for discharge. Models of transitional mental health care (cf. [11,13,14]) recommend the transitional care adjusted to persons' narrated experiences about their situation and care needs, and provided within partnership and cooperation between the person in care and the mental health nurses. We know that the nurses and the persons in care may have different understanding about the time for discharge, and about their medical and care needs [18,19]. We also know that some persons who suffer from severe mental illness and substance abuse may have limited economy, bad housing facilities or being homeless which must be considered by the nurse during the discharge planning [17]. Noseworthy et al. [17] described in a study that smooth transition from the acute ward to community care for a person requires trusting relationships between the person in care and the nurse, sharing knowledge and respecting each other's knowledge, even the lack of resources in the communities and work for the best of solutions for the person in care. These circumstances show some of the complexity of planning the discharge from acute psychiatric ward and the challenge for both mental health nurses and persons in care when to provide the best of transitional mental health care.

The results of our study highlight that participants are aware of their mental health care needs and the time needed for transition to become ready for discharge from the acute psychiatric ward. The participants reported the following care needs: nurses' sensitivity to the participants' care needs associated with their physical and mental wounds and wounded relationships following the acute psychotic illness; the need for a combination of nursing care on the ward and visits home to feel better before discharge; the need for nurses, together with the person in care, to access the person's experienced readiness for discharge based on his/her experienced signs of feeling better and opinions about the quality of care provided at home to confidently live at home.

Methodological considerations and limitations

To ensure the trustworthiness of our approach, we used specific verification strategies throughout the research process [30, 40]. The sample includes persons in care who reported suffering from psychotic illness, which might elicit questions about the reliability of the study. However, previous studies have found that persons' self-report of signs of psychotic illness are generally reliable [52]. The number of participants and the variation in the sample appeared sufficient to describe the nuances and variations in their experiences and was small enough to allow a thorough analysis of the data [30]. We discussed the breadth, depth and nuances of the interviews during the data collection, which allowed the interviewer to modify interviews to

ensure sufficient data [40]. During the content analysis, we critically viewed our chosen focus, coding, the constructions of subcategories and categories and the interpretation of the underlying meaning from different perspectives. This strategy allowed us to explore and reflect on the results and to ensure that our presentation of the results fully captures the participants' narrated experiences.

Our study is limited by the sample size; however, our intention was to present rich descriptions of the topic explored, resulting in a high degree of content validity [40]. The rich detailed descriptions presented in our results allow the reader to consider the transferability of the results to other contexts and may, thus, contribute to the development of nurses' transitional care to help persons for discharge and return home. Aspects of our results are consistent with previous research describing transitions in persons' psychotic illness experiences [53, 54] and provide new knowledge. The new knowledge informs about the transitional period when persons psychotic symptoms decreased and about their needs of nurses transitional care.

Conclusion

Nurses' transitional care activities that seem to be most important for persons with psychotic illness are planning for discharge together with the persons in care and following up with the persons' care at home. However, the new results of our study indicate that only to meet the persons' medical, social and nursing care needs when planning for discharge from an acute psychiatric ward is not sufficient. Persons who recently suffered from acute psychotic illness highlighted the need for time to transition to become ready for discharge from the acute psychiatric ward and the need for care from nurses on the ward and visits home during the transition to become ready for discharge. Mental health nurses need seriously to consider this experiential knowledge as a contribution to improve the transitional mental health care that they provide to persons who recently experienced acute psychotic illness discharged from acute psychiatric wards.

Competing Interest

The authors declare that they have no competing interests.

Author Contributions

All authors contributed in the design of this study. KS performed the data collection guided by AGT. All authors contributed to the analysis and interpretation of the data. KS was responsible for drafting the manuscript. All authors revised the manuscript critically and made a substantial contribution in revising the manuscript. All authors read and approved the final manuscript.

Acknowledgement

Profound gratitude is extended to the participants for their generosity and openness during the interviews.

Funding

The Northern Norway Regional Health Authority funded this study. Scholarship is received from The Norwegian Nurses Organisation. The financial sources had no influence of the conduct of the study.

References

1. Thornicroft G, Tansella M (2013) The balanced care model: the case for both hospital- and community-based mental healthcare. *Br J Psychiatry* 202: 246-248.
2. Bowers L, Simpson A, Alexander J, Hackney D, Nijman H, et al. (2005) The nature and purpose of acute psychiatric wards: the Tompkins acute ward study. *J Ment Health* 14: 625-635.
3. Norwegian Directorate of Health (2013) National guidelines for diagnosis, treatment and follow-up of persons with psychotic disorders. Oslo: Anword Grafisk AS.
4. McGorry PD, Killackey E, Yung A (2008) Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry* 7: 148-156.
5. NICE (2014) National Institute of Clinical Excellence Guidelines: psychosis and schizophrenia in Adults: Treatment and Management.
6. Mental Health Commission Scotland (2012) Guidance document on individual care planning mental health services.
7. Norwegian Directorate of Health (2015) Rehabilitation, habilitation, individual care plan and coordinator. Guideline. Oslo: Anword Grafisk AS.
8. Schumacher KL, Meleis AI (1994) Transitions: a central concept in nursing. *Image J Nurs Sch* 26: 119-127.
9. Tomita A, Herman DB (2012) The impact of critical time intervention in reducing psychiatric rehospitalization after hospital discharge. *Psychiatr Serv* 63: 935-937.
10. Mistiaen P, Francke AL, Poot E (2007) Interventions aimed at reducing problems in adult patients discharged from hospital to home: a systematic meta-review. *BMC Health Serv Res* 7: 47.
11. Barker P, Buchanan-Barker P (2010) The tidal model of mental health recovery and reclamation: application in acute care settings. *Issues Ment Health Nurs* 31: 171-180.
12. Rock BD (1987) Beyond discharge planning. *Hosp Community Psychiatry* 38: 529-530.
13. Reynolds W, Lauder W, Sharkey S, Maciver S, Veitch T, et al. (2004) The effects of a transitional discharge model for psychiatric patients. *J Psychiatr Ment Health Nurs* 11: 82-88.
14. Forchuk C, Martin ML, Chan YL, Jensen E (2005) Therapeutic relationships: from psychiatric hospital to community. *J Psychiatr Ment Health Nurs* 12: 556-564.
15. Lien L (2002) Are readmission rates influenced by how psychiatric services are organized? *Nord J Psychiatry* 56: 23-28.
16. Loch AA (2014) Discharged from a mental health admission ward: is it safe to go home? A review of the negative outcomes of psychiatric hospitalization. *Psychol Res Behav Manag* 7:137-145.
17. Noseworthy AM, Sevigny E, Laizner A, Houle C, La Ricca P (2014) Mental health care professionals' experiences with the discharge planning process and transitioning patients attending outpatient clinics into community care. *Arch Psychiatr Nurs* 28: 263-271.
18. Walsh J, Boyle J (2009) Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means to empowerment. *Issues Ment Health Nurs* 30: 31-38.
19. Glasby J, Lester H (2005) On the inside: a narrative review of mental health inpatient services. *Br J Soc Work* 35: 863-879.
20. Cleary M, Horsfall J, Hunt GE (2003) Consumer feedback on nursing care and discharge planning. *J Adv Nurs* 42: 269-277.
21. Manuel J, Hinterland K, Conover S, Herman D (2012) "I hope I can make it out there": perceptions of women with severe mental illness on the transition from hospital to community. *Community Ment Health J* 48: 302-308.
22. Gerson LD, Rose LE (2012) Needs of persons with serious mental illness following discharge from inpatient treatment: patient and family views. *Arch Psychiatr Nurs* 26: 261-271.
23. Puschner B, Steffen S, Volker KA, Spitzer C, Gaebel W, et al. (2011) Needs-oriented discharge planning for high utilizers of psychiatric services: multicenter randomized controlled trial. *Epidemiol Psychiatr Sci* 20: 181-192.
24. Vigod S, Kurdyak P, Dennis CL, Leszcz T, Taylor VH, et al. (2013) Transitional interventions to reduce early psychiatric readmissions in adults: systematic review. *Br J Psychiatry* 202: 187-194.
25. Steffen S, Kösters M, Becker T, Puschner B (2009) Discharge planning in mental health care: a systematic review of the recent literature. *Acta Psychiatr Scand* 120: 1-9.
26. Khankeh H, Rahgozar M, Ranjbar M (2011) The effects of nursing discharge plan (post-discharge education and follow-up) on self-care ability in patients with chronic schizophrenia hospitalized in Razi psychiatric Center. *Iran J Nurs Midwifery Res* 16: 162-168.
27. Potkin SG, Gharabawi GM, Greenspan AJ, Rupnow MF, Kosik-Gonzalez C, et al. (2005) Psychometric evaluation of the Readiness for Discharge Questionnaire. *Schizophr Res* 80: 203-212.
28. Barker P (2001) The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *J Psychiatr Ment Health Nurs* 8: 233-240.
29. Mishler EG (1991) *Research Interviewing: Context and Narrative*. Cambridge, MA: Harvard University Press.
30. Graneheim UH, Lundman B (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 24: 105-112.
31. Vaismoradi M, Turunen H, Bondas T (2013) Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nurs Health Sci* 15: 398-405.
32. WMA Declaration of Helsinki (2013) Ethical Principles for Medical Research Involving Human Subjects.
33. Hem MH, Heggen K, Ruyter KW (2007) Questionable requirement for consent in observational research in psychiatry. *Nurs Ethics* 14: 41-53.
34. Hategan A, Parthasarathi U, Bourgeois JA (2014) Obtaining informed consent for research in an acute inpatient psychiatric setting. *Cur Psychiatry* 13: 39-40.
35. Carpenter WT Jr, Gold JM, Lahti AC, Queem CA, Conley RR, et al. (2000) Decisional capacity for informed consent in schizophrenia research. *Arch Gen Psychiatry* 57: 533-538.
36. Ruud T, Grawe R, Hatling T (2006) Akuttpsykiatrisk behandling i Norge - resultater fra en multisenterstudie (Acute psychiatric treatment in Norway - results from a multicenter study). Oslo: SINTEF.
37. (2001) Patients and Users Rights Act 1999-07-02-64: Act Relating to Patients and User Right. Oslo: Norwegian Department of Health.
38. Norwegian Directorate of Health (2008-2009) The reform of cooperation - The right treatment - in right care-setting - to the right time. Oslo: 07 Gruppen AS.
39. (2001) Mental Health Act 1999-07-02-62: Act Relating to the Establishment and Provision of Mental Health Care. Oslo: Norwegian Department of Health.
40. Elo S, Kaariainen M, Kanste O, Polkki T, Utriainen K, et al. (2014) Qualitative content analysis: a focus on trustworthiness. *SAGE Open* 2014: 1-10.
41. Chick N, Meleis A (1986) Transitions: a nursing concern. In: Chinn PL (Ed) *Nursing Research Methodology*, Aspen Publishers; Boulder, CO, pp. 237-257.
42. Meleis AI, Sawyer LM, Im EO, Hilfinger Messias DK, Schumacher K (2000) Experiencing transitions: an emerging middle-range theory. *ANS Adv Nurs Sci* 23: 12-28.
43. Frank AW (2001) Can we research suffering? *Qual Health Res* 11: 353-362.
44. Toombs SK (1990) The temporality of illness: four levels of experience. *Theor Med* 11: 227-241.

-
45. Delmar C, Bøje T, Dylmer D, Forup L, Jakobsen C, et al. (2005) Achieving harmony with oneself: life with a chronic illness. *Scand J Caring Sci* 19: 204-212.
 46. Helene Hem M, Heggen K, Ruyter KW (2008) Creating trust in an acute psychiatric ward. *Nurs Ethics* 15: 777-788.
 47. Sebergesen K, Norberg A, Talseth AG (2016) Confirming mental health care in acute psychiatric wards, as narrated by persons experiencing psychotic illness: an interview study. *BMC Nurs* 15: 3.
 48. Fenwick AM (1979) An interdisciplinary tool for assessing patients' readiness for discharge in the rehabilitation setting. *J Adv Nurs* 4: 9-21.
 49. Heine J, Koch S, Goldie P (2004) Patients' experiences of readiness for discharge following a total hip replacement. *Aust J Physiother* 50: 227-233.
 50. Lapum J, Angus JE, Peter E, Watt-Watson J (2011) Patients' discharge experiences: returning home after open-heart surgery. *Heart Lung* 40: 226-235.
 51. Lithner M, Klefsgard R, Johansson J, Andersson E (2015) The significance of information after discharge for colorectal cancer surgery-a qualitative study. *BMC Nurs* 14: 36.
 52. Jorgensen P (1998) Early signs of psychotic relapse in schizophrenia. *Br J Psychiatry* 172: 327-330.
 53. Sebergesen K, Norberg A, Talseth AG (2014) Being in a process of transition to psychosis, as narrated by adults with psychotic illnesses acutely admitted to hospital. *J Psychiatr Ment Health Nurs* 21: 896-905.
 54. Uttinger M, Koranyi S, Pappmeyer M, et al. (2015) Early detection of psychosis: helpful or stigmatizing experience? A qualitative study. *Early Interv Psychiatry* .