Acute mental health inpatient care settings within the UK

A thesis submitted to the University of Manchester for the Degree of Doctor of Clinical Psychology in the Faculty of Biology, Medicine and Health

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Word Count: 20,332 (excluding figures, tables, references, and appendices)
Thesis Abstract

This thesis focuses on acute mental health inpatient care settings within the UK, with a systematic review on factors influencing length of stay (LOS) and service users’ experiences of care from admission to readmission.

Paper One: Presents a systematic review, which aimed to synthesise and evaluate the research to date looking at predictors of length of stay in acute mental health inpatient care within the UK. Thirteen studies were identified for inclusion, exploring demographic, clinical, social, and provider level factors related to LOS. There was substantial variation in the factors examined in relation to LOS across studies, where consistency in findings across the factors investigated varied. However, older age, black and minority ethnic groups and involuntary admission were most consistently associated with increased LOS, and alcohol and substance misuse with a shorter LOS. Limitations of the literature and the review, and future clinical and research implications are discussed.

Paper Two: Aimed to explore service users’ experiences of care from admission to readmission to acute mental health inpatient care. The study used Interpretative Phenomenological Analysis (IPA) to gain an in-depth understanding of service users’ experiences of care, including during admission, at discharge and follow-up care in the community and whether from their perspective this care met their needs. Participants’ narratives highlighted inconsistencies in services abilities to meet their needs across the care pathway, which appeared to influence their need for readmission. Clinical implications and areas for future work are considered.

Paper Three: Provides a critical reflection on the systematic review and empirical paper, including the planning, implementation, and interpretation during the research process, as well as clinical implications and areas for future research. Personal reflections on the research process are also provided.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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Acknowledgements

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A big thank you to my wonderful cohort who have been a supportive force throughout my training journey, in particular Hannah who has made my move to Manchester a less daunting and very fun experience! I would like to thank my friends and family for their support, especially Simon, thank you for all your reassurance and calmness in my moments of self-doubt! I couldn’t have done it without you.
1. Systematic Review

Length of stay in acute mental health inpatient care: A systematic review

The following paper has been prepared for submission to the British Journal of Psychiatry. Publication guidelines can be found in Appendix A.

Word count: 7,893 (excluding Tables, Figures, References)
Abstract

**Aims**: To systematically review individual, social, and provider factors related to length of stay (LOS) in adult acute mental health inpatient wards within the UK.

**Methods**: Six databases were searched, MEDLINE, PubMed, CINAHL, EMBASE, PsycINFO and Web of Science, for studies investigating predictors of length of stay for UK adult acute mental health inpatients. Thirteen articles were eligible for inclusion. Data was extracted on study characteristics and study quality was appraised.

**Results**: Findings across studies indicated older age, black and minority ethnic groups and involuntary admission were associated with increased LOS. Diagnosis was also found to be a significant predictor of LOS, with psychotic diagnoses associated with increased admission duration. Substance and alcohol misuse was consistently associated with a shorter LOS. There was less reliable evidence for the influence of gender and marital status on LOS. Where other factors were investigated, including history of readmission, living arrangements, postcode deprivation and employment, evidence of association was generally weaker or inconsistent.

**Conclusions**: Further research is required to develop the UK evidence base for predictors of LOS in acute mental health inpatient wards. Where possible, future research should be conducted on up-to-date national data, with large study populations. The selection of variables should be hypothesis-driven to examine LOS, considering not only stable factors (e.g. age), but variables that can be modified by services to provide efficient and effective care, and where appropriate minimise LOS without effecting the quality of care.

**Keywords**: Length of stay, inpatient care, review.
Inpatient mental health care is a vital part of the service provision in supporting people with acute mental health difficulties in times of crisis. It represents a substantial part of expenditure across mental health care, with high numbers of admissions year-on-year, despite a limited number of available beds (British Medical Association, 2017; Gilburt, 2015; Commission on Acute Adult Psychiatric Care, 2016). Relieving the strain on inpatient care is a global priority, with services striving to reduce admissions and ensure necessary stays are only as long as required. Steps to prevent and reduce lengthy admissions have clinical, as well as financial implications. Where possible, avoiding long admissions to inpatient care has the potential to benefit patients by minimising negative experiences of restrictive hospitalisation, limiting exposure to coercive ward practices, and reducing the challenges faced in re-engagement with community life post-discharge (Babalola, Gormez, Alwa, Johnstone, & Sampson, 2014; Care Quality Commission (CQC), 2017; Commission on Acute Adult Psychiatric Care, 2016; Nugteren et al., 2016). There are further advantages for services under pressure to save costs, reinforced by changes in funding that look to incentivise a reduction in the length of admissions through payment by performance schemes (Cashin, Chi, Smith, Borowitz, & Thomson, 2014; Jacobs et al., 2016; Wright, Cornick, Jones, Marshall, Roberts, 2017).

Much research has been conducted to identify factors that predict length of stay (LOS) in mental health inpatient settings, which has resulted in reviews on determinants of LOS in Europe and internationally. Previous non-systematic reviews conducted in the United States (USA) noted that studies have historically tended to focus their efforts on investigating the influence of diagnosis on LOS, despite the limited variance explained by diagnosis alone (Kirshner, 1982; Canton & Gralnick, 1987; McCrone, 1995). Authors have therefore emphasised the importance of considering a wider range of factors that may influence LOS, such as socio-demographic, clinical, and also treatment factors that may arise due to variation in hospital populations, resources and standards of practice.
More recently, Gopalakrishna, Muaid Ithman, & Malwitz (2015) reviewed the literature on acute inpatient care across a number of countries. They focussed on demographic, treatment and diagnostic factors, and found that, across the studies reviewed, these factors alone were able to account for between 10-37% of the variance in LOS. Findings highlighted a number of factors associated with a decreased LOS: substance misuse, being married, having children in the home, a high psychiatrist caseload, and employment. Conversely, mood and psychotic diagnoses, involuntary admission, use of ECT and restraint, comorbidities, bed availability and challenges with post-discharge placement were associated with longer stays. However, findings were inconsistent in relation to education, previous admissions, cognitive impairment, type of hospital, gender and age. The review thus provides a comprehensive synthesis of the varying factors related to LOS investigated across the studies included. However, the review does not directly assess the methodological quality of the studies it reviewed, and the weight of evidence associated with the various factors is therefore unclear. Further, the review itself was not systematic, and it is therefore not clear how their implicit search criteria influenced the results.

Two further systematic reviews have investigated determinants of LOS in inpatient care in Germany (Melchior et al., 2010) and the USA (Tulloch, Fearon, & David, 2011), highlighting a number of service user- and treatment-related factors predictive of LOS. Melchior et al. (2010) examined socio-demographic and clinical predictors, concluding that living alone, increased symptom severity on admission, duration of mental health difficulties, previous admission, unemployment and comorbidities were associated with increased LOS. Differences in diagnoses were identified, including longer stays for individuals with obsessive-compulsive, eating and personality disorders, in comparison to depressive, anxiety, somatoform, and adjustment diagnoses with shorter admissions. However, inconsistencies were found regarding age, gender, education and profession.
Tulloch et al. (2011) also identified differing factors related to LOS across studies. In larger studies, diagnosis was consistently found to have a significant impact on LOS; specifically psychotic diagnoses and being female were both associated with increased LOS. A non-linear effect of age was found, with shorter stays in middle age compared to younger and older groups. Overall, being married, involuntary admission and prospective payments were identified to be associated with shorter admissions. However, limited evidence was noted for the effect of substance misuse and general functioning on LOS, and no association was found for hospital type, number of psychiatrists and ethnicity.

Both the US and German reviews find inconsistent evidence as to the most important influencers on LOS and identify a number of limitations in their ability to draw conclusions across studies, including variation in study populations, treatment, analysis methods, as well as the inclusion of studies with limited statistical power (Melchior et al., 2010; Tulloch et al., 2011). Authors emphasised the need for future research with up-to-date data and large samples in order to more accurately identify factors predictive of LOS (Tulloch et al., 2011). More recently, Dimitri et al. (2018) further suggested that differences in predictors of LOS might arise due to varying clinical practice across countries that may impact on the admission and discharge process. Based on this, they suggest a need for future research conducted within individual countries to better understand the predictors of LOS for country-specific populations and clinical services.

In the UK, mental health care is predominately provided by the National Health Service (NHS), which provides free universal care for the whole population with the aim of delivering equal care for all. In some cases, however, individuals may also pay to access private health care (Berry, 2015). This differs from the majority of other care systems worldwide, where populations require private insurance or receive only partially funded public health care coverage. Indeed, in comparison to many other developed countries, the UK has been identified as having a greater LOS in acute inpatient care (Moran & Jacobs, 2013; Samele
Given these differences in healthcare systems, as well as the lack of previous systematic reviews that directly address determinants of LOS within the UK context, a review of studies of LOS in acute inpatient mental health care was undertaken.

**Objectives**

This review aims to provide a comprehensive understanding of the demographic, social, clinical and provider factors associated with LOS in adult acute mental health inpatient wards in the UK, with a view to informing future research and clinical practice. This includes systematically searching, quality appraising, and synthesising the available literature.

**Method**

**Search Strategy**

MEDLINE, PubMed, CINAHL, EMBASE, PsycINFO and Web of Science databases were systematically searched for relevant studies investigating predictors of length of stay for UK adult acute mental health inpatients published prior to December 2018. Combinations of key search terms describing, predictors, length of stay and acute mental health inpatient care were used (either as MeSH terms or free-text dependent on the database). See Table 1 for a full list of search terms. Reference lists of included studies were reviewed to identify any additional relevant studies.

**Table 1: Search Terms**

<table>
<thead>
<tr>
<th>Population</th>
<th>Ward-based</th>
<th>Factors</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Inpatient</td>
<td>Predict*</td>
<td>Length of stay</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>Psychiatric Inpatient</td>
<td>Factor*</td>
<td>Length of hospitalization</td>
</tr>
<tr>
<td>Mental Disorder</td>
<td>Psychiatric Hospital</td>
<td>Determinant*</td>
<td>Length of hospitalisation</td>
</tr>
<tr>
<td>Psychiatric Illness</td>
<td>Psychiatric Unit</td>
<td>Variable*</td>
<td>Duration of hospitalisation</td>
</tr>
<tr>
<td>Psychiatric Disorder</td>
<td>Psychiatric Ward</td>
<td>Characteristic*</td>
<td>Duration of hospitalization</td>
</tr>
<tr>
<td>Psychiatric Patient</td>
<td>Acute Inpatient</td>
<td></td>
<td>Days in hospital</td>
</tr>
<tr>
<td></td>
<td>Hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospitalisation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Selection Criteria

All titles and abstracts of articles were assessed for eligibility and full articles of potentially relevant studies were then reviewed to ensure they met the inclusion criteria outlined below. The first author completed the initial search, and a second reviewer independently reviewed 10% of all full-text publications to ensure reliability (Cohen’s K=0.820). The final articles were agreed by all authors; where disagreements arose they were discussed and a consensus was reached.

Inclusion Criteria

Studies were included if they:

1) Examined factors associated with length of stay in adult acute inpatient mental health wards, or evaluated predictive models for LOS.

2) Included participants admitted to acute inpatient wards in the UK. In cases where studies did not specifically state the type of inpatient care, and authors could also not be contacted to confirm the sample consisted of acute admissions, studies were assumed to refer to acute inpatient care.

3) Reported more than 75% of the sample were aged 16 years and over.

4) Were published in an English language peer-reviewed journal.

Exclusion criteria

Studies were excluded if they:

1) Stated that they involved specialist units (e.g. assessment wards, rehabilitation wards, specialist eating disorder, learning disability or substance misuse units, forensic, and psychiatric intensive care units).

2) Did not report information on the association between independent variables and LOS.

Data Extraction

The characteristics of studies was extracted by the first author including, author and publication year, study objective, number of wards or sites, methods of data collection, study population, sample size, age in years (mean, median,
range), data source, collection period, study design, length of stay (both how the variable was measured e.g. continuous in days and mean, geometric mean or median) and statistical method used (see Table 2 for study characteristics). Subsequently, predictors were then classified into demographic, clinical, social and provider characteristics.

**Quality Appraisal**

The Quality in Prognostic Studies (QUIPS) tool was used to evaluate the quality of studies (Hayden, Côte, & Bombardier 2006; see Appendix B for tool), although studies were not excluded on the basis of poor quality. The QUIPS is primarily design for prognostic studies, which follow participants up over a period of time using longitudinal designs. However, with some adaption, the tool was still deemed relevant to the LOS studies included in the review, as data on exposure variables was typically recorded prior to the LOS, even though researchers might have accessed both data on exposure variables and LOS from hospital records at one point in time. The quality of studies was considered in the following areas; study participation (the sample is representative of the target population), factor measurement, outcome measurement, study confounding (key confounding factors are considered and controlled for), statistical analysis and reporting (the method of analysis is appropriate and all key findings are reported). The domain of study attrition was excluded from the overall quality assessment rating, as due to the design of studies, with outcome data in the majority of cases collected from hospital records this domain was not applicable. However, a rating for this domain is provided for studies where this was applicable. The first author appraised all studies, and a second reviewer independently assessed 30% of studies for inter-rater reliability. Any disagreements in ratings were discussed and a consensus reached (Cohen’s k= 0.692).

**Data Synthesis**

Due to the heterogeneity of studies included in the review, both methodologically and in the populations investigated, it was not appropriate to
conduct a meta-analysis on the data (Sharpe, 1997). We therefore conducted a narrative synthesis of the available evidence, discussing its limitations where appropriate.

**Results**

The systematic search retrieved 7,142 articles, which was reduced to 5,738 following the removal of duplicates. At initial screening of titles and abstracts, 5,633 studies did not meet the inclusion criteria, leaving 105 studies to be reviewed at the full article stage. A total of 13 studies met the review criteria (Figure 1).

![Flow diagram for systematic search](image)

**Figure 1**: Flow diagram for systematic search
Description of LOS studies

There are a number of important factors to consider when looking across all these studies, which represent particularly important sources of variation: (1) variation in study population, (2) variation in the study design, (3) variation in the way LOS is measured, (4) variation in predictor variables addressed, and the way in which these were measured, and (5) statistical model used.

1) Study populations
Ten studies included all admitted service users in their analysis, with the remaining three focusing on varying subsets of this total population. For example, ‘heavy users’ of inpatient services (determined by number of admissions and bed days) or specific diagnoses for example, psychotic diagnoses or severe mental illness (Jacobs et al., 2015; Lucas et al., 2001; McCrone & Lorusso, 1999). Studies varied in whether they excluded organic diagnosis or services users with cognitive impairment within the sample. Population age varied and many excluded service users above 65 years (Creed, Tomenson, Anthony, & Tramner, 1997; Hodgson, Lewis, & Boardman, 2000; Sinclair & Latifi, 2008; Tulloch, Khondoker, Faron, & David, 2012; Weinberg, Greaves, Creed, & Tomenson, 1998). Two studies focused solely on admissions of older adults 65 years and above (Greene et al., 2001; Tucker, Hargreaves, Wilberforce, Brand & Challis, 2017).

2) Study design
Seven studies stated they collected data from one hospital or trust site and six reported data was collected from multiple wards or hospitals. Data were collected from NHS sites, except for one study, which included data from private wards. All studies in this review employed observational designs. Data was sourced in two ways across studies; the majority of studies collected data retrospectively, sourcing information from national and local clinical databases. In some cases data were collected prospectively on admission, usually by the researcher or clinicians, and LOS recorded upon discharge.
3) Measurement of LOS

Length of stay was measured in two ways within studies; generally it was treated as a continuous variable, investigating the number of days from admission to discharge (Bird et al., 2018; Creed et al., 1997; Greene et al., 2001; Hodgson et al., 2000; Jacobs et al., 2015; Lucas et al., 2001; Moran, Jacobs & Mason, 2017; Newman, Harris, Evans, & Beck, 2018; Tucker et al., 2017; Tulloch et al., 2012; Weinberg et al., 1998) or over a predetermined time-frame (e.g. one year) (Creed et al., 1997; Lucas et al., 2001). Six studies stated that LOS was logarithmically transformed to handle the variable being highly skewed or to account for the existence of non-linear relationships between independent variables and LOS (Creed et al., 1997; Greene et al., 2001; McCrone et al., 1999; Newman et al., 2018; Tulloch et al., 2012; Weinberg et al., 1998). However, others grouped length of stay into categories (0-7 days; 8-30 days; >31 days; Sinclair et al., 2008), or the stage of discharge early or late at different quartiles (Bird et al., 2018).

4) Predictors

Measurement of independent predictors varied across studies, including a combination of demographic, clinical, social, and provider factors. A significant number of factors were investigated within the studies, with more recent studies accounting for a higher number of potentially influencing factors. All studies considered at least one demographic factor, which was most commonly, gender or age. Twelve studies considered clinical variables, such as diagnosis and substance and alcohol misuse. Social factors, such as living arrangements related to accommodation and household composition (e.g. living alone), and measures of income associated with employment were also often examined. Finally, provider characteristics linked to community service support, ward, hospital and trust characteristics were investigated in a small proportion of studies.

Importantly, while there is some congruence in the variables used across studies, their precise measurement, as well as the manner in which they are
encoded in the model (e.g. continuous linear predictor, continuous quadratic predictor, ordinal predictor, etc.) was not uniform across studies. For example, age was treated as both a categorical factor (e.g. 16-25, 26-35, 36-45 years; Tulloch et al., 2012) and continuous predictor (e.g. 16-64 years; Hodgson et al., 2000).

5) Statistical Model
Studies analysed data using a variety of statistical techniques. All studies considered the influence of more than one independent variable on LOS, where the association between predictor variables and LOS was examined by controlling for other explanatory variables. Studies can be broadly distinguished by those that used generalised linear models for example, linear regression, logistic regression, poisson regression etc., versus the remainder that used different approaches, such as survival analysis techniques (e.g. Cox regression).
## Table 2: Summary of study characteristics

<table>
<thead>
<tr>
<th>Author (Year)</th>
<th>Objectives</th>
<th>Number of wards/sites</th>
<th>Sample Size</th>
<th>Population</th>
<th>LOS measurement/mean</th>
<th>Age</th>
<th>Data source (year)/Design</th>
<th>Analysis</th>
<th>Quality review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Creed et al. (1997)</td>
<td>To assess factors which predict LOS in a single psychiatric unit. That a significantly greater proportion of the variation of LOS would be explained if detailed clinical and social data were used in addition to diagnosis.</td>
<td>1 NHS Hospital</td>
<td>115</td>
<td>Patients included those randomised to inpatient arm or excluded as sectioned from RCT.</td>
<td>Continuous days (Log transformed) Single admission: (Geometric mean =31.3 days, CI=26.2-37.4) Year-long: (Geometric mean =49.2 days per year, CI = 40.6-59.6)</td>
<td>18-65</td>
<td>Psychiatric assessment interviews on admission. (Over 9 months) Cross-sectional</td>
<td>Hierarchical Stepwise Multiple Regression</td>
<td>Low</td>
</tr>
<tr>
<td>2 Weinberg et al. (1998)</td>
<td>To predict whether severity of illness along with other factors predicts LOS.</td>
<td>19 NHS Units</td>
<td>815 analysed (2230 total)</td>
<td>All admitted</td>
<td>Continuous days (Log transformed) (Median 17-39 days, across units)</td>
<td>16-65</td>
<td>Case notes and assessment on admission. (Over 6 months) Cross-sectional</td>
<td>Multiple Regression</td>
<td>Moderate</td>
</tr>
<tr>
<td>3 McCrone et al. (1999)</td>
<td>To assess if diagnosis-based case-mix is a poor predictor of LOS.</td>
<td>1 NHS Hospital</td>
<td>169 service users (523 care episodes)</td>
<td>Psychotic diagnoses only</td>
<td>Continuous days (Log transformed) (Median = 16-33, across diagnoses)</td>
<td>16+</td>
<td>Requested information from hospital sites (Over 3 years) Cross-sectional</td>
<td>Multiple Regression</td>
<td>Low</td>
</tr>
<tr>
<td>4 Hodgson et al. (2000)</td>
<td>To examine the effects of clinical, administrative and demographic variables on LOS. To develop a prediction model for LOS</td>
<td>4 NHS wards</td>
<td>4139</td>
<td>All admitted</td>
<td>Continuous days (Mean= 37 days)</td>
<td>16-64</td>
<td>Routine Data (Korner returns) and case notes. (1987-1993) Cox Regression</td>
<td>Retrospective cohort</td>
<td>High</td>
</tr>
<tr>
<td>5 Greene et al. (2001)</td>
<td>To identify factors that may contribute to prolonged LOS in elderly acute psychiatric inpatient setting.</td>
<td>Private Psychiatric Hospital</td>
<td>150</td>
<td>All admitted including organic diagnoses</td>
<td>Continuous days (Log transformed) (Median=33 days)</td>
<td>65-95</td>
<td>Case notes (Over 3 years) Cross-sectional</td>
<td>Backwards Stepwise Logistic Regression</td>
<td>Moderate</td>
</tr>
<tr>
<td>No</td>
<td>Author and Year</td>
<td>Study Objective</td>
<td>General description of predictors</td>
<td>Study Setting</td>
<td>Sample Size</td>
<td>Predictor Details</td>
<td>Methodology</td>
<td>Study Design</td>
<td>Effect Size</td>
</tr>
<tr>
<td>----</td>
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</tr>
<tr>
<td>6</td>
<td>Lucas et al. (2001)</td>
<td>To study the characteristics of heavy users and the factors that contributes to their pattern of inpatient use.</td>
<td>1 NHS Hospital</td>
<td>193 ‘Heavy Users’ (Ordinary users 1706)</td>
<td>Frequently admitted and high number of bed days= ‘Heavy users’</td>
<td>Continuous days (Heavy Users Mean = 52.6 days per year, CI=45.7-59.4) (Ordinary Users Mean = 12.3 days per year, CI=10.1-14.4)</td>
<td>Clinical database and interview assessment to determine ‘heavy users’ (1988-1994) Case-control</td>
<td>Stepwise Linear Regression</td>
<td>Low</td>
</tr>
<tr>
<td>7</td>
<td>Sinclair et al. (2008)</td>
<td>To assess the prevalence of alcohol and substance misuse and examine the relationship of substance misuse on LOS.</td>
<td>1 NHS Trust Site</td>
<td>178</td>
<td>All admitted</td>
<td>Three categories of LOS: (0-7 days; 8-30 days; 31+ days) (Median = 18.5 days)</td>
<td>Basic demographic data collected and interview on admission. (2005- over 4 months) Cross-sectional</td>
<td>Ordinal Logistic Regression</td>
<td>Moderate</td>
</tr>
<tr>
<td>8</td>
<td>Tulloch et al. (2012)</td>
<td>To estimate the associations between LOS, homelessness, residential mobility and other factors, and to estimate the extent to which variation in LOS was accounted for by each of these factors.</td>
<td>1 NHS Trust Site</td>
<td>4885</td>
<td>All admitted</td>
<td>Continuous days (Log transformed) (Median = 22 days)</td>
<td>BRC case registry (2007-2009) Cross-sectional</td>
<td>Log Linear Regression</td>
<td>High</td>
</tr>
<tr>
<td>9</td>
<td>Jacobs et al. (2015)</td>
<td>To assess the independent effects of patient characteristics and local area characteristics on LOS, and study if there is heterogeneity in those effects across patient sub-groups with SMI. To assess the degree of unexplained variation in the provider LOS after controlling for patient/local area characteristics.</td>
<td>67 NHS Hospitals</td>
<td>89510</td>
<td>Primary diagnosis SMI (Schizophrenia, psychotic, manic and bipolar diagnoses)</td>
<td>Continuous days (Mean (SD) = 43.9 days, SD=39.7)</td>
<td>National databases: Hospital Episode Statistics; (HES); Office of National Statistics (ONS; Department of Works and Pensions (DWP); Quality &amp; Outcomes Framework (QOF); GP Patient Survey (GPPS) (2006-2010) Retrospective cohort</td>
<td>Poisson Regression Models</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Authors</td>
<td>Research Objective</td>
<td>General description of predictors</td>
<td>Study Population</td>
<td>Outcome Variable</td>
<td>Study Design</td>
<td>Data Collection Period</td>
<td>Statistical Methodology</td>
<td>Study Quality</td>
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<tr>
<td>10</td>
<td>Moran et al. (2017)</td>
<td>To examine variation in LOS among mental health providers.</td>
<td>General description of predictors</td>
<td>63 NHS Providers</td>
<td>All admitted with mental health diagnoses</td>
<td>Continuous days (Mean (SD)=43 days, SD=66)</td>
<td>&lt;100</td>
<td>National databases: Hospital Episode Statistics (HES), The Care Quality Commission (CQC); Department of Health Staffing Survey (DoHSS). (2009-2011)</td>
<td>Multi-level Generalised Linear Model</td>
</tr>
<tr>
<td>11</td>
<td>Tucker et al. (2017)</td>
<td>To examine the factors identified with increased LOS on acute psychogeriatric wards.</td>
<td>General description of predictors</td>
<td>7 NHS Wards</td>
<td>All admitted including organic diagnoses</td>
<td>Continuous days (Mean (SD) = 63.6 days, SD=51.5)</td>
<td>65&lt;</td>
<td>Data collected on admission and discharge (2010-2011)</td>
<td>Cox Proportional Hazards Model</td>
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<tr>
<td>12</td>
<td>Newman et al. (2018)</td>
<td>To examine factors that predicts LOS.</td>
<td>General description of predictors</td>
<td>1 NHS Site</td>
<td>All admitted</td>
<td>Continuous days (Log transformed) (Median = 19 days, IQR = 7-44.5)</td>
<td>Adult (Not Stated)</td>
<td>Trust clinical database (2009-2012).</td>
<td>Multiple Regression</td>
</tr>
<tr>
<td>13</td>
<td>Bird et al. (2018)</td>
<td>To provide evidence and compare two key indicators of the quality treatment-patient satisfaction and LOS in functional and sectorised care.</td>
<td>General description of predictors</td>
<td>80 NHS Wards</td>
<td>All admitted</td>
<td>Continuous days (Mean = 46.4 days, SD= 63.5)</td>
<td>18&lt;</td>
<td>COfI data, Medical records, assessment on admission (2014-2015)</td>
<td>Quartile Regression</td>
</tr>
</tbody>
</table>
Quality appraisal of LOS studies

Table 3 outlines the findings from the quality assessment of included studies. Across studies, study populations varied in relation to diagnostic sub-groups or age groups, where seven studies had a sample from a single ward or hospital site. Consequently, it is likely that many studies might not be representative of the general service user population seen within acute mental health inpatient wards.

There were differences noted in the analysis of data across studies. There was limited description in some cases as to the variables controlled for within the analysis, adding to the complexity of interpreting findings across studies. Furthermore, a high number of studies did not justify the approach chosen to analyse their data, with many employing multiple modelling strategies, leading to inconsistencies in findings within individual studies themselves. Where studies had used a large number of tests generally there was a failure to acknowledge the potential for increased risk of Type 1 error. Few studies reported how they handled missing data, which may have led to under or overestimations of the effect of given variables on LOS.

Poor reporting of findings was seen across studies, with studies in some cases only stating the variance explained and significance levels, or only reporting the best predictors for LOS, omitting weaker predictors or those that were not significant, or adjusting for other variables but not reporting their effects. Limited reporting of results, alongside unclear descriptions of analysis introduced challenges in interpreting findings and the ability to consider whether a given variable had a clinically relevant impact on LOS.

The majority of studies used appropriate measures and validated tools to investigate independent predictors of LOS. The majority of studies collected data retrospectively from routine clinical databases, and, although there are benefits from drawing information from data already collected within clinical
practice, biases may have arisen due to the quality of data available (e.g. data on some variables may have been under reported or missing).

Table 3: Quality appraisal ratings using (QUIPS) tool.

<table>
<thead>
<tr>
<th>Author (Year)</th>
<th>Study Participation</th>
<th>Study Attrition</th>
<th>Factor Measurement</th>
<th>Outcome Measurement</th>
<th>Study Confounding</th>
<th>Statistical Analysis and Reporting</th>
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</thead>
<tbody>
<tr>
<td>Creed (1997)</td>
<td>High</td>
<td>N/A</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
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<tr>
<td>Weinberg (1998)</td>
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<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>McCrone (1999)</td>
<td>High</td>
<td>N/A</td>
<td>Moderate</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Hodgson (2000)</td>
<td>Low</td>
<td>N/A</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
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<tr>
<td>Greene (2001)</td>
<td>Moderate</td>
<td>N/A</td>
<td>Moderate</td>
<td>Low</td>
<td>Moderate</td>
<td>Low</td>
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<tr>
<td>Lucas (2001)</td>
<td>High</td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Sinclair (2008)</td>
<td>Moderate</td>
<td>N/A</td>
<td>Moderate</td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
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<tr>
<td>Tulloch (2012)</td>
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<td>Jacobs (2015)</td>
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<td>Moran (2017)</td>
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<td>Tucker (2017)</td>
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<td>Moderate</td>
<td>Low</td>
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<td>Moderate</td>
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<tr>
<td>Newman (2018)</td>
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<td>Low</td>
<td>Low</td>
<td>Low</td>
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<tr>
<td>Bird (2018)</td>
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<td>Low</td>
<td>Moderate</td>
<td>High</td>
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</tbody>
</table>

Factors associated with LOS

Due to the significant number of independent factors investigated within studies, only factors where three or more studies had reported findings have been discussed below (see Table 5 for direction of effects for factors on LOS); additional variables considered by studies are outlined in Appendix C.
Table 5: Direction of effects for factors on LOS

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<tr>
<td>Age (Older)</td>
<td>?</td>
<td>Increase NL</td>
<td>Increase NS</td>
<td>NS</td>
<td>?</td>
<td>NL</td>
<td>Increase ?</td>
<td>NL</td>
<td>?</td>
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<td>NS</td>
<td>Increase NS</td>
<td>NS</td>
<td>?</td>
<td>NS</td>
<td>NS</td>
<td>Increase</td>
<td>Mixed Decrease</td>
<td>Decrease</td>
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<td>Ethnicity</td>
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<td>NS</td>
<td>NS</td>
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<td>Increase</td>
<td>Increase</td>
<td>Increase</td>
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<td>?</td>
<td>S</td>
<td>S</td>
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<td>Increase</td>
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<td>Increase</td>
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<td>NS</td>
<td>NS</td>
<td>Increase</td>
<td>Increase</td>
<td>Increase</td>
<td>Increase</td>
<td>?</td>
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<td>Decrease</td>
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<td>NS</td>
<td>NS</td>
<td>Mixed</td>
<td>NS</td>
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<td><strong>Social Characteristics</strong></td>
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<td>?</td>
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<td>Increase</td>
<td>Decrease</td>
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<td></td>
<td></td>
<td></td>
<td>Increase</td>
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<tr>
<td>Residential mobility</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Increase</td>
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<td>Postcode deprivation</td>
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<td>?</td>
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<td>Increase</td>
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<td>NS</td>
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</tbody>
</table>

*NS* = No significant association on LOS, *?* = Results not reported/unclear, *S* = Significant association with LOS, *NL* = Non-linear effect, *Increase* = factor is associated with an increase in LOS, *Decrease* = factor is associated with a decrease in LOS, *Mixed* = Inconsistent finding within study.
Demographic characteristics

Age

Eight studies examined age as a predictor. Three studies reported a non-linear effect of age: in two, length of stay was higher for both younger service users and older service users, but not middle-age users (McCrone et al., 1999; Moran et al., 2017), while in the third, there was a positive association, but one that accelerated with increasing age (Tulloch et al., 2012). Three studies noted longer admissions were associated with increasing age (Hodgson et al., 2000; Jacobs et al., 2015; Weinberg et al., 1998) and two studies reported no association between age and LOS (Greene et al., 2001; Lucas et al., 2001).

Studies that reported an effect of age had larger samples sizes, with data collected from a greater number of wards, with a sample age range more representative of the population of interest (typically between 16-65 years). There was great variation of clinical and socio-demographic factors controlled for within studies. However, studies typically controlled for factors, such as gender, diagnosis and involuntary admission where age remained associated with LOS.

In comparison, studies that reported no significant association between age and LOS had smaller sample sizes and, in one study, only examined older adults (>65 years; Greene et al., 2001). As this study only investigated a narrow age-range it is likely that there is not enough variation within the age variable to identify an association with LOS. Overall, given the consistency of positive association in high quality studies, and absence of studies that report a negative association between LOS and age, these results suggest that LOS generally increases with increasing age. While there is some evidence of increased LOS in younger participants, only two studies investigated this with variation in the quality ratings of these studies; therefore limiting the conclusions that can be drawn from these results.
Ethnicity

Five studies examined the effect of ethnicity on LOS. Three studies identified that black and mixed ethnicity categories were consistently associated with an increased LOS in comparison to participants of white ethnicity (Jacobs et al., 2015; Moran et al., 2017; Newman et al., 2018). For example, two studies reported a 4-day or 17-31% increase in LOS (Jacobs et al., 2015; Moran et al., 2017). Two studies also identified greater LOS for participants of Asian ethnicity in comparison participants of white ethnicity (Moran et al., 2017; Newman et al., 2018), and one finding no association between Asian ethnicity and LOS (Jacobs et al., 2015). Two studies reported no effect of ethnicity on LOS at all (Lucas et al., 2001; Tulloch et al., 2012).

Studies demonstrating an association between LOS and ethnicity tended to have larger sample sizes, compared to studies identifying no effect. It is possible that smaller studies may have lacked power to detect an effect of ethnicity on LOS. Studies that found an effect of ethnicity adjusted for a wide range of potential socio-demographic and clinical confounders and some provider-level factors, with the effect of ethnicity still remaining present. Importantly, the majority of studies controlled for detention under the mental health act, as well as psychotic diagnoses, both confounders indicated to be related to ethnicity (Barnett et al., 2019; Kirkbride, Errazuriz, & Croudace, 2012), suggesting that the effect is not solely due to these factors.

Gender

Nine studies included gender as an independent factor. The influence of gender on length of stay was mixed. Two studies identified being female as associated with an increased LOS (Hodgson et al., 2000; Tucker et al., 2017), although the latter study highlighted that this effect was weak. Conversely, two studies reported being male as associated with increased LOS (Moran et al., 2017; Newman et al., 2018). However, Moran et al. (2017) found the effect of gender did not remain significant, when an alternative analysis was completed, which
accounted for patients having admissions to more than one provider. Five studies reported no association between gender and LOS (Greene et al., 2001; Jacobs et al., 2015; Lucas et al., 2001; McCrone et al., 1999; Tulloch et al., 2012). The inconsistent findings across studies, even when only looking at higher quality studies with larger sample sizes, suggests that gender may not be as strong or reliable factor on LOS in comparison to other variables investigated.

**Clinical Characteristics**

*Psychotic-related Diagnoses*

Seven studies identified diagnoses incorporating psychotic experiences to be associated with increased LOS compared to all non-psychotic related diagnoses such as, for example personality disorder, affective disorders and substance misuse (Hodgson et al., 2000; Moran et al., 2017; Newman et al., 2018; Tulloch et al., 2012; Weinberg et al., 1999). One study (Jacobs et al., 2015) investigated the impact of diagnoses within three specific diagnostic categories (schizophrenia, psychotic and schizoaffective disorders, mania and bipolar disorders). Overall, this study identified schizophrenia as having the highest risk of increased LOS across categories. However, Jacobs et al. (2015) also identified variation in LOS for sub-groups within these broader diagnostic categories, with schizotypal diagnoses being associated with a shorter LOS in comparison to acute transient psychotic, non-organic psychotic, and unspecified psychotic diagnoses. A single study described above reported no significant effect between psychotic diagnoses and LOS (McCrone et al., 1999). This study had a small sample and investigated psychotic diagnoses only. Studies that identified psychotic diagnoses were associated with increased LOS had larger study populations, were generally identified as moderate to high in quality and typically controlled for gender and ethnicity, which has been thought to influence psychotic diagnosis in clinical practice.
Personality Disorder

Four studies examined the influence of personality disorder on LOS where findings across studies were inconsistent. Four larger studies reported a diagnosis of personality disorder to be associated with shorter LOS; compared to schizophrenia, mania, depression (Weinberg et al., 1999), and psychosis (Newman et al., 2018). Moran et al. (2017) reported opposite findings within their models, one identifying personality disorder as increasing LOS, and the other decreasing LOS. Two studies examined the presence of co-morbid personality disorder. For these studies this was associated with a shorter LOS compared with psychotic, manic, and bipolar diagnoses (Jacobs et al., 2015; Newman et al., 2018). Overall, studies identified a shorter LOS and tended to be larger, were deemed to be of higher quality, and included a wide range of potential socio-demographic and clinical confounders.

Substance and alcohol misuse

Seven studies investigated substance and alcohol misuse, which was explored in a variety of ways, including measurement on admission, or records of substance and alcohol misuse in case notes, or recorded as a diagnosis. All studies that reported findings identified that substance and alcohol misuse was associated with a shorter LOS (Hodgson et al., 2000; Jacobs et al., 2015; Moran et al., 2017; Newman et al., 2018; Sinclair et al., 2008; Tulloch et al., 2012; Weinberg et al., 1999), and typically controlled for age, gender, diagnosis and involuntary detention. The exception was a smaller study, which focused solely on alcohol use (Sinclair et al., 2008). All studies that reported an effect had larger samples and focused on substance and alcohol misuse generally, rather than with reference to specific substances.

Involuntary admission

The influence of detention under the Mental Health Act (MHA) was reported by five studies, where involuntary admission was associated with a longer LOS (Hodgson et al., 2000; Jacobs et al., 2015; Moran et al., 2017; Tulloch et al., 2012; Weinberg et al., 1999). All studies that examined the impact of
compulsory admission had samples of 815 participants or over. Overall these studies were identified as moderate to high during quality appraisal. All studies included a range of potential demographic, social and clinical confounders, for example diagnosis, ethnicity, and emergency admissions; with compulsory admission still remaining a significant predictor.

**Readmissions**

Three studies reported findings regarding previous admissions for mental health inpatient care. Hodgson et al. (2000) identified an increase in LOS with prior admissions in the last 12 months. Conversely, Moran et al. (2017) noted previous admissions were associated with a decrease in LOS. However, one study reported no significant association between previous inpatient treatment and LOS (Tulloch et al., 2012). While all studies had larger sample sizes (>4000) and were as deemed to be of higher quality, there was substantial variation in the potential confounders adjusted for across studies. For example, one study included scales to assess severity of symptoms (Hodgson et al., 2000), one controlled for provider factors, such as access to crisis care (Moran et al., 2017), and another included a measure around general functioning and controlled for homelessness (Tulloch et al., 2012). Based on the available evidence and the substantial variation in the factors controlled for in these studies, the impact of readmission on LOS therefore remains unclear.

**Social Characteristics**

**Marital Status**

Marital status was reported as having no association with LOS in four studies (Greene et al., 2001, Hodgson et al., 2000; Newman et al., 2018; Tulloch et al., 2012). Conversely, one study reported a significant effect of marital status on LOS, but with the direction of effect varying between each of their two modelling approaches, depending on whether they accounted for service users having admissions to more than one provider (Moran et al., 2017). With the exception of one study (Greene et al., 2001), all other studies had larger sample
sizes and were similar in quality rating. Overall, marital status does not appear to be a consistent or important factor on LOS in comparison to other variables considered.

*Living situation*

Six studies investigated the influence of living situation on LOS. This was explored in two different ways; the living arrangement (if the individual lived alone or with others) and the physical accommodation (type of housing the individual lived in). There was some variation in associations with living arrangement. Creed et al. (1997) identified living alone to be associated with an increased LOS, while; similarly, Weinberg et al. (1999) found living with a relative or a spouse to be associated with a decreased LOS. However, Greene et al. (2001) did not find an association between living arrangement and LOS (Greene et al., 2001). The study which identified living with a relative or spouse to be associated with a shorter LOS had an overall larger sample and controlled for more potential socio-demographic and clinical confounders in comparison to the other studies with far smaller samples (n<150). However, these studies did not explore the level or availability of support within the living arrangement.

Three studies also reported findings in relation to different types of accommodation. Living in a hostel was associated with longer stays (Creed et al., 1997), being a council tenant was associated with a shorter admission, and living in supported or nursing care was associated with longer stays compared to private or rented accommodation (Newman et al., 2018). Residential mobility (frequent moves between addresses), and homelessness was found to increase LOS (Tulloch et al., 2012), although the strength of these effects varied across studies (Newman et al., 2018; Tulloch et al., 2012). These results must be interpreted cautiously, as the accommodation categories included within studies varied between studies. Two of these studies had large study populations and were quality rated as high (Newman et al., 2018; Tulloch et al., 2012). The third study was deemed as low in quality and had a small sample (Creed et al., 1997). However, Newman et al. (2018) reported considerable
missing data for the accommodation status variable, which may have impacted on effects identified.

It may be possible that having more unstable accommodation is linked to greater LOS. Newman et al. (2018) identified an effect of supported or nursing care accommodation on increased LOS. This may reflect the severity of difficulties experienced by service users, which were not adjusted for within the study. In a smaller study (Tucker et al., 2017), LOS was found to be greater for care home residents compared to individuals living at home. However, in a larger multivariate analysis controlling for daily functioning and severity of challenging behaviour this finding was no longer significant.

**Postcode Deprivation**

Three studies described findings on the impact of postcode deprivation on LOS, all with large sample sizes (>4000) and rated as high quality. Two studies reported that living in a more affluent area was associated with a shorter LOS (Jacobs et al., 2015; Moran et al., 2017). Conversely, another study found living in a more affluent area was associated with greater LOS (Hodgson et al., 2000). Caution must be taken when considering the impact of postcode deprivation on LOS as only a limited number of studies reported results relating to this variable. Furthermore, postcode deprivation was measured differently across all three studies, making it harder to accurately compare between studies. Although all studies controlled for a range of socio-demographic and clinical factors, none considered living situation (e.g. accommodation) as a potential confounder.

**Employment**

Four studies reported findings on the impact of employment on LOS. Two studies identified unemployment as associated with an increased LOS (Newman et al., 2018; Weinberg et al., 1998). These studies measure employment in two ways (e.g. employed, unemployed/retired or training; off work <3months). Two studies found no significant relationship between employment and LOS (Hodgson et al., 2000; Tulloch, et al. 2012), measuring employment in different
ways (e.g. employed or not employed; electoral ward unemployment rate), with the two largest studies noting significant missing data related to this variable (Newman et al., 2018; Tulloch et al., 2012). Overall, studies that identified a greater LOS for unemployment or no association were rated as moderate or high in quality review and included a range of sample sizes, making it difficult to draw conclusions and may reflect the variation in the way this variable was measured.

**Provider Characteristics**

Four studies examined how provider factors might impact LOS (Bird et al., 2018; Hodgson et al., 2000; Moran et al., 2017). However, as no three studies investigated the same provider level variables, we were unable to draw any conclusions from the evidence available on such factors. However, it felt important to highlight some examples of the types of provider level factors that have been considered within studies, bed availability, percentage of full time nurses or medics, whether care was provided in a mental health or foundation trust (Moran et al., 2017), whether care was provided by the same psychiatrist during admission and in the community (sectored care) or treated by separate psychiatrists in these settings (functional care) (Bird et al., 2018), whether the admission occurred on a weekday (Hodgson et al., 2000), access to and quality of primary community care (Jacobs et al., 2015).

**Discussion**

This review aimed to provide a comprehensive understanding of factors associated with LOS in adult acute mental health inpatient wards, within the UK. Broadly, studies focused on variables related to demographic, social, clinical, and provider characteristics. Factors consistently associated with a longer LOS across studies included older age, black and minority ethnic groups, and involuntary admission. Findings also indicated diagnosis to be a significant predictor of LOS, with psychosis-related diagnoses associated with lengthier hospital stays compared to other diagnoses. There was also evidence that a
diagnosis of a personality disorder was associated with a decreased LOS. Finally, substance misuse was consistently associated with shorter admissions. Factors less reliably associated with LOS were gender and marital status. There was inconsistent or limited evidence for other diagnoses, readmissions, living arrangements, postcode deprivation and employment on LOS, which is likely to be influenced by the variation in study methods. There was considerable heterogeneity of study methodologies in relation to study population, sample size, measurement of LOS, selection of predictor variables and there measurement, as well as methods for analysing data. This presented challenges for interpreting findings across studies, and these difficulties have also been raised in previous reviews (Melchior et al., 2010; Tulloch et al., 2011). In comparison to research exploring predictors of LOS in Europe and worldwide, particularly in the USA, this review highlights that research in this area still remains less developed within the UK.

The general suggestion was that LOS increases with age, though two studies also found evidence of higher LOS in younger participants, relative to those in middle age, and two did not find any statistically significant association. A previous review conducted in the USA found that middle age was associated with the lowest LOS (Tulloch et al., 2011), while two other reviews report inconsistent findings with regards to age and LOS (Gopalakrisha et al., 2015; Melchior et al., 2010). These inconsistencies across findings may reflect variation in the methodologies applied within studies reviewed. Longer admissions for service users’ of an older age may be explained by co-morbid physical health difficulties that may need to be addressed during admission. This could delay the discharge of older service users until appropriate support is found that meets both their physical and mental health needs, where research has highlighted the challenges of identifying appropriated accommodation for discharge that addresses older service users’ complex needs (Paton, Fahy & Livingston, 2004).
The finding that black and minority ethnic (BME) groups were associated with increased LOS differs from a previous review, which found limited evidence for an association of ethnicity with LOS (Tulloch et al., 2011). However, Tulloch et al. (2011) did state that this factor was only considered within small studies. Longer duration of admission for BME service users in comparison to service users of white ethnicity may be explained by severity of difficulties. Previous reviews have suggested perceived greater risk by professionals and discrimination as potential explanations for compulsory admission for BME groups (Barnett et al., 2019; Singh, 2007), where these factors may also influence LOS. Furthermore, research has highlighted barriers to accessing community services, or delayed help-seeking in BME groups (Halvorsrud, Nazroo, Otis, Brown Hajdukova, & Bhui 2018; Memon et al., 2016; Morgan et al., 2005), which may result in individuals presenting to services with more severe difficulties leading to longer admissions.

Psychotic diagnoses were consistently associated with the longest admissions compared to other diagnoses explored within studies. Past reviews support this finding where psychosis has been consistently found to be associated with increased LOS (Gopalakrisha et al., 2015; Tulloch et al., 2011). This finding may be more indicative of the severity and chronicity of difficulties experienced by service users with psychotic diagnoses. It may also reflect concerns within clinical practice related to risk to others compared to other diagnoses. Previous studies have highlighted that severity may serve as a better predictor of LOS compared to diagnostic categories (Creed et al., 1997; McCrone & Phelan, 1994). While a small proportion of studies within this review did consider severity as a predictor of LOS or specific symptom scales, it was so variably measured that it was not possible to make direct comparisons between these.

There was evidence to suggest a decrease in LOS for service users with a diagnosis of personality disorder, a factor that has not been reported in previous reviews. Previous research has identified stigma and negative attitudes displayed by professionals working with service users with a diagnosis of
personality disorder (Markham, 2009; Ross & Goldner, 2009). Difficulties have also been identified with therapeutic-alliance, reduced empathy, and motivation from professionals supporting this population (Loader, 2017; Sansone & Sansone, 2013). Therefore, these challenges are likely to present obstacles for effective treatment, where professionals may deem difficulties associated with personality disorder to be less treatable in comparison to psychotic symptoms, which may impact on treatment duration.

Substance and alcohol misuse was consistently found to be associated with shorter LOS. This is supported by findings from a previous non-systematic review, which reported substance and alcohol misuse to be associated with a decrease in LOS across studies worldwide (Gopalakrishna et al., 2015). This may indicate such service users have less severe mental health difficulties, and following a period of detox are able to be discharged sooner (Sinclair, 2008). Moreover, reduced LOS for individuals with substance and alcohol misuse difficulties could be suggestive of stigma related to substance misuse from mental health professionals that may impact on the delivery of care and length of admission (van Boekel, Brouwers, van Weeghel & Garretsen, 2013).

Studies that investigated the effect of being detained under the Mental Health Act were unanimous in their findings, with compulsory admission related to an increase in LOS. This is not consistent with the findings of previous reviews that found compulsory admissions to be associated with both a shorter LOS (Tulloch et al., 2011) and a longer LOS (Gopalakrishna et al., 2015). The inconsistency across findings may reflect differences across countries with regards to involuntary admission rates, where research has suggested that varying clinical practices, including availability of services, such as access to other care options in the community to prevent involuntary admission, as well as social, cultural and political factors may explain these differences (Sheridan Rains et al., 2019). Compulsory admissions may be an indicator of more severe mental health difficulties, a confounder often not considered within the studies reviewed. This may suggest why service users who are detained may have longer admissions.
Firm conclusions could not be drawn for a number of factors, including gender. While previous reviews have identified inconsistencies in relation to gender (Melchior et al., 2010; Gopalakrishna et al., 2015), there is some contradiction with findings from the USA, where females were identified as at a greater risk of increased LOS (Tulloch et al., 2011). However, the review did note that coefficients tended to be small in magnitude, suggesting that gender may have a relatively weak effect on LOS. Studies indicated that marital status might also be a poor predictor of LOS. As marital status is a factor that cannot be modified by services, there may be more merit in considering other related factors, such as access to supportive social networks or dependents at home, which may give more insight into how relationships may influence LOS. For example, research has suggested the benefits of considering social networks in understanding healthcare use (Pitkin Derose & Varda, 2009). This did not support the findings of two previous reviews where marital status appeared to be more consistently associated with shorter LOS (Tulloch et al., 2011; Gopalakrishna et al., 2015).

The effect of readmissions was inconsistent across studies. Previous reviews have reported mixed results, including inconsistencies across studies (Gopalakrishna et al., 2015) and previous admissions to be associated with an increased LOS (Melchior, 2010). Readmissions have been highlighted as an important factor in service utilisation, particularly as an indicator of future admissions (Donisi et al., 2016). Given this, it is surprising that the majority of studies did not investigate readmissions as a factor in their analyses. This may reflect the challenge in capturing readmissions within LOS study designs. However, it also suggests a need for further investigation of the effect of readmission on LOS to gain a greater understanding around factors predictive of service utilisation, in order to effectively plan care.

Inconsistent findings were noted across social factors reviewed within studies, including living situation (living arrangements and accommodation), postcode deprivation and employment status. This in part was due to limited number of
studies that considered these factors, as well as variation in the measurement of these variables across studies. However, more closely considering factors related to the mechanisms behind living arrangements e.g. the levels of support people have access to from others (emotionally and practically) rather than whom they live with may provide more superior predictors of LOS, where social support and isolation have been linked to the development and recovery of mental health difficulties (Tew et al., 2011; Wang, Mann, Lloyd-Evans, Ma & Johnson, 2018). Findings from a previous review were more consistent where living alone was associated with increased LOS (Melchior et al., 2010).

There was some evidence for more unstable accommodation and increased LOS, although the number of studies investigating this were limited, where it is possible unstable accommodation is likely to delay discharge to the community while appropriate accommodation is sought. A survey conducted in a local NHS trust identified 44% of prolonged admissions in acute inpatient wards investigated were due to accommodation issues (Smith & Chakraborty, 2012).

Due to inconsistencies and limited evidence for the factor of employment the effect this variable has on LOS was unclear. Variation in this variable has been noted in previous reviews, with a systematic review including German studies identifying unemployment to be associated with an increase in LOS (Melchior et al., 2010), and a non-systematic review worldwide finding a decrease in LOS (Gopalakrishna et al., 2015). Similarly, there were mixed results with regards to postcode deprivation on LOS. Level of deprivation is typically examined using indices, which look at the average level of deprivation in a given area. However, there has been evidence to suggest that level of deprivation and associated health disparities may be more related to within neighbourhood differences, where an individual’s health may be affected by imbalances in socioeconomic status between neighbours rather than the neighbourhood as a whole (Stafford & Marmot, 2003). It may be more beneficial clinically to focus on more specific and modifiable factors related to postcode deprivation, such as, employment and housing, which may influence LOS.
Furthermore, despite being an important consideration in clinical practice, risk (e.g. risk to self or to others) was specifically explored in very few studies. This may be an important factor to investigate in future research where risk reduction and management are a key concern within inpatient care and are central to decisions around admission.

**Strengths and Limitations**
Limitations of this review include due to the heterogeneity of studies a meta-analysis was not conducted, therefore investigation of average effect sizes or associations for factors on LOS could not be determined. Furthermore, grey literature sources were not included within this review, which may have led to publication bias (Joober, Schmitz, Annable & Boksa, 2012). Furthermore, a small number of studies did not specifically state the type of inpatient care, where it was assumed these studies referred to acute inpatient care. However, this may have resulted in other types of inpatient care being included within these samples. However, literature was systematically searched and quality appraised to ensure a comprehensive synthesis of the available evidence on factors related to inpatient LOS within the UK.

**Clinical implications and future research**
Further research is required to develop a UK-specific evidence base for predictors of LOS in acute mental health inpatient wards. Many of the studies’ findings are based on datasets from previous decades, where there has likely been much change in the delivery of services overtime. Therefore, it is important that future studies are conducted on up-to-date, and where possible, national datasets, with study samples that are representative of the ward populations seen within clinical practice. Furthermore, with regards to the quality of LOS studies it is essential that future research provides a clear description of variables selected for analysis, fully reporting all findings and considering a priori analysis plans.
Factors that were most consistently associated with LOS across studies tended to be those that are not modifiable through services, such as age, diagnosis, ethnicity, and whether or not admission was voluntary. While these findings may still be used to help clinicians identify service users at increased risk of longer admissions, they do not directly inform clinical practices that might reduce or otherwise modify LOS. They might however still be used to inform whether or not a patient would benefit from enhanced planning of their care on arrival to hospital. Services may benefit from a thorough assessment of the needs of these service user groups on admission and regularly throughout admission to minimise the risk of unnecessarily lengthy stays.

It is apparent that factors looking directly at the ward environment and wider organisational factors that are likely to impact on LOS factors have been less well studied. Predominately, it has been service user characteristics that have been studied. This may reflect a culture that tends to locate difficulties within the service user rather than exploring provider level factors (e.g. community care resources) and social factors that are likely to impact on LOS. For example, the association between ethnicity and LOS may be influenced by factors such as professionals’ perception of risk or prejudice; where such factors would be modifiable to change within inpatient care. It is essential that future studies carefully consider selecting variables that are theoretically significant. In addition to stable factors (e.g. age) that are predictive of LOS, future research on factors that are amenable to intervention within services would be useful. These findings could then be used to inform care practices and help to improve care as well as potentially reducing LOS.
References


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2. Empirical Paper

Experiences of acute mental health inpatient care in the UK: From admission to readmission

This paper has been prepared for submission to ‘Psychosis’. Publication guidelines can be found in Appendix D.

Word count: 6,257 (excluding Tables, Figures, References)
Abstract

Aim: The current research aimed to explore service users’ experiences of acute mental health inpatient care from admission to readmission in the UK, focusing on experiences of care on the ward, at discharge and in the community.

Method: Eight service users with a psychosis-related diagnosis were interviewed regarding their experiences of care and whether they perceived the support provided by services met their needs. All participants had at least one other admission to an acute mental health ward in the preceding six months.

Results: Interviews were analysed using Interpretative Phenomenological Analysis (IPA). Three themes were identified: 1) Knowing you matter, 2) Adjusting to sudden shifts in care: consistency, predictability, availability, 3) The ward as a coping mechanism to escape unmet need.

Conclusions: Although participants acknowledged positive care experiences within their narratives, significant challenges were evident in the abilities of services to effectively meet service users’ needs across the care pathway. Findings highlight the importance of consistent support centred on service users’ needs at all stages of care. In particular, the need for support and interventions that help service users build autonomy and coping skills to sustain meaningful recovery within the community and reduce the likelihood of readmission.

Keywords: Interpretative Phenomenological Analysis, Qualitative Research, Psychosis, Acute Psychiatric Inpatient.
**Background**

Acute mental health inpatient services are an essential part of care for individuals experiencing severe mental health difficulties across the UK, with an estimated 102,052 admissions to NHS adult inpatient mental health wards between 2017/2018 (NHS Digital, 2018). Guidance from the National Institute for Health and Care Excellence (NICE, 2016) emphasises the importance of collaborative, person-centred and suitably paced acute inpatient mental health care that focuses on recovery by supporting individuals’ needs during all stages of the care process. Despite this guidance, high readmission rates to acute inpatient care continue to be seen, with service users with a psychosis-related diagnosis at particular risk of multiple admissions (Machado, Leonidas, & Santos, 2012; Thompson, Neighbors, Munday, & Trierweiler, 2003; Mark et al., 2013), with higher average readmissions in the UK in comparison to other developed countries (Berry, 2015) and the highest users of NHS bed occupancy (Pillay & Moncrieff, 2011).

As demands on acute inpatient care continue to rise, there is increasing pressure to reduce readmission rates by enhancing the effectiveness of care provided, with the aim of improving patient outcomes and reducing the financial burden on the NHS (Care Quality Commission (CQC), 2017; McCrone et al., 2008; Mental Health Task Force, 2016; Sabes-Figuera et al., 2016). Recent reviews, examining variables that predict readmission, suggest that both pre- and post-discharge factors may be involved in determining the likelihood of readmission, though they also note that these tend to display limited consistency across studies (Donisi et al., 2016; Stfetcu et al., 2017).

An essential approach to understanding the influencers of readmission is to focus directly on the service user experience throughout the care pathway. There are a number of qualitative studies that address the question of service users’ experiences of their admission to inpatient care. A recent review of patients’ experiences across Europe consistently identified relationships with professionals to be the most significant part of the care experience. Findings
identified both positive and negative experiences of care, with service users’ emphasising the importance of professionals providing collaborative, empathetic and inclusive care and need for a safe and therapeutic environment (Wood & Alsawy, 2016). Where studies examined the discharge process, they highlighted the need for service users to be involved in discharge planning and the importance of continuity of care into the community.

Studies examining the transition from inpatient care to the community, have found differences in how services users’ experience care post-discharge. Gerson & Rose (2012) identified a general satisfaction with follow-up care, but also raised concerns that it focused heavily on medication management, rather than other forms of support. Service users also reported feelings of being left to cope alone, with accounts of limited and brief input from community services (Hasson-Ohayon, Lerer, Tuval-Mashiach, Shamir, & Roe, 2016).

There has been limited research focusing on service users’ perspectives of hospital care specifically in relation to readmission (Machado et al., 2012). To our knowledge only two studies have addressed the phenomenon of readmission from the perspective of service users. Durhig, Gunasekara, & Patterson (2017) interviewed 13 service users readmitted within 28 days to inpatient care in Australia, exploring their experiences of care from admission to readmission. Findings indicated that service users experienced multiple challenges in the care they received across the care pathway, including premature or overdue discharge from hospital, returning to unstable community environments, and resorting to inpatient care as a ‘sanctuary’ from the difficulties they were experiencing in the community. The study emphasised how individuals had limited resources to help them remain in the community, reducing chances of recovery.

Similarly, Ådnanes et al. (2018) conducted focus groups to explore service users’ experiences of re-hospitalisation to acute wards across six European countries. Results highlighted similarities in service users’ experiences in all countries, where readmission was perceived as a necessary and accepted part of the care
process. Findings emphasised challenges within the care system in ensuring care is recovery orientated, such as lack of access to specialist interventions and inadequate community services.

In recent years, focus has been placed on improving service users’ care experiences (NICE, 2011), therefore placing greater value on research based on service users’ perspectives. To our knowledge, to date there have been no qualitative studies that have focused on the whole pathway of care from admission to readmission to acute inpatient care with service users experiencing psychosis, and if the care they receive meets their needs. Furthermore, all studies conducted thus far have been outside of the UK, meaning the care provided may not reflect that of the NHS inpatient provision of care.

**Objectives**

The aim of the current research was to explore service users’ views of their care, from admission to readmission in the UK. Specifically, we ask whether the package of care they received prior to their readmission, including their care during admission and post-discharge met their needs. This will allow for a greater understanding of readmission to inpatient settings and may provide new knowledge on how the care process within the NHS can be enhanced to promote recovery and minimise readmission to services.

**Method**

**Participants and recruitment**

Eight participants (aged 31-65 years) who experienced readmission to an adult acute mental health ward were recruited from four wards across two NHS Trusts in the North of England. Inclusion criteria were: at least one other admission to an acute mental health ward in the preceding six-months, case-recorded diagnosis of a psychosis-related disorder, and English speaking. Service users diagnosed with an organic pathology or considered by clinicians not clinically able to participate were excluded. Participant demographics are outlined in Table 5.
Table 5: Participant Characteristics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Number of Admissions</th>
<th>Length of index Admission</th>
<th>Length in Community</th>
<th>Diagnosis</th>
<th>Comorbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Deborah</td>
<td>58</td>
<td>Female</td>
<td>White British</td>
<td>6</td>
<td>5 weeks</td>
<td>5 weeks</td>
<td>Schizoaffective Disorder</td>
<td>-</td>
</tr>
<tr>
<td>2: Aisha</td>
<td>47</td>
<td>Female</td>
<td>Asian British</td>
<td>9</td>
<td>5 weeks</td>
<td>4 months</td>
<td>Schizoaffective Disorder</td>
<td>-</td>
</tr>
<tr>
<td>3: Steven</td>
<td>31</td>
<td>Male</td>
<td>White British</td>
<td>6</td>
<td>2 weeks</td>
<td>2 weeks</td>
<td>Schizoaffective Disorder</td>
<td>-</td>
</tr>
<tr>
<td>4: Laura</td>
<td>31</td>
<td>Female</td>
<td>White British</td>
<td>10</td>
<td>2 weeks</td>
<td>5 months</td>
<td>Schizoaffective Disorder</td>
<td>EUPD</td>
</tr>
<tr>
<td>5: Jess</td>
<td>33</td>
<td>Female</td>
<td>White British</td>
<td>5</td>
<td>4 weeks</td>
<td>2 weeks</td>
<td>Bipolar affective disorder with Psychotic Features</td>
<td>Substance Misuse</td>
</tr>
<tr>
<td>6: Mary</td>
<td>65</td>
<td>Female</td>
<td>White British</td>
<td>3</td>
<td>3 months</td>
<td>7 weeks</td>
<td>Paranoid Schizophrenia</td>
<td>-</td>
</tr>
<tr>
<td>7: Zara</td>
<td>50</td>
<td>Female</td>
<td>Asian British</td>
<td>6</td>
<td>3 months</td>
<td>4 months</td>
<td>Schizoaffective Disorder</td>
<td>Substance Misuse</td>
</tr>
<tr>
<td>8: Karen</td>
<td>45</td>
<td>Female</td>
<td>White British</td>
<td>17</td>
<td>3 weeks</td>
<td>5 months</td>
<td>Schizoaffective Disorder</td>
<td>-</td>
</tr>
</tbody>
</table>

* Pseudonyms have been used to protect the participants' identity.
Procedure and ethical considerations

Ethical approval was provided by North West – Greater Manchester Central Research Ethics Committee (Ref: 18/NW0350) and from local participating NHS trusts. Eligibility to participate was confirmed by the service users’ care team and informed consent was obtained from all participants (see appendices E, F, G, and H for recruitment and consent materials). The first author (CP) conducted semi-structured interviews, lasting between 30-66 minutes, in a private room on the ward. Interviews were audio-recorded. Participants received a £10 voucher to thank them for participating.

Interviews

The interview topic guide (Appendix I) was developed following Interpretative Phenomenological Analysis (IPA) guidelines (Smith, Flower & Larkin, 2009), and in consultation with services users, with previous experience of inpatient care. Interviews explored the following topics:

- To what extent do service users’ perceive their needs to have been met during an index admission to acute inpatient?
- How do service users experience follow-up care following discharge?
- What experiences led to their readmission?

Reflexivity

The process of reflexivity involves constant consideration of how one’s own views, assumptions and experiences may impact on the conclusions drawn throughout the research process (Jootun, McGhee, & Marland, 2009). All authors work within the discipline of clinical psychology, with two authors working extensively with individuals experiencing psychosis within inpatient settings and research, where these experiences have the potential to influence the conclusions drawn. All authors acknowledge that whilst acute inpatient care is important for service users in times of crisis, they recognise the negative impact restrictive practices and inadequate continuity of care can have on service user outcomes. Consequently, during analysis, care was taken to remain aware of and reflect on authors’ personal
beliefs to ensure that findings were derived from the data and codes were clearly related to the themes.

Analysis
Interview data was analysed using IPA, which adopts an idiographic approach to examining the unique and personal lived experiences of individuals. IPA has its theoretical underpinnings within phenomenology and hermeneutics (Smith et al., 2009). This allows for exploration of what a given experience of a particular phenomenon was like for the individual (phenomenology), as well as the individual’s interpretation of their experiences, how they make sense of these, and the meanings they place on these events (hermeneutics). Therefore, this method allowed for a rich understanding of service users’ unique care and readmission experiences, considering both the idiosyncratic nature of each account, as well as the similarities between participants’ experiences.

Analysis was an iterative process, reviewing and re-reviewing codes derived from interview transcripts until the key themes emerged. Transcripts were first read multiple times to allow the researcher to become familiar with the data. Transcripts were then analysed through initial line-by-line exploratory coding of the linguistic, descriptive and conceptual ideas, with the aim of identifying emergent themes. Then, looking across all transcripts, emergent themes were clustered to generate superordinate and subordinate themes by considering similarities and differences between accounts (see appendices for examples of the analytic process J, K, L, and M). The researcher used an analytic diary following interviews and during the coding process to record any personal reflections and theoretical understandings related to the data.

CP coded all transcripts, and extracts of three of the transcripts were coded by an independent researcher to ensure rigour. Codes and themes were also compared and discussed within the research team to ensure they were derived from the data; where disagreements arose these were discussed and a consensus reached.
Results

All participants referred to their experiences of care in relation to the perceived levels of support they received from professionals across the care cycle. This resulted in three closely related superordinate themes emerging during analysis, each of which contained a number of subordinate themes: 1) Knowing you matter, 2) Adjusting to sudden shifts in care: consistency, predictability, availability of care, and 3) The ward as a coping mechanism to escape unmet need (Figure 2 and 3).

![Superordinate Theme Structure](image)

**Superordinate theme 1: Knowing you matter**
- Compassionate, attuned and dismissive care
- Empowering and disempowering care

**Superordinate theme 2: Adjusting to sudden shifts in care – Consistency, predictability and availability**
- The swift discharge process
- Tolerating life in the community

**Superordinate theme 3: Ward as a coping mechanism to escape unmet need**
- Inevitable readmission

Figure 2: Diagram of theme structure.

**Superordinate Theme 1: Knowing you matter**

Service users spoke about relationships with professionals needing to feel consistent, available and trusting. When this was provided it helped service users feel like they mattered. All described seeking opportunities to feel connected to staff in order to meet their needs and unanimously highlighted needing more time with professionals.

**Subordinate theme 1.1: Compassionate, attuned and dismissive care**

All participants spoke of moments when professionals were fully attuned to their emotional needs were fundamental and memorable parts of their care experience.
For many, individual time with staff provided service users with a space to be heard, validated and understood; a need many were often deprived of outside the care system.

Aisha valued having professionals who she could confide in: they provided an independent perspective, as well as opportunity for self-reflection and interpreting life events. For her, discussions with staff were a more acceptable way of expressing her needs, as she often spoke of fears of burdening her family with problems.

**Aisha:** I just need support at the end of the day. There are some things you can tell your family and some things you can’t.

Zara conveyed a strong sense of emotion regarding moments in which she connected with staff, evident through her use of metaphorical language when describing such moments. Professionals normalising and empathising with her made her feel it was ok to have emotions and that someone was there to support her, a need often unmet in her personal relationships.

**Zara:** I wish there was always blue sky and fluffy clouds, but sometimes it’s not, it’s a grey day and that can get you down. But it’s helpful sometimes someone just saying ‘look listen I feel the same way. I can empathise with you’ and just knowing you’re not alone.

As Jess reflected on what she had found helpful about her care, there appeared to be a realisation about the loss of supportive relationships in her life, and how these were substituted by both professionals and other patients on the ward.

**Jess:** All I needed was probably just a friend. I pushed all my friends out, that’s why I didn’t have any.
This was common across many other narratives, suggesting a blurred line in service users’ perceptions of professional relationships, seeing them more as friendships or familial relationships. Many service users’ accounts suggested that professionals often failed to recognise the importance of these relationships, where inconsistent staffing or endings in care could leave needs unmet, triggering or further contributing to their distress.

Mary appeared to experience great losses in the ending of relationships with staff. She perceived staff did not reciprocate this loss, which made discharge to the community a more challenging experience for her. Mary continued to return to the ward and fight for more community support, in what appeared to be an attempt to feel close to staff.

*Mary: I felt as though I wasn’t wanted anymore. It made me feel...it hurt me.*

For others, although they valued direct emotional support from staff, it was merely the reassurance of knowing professionals were present that mattered. For Karen, knowing she had professionals watching over her with concern in the community gave her a sense that she mattered to someone, helping her to feel less alone.

*Karen: It just made me feel like there was somebody there; on the outskirts concerned about me.*

Many participants recalled times during their care experience where they felt their needs were dismissed by professionals, and spoke of feeling that staff did not have time or want to hear about their difficulties. This was apparent throughout Deborah’s narrative where she consistently returned to times she had felt frustrated with professionals’ responses to her seeking emotional support. Her account alluded to experiences of being treated as a patient rather than as a person, and a sense of feeling she was not worthy of professionals’ time.
**Deborah:** Just always having the time to talk to you. It would have just been better if everybody [the staff] could or wanted to give time for you.

**Subordinate theme 1.2: Empowering and disempowering care**

Participants frequently described wanting professionals to involve them in care decisions and provide opportunities for them to express their needs. When professionals used a collaborative care approach it appeared to help address the underlying needs that were maintaining service users’ difficulties. Many discussed the benefits of being encouraged by staff to realise their potential and develop skills to cope, giving them strength to move forward during challenging times.

Within Aisha’s account she often expressed low self-efficacy in her ability to cope with her feelings. She shared experiences of working alongside a community nurse, who involved her in care decisions. His encouraging approach appeared to combat her self-doubt, empowering her to feel confident in managing in the community and instilling hope for recovery.

**Aisha:** He just did things to make me get better. I think he believed in me that I was ok. He just...did what I asked.

Many participants spoke of a power imbalance, where professionals took an authoritative approach to care decisions. In their accounts, service users’ needs were dismissed, silenced, ignored, or professionals did not attempt to seek their perspectives, resulting in disempowering care experiences. During these times, participants expressed that their emotional needs often went unrecognised.

Aisha generally was apathetic towards the care she received on the ward and alluded to the fact that she knew she would not be able to get her needs met, feeling only ‘simple’ aspects of care could be addressed. She had learnt that being able to leave hospital was more about suppressing her needs and defaulting to professionals’ decisions, rather than true recovery.
Aisha: I’m just compliant with the rules, and I know if I comply with the rules, they can let you leave.

Participants’ accounts suggested that the burden tended to be placed on them to voluntarily express their needs, and that it was a challenge to find the strength or confidence to do this. Aisha continued to reflect on experiences of care that she had found less helpful. She not only shared feeling unable to express her needs, but this hesitance was also apparent in the tentative language she used to describe her experiences. Her language suggested that she felt she should be grateful for her care, and also a concern about expressing overly negative views about her care.

Aisha: I can’t say that...It sounds silly...but I can’t say they didn’t look after me because they are professionals at the end of the day...but if I don’t speak up and tell them what’s going on then they aren’t going to know are they.

Superordinate theme 2: Adjusting to sudden shifts in care - consistency, predictability and availability

Participants spoke of adjusting to sudden shifts in care from admission to readmission. As highlighted previously, consistency and availability of care was important on the ward. However, the most prominent difficulties were seen in the breakdown of care during discharge and within the community.

Subordinate theme 2.1: The swift discharge process

Service users expressed unrecognised or neglected needs during the discharge process, and unanimously questioned their readiness for discharge. Zara’s account illustrated the conflicting emotions and uncertainty she experienced, as she described her anxieties around leaving the ‘cocoon’ of the ward. Interestingly, as she discussed her readiness for discharge, she began to question her understanding of the discharge process itself. She acknowledged a sense of pressure on professionals to discharge, even if they may be aware the individual’s needs had not been met.
**Zara:** On one hand I’m thinking ‘yeah great! I’m released and I’m going back to my place’...on the other hand I was a bit apprehensive. I was thinking...’Am I ready for this’. I feel as though it’s just...kind of dropped on to you ...there you go; you can go now, instead of like a day or two. I’m not sure why they do that...I think maybe preparation, so that if you are poorly then you’re not given that opportunity to say well I’ll do this or I’ll do that before I go. But if you are poorly then you wouldn’t be discharged.

The majority of participants’ narratives highlighted that there was little warning during this pivotal transition to prepare them for community life. Discharge for many was an uncontained and overwhelming experience, often mirroring the unstable environments individuals were returning to. There was a tone of disbelief in Zara’s voice as she recalled leaving the ward and the suggestion that it was a belittling experience for her. Her account suggested that the emotional impact of discharge had not been fully considered, with professionals failing to recognise the difficulties of returning to the community.

**Zara:** I had to pack my own things...I don’t mind, because they are my things. The lady that helped me was the lady that usually does the clerical work...I think the emotional support wasn’t there...I think I needed somebody with me.

This echoed Steven’s account of discharge, where his experience was not tailored to his individual needs, but rather a result of his section coming to an end. Steven appeared to accept that the priority of discharge was efficiency, rather than considering future plans to meet his recovery needs

**Steven:** It was basically, you come to the end of your section, then rescinded and then left to go home.

Like many other participants he later linked the rushed discharge process as having a significant influence on his need for readmission.
Steven: *The state of play of what I was discharged in is why I’m back in here.*

A small proportion of participants described a more planned discharge tailored to their needs, and recognised the benefits of this preparation. For example, Karen had previously expressed anxiety around needing the ward to help her function. Gradually increasing her leave prior to discharge helped her to feel prepared and confident in her abilities.

Karen: *It’s a goal. It’s like I’d achieved something, like getting a bit stronger. Trying to help myself as well and get myself stronger slowly.*

Subordinate theme 2.2: Tolerating life in the community

Community care was also a challenging and anxiety-provoking shift in care for the majority of participants. Although service users described the contact they received in the community as predominately helpful, several expressed needing more regular and consistent community care. Laura explained how inconsistent community support was unsettling and destabilising, and this appeared to trigger a loss of confidence in professionals’ ability to support her needs, as well as in her own coping skills, leading to distress prior to readmission.

Laura: *Just people turning up when they say they would...my support worker...turns up two days early or just not turn up at all and not phone and explain why. You kind of look forward to it because you know you’re going to get the chance to talk to somebody about how you’re feeling so you prepare in your mind about what you’re going to say and what you want to talk about, but then they don’t turn up and you’ve got all these feelings floating around and no one to talk to about it.*

She reflected on how inconsistencies in the level of support she received while in the community had influenced her readmission. While she did not find the ward helpful, it at least provided care that was predictable and consistent.
Laura: My structure and support was falling to pieces, so being left with limited care just sent me over the edge.

Others described experiencing a complete absence of community support upon returning to what was often an inadequate and hostile living environment. Steven felt angry about returning to the community, where he had a sense of being abandoned by services. Throughout Steven’s narrative he conveyed a sense of helplessness, as he tried to seek support to create some stability in his environment. However, similar to many other participants’ experiences, he frequently described being met by inadequate responses from services that did not address his needs, forcing him to cope with the limited resources he had available to him.

Steven: I found my door was sealed up…I was financially, psychologically, geographically just all over the place…they said ‘stay in all day we will send a surveyor’. No surveyor came and I slept with no door on for 3, 4 days…I felt completely neglected.

Two individuals reflected feeling unable to accept care or recognise what they needed in the community. Subsequently, professionals were unable to identify and meet their needs effectively. Zara highlighted a conflict between knowing she needed support, but wanting freedom from services when in the community, leading to her experiencing services as intrusive.

Zara: I think I kept putting them off, but then on the one hand I was thinking ‘Oh god they’re not supporting me and they’re not there for me’…I was putting them off, because I just wanted to do my own thing.

Superordinate theme 3: Ward as a coping mechanism to escape unmet need

Regardless of whether service users experienced the ward as helpful or unhelpful, it often appeared to be the best short-term support available to them. Participants’ narratives highlighted the dependency inadvertently created by the care system
itself, where the ward had become a coping mechanism to meet needs unmet in the community.

Unmet relational and psychological needs

Many participants described unmet relational and psychological needs in their lives, where the ward provided a means of coping with these difficulties. All participants spoke of isolation or loneliness in the community. The ward provided a temporary relief from this, with a more consistent social network. Mary was very contradictory in her narrative, where she expressed much anger at the quality of the care she received on the ward, but at the same time, shared how she did not want to return home. Mary appeared reluctant to ask for emotional support from professionals, but by physically being on the ward she was able to gain a sense of belonging, a need she could not meet living alone with little social contact in the community.

Mary: One day [a nurse] was going home and I felt so alone! I used to put a chair out on the landing and just sit there right. They looked after me that well. I never met so many nice people in all my life as them staff. I said I would stay here forever. And I meant it.

For Karen the ward provided protection from unmanageable emotions, where her descriptions revealed how the ward provided her with a mechanism to regulate her emotions.

Karen: I tend to come in when I’m very worried about something.

Many participants spoke of feeling overwhelmed in the community, and the ward provided a means of containment. Aisha expressed a feeling of relief at admission, needing professionals to take control when she felt unable to take responsibility for herself. At times, it seemed that being on the ward allowed her to relinquish control and default to professionals’ care decisions, who in these moments she perceived as the experts that could make her ‘better.’
**Aisha:** I think I was too far gone to go to the [Crisis Team]. They look after you, but you have to take your medication on your own and I don’t think I was ready for that. Then I had to come back in to hospital to get better...the medical staff are watching you take your medication and things like that.

**Unmet physical and environmental needs**
For some participants they described a sense of vulnerability related to unmet physical and environmental needs in their lives. Although participants described feeling *‘on eggshells’* and not always safe around other service users on the ward; overall they felt protected by the presence of professionals. Zara expressed a need for physical safety and often alluded to wanting to avoid negative relationships in the community. The ward seemed to shield her from the uncertainty and vulnerability of life in the community, allowing her to regain strength.

**Zara:** I think I did get that kind of reassurance to say you’re in a place of safety. That the community can’t touch you. That people out there can’t take from you...I felt ok in [the ward] I got that kind of feeling that I could rest now, I can rest now.

**Subordinate theme 3.1: Inevitable readmission**
The majority of patients accepted that services were a necessity in their lives, and acknowledged the inevitability of readmission in times of distress. Throughout service users’ accounts, evidence of an internal conflict emerged: on one hand they valued services’ support, feeling they could not survive without it; on the other they felt helpless that they had to depend on services. Aisha revealed a sense of hopelessness, where she appeared to feel trapped in an inescapable cycle of readmission. Aisha acknowledged the link between loneliness and readmission; however she seems powerless as to how she can break this cycle and meet this need.

**Aisha:** It’s sad that coming into hospital...I think it’s sad because I’ve been coming in and out of hospital for years and...I just want normality to come back in my life. I know I’ve a family. But for me it’s just loneliness.
Many participants shared hopes of finding ‘other ways of coping with life’. Laura expressed a desire to develop new coping skills and prevent readmission, but felt unsupported in this. As a result this appeared to undermine her confidence and reinforce her sense of fragility and inability to cope without services. This led to a cycle in which needs went unmet and this led to later readmission.

**Laura:** The PRN you get given, when you’re discharged you don’t get it in the community, so you get reliant on it and when you’re discharged you’re discharged without it, so you have to find your own coping-ways.

Similarly, Steven reflected on what he felt was needed from services to support recovery. Here, he reveals the importance of building meaning and purpose in daily life in order to sustain long-term recovery, rather than shorter-term solutions that have prevented him breaking the readmission cycle.

**Steve:** The answer isn’t always medication or therapy, but people need to find a balance doing things they are passionate about.

Figure 3: Diagram of connections between themes.
Discussion

This research aimed to explore service users’ views of their experiences of care from admission to readmission in the UK. Three key related themes were identified from participants’ accounts: 1) knowing you matter, 2) adjusting to sudden shifts in care: consistency, predictability, availability, and 3) ward as a coping mechanism to escape unmet need. Although participants acknowledged positive care experiences, it was evident that significant challenges were present in services’ abilities to effectively meet their needs.

Participants emphasised the integral role of relationships with professionals, in which their needs were met by care that was compassionate, attuned and empowering. This finding is consistent with previous research, which highlights the benefits of empathetic communication and mutual respect from professionals (Gilburt, Rose, & Slade, 2008; Johannsson & Eklund, 2003, Wood et al., 2016; Rydon, 2005). Despite the quality of therapeutic relationships being fundamental in service users’ accounts, participants’ often perceived this not to be prioritised by services, often describing a focus on medication management and pressure on staff to complete service related administrative tasks, indicating a disconnect between service user and service priorities. Therefore, services need to consider approaches to improve the quality of interactions and promote more contact between staff and service users. Previous research has highlighted the benefits of training in communication strategies (Kornhaber, Walsh, Duff, & Walker, 2016), as well as protected therapeutic nurse and service user time (Thomson & Hamilton, 2012).

Inconsistent and unpredictable care during discharge resulted in failures to recognise service users’ needs. This is in line with previous research, which has highlighted a ‘discordant’ discharge process (Duhig et al., 2017). Challenges in the transition to the community have been well documented, including limited beds putting pressure on professionals to complete discharge quickly, poor preparation, services users not feeling ready for discharge, and their voice being lost in the process (Mind, 2017; Wright, Rowley, & Gregoriou, 2015). Others have also recommended interventions during this transitional phase, such as structured
needs assessments, pre- and post-discharge psychoeducation and enhanced communication between inpatient and outpatient services, in order to reduce the likelihood of early readmission (Vigod et al., 2013). This study indicates that the discharge process is a pivotal part of the readmission process, in particular, highlighting the unrecognised emotional needs and support service users require during discharge. Therefore, services should not consider discharge as merely a formality, but a complex process where service users will be adjusting psychologically to their return to the community.

Participants’ narratives also highlighted difficulties meeting their needs in the community with inconsistent support from services and lack of resources to cope leading to readmission. This is supported by previous research identifying brief service involvement in the community (Hasson-Ohayon et al., 2016), and experiences of isolation and inadequate living environments prior to readmission (Duhig et al., 2017). Social, personal and environmental factors, including the need for purpose, social support and a safe place to live have been highlighted as essential aspects of recovery for service users with psychosis (Law & Morrison, 2014). Furthermore, research has identified the negative impact of the loneliness (Lim, Gleeson, Alvarez-Jimenez, & Penn, 2018), poverty (Topor et al., 2014), and the benefits of social networks on outcomes for individuals with psychosis (Bjornestad et al., 2016). Therefore, it appears more focus is required on ‘social recovery’ in the community to maintain stability. A recent review emphasised the need for psychosocial rehabilitation interventions to be delivered as part of standard practice to promote recovery, with studies identifying reductions in readmissions, relapse and functioning (Morin & Franck, 2017).

Participants’ accounts highlighted how the ward provided a coping mechanism, as a safe space to regulate emotions, and seek comfort and security. Findings are strikingly similar to previous research, where the ward was identified as a ‘sanctuary’ from difficulties in the community (Ådnanes et al., 2018; Duhig et al., 2017). These results can be explained by the mechanism of learned helplessness (Seligman, 1972): challenges in the community lead service users to access acute
care, which then creates a cycle of behaviour in which service users learns to avoid difficulties in the community through the relief of readmission. This highlights the gap across care where access to specialist interventions and support are needed to build alternative and long-term resources to cope in the community. This also raises the question as to the role of inpatient care and whether more opportunities for access to specialist interventions should be available within this environment, with study findings indicating that service users who had access to psychological therapy on acute inpatient wards felt empowered and better able to manage their difficulties (Small, Pistrang, Huddy, & Williams, 2018).

The marked dependency created by the care system was prominent in participants’ discourses, where participants perceived readmission to be inevitable. This is in line with previous research identifying limited focus on progression and recovery within services (Ådnanes et al., 2018). The reliance on readmission to meet their needs may be explained by low self-efficacy in their own abilities to cope (Bandura, 1997). Policy and guidance continues to stress the importance of recovery-focused care (NICE, 2014; NICE, 2016) and this in its essence requires professionals to empower and promote self-efficacy in service users to feel skilled and able to meet their own needs.

Attachment theory is relevant to all themes that emerged from participants’ narratives. Attachment theory proposes that early caregiving relationships inform how we develop ways to respond to distress, seek safety and security, build autonomy and form relationships (Bowlby, 1977; Bowlby, 1982). Severe mental health difficulties have been linked to unmet needs in early caregiver relationships, which can lead to difficulties with insecure attachments, resulting in challenges in interpersonal relationships, regulating emotions and help-seeking (Bowlby, 1982). Participants’ views on care appeared to reflect unmet attachment needs from admission to readmission, where staff relationships and the ward were used as a safe and secure base to provide comfort and security and help regulate distress. It appears for services to effectively meet service users’ needs, services may benefit from treatment being guided by attachment principles. This approach could
support individuals to develop more adaptive ways to manage distress, build autonomy and form longer-term supportive relationships, in order to maintain recovery (Bucci, Roberts, Danquah, & Berry, 2015).

For example, psychological formulation with staff teams, which incorporates attachment principles, may be helpful to improve the care provided for individuals who are readmitted to the ward. Formulating with attachment principles in mind may help staff to recognise repeated patterns of ward use and gain a greater understanding of needs that may be underpinning individuals’ readmission, which may be linked to unmet attachment needs (e.g. sense of security in their relationships or environment). This may allow services to identify ways to intervene to more effectively meet these needs, both on the ward and in the community, through longer-term support to prevent readmission.

**Limitations and future research**

All participants were recruited from the same geographical area, and therefore participants’ accounts are likely to reflect local service practices and resources that may differ from other areas across the UK. Similarly, the views were confined to those service users who were deemed suitable to take part by ward staff and were primarily female service users. Interviews were carried out on the ward, and this may have influenced participants’ sense of freedom to freely express their views around their care experiences. Although efforts were made to minimise subjectivity and ensure the validity of findings, approaches such as member checking could have been beneficial (Birt, Scott, Cavers, Campbell, & Walter, 2016).

Future research would benefit from exploring professionals’ experiences of supporting service users who are regularly readmitted to inpatient care. This would aid in identifying consistencies and differences between service user and professionals’ views on care practices leading up to readmission. Further, exploring of professionals’ views would aid in identifying professionals’ attitudes and practical aspects to the delivery of care that may facilitate or hinder services abilities in meeting the needs of individuals that are frequently readmitted to hospital.
Conclusions

The results of this study emphasise the need of greater recovery-focused care centred on long-term management of service users’ needs, in order to minimise readmission and increase service users’ time spent in the community. This requires professionals to build stronger links at each stage of care, to ensure that when service users’ needs are identified, they continue to be supported consistently across the care pathway. While it can be a challenge to effectively meet individuals’ complex needs within service remits and limited resources, professionals should be aiming to identify and explore service users’ needs as a first step to future care planning. It is therefore vital that professionals work collaboratively with service users to identify underlying needs, as well as their priorities for care, so as to promote more meaningful recovery-focused goals.
References


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3. Critical Reflection

This paper is a reflective piece and not intended for publication

Word count: 4,815 (excluding Tables, Figures, References)
Overview

This paper aims to provide a critical appraisal and personal reflections on the systematic review and qualitative paper presented within this thesis. The aim will be to consider the process of planning, implementing and interpreting of this research, where both strengths and limitations will be evaluated.

Paper One - Systematic Review

Topic selection

There has been a considerable amount of research into mental health inpatient care in recent years, aiming to improve the efficiency and experiences of care for service users. Service users can spend a significant amount of time in hospital, where steps have been taken to minimise the use of restrictive practices. As the author aimed to gain a greater understanding of services users’ experiences of care within their empirical project, it was thought it would be important to think about the use of inpatient services by individuals. During the decision process, the author reflected on the growing presence of clinical psychology within acute inpatient settings (British Psychological Society (BPS), 2012). Further, the important role of a psychologist engaging with research at a wider service-level, where as a discipline we may have unique perspectives on possible approaches to improving care (BPS, 2007).

The author initially considered investigating factors related to readmission to compliment and further build on understandings from the empirical project. However, there have been a number of recent reviews focussing on this area (Donisi, Tedeschi, Wahlbeck, Haaramo, & Amaddeo, 2016; Sfetcu et al., 2017), as well as a recent review on service users’ experiences of care specifically within inpatient settings (Wood & Alsawy, 2016). While, considering restrictive practice, the author not only recognised the importance of reducing readmission to acute inpatient care, but also the importance of reducing unnecessary long admissions to hospital where appropriate. Therefore, the decision was made to investigate factors associated with LOS in acute mental health wards. Furthermore, to the author’s and wider research team’s knowledge there were no systematic reviews on factors
associated with length of stay (LOS) within UK acute mental health inpatient care. Therefore, a synthesis of the current available evidence seemed timely. There were discussions around whether to examine the literature on a wider scale, for example across Europe, however recent evidence had suggested the importance of considering LOS within individual countries due to differences in populations, clinical practice and legislation (Dimitri et al., 2018). While a previous systematic review had examined the German evidence-base for factors related to LOS in inpatient care (Melchior et al., 2010), in hindsight the author recognises that drawing on the whole European evidence-base may have allowed for broader and firmer conclusions to be made.

**Search strategy**

To assist with the selection of search terms, early scoping exercises, reviewing keywords within relevant studies and discussion with the wider research team was carried out. The author also reviewed the search terms used within previous reviews, however, limited information on the terms used was provided. The PICO (Population, Intervention, Comparison, Outcome) tool was also used to guide the planning of search terms (Huang, Lin & Demner-Fushman, 2006), and feedback was sought from the Systematic Review Service (University of Manchester Library), to check the suitability of search terms. Many of the studies retrieved did not report LOS within the title, resulting in extra care being taken to search abstracts for reference to LOS. Furthermore, it was often not clear from the titles and abstracts as to the country the study was completed in; therefore during the screening process a number of articles were reviewed to ensure they did not include UK data.

To increase the likelihood of collating relevant studies the decision was made to search a greater number of databases than previous reviews. As a result, there was a large amount of duplication retrieved from the search, where on reflection it may have been helpful to consider other possible search limits that could have been applied to reduce the number of articles retrieved. However, it was felt by keeping the search broad it would allow for a comprehensive search of the literature, despite this it is possible that some studies may have been missed.
Inclusion and exclusion criteria

Refining the inclusion and exclusion criteria for the review was a particular challenge. Discussions were had around whether to limit the search to certain diagnoses, in particular samples, which exclude individuals with organic diagnosis or cognitive impairment. However, it was decided to keep the inclusion broad with any service user admitted to acute inpatient care irrespective of diagnosis, where this is likely to reflect the varying ward populations present in clinical practice.

Studies stating they included specific specialist wards (e.g. forensic, eating disorder, learning disability, rehabilitation wards) were excluded from the review. While some of these services may be supporting service users during the acute stages of their care, the practices and populations seen within these specialist wards may vary greatly from general acute inpatient care and impact on the duration of admission. In particular, discussions were had around the inclusion of studies investigating LOS in psychiatric intensive care units. However, it was felt the care provided in this type of ward is very unique, with admissions, which are typically brief in order to stabilise service users, so they can be transferred to general acute mental health wards.

Finally, during the shortlisting process a small proportion of studies did not state the type of inpatient care investigated. To avoid excluding any potentially relevant data, where authors could not be contacted to confirm the ward type the assumption was made that these samples were from acute inpatient care, as this is the predominate type of care in the UK. However, it is recognised this is a limitation of the review, which as a result may have led to the inclusion of some data that is not from acute inpatient care. This may have impacted on findings, as influencers on LOS may be different for other ward types.
Quality appraisal

Quality appraisal of studies is a key component of a systematic review (Atkins, 2004). There are a vast number of tools available to assess the quality of studies, however many are best used for assessing randomised-controlled trials with few validated tool for non-randomised studies such as observational studies (Jarde, Losilla, & Vives, 2012). A number of tools were reviewed, including the Newcastle-Ottawa Scale (NOS; Wells et al.), Effective Public Health Practice Project tool (EPHPP; Thomas, Ciliska, Dobbins, & Micucci, 2004) and the Quality Appraisal tool for Prognostic Studies (QUIPS; Hayden, Côte & Bombardier, 2006). All tools had similarities for assessing the quality of studies, however the QUIPS tool was chosen.

The QUIPS tool had previously been used within the USA review on predictors of LOS. Although, this tool is typically used for prognostic studies, studies within this review typically collected data either prospectively on admission prior to the collection of the LOS outcome, or retrospectively from hospital records. Where data was gathered retrospectively, exposure variables measured tended to be collected upon admission prior to LOS outcome. However, in some cases the exact time of measurement was not reported within studies. The tool was adapted for use in the review; in particular the bias domain for attrition was not included in the overall assessment rating, as this was not relevant for many of the reviewed studies, with outcome data collected from hospital records in the majority of studies. However, for studies where the study attrition domain was relevant an individual rating for this domain was determined.

The EPHPP tool was not selected due to it including many domains, which were less applicable to the observational studies within this review, such as attrition, blinding and randomisation. However, the EPHPP tool did appear to have very robust scoring system in comparison to the QUIPS, where on reflection this tool could have been adapted to evaluate the studies within this review. Furthermore, as the tool is designed for use with prognostic studies, it is possible key aspects that may have been important to the quality of the studies reviewed may not have been considered. This may reflect why inter-related reliability was not as high as
expected (k= 0.692), where quality appraisal tools have also been highlighted as susceptible to poor inter-rater reliability (Higgins, Altman & Sterne, 2011).

Data synthesis
Due to the heterogeneity in study designs and methodologies it was deemed not appropriate to complete a meta-analysis, as this variation may have led to misleading conclusions (Sharpe, 1997; Lee, 2018). Consequently, a narrative synthesis of the available evidence was conducted (Popay, 2006). Clearly synthesising findings was a challenge due to the substantial variation in the factors examined across studies, therefore the decision was made to present the most consistently investigated factors associated with LOS. This allowed for a more meaningful and coherent presentation of findings, where factors were grouped into demographic, clinical, social, and provider categories. Additionally, variation in the measurement of particular factors across studies, also led to difficulties in synthesising findings. For example, diagnosis was a particular challenge to clearly present with substantial variation in the diagnostic categories included within studies.

Paper Two - Qualitative Paper
Rationale for topic
Service users’ experiences and views on their care are increasingly being acknowledged as important in the development and improvement of services. Where seeking service users’ opinions on their treatment is essential in ensuring the provision of high quality care that meets their needs (National Institute of Clinical Excellence, 2011). This is particularly apparent in mental health inpatient care, where to date much research has focused on exploring patients’ experiences of admission and satisfaction with the care they receive (Hopkins, Loeb, & Fick, 2009; Wood et al., 2016). The author acknowledged that whilst the care provided on the wards is important, in order to promote recovery both support at discharge, and follow-up care post-discharge must be considered, where difficulties arising in the continuity of care are likely to contribute to readmission.
The author and wider research team were aware of the importance of reducing readmission in acute inpatient services, with much quantitative research focusing on this area. Despite, this on further investigation minimal research has explored service users’ experiences of the whole care process from admission to readmission (Ådnanes et al. 2018; Duhig, Gunasekara, & Patterson, 2017). Therefore, the decision was made to qualitatively investigate services users’ experiences of acute inpatient care from admission to readmission to gain an understanding of whether the care provided met their needs. The author consulted former service users with experience of acute inpatient care from the Community Liaison Group (CLG) at the University of Manchester. They provided their perspectives at the early planning stage of the project, providing valuable insights into barriers that may arise when conducting research on inpatient wards. For example, participants’ fears around confidentiality and ensuring participants feel at ease during the interview. As well as practical recommendations around completing interviews with service users, such as avoiding certain times on the ward (e.g. meal and medication times), which may cause disruptions in staff and service users’ routine.

*Ethical approval*

In order to recruit participants from NHS acute inpatient units, ethical approval was sought. This was a significant learning process for the author, using systems that at times were a challenge to navigate. However, in retrospect the author recognised the benefits of this process in providing them with a greater knowledge of all the essential approval steps required to conduct clinical research within the UK.

*Rationale for Interpretive Phenomenological Analysis*

Interpretative Phenomenological Analysis (IPA) was used to collect and analyse interview data following the protocol described by Smith, Larkin and Flowers (2009). The theoretical framework provided by IPA was chosen to gain a rich understanding of service users’ unique experiences and interpretations of the care they received from admission to readmission.
However, the author considered other qualitative methodologies. Thematic analysis was considered to analyse the data, which would have allowed for more general themes and broader similarities between service users’ experiences of care (Braun & Clarke, 2006). Therefore, thematic analysis felt less applicable to the aim of the project, which was to gain a deeper understanding of the personal experiences of each participant, and how they interpreted and experienced their own individual care from admission to readmission. Grounded Theory was also considered as a method to analyse the data (Charmaz, 2000). However, grounded theory aims at developing a more generalisable theory to participants’ experiences. Again, this approach felt less appropriate for the research question, which was to gain a rich phenomenological understanding of each individual participant’s experience.

**Development of the topic guide**

The topic guide was developed in line with guidance from Smith et al. (2009), and through reviewing previous qualitative research exploring service users’ experiences of different aspects of care within inpatient wards and readmission (e.g. Durhig et al. 2017). Furthermore, discussions were had within the research team as to interview questions that would most effectively answer the research questions. The author was also very fortunate to be able to seek consultation from a Patient and Public Involvement group, which included individuals who had previous experience of inpatient mental health care. The group gave positive feedback on the acceptability of the interview questions, as well as advice around engaging service users in the interview process and the importance of not asking overly complex questions.

Participants not only described the care and events that led up to their readmission, but often expressed how they felt about requiring readmission, which was highlighted in many participants describing readmission as inevitable. However, during analysis the author reflected on how it may have been beneficial to add further questions to the topic guide to explore participants’ views on how they felt readmission was impacting on their recovery. This may have helped gain further details on this stage of the care process.
Experiences of recruitment and participants

A substantial part of recruitment involved attending meetings and liaising with service managers to seek their approval to recruit from their wards, which caused significant delays in recruitment. Openness to research varied across wards, where supporting research was viewed by some professionals as unfeasible due to significant service demands and resources. However, other professionals acknowledged the benefits for service users having the chance to express their views on their care, and participate in a non-ward based activity. There were also challenges promoting the research on the wards and engaging staff in identifying eligible service users, due to the significant demands on their time and the limited resources available to them. Therefore, building relationships with staff to identify participants was essential, as well as being flexible with visiting times to avoid interrupting the staff and services users ward routines. This required great perseverance; regularly visiting the wards to promote the study to ensure that as many potentially eligible service users as possible were approached by staff.

A quality indicator used within services is to prevent 30-day readmission rates post-discharge, recruiting service users who had been readmitted within this time period was discussed, however it was felt that this time frame may be too narrow to recruit patients. Also to define the readmission time-frame, the author contacted another researcher recruiting from inpatient wards in the local area to discuss readmission rates, which helped inform their decision. Therefore, the decision was made to recruit participants who had at least one other admission to an acute mental health ward in the preceding six months. This time-frame was selected to capture service users who are regularly readmitted to hospital and would be able to easily recall these recent experiences. As a result, participants who had significant readmission histories, and were quickly returning to the ward following discharge were recruited. However, narrowing of the readmission window did result in a significant number of participants who had a readmission in the preceding year being excluded, which on reflection would have led to a larger sample. Therefore, it may have been helpful to broaden the inclusion criteria, extending the time frame since last admission.
A final sample of eight participants was recruited, included one male and seven females. Smith et al. (2009) recommends a sample between 5-10 participants to examine the unique personal experiences in each account, but still allow for examination of the differences and similarities between individuals. Although, the author did recruit to target, and that similarities in service user accounts reflected that data saturation appeared to have been reached (Saunders et al. 2017), the author acknowledged that with more time they would have continued to recruit to ensure data saturation had been achieved.

Opportunistic sampling was used due to practicalities of recruitment. The final sample consisted of predominately the views of white female service users, with one male included in the final sample. During recruitment clinicians often cited increased ‘risk to others’ as the reason for fewer eligible male service users. As a result, this led to a less diverse sample, and the author acknowledges that findings may therefore not represent the experiences of service users from other ethnic backgrounds and of male gender. Furthermore, the lack of diversity in the sample may also be related to potential participants being referred due to professionals’ perspectives of who they felt would be most suitable or likely to take part in research, which may have led to a risk in selection bias. This is supported by research findings, identifying that most service users with psychosis expressed a willingness to participate in research. However, findings suggested that professionals tended to only approach patients they felt were less unwell (Patel et al., 2017).

Eighteen eligible service users were approached during the course of the study. In order to recruit participants, individuals had to be first approached by their care team to identify whether the participant would be happy to discuss the research using a consent to contact form. This introduced a barrier to recruitment when often it was a challenge for professionals to find opportunities to approach service users, when completing daily ward tasks. Furthermore, the author was unsure of how much information professionals were providing to service users regarding the
study, it is possible that limited information and explanation may have resulted in service users declining for their details to be shared with the researcher.

Experiences of interviewing

The author was a novice to qualitative research and re-listened and sought feedback from the wider research team to help further develop her interview skills. Although, the author completed a test interview with a fellow researcher, in retrospect it would have been beneficial to complete a test interview with an individual who had lived experience of readmission to acute inpatient care. This would have helped the author gain further feedback on the clarity and pacing of their questioning.

Service users were very positive about participating in the research and reported valuing the opportunity to share their views. The positive responses to participating in the study may reflect limited opportunities available for service users to provide their perspectives on the support they receive. Participants did report difficulties with sustaining attention due to the effects of medication; therefore breaks were needed during interviews to support participants to give as much detail as possible about their experiences. A key part of the interview process was building a rapport with participants to enable them to feel more comfortable in sharing their views. Therefore, prior to starting the interview time was spent reiterating the aims of the study, explaining confidentiality and answering any outstanding questions. To ensure service users felt in control of the questions being asked of them, the author also made it clear that service users could decline to answer any questions and could take a break or end the interview at any time. Following interviews, the author often reflected on the difficulties of conducting interviews in the ward environment. In particular, how being in the ward environment may have reminded some individuals of the presence of professionals nearby, which for some may have made them reluctant to fully express their views on care.
**Analysis**

The author transcribed all the data, which allowed for a strong understanding of each participant’s narrative. The line-by-line coding of transcripts produced a significant number of codes, where the author in retrospect may have been overly detailed with their coding at times, leading to vast amounts of data. The development of themes was an iterative process, where a significant amount of time was spent identifying connections and distinctions between emergent themes, where the author made reference to their reflective diary to aid in interpretation of participants’ accounts. For example during the interview and analysis process, the author noted findings that were surprising to them and often did not fit with their assumptions of care (e.g. positive experiences of medication; theoretical understandings of participants experiences (e.g. attachment principles) and experiences of interviewing within the ward environment and participant engagement (e.g. interruptions, strict ward routine).

To ensure the themes were derived from the interview data, codes and themes were discussed with the wider research team. Furthermore, extracts from three transcripts were independently coded by a fellow researcher and compared to ensure rigour. However, member checking with an individual who had lived experience of readmission to inpatient care would have been beneficial to minimise subjectivity and enhance the validity of findings (Birt, Scott, Cavers, Campbell, & Walter, 2016).

**Reflexivity**

The importance of reflexivity was key during the entire research process, where efforts were made by both the author and the wider research team to remain aware of how their own beliefs, experiences and views have the potential to influence the collection and interpretation of data (Jootun, McGhee, & Marland, 2009).

All authors work in the discipline of clinical psychology with individuals who have mental health difficulties, these experiences have may have influenced the way
data was interpreted. In particular, the author was mindful of their views on the restrictive nature of the ward environment and the potential negative impact this can have on service users’ outcomes. Furthermore, all authors recognised the importance of admission in times of distress for service users, however all placed importance on promoting recovery, where the author within their clinical practice had noted the difficulties that can arise from poor continuity of care across services and had the belief that this may likely be a contributing factor in readmission.

Throughout the analysis process, efforts were made to limit the influence of any possible preconceptions the author and wider research team may have that could influence the data. This was done through self-monitoring and reflection during wider team discussions and use of a reflective diary. However, it is possible that the researchers’ prior beliefs and experiences may still have impacted on the analysis of data. For example, the author was aware during analysis that the team would often be surprised by the positive aspects of the ward environment that participants described, and as a result would return to the data to ensure coding and theme development reflected participants’ accounts.

**Clinical implications and future research**

Factors that were identified as consistently associated with LOS, included psychosis, substance misuse, and involuntary admission. However, for many factors findings were inconsistent. This is very likely due to the variation in methodologies applied within studies, particularly in sample size, measurement of variables and study populations, which limited the conclusions that could be drawn. It was evident that the evidence-base for predictors of length of stay in acute inpatient mental health care within the UK is limited; with few studies conducted using recent clinical data. While findings from earlier studies provide valuable information, clinical practices are likely to have changed overtime and as a result this may impact on the factors that are related to LOS.

Therefore, the review highlights the need for future research using large samples representative of the service user populations seen within acute inpatient care.
Importantly, future research should consider factors that may be amenable to change to allow for service improvements or interventions to be implemented, rather than solely considering factors that only aid in the identification of service users that are likely to have prolonged admissions. Provider level factors would be of particular importance to investigate, allowing services to identify possible ways to improve the delivery of care. In particular, it may be helpful for studies to consider factors, such as ward characteristics (e.g. staffing levels, access to specialist interventions, bed capacity), as well as access to care in the community prior to admission (e.g. crisis care, social care support), which may influence LOS. Despite, findings from the review identifying factors that are less likely to be modifiable by services (e.g. older age), the results may however help to support services to identify services users who may be at risk of prolonged LOS and require more intensive support on admission.

With regards to the empirical research conducted, findings highlighted experiences of care, which were both positive and negative from admission to readmission. However, it was evident in all service users’ narratives that the support provided was inconsistent in meeting their needs and emphasised the need for care which is recovery-focused. Findings are discussed in the empirical paper; however, the author was struck by the limited opportunities for service users to be supported to build their own coping skills and confidence to manage in community life, leading to dependency on the ward environment. Therefore, this may suggest the need for increased access to specialist interventions not only in the community, but also during admission, where service users’ have reported positive experiences of psychological intervention on acute wards found participants felt more able to build hope and confidence for future recovery (Small, Pistrang, Huddy, & Williams, 2018).

Furthermore, findings showed the need for service users’ requiring ‘other ways of coping’ in the community to prevent readmission. Therefore, psychosocial interventions that are tailored to the individual needs of service users’ appear to be particular important in order to sustain recovery, where previous research suggesting such interventions should be provided as a standard part of care to
reduce the risk of relapse (Morlin & Franck, 2017). Future research may consider investigating staffs’ views and experiences of supporting service users with multiple admissions. This may help build an understanding of the facilitators and barriers from the perspective of professionals in meeting the needs of individuals with repeat admissions, considering both individual staff factors and service level factors that may influence care practices.

**Personal reflections**

As part of the doctorate, the trainee was both apprehensive and enthusiastic about the research process, however hoped to complete a meaningful project, which could benefit the clinical care of service users. In particular, the trainee had limited exposure to acute inpatient wards and working clinically with service users’ experiencing psychosis, hence their choice of project. The trainee hoped to gain further insights and experience of this aspect of mental health care and service user group, which they felt had been an important experience that was missing from their training.

The trainee thoroughly enjoyed their first experience of completing qualitative research and valued the opportunity to directly hear service users’ views. The process of planning and implementing the empirical project, although challenging at times allowed them to gain a greater knowledge of the process of conducting clinical research within the NHS. While analysing the data seemed overwhelming, overall it was an enjoyable experience interpreting service users’ accounts, where the trainee often reflected on the importance of always seeking service users’ feedback within their own clinical practice. In particular, the skills the trainee has gained from completing the empirical project will encourage them to continue to look for opportunities to be involved in clinical research to improve services within their future practice in the NHS.

Through participants’ accounts the trainee was struck by a sense of dependency on services, which appeared to be inadvertently created by the care system itself and seemed to perpetuate service users’ difficulties. The trainee reflected on the
relevance of promoting recovery within their own clinical work, where it is important therapeutically that service users’ are supported to find long-term ways to sustain change and feel more confident in their abilities to manage independently. In particular, the trainee considered how the skills they have developed through training, such as formulating within multi-disciplinary teams will be important within their future practice to identify the best way to support service users’ and acknowledge clinical practices that may be hindering recovery.

The systematic review was a steep learning curve, where more time would have been beneficial; however, the trainee has gained a greater understanding of the steps required to synthesise scientific evidence. The trainee is hopeful that the skills and knowledge they have gained through critically appraising the evidence-base, can be applied to their future practice, so they are able to consider both the strengths and limitations of given therapeutic and service-related evidence that they may wish to implement clinically. Overall, although, it was a struggle to balance clinical, research, academic and personal commitments. The trainee has learnt a great deal from the entire process, which has helped to develop her skills as a scientist-practitioner.
References


Appendices
Appendix A: Publication guidelines for British Journal of Psychiatry

Instructions for contributors

Jump To: Preparing your Submission | Article Types | Policies | After Acceptance

About

The British Journal of Psychiatry (BJPsych) is a leading international peer-reviewed journal, covering all branches of psychiatry with a particular emphasis on the clinical aspects of each topic. Please visit About the BJPsych for further information about the focus, mission, ownership, management content and audience of the journal.

Submission

Manuscripts should be submitted online as a word document via https://mc.manuscriptcentral.com/bjpsych. Authors may track the progress of their manuscript(s) at any time via the submission website. For assistance with online submission, please email bjp@rcpsych.ac.uk or call +44 (0) 20 3701 2546.

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The editor is unable to offer a review of a manuscript’s suitability before submission.

Authors should be aware of the criteria listed in the document ‘What is a BJPsych paper?’ which helps the editorial team assess all the high-quality papers submitted to the journal.

All papers published in this journal are peer reviewed. All submissions are initially assessed for suitability by the Deputy Editors-in-Chief. After the initial assessment, submissions are single-blind peer-reviewed by two independent, anonymous expert referees and the assigned Handling Editor. The Handling Editor will recommend a decision to the Editor-in-Chief who is responsible for making the final decision. Find out more about what to expect during peer review here.

No person is permitted to take any role in the peer-review of a paper in which they have an interest, defined as follows: fees or grants from, employment by, consultancy for, shared ownership in, or any close relationship with, an organisation whose interests, financial or otherwise, may be affected by the publication of the paper.

Preparing your Submission

Checklist: What to Include

Authors will be asked to confirm the following elements are included during submission. Any omissions may cause delays.
Word Document:

1. **Title** – The title should be brief and relevant. Titles should not announce the results of articles and (apart from editorials) they should not be phrased as questions.

2. **Author Names** – The full names of the authors should appear on the title page in the form and order that is wished for publication.

3. **Main Text** – See relevant Article Type for individual specification.

4. **Clinical Trials Registration** – In accordance with ICMJE guidelines, the BPsych requires all clinical trials to be registered in a public trials registry at the beginning of the research process (prior to patient enrolment). Trial registration numbers should be included in the abstract, with full details of the trial in the Methods section.

5. **Ethics Statement** – All authors are required to follow the ICMJE guidelines on the protection of research participants. Reports on research involving human participants must include the following statement in the Methods section: The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human subjects/patients were approved by [name of the relevant local, regional or national review body and approval number]. For further assistance in writing an ethics statement please visit Ethics Statement Generator.

6. **Consent Statement** – Reports on research involving human participants must include the following statement in the Methods section: Written [or verbal] informed consent was obtained from all subjects/patients. Where verbal consent was obtained this must be followed by a statement such as: Verbal consent was witnessed and formally recorded. This confirms that any research participant has consented to the inclusion of material pertaining to themselves, that they acknowledge that they cannot be identified via the manuscript; and that the participant has been fully anonymized by the author. If research participants are identifiable, authors should complete and upload a Consent Form. Where someone is deceased, please ensure you have written consent from the family or estate.

7. **Author Details** – At the end of the manuscript list the degrees, job titles, affiliations and countries at the time the work described in the paper was carried out. Identify one corresponding author with a full postal address (including post/zip code) and email address appropriate for publication.

8. **References** – References should be numbered in the order that they appear in the text and listed at the end of the manuscript using the Vancouver style. Unpublished doctoral theses may be cited but no other citation of unpublished work, including unpublished conference presentations, is permissible. Authors are responsible for checking all references for accuracy and relevance before submission.

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2. Funding – Please provide details of the sources of financial support for all authors, including grant numbers. Grants held by different authors should be identified as belonging to individual authors by the authors’ initials. For example: This work was supported by the Wellcome Trust (A.B., grant numbers XXXX, YYYY), (C.D., grant number ZZZZ); the Natural Environment Research Council (E.F., grant number YYYY); and the National Institutes of Health (A.B., grant number GGGG), (E.F., grant number HHHH). Where no specific funding has been provided for research, please provide the following statement: This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

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4. Author Contribution – All authors should meet all four ICMJE criteria for authorship. Please provide a very brief description of the contribution of each author to the research including their roles in formulating the research question(s), designing the study, carrying it out, analysing the data and writing the article.

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1. Tables – Tables should be numbered (e.g. Table 1, Table 2...) and referenced in the text of the manuscript. Authors must indicate the desired position of the table in the manuscript. Authors must obtain permission from the original publisher if they intend to use tables from other sources, and due acknowledgement should be made in a footnote to the table as follows: Permission to replicate this table has been given to the authors by XXX.

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maximum of 3 faulty $1000 per article. To request further figures in print, please tick the appropriate box when submitting your manuscript.

3. **Supplementary Material** - Material related to a paper but not essential to a general understanding of the paper will be published as an online data supplement. Supplementary material is peer reviewed but will not be copyedited or typeset and should be supplied as authors wish to appear online. Supplementary material should be uploaded as a separate file and referenced in the manuscript. This material includes, but is not restricted to:
   - Additional data presented as tables or figures
   - Details of search strategy employed in a literature review
   - Details of the literature retrieved but not further discussed in the body of the manuscript
   - Technical details of specialist (but not novel) methodology, statistical analysis and supporting references
   - Authors who have contributed in some sense to the paper but don’t qualify for an authorship credit (e.g., group authorship) should be added to supplementary material rather than included in the footnote or acknowledgement section.

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5. **Copyright Form** - A signed Copyright Assignment Form must be submitted online when submitting a revised version of the manuscript, or immediately after acceptance if no revision is required.

6. **CONSORT, PRISMA, or CHEERS Checklist/Flow Diagram** - If relevant, see here for more information.

**During Online Submission:**

1. **Relevance statement** - Authors are required to provide a relevance statement that explains in no more than 100 words the relevance of the research to practising psychiatrists.

2. **Fast-track assessment** - Authors can request fast-track assessment during submission if they believe their paper has the potential directly to improve clinical practice or influence public policy.
   - **Appropriate reasons for fast-track assessment:**
     - Findings suggest an immediate change in practice for reasons of patient safety
     - Findings suggest that aspects of current practice are no longer ethical
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     - The first report of a novel and clinically useful therapy
     - The first report of good evidence for a novel aetiological mechanism.

A decision regarding the fast-track route will be made within 10 days of submission. All manuscripts approved for the fast-track route will be assessed within 4 weeks of submission.
The first report of good evidence for a novel endoluminal mechanism.

A decision regarding the fast-track route will be made within 10 days of submission. All manuscripts approved for the fast-track route will be assessed within 4 weeks of submission.

Article Types


Paper

- The word count should be between 3,000 and 4,000 words (excluding references, tables and figure legends) and may include up to 25 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study.
- Structured abstract of up to 250 words with the headings: Background; Aims; Method; Results; Conclusions (Trial Registration Number and Data Set Information where appropriate). Please find further guidance on writing an effective abstract here.
  - Quantitative studies: abstracts should provide effect sizes with confidence intervals (not P-values alone).
  - Conclusions, in isolation, are likely to be used by others citing or promoting the work and must therefore be an accurate reflection of the study’s main findings.
- Main text should include the following sections: Introduction, Method, Results and Discussion.
  - Introductions should be no more than one paragraph. Longer introductions may be permissible but should be split with subheadings if they exceed two paragraphs.
  - Discussion section should always include limitations of the paper to ensure balance, use of subheadings is encouraged in this section.
  - A Conclusions section is not required in the main text.
- In total, up to four tables and figures may be included in the print version of each paper (e.g. three tables and one figure). Additional tables and figures may be included as online only supplementary material. All large tables (exceeding one journal page) will be published as online only supplementary material. Authors are encouraged to present key data within smaller tables for print publication.

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<td>Abstract only plus link to VoR on cambridge.org</td>
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<td>Personal web page</td>
<td>Department or institutional repository</td>
<td>Non-commercial subject repository</td>
<td>Commercial repository or social media site (e.g. ResearchGate, Academia.edu, SSRN)</td>
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<td>On acceptance</td>
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CLOCKSS (journals) Portico (journals and books)

*Last Updated: April 2019*
### Appendix B: Quality appraisal tool (QUIPS adapted)

<table>
<thead>
<tr>
<th>Bias Domain</th>
<th>Issues to consider for judging overall rating of &quot;Risk of bias&quot;</th>
<th>Explanations</th>
<th>Rating of reporting</th>
<th>Rating of risk of bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asses the risk of each potential bias</td>
<td>These issues will guide your thinking and judgement about the overall risk of bias within each of the 6 domains.</td>
<td>Comments</td>
<td>Y: Yes</td>
<td>HIGH MODERATE LOW UNKNOWN</td>
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<td>N: No</td>
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<td>P: Partial</td>
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<td>U: Unknown</td>
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<td>N/A: Not Applicable</td>
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</tbody>
</table>

#### 1) Study Participation

Goal: To judge the risk of selection bias

- a. Adequate participation in the study by eligible persons
- b. Description of the source population or population of interest
- c. Adequate description of the study sample (demographest on individuals entering the study)
- d. Adequate description of the sampling frame and recruitment. (where recruited from, how data was collected, including methods to identify the sample sufficient to limit bias)
- e. Adequate description of the period and place of recruitment (geographical location/hospital, time-frame)
- f. Adequate description of inclusion and exclusion criteria (e.g. explicit diagnostic criteria)

Summary: The study sample adequately represents the population of interest

#### 2) Study Attrition

Goal: To judge the risk of attrition bias. The study data available (i.e. participants not lost to follow-up) adequately represent the study sample

- a. Adequate completeness of follow-up
- b. Description of attempts to collect information on participants lost to follow-up
- c. Reasons for loss to follow-up are provided
- d. Adequate description of participants lost to follow-up
- e. There are no important differences between participants who completed the study and those who did not
### Summary: Loss to follow-up (from baseline sample to study analysis) is not associated with key characteristics (i.e. the study data adequately represents the sample).

<table>
<thead>
<tr>
<th>3) FACTOR(S) MEASUREMENT</th>
<th>Goal: To judge the risk of measurement bias related to how factors are measured - The factor(s) is measured in the same way for all participants</th>
<th>DOMAIN RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. A clear definition or description of the factor(s) are provided</td>
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<tr>
<td>b. Method of factor(s) measurement is adequately valid and reliable (i.e. direct assessment, hospital record, may include outside sources of information, blind measurement, limited reliance on recall bias)</td>
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<tr>
<td>d. The method and setting of measurement of factor(s) is the same for all study participants</td>
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<tr>
<td>e. Adequate proportion of the study sample has complete data for factor(s)</td>
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<tr>
<td>f. Appropriate methods of imputation are used for missing factor(s) data</td>
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</tbody>
</table>

Summary: Factor(s) is adequately measured in study participants to sufficiently limit potential bias.

<table>
<thead>
<tr>
<th>4) OUTCOME MEASUREMENT</th>
<th>Goal: To judge the risk of bias related to the measurement of outcome - The outcome of interest is measured in the same way for all participants. (i.e. The definition and measurement of LOS should be the same for all participants; for case-control studies treat the case definition as the outcome measure)</th>
<th>DOMAIN RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. A clear definition of the outcome of interest is provided</td>
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<tr>
<td>b. Method of outcome measurement used is valid and reliable (i.e. hospital records, registers)</td>
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<tr>
<td>c. The method and setting of outcome measurement is the same for all study participants</td>
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</tbody>
</table>

Summary: Outcome of interest is adequately measured in study participants to sufficiently limit potential bias.

<table>
<thead>
<tr>
<th>5) STUDY CONFOUNDING</th>
<th>Goal: To judge the risk of bias due to confounding - Important potential confounders are appropriately accounted for.</th>
<th>DOMAIN RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Important confounders are measured (i.e. age, gender, diagnosis, ethnicity, marital status, detention under MHA: X=0; Pa=1-2; Ts=3+)</td>
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<tr>
<td>b. Clear definitions of the important confounders measured are provided</td>
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<tr>
<td>c. Measurement of all important confounders is valid and reliable</td>
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</tbody>
</table>
4. The method and setting of confounding measurement are the same for all study participants.

5. Appropriate methods are used if imputation is used for missing confounder data.

6. Important potential confounders are accounted for in the study design (by limiting the study to specific population groups, or by matching) or analysis (by stratification, multivariate regression).

**Summary:** Important potential confounders are appropriately accounted for, limiting potential bias with respect to the relationship between factor(s) and outcome.

### 6) Statistical Analysis and Reporting

**Goal:** To judge the risk of bias related to the statistical analysis and presentation of results - The statistical analysis is appropriate, and all primary outcomes are reported.

<table>
<thead>
<tr>
<th>Domain Rating</th>
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</thead>
<tbody>
<tr>
<td>a. Sufficient presentation of data to assess the adequacy of the analytic strategy</td>
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<tr>
<td>b. Strategy for model building is appropriate and is based on a conceptual framework or model</td>
</tr>
<tr>
<td>c. The selected statistical method is appropriate for the study design (there should be description available of statistical analysis)</td>
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<tr>
<td>d. There is no selective reporting of results</td>
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</tbody>
</table>

**Summary:** The statistical analysis is appropriate for the design of the study, limiting potential for presentation of invalid or spurious results.

**Rating Guide**

<table>
<thead>
<tr>
<th>Study Participation</th>
<th>L = The sample is likely to represent the population of interest.</th>
<th>M = There may be differences between the study sample and population of interest.</th>
<th>H = The sample is unlikely to be representative of the population of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study attrition</td>
<td>L = It is unlikely that there are differences between completing and non-completing participants.</td>
<td>M = There may be differences between completing and non-completing participants.</td>
<td>H = It is very likely that there are differences between completing and non-completing participants.</td>
</tr>
<tr>
<td>Factor(s) measurement</td>
<td>L = Factor(s) is adequately measured in study participants to sufficiently limit potential bias.</td>
<td>M = Factor(s) measured in study participants might have resulted in potential bias.</td>
<td>H = Factor(s) is not adequately measured in study participants to sufficiently limit potential bias.</td>
</tr>
<tr>
<td>Outcome measurement</td>
<td>L = Outcome is adequately measured in study participants to sufficiently limit potential bias.</td>
<td>M = Outcome measured in study participants might have resulted in potential bias.</td>
<td>H = Outcome is not adequately measured in study participants to sufficiently limit potential bias.</td>
</tr>
<tr>
<td>Study confounding</td>
<td>L = The observed effect of the factor on the outcome is very likely to be distorted by another factor related to the outcome.</td>
<td>M = The observed effect of the factor on outcome may be distorted by another factor related to the outcome.</td>
<td>H = The observed effect of the factor on the outcome is very likely to be distorted by another related factor related to the outcome.</td>
</tr>
<tr>
<td>Statistical analysis and reporting</td>
<td>L = The reported results are unlikely to be spurious or biased related to analysis or reporting.</td>
<td>M = The reported results may be spurious or biased related to analysis or reporting.</td>
<td>H = The reported results are very likely to be spurious or biased related to analysis or reporting.</td>
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### Appendix C: Table of additional factors included within LOS studies

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<td>Transfer out/out</td>
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<td>% MHA admissions</td>
<td>CPA follow-up</td>
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<td>FTE nurses</td>
<td>Sectorised care</td>
<td>No care coordinators</td>
<td>Admission source - home</td>
<td>Patient experience score</td>
<td>Emergency admit rate</td>
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</tbody>
</table>

X = Factor present  ?= Unclear reporting of factor
Appendix D: Publication guidelines for Psychosis

Psychosis: Psychological, Social and Integrative Approaches

Instructions for authors
Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal’s requirements. For general guidance on the publication process at Taylor & Francis please visit our Author Services website.

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All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration
of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits
Please include a word count for your paper.
The maximum word length for an Article in this journal is 6000 words (this limit includes tables, references and figure captions).
The maximum word length for a First Person Account is 3500 words.
The maximum word length for a Brief Report is 1500 words.
The maximum word length for an Opinion Piece is 1500 words.
The maximum word length for Letters to Editor is 400 words.
The maximum word length for a Book Review is 1000 words.

Style Guidelines
Please refer to these quickstyle guidelines when preparing your paper, rather than any published articles or asample copy.

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”.
Please note that long quotations should be indented without quotation marks.

Formatting and Templates
Papers may be submitted in Word format. Figures should be saved separately from the text.
To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

References
Please use this reference guide when preparing your paper.

An EndNote output style is also available to assist you.

Checklist: What to Include

1. **Author details.** Please ensure everyone meeting the International Committee of Medical Journal Editors (ICMJE) requirements for authorship is included as an author of your paper. All authors of a manuscript should include their full name and
affiliation on the cover page of the manuscript. Where available, please also include ORCIDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.

2. Should contain a structured abstract of 200 words.

3. You can opt to include a video abstract with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.

4. Between 5 and 6 keywords. Read making your article more discoverable, including information on choosing a title and search engine optimization.

5. Funding details. Please supply all details required by your funding and grant-awarding bodies as follows:
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registered as legislation requires. Authors who do not have formal ethics review committees should include a statement that their study follows the principles of the Declaration of Helsinki.

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All authors are required to follow the ICMJE requirements on privacy and informed consent from patients and study participants. Please confirm that any patient, service user, or participant (or that person’s parent or legal guardian) in any research, experiment, or clinical trial described in your paper has given written consent to the inclusion of material pertaining to themselves, that they acknowledge that they cannot be identified via the paper; and that you have fully anonymized them. Where someone is deceased, please ensure you have written consent from the family or estate. Authors may use this Patient Consent Form, which should be completed, saved, and sent to the journal if requested.

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Authors are further encouraged to cite any data sets referenced in the article and provide a Data Availability Statement.

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Updated 18-05-2018
Appendix E: Recruitment Poster

Service users’ experiences of acute mental health inpatient care

Have you been readmitted to hospital?

We are running a research study looking at people’s experiences of mental health inpatient care who have been readmitted to hospital.

Who?

We are inviting people to take part who:
- Are currently in hospital
- Have had a previous admission(s) to hospital in the last 6 months
- Have a diagnosis of a psychosis-related disorder

What?

The study will involve completing an interview about your views on the care you received both during your last stay in hospital through to the care you received after leaving hospital and how helpful you found this support.

Why?

We want to learn more about your care experiences to find out what the best ways are to support people.

If you would like some more information or are interested in taking part please contact Charlotte Phillips at:

The research is being run by the University of Manchester and has been approved by the North West Research Ethics Committee (REC Ref.18/NW/0350)
Appendix F: Participant Information Sheet

Participant Information Sheet

Service users’ experiences of acute mental health inpatient care
Version 2.0 dated 31st May 2018

Research Team: Miss Charlotte Phillips, Dr Sara Tai & Dr Katherine Berry
(University of Manchester)

We would like to invite you to take part in this research study. Joining the study is entirely up to you. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will answer any questions you have.

We recommend that you take a minimum of 24 hours to consider the information below before deciding whether to take part.

What is the study about?

You are being invited to take part in a research study about service users’ experiences of readmission to mental health hospital care. We are interested in finding out about service users’ views on the care they received both during their last stay in hospital and the care they had after leaving hospital. We would like to know what they found helpful or unhelpful about this care and if they feel it supported their needs. It would be useful to gain more information about this so we can find out if there are areas where care needs to be improved to better support people. The study is being run by Charlotte Phillips as part of doctorate training in Clinical Psychology at the University of Manchester.

Why have I been invited to take part?

We are inviting you to take part because you:

- Are currently in hospital
- You have had a previous admission(s) to hospital within the last 6 months
- You have a diagnosis of a psychosis-related disorder

OR

- You have just been discharged from hospital, have had a previous admission(s) to hospital within the last 6 months, and have a diagnosis of a psychosis-related disorder.
Do I have to take part?

No, you do not have to take part. Taking part is voluntary, this means it is completely up to you to decide whether or not to take part. Before you decide, it is important that you know what the study is for and what it will involve. We are happy to answer any questions you have about the study. If you decide to take part you will be asked to sign a consent form. If you decide to take part and later change your mind, you are free to withdraw your data from the study up until the point when it is analysed and without giving a reason. Your decision to participate in this study will not be connected to the health care you are receiving now or in the future.

What will I have to do?

If you decide to take part:
- You will be asked to complete a consent form to show you are happy to take part in the study.
- Following this an interview will be booked at a time and place that is convenient for you. One member of the research team will interview you. This will take about 1 hour 10 minutes (60 minutes for the interview and 10 minutes to answer any questions you have at the end).
- The interview will involve asking you some questions about your experiences of the mental health care you received before you were readmitted to hospital, including your views on your care during your last hospital stay and the care you received after leaving hospital.
- You will also be asked to give some basic information about yourself, such as the contact details of you and the GP or clinician involved in your care, your name, age and ethnicity. We will also ask for your clinical diagnosis, the number and length of admissions you have had to mental health hospital care. We will ask for your permission to check this information with your GP or clinical care team.

What are the possible benefits of taking part?

There are no direct benefits of taking part for you, but the information gained will help mental health services to better understand the care needs of service users. It will help professionals to understand what it is like to receive care whilst in hospital and after leaving hospital. The information you provide may help find ways to improve care to prevent people needing to return to hospital, which may help support other service users in the future.
What are the possible disadvantages and risks of taking part?

The disadvantages of taking part are likely to be small. It is possible that the interview might raise issues related to care experiences, which could be sensitive or distressing to think about. If during the interview you were to feel uncomfortable or distressed for any reason, we would of course stop the interview and only carry on afterwards if you were happy to do so. There would also be time to talk about this at the end of the interview. If you were to tell us something that makes us believe there is a risk of harm to either yourself or others during the interview, we would need to talk to another professional, such as your GP and/or direct clinical care team, this is to ensure everyone is kept safe and well.

Will my taking part in the study be kept confidential?

Yes. We will handle data sensitively and keep all information in the strictest confidence. Only certain members of the research team will have access to your information. We will give you a unique ‘ID number’ so that your name and personal details are not stored with any information from the study.

If you decide to take part we will write to your GP and/or care team with your permission, but only to let them know you are taking part in the study. Otherwise everything you say will be treated confidentially. The only reason we would break this is if something you said suggested that there was a risk to your safety or the safety of other people. In this case we would need to share this with your direct care team and/or GP as soon as possible. Whether or not you decide to take part will not in any way affect the health care you receive.

Individuals from the University of Manchester, NHS Trust or regulatory authorities may need to look at the data collected for this study to make sure the project is being carried out as planned. This may involve looking at identifiable data, but all individuals involved in auditing and monitoring the study will have a strict duty of confidentiality to you as a research participant.

What will happen to my information?

All of your information will be stored securely and will only be accessible by certain members of the research team. In accordance with University of Manchester policy, anonymised research data and consent forms will be kept for 5 years after the end of the study, following this all information will be destroyed. However, items such as contact details and any other identifiable information will be deleted as soon as they are no longer needed.
During this time it may be helpful to use your anonymised data for other future related research, which would be ethically approved, it is up to you whether you agree to this or not.

Interviews will be audio recorded. Immediately after the interview the recording will be transferred on to an encrypted university laptop and the recording will be password protected. The laptop will be stored securely before transferring the recording on to secure university computers. Any documents will be stored securely in locked filing cabinets at the University. The recorded interviews will be typed up (transcribed) by the researcher (Charlotte Phillips). All names and identifiable data will be removed from the transcription. Transcriptions will be stored in a password-protected folder securely on University computers. You will be given an ID number for this process, so your name will not be used. All audio recordings will be destroyed securely as soon as they have been transcribed for analysis.

We plan to publish the research; names of participants will not be used, although if you consent we will use direct, fully anonymised quotes.

What will happen if I do not want to carry on with the study?

You can withdraw your data from the study without giving a reason up until the analysis of the data has begun. Withdrawing from the study will not affect your health care. When the data is analysed it will not be personally identifiable.

What will happen to the results of the study?

We will publish the results of the study in scientific journals and will present them to local services and possibly at conferences. All information will be anonymised and you will not be identifiable in the results or publications. All participants who request a summary of our findings will be sent a copy.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, in order to protect your wellbeing, rights, safety, and dignity. This study has been reviewed and given favourable opinion by North West–Greater Manchester Central Research Ethics Committee.

Who is organising and funding the research?

This research is being conducted as part of the Doctorate in Clinical Psychology at the University of Manchester for Trainee Clinical Psychologist Miss Charlotte Phillips. It will be carried out under the guidance of Dr Sara Tai and Dr Katherine Berry (Research Supervisors). The study is being funded by the University of Manchester.
Will I receive any payment for taking part in the study?

No, participants will not receive any payment for taking part. However, upon completion of the interview, you will be sent a £10 shopping voucher as a thank you for taking part.

What if there is a problem?

Minor complaints

If you have a minor complaint then you need to contact the researcher(s) in the first instance.
Appendix G: Participant Consent Form

<table>
<thead>
<tr>
<th>Statement</th>
<th>Initial Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>I confirm that I have read the participant information sheet (version 2.0, dated 31/05/2018) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.</td>
<td></td>
</tr>
<tr>
<td>I understand that taking part is voluntary and that I am free to withdraw from the study up until the research data has been analysed without giving any reason and without my medical care or legal rights being affected.</td>
<td></td>
</tr>
<tr>
<td>I understand that confidentiality may be broken should I share any information that raises concerns in relation to risk to my safety or risk to the safety of others.</td>
<td></td>
</tr>
<tr>
<td>I understand that sections of my research notes may be locked at by responsible individuals from the University of Manchester, NHS Trust, or regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.</td>
<td></td>
</tr>
<tr>
<td>I agree to my research data being securely stored at the University of Manchester for up to 5 years.</td>
<td></td>
</tr>
<tr>
<td>I agree for the interview to be audio-recorded and written out in full (transcribed) by the research team for the purpose of the study.</td>
<td></td>
</tr>
<tr>
<td>I agree that anonymised quotations from sections of my audio recording may be used for publications.</td>
<td></td>
</tr>
<tr>
<td>I agree to my General Practitioner or mental health care team being informed of my participation in the study.</td>
<td></td>
</tr>
<tr>
<td>I agree to my GP or member of my direct clinical care team being contacted to confirm my clinical diagnoses, number of hospital admissions and length of these stays.</td>
<td></td>
</tr>
<tr>
<td>Optional: I agree for my anonymised data to be used for future research purposes. (You can say 'No' to this and still participate in the study).</td>
<td></td>
</tr>
<tr>
<td>I would like to receive a summary of the findings at the end of the study.</td>
<td></td>
</tr>
<tr>
<td>I agree to take part in the above study.</td>
<td></td>
</tr>
</tbody>
</table>

**PARTICIPANT:** YOUR NAME  **SIGNATURE**  **DATE**

**RESEARCHERS NAME**  **SIGNATURE**  **DATE**

*One copy for the participant, one copy for the site file, one copy for medical records* 
IRAS ID: 239273  Consent Form: Version 2.0, 31-May-18
Appendix H: Data collection form

Demographics and Clinical Status Form
Service users’ experiences of acute mental health inpatient care

Chief Investigator: Charlotte Phillips

<table>
<thead>
<tr>
<th>Participant Code: (to be completed by researcher)</th>
</tr>
</thead>
</table>

**DEMOGRAPHICS**

1. Age:
2. Gender:
3. Ethnicity:

**CLINICAL INFORMATION**

1. Clinical Diagnoses *(Clinician to provide from clinical notes)*:

2. Number of admissions to inpatient care, date of each stay, length of each stay *(Clinician to provide from clinical notes)*:
Appendix I: Topic Guide

Topic Guide:
Service users' experiences of acute mental health inpatient care

A guide to the topics and possible prompts that are likely to be covered in participant interviews. During the interviews topics may emerge spontaneously and the order of the questions and content may vary.

1) **During service users’ index admission to acute inpatient care were their needs met?**
   - Tell me a bit about your experiences of care during your last stay in hospital before your readmission? (Probe for: description of the care they received; discharge process).
   - What are your feelings on the care you received at that time in hospital?
   - What was helpful/unhelpful about this care in meeting the needs/difficulties you had when you came to hospital? (Probe for: reasons for admission, what they identify as their needs at that time; views (positive or negative) towards hospital care; satisfaction with hospital care in supporting their needs).
   - What changes would you have made to your care whilst in hospital?
   - What would your ideal hospital care have looked like?

2) **Did the follow-up care service users received following discharge meet their needs?**
   - Tell me a bit about your experiences of care after you were discharged from hospital? (Prompt: What care and support did you receive after being discharged from hospital? Length of this care?).
   - What are your feelings on the care you received after leaving hospital?
   - What was helpful/unhelpful about this care in meeting your needs and supporting your recovery? (Probe for: views of follow-up care (positive or negative/helpful or unhelpful), satisfaction of after care in supporting their needs).
   - What changes would you have made to your care following discharge from hospital?
   - What would your ideal care following discharge have looked like?

3) **What experiences led to their readmission?**
   - What do you think might have led to you to having to come back into hospital? (Probe for: reasons relating to living situation, social support, care available, symptoms).

4) **General experiences of care**
   - Throughout your care experience, what things do you think would have made a difference in supporting your needs and recovery? (Prompt for: availability of information, care and support).

Do you have any further points that you would like to make? Any questions?
Thank you very much for your time.
### Appendix J: Example participant transcript extract.

<table>
<thead>
<tr>
<th>Emergent themes</th>
<th>Original transcript</th>
<th>Exploratory Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexpected, unplanned and unpredictable discharge.</td>
<td>I: So if we start with your last stay. So when we talked about when you were here before.</td>
<td>Surprised, sudden, unpredictable, change of discharge.</td>
</tr>
<tr>
<td>No opportunity to prepare for discharge.</td>
<td>P7: In [ward name]?</td>
<td>Knowing improving. Tentative, past tense, need to prepare to leave ward.</td>
</tr>
<tr>
<td>Intrusive, power imbalance.</td>
<td>I: Yes. Do you mind telling me a little bit about your experiences of the care you received there?</td>
<td>Making sense in her mind – should she have known she would be discharged?</td>
</tr>
<tr>
<td>No control or involvement in discharge decisions.</td>
<td>P7: Ermm...I saw a consultant. I wasn’t expecting to be discharged, although I had an idea that maybe I would be, but not on that day. Maybe I thought I would be given a day or two to prepare myself for discharge. Umm...I mean...does it sound daft, but I was in the shower, washing my hair, face mask, consultant sat here calling me in <strong>shouting</strong> ‘Now [P7’s name] you’re needed now, the consultant needs to see you now.’ I was sat there with my facemask on, not that it matters, then the consultant psychiatrist says ‘right [P7’s name] its discharge today’. And I on one hand am thinking ‘yeah great! I’m released and I’m going back to you know my place’. Err...but on the other hand I was a bit apprehensive. Yeah I was thinking umm...'Am I ready for this’. It’s kind of...I feel as though it’s just...kind of dropped on to you. You know it’s just like...there you go, you can go now, instead of like a day or two. I’m not sure why they do that. Umm...yeah...I think maybe preparation, so that if you</td>
<td>‘Shouting’ – staff demanding, being summoned. Repeated ‘now’- Her time/opinions are not as valued as the staffs’.</td>
</tr>
<tr>
<td>Apprehension - Inner conflict around discharge (care vs. freedom).</td>
<td></td>
<td>Consultant very important in hierarchy, their view is important.</td>
</tr>
<tr>
<td>Dropped from the ward</td>
<td></td>
<td>Inner conflict about readiness to leave the ward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Glad but apprehensive, unsure in abilities to cope in the community (Monologue of inner thoughts).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge decision being ‘dropped’, on you ‘kind of’ tentative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dismissed ‘there you go’ – told no choice in care decisions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doesn’t understand rationale of process. Needing preparation to</td>
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</tbody>
</table>
Views not sought in discharge process.

Mixed emotions at discharge

Absence for support in key moments of change in care.
Left to cope alone - Lack of supportive relationships at discharge.
Feeling insignificant, unimportant in the discharge process.
Emotional support at discharge lacking or unrecognised.
Lack of supportive relationships

are poorly then you’re not given that opportunity to say well I’ll do this or I’ll do that before I go. But if you are poorly then you wouldn’t be discharged. So you’re thinking ‘yeah I’m well enough to be discharged’. A bit of pressure, a bit of anxiety, but at the same time it was good. I was glad that I’d been discharged.

I: Ok, so you’ve told me a little bit about that process. Was there anything that happened in particular during that discharge process?

P7: I think I had become more settled in myself. Umm...umm...yeah I think I was just getting more used to the environment. Yeah.

I: Ok. And did you feel that that discharge process supported you with what you needed at that time when you were leaving hospital?

P7: Not really. Support worker wasn’t present. I had to pack my own things, not that...I don’t mind, because they are my things. The lady that helped me was the lady that usually does the clerical work...umm...no, no support worker there, no partner, no friend, just the lady who did the clerical work helping me carry my bags to the taxi. Taxi on my own, taxi driver to my home, bags unpacked...err you know dropped off at my place. No I...I didn’t feel like I’d received the right support. I thought apart from the packing and the physical carrying of the bags. I think the emotional support wasn’t there. I don’t think it was there. I think I needed somebody with me like either like a family member, which I don’t have, but partner or support worker, I think somebody should have leave ward. Voice tone lower, not first person, externalising – thinking making sense of process - Sending people home when not well. Not feeling ready to leave but being told you are by staff. Mixed emotions about discharge. Conflicted about leaving the ward.

More settled in self. Rationalising/making sense of how decision was made by staff. Is discharge just about being more settled rather than ready?

Discharge didn’t support needs. No support from staff. ‘Not that I mind’ hesitant to question care.

‘Just the clerical lady’ not who should have been supporting her. ‘No’ repeated – sign of lack of support. Stranger supporting. Alone.

Not the right support at discharge in relation to her needs. No emotional support – needed this it was lacking. Emotional support from somebody she knew a closer relationship - ‘should’ – essential part of care missing. Sense of being left to cope alone/people not caring.
at discharge.

No opportunity to express needs at discharge.

Need for a familiar supportive relationship at discharge.

Feeling insignificant, belittling discharge process.

‘Ward a cocoon’ place of safety, & protection from the outside world.

Shift from protective ward to sudden exposure to the community.

Emotional support absent and neglected at discharge

been with me.

I: Ok. How would that have helped you having someone with you?

P7: It would have helped me settle...it would have been less anxious. And also it would have given me the opportunity and that time if I had wanted to speak about anything...it would have...I would have. And just the support...just having somebody there that I know or virtually know, even if I don’t know them too well, rather than just been bundled into a taxi in the back seat with my belongings in the boot and the taxi driver. You know it’s like I’m here [ward]...almost like a cocoon...it’s like you’re wrapped up in here and then woah you’ve fallen in to the real world.

I: Yeah. So that’s what you would have changed is it?

P7: Yeah. I would have changed it. I would have liked to have had somebody with me, like my partner, but my partner works during the day, but if she’s not available, but support worker. You know apart from the muscle work with the bag. I mean the actual emotional support you know...the...umm...yeah the psychological emotional support.

I: Is that something that would have been helpful...

P7: Useful [nods].

I: Overall what did you think of the discharge process in your...

‘It would have’ repeated – emphasis on missed opportunities. Need to feel settled, less anxious during discharged – strong emotions at discharge need support to feel more in control and contained on leaving the ward.

Being supported by someone familiar not a stranger. ‘Bundled’ – sense she has been rejected/sent away by the ward, dismissed, no longer important.

Ward is like a ‘cocoon’ protective, safe, wrapped up ‘Fallen into the real world’, unprepared, shock, out of her control. Sudden change.

Importance of needing someone for support at discharge.

Repetition of emotional support = emphasising its importance Speech slows, thinking making sense of what she needed – emotional support absent.

Useful to have someone there supporting at discharge
Unplanned discharge.

Expectation to adjust to sudden shift in care.

Feeling rejected and insignificant to services.

Impact of discharge unrecognised

Need for opportunity to share fears and apprehension at discharge.

Need for supportive relationships during transition to community.

Unplanned discharge.

No opportunities to express needs or prepare for future in community.

Voice supressed, couldn’t express true views on care.

Ward is a break from community life.

opinion?

P7: Not very well. Not planned properly, a bit...a bit up in the air...you know a bit you know there you go, gone. You know it...yeah...umm...it wasn’t very good no. Even though the excitement is there and warmth on being discharged, I think the emotional support is not there. Because you can imagine being here for so many months and then it’s dropped, right you can go now. Imagine what you’re feeling inside. There’s that mixture of anxiety and apprehension inside, so there’s that mix of anxiety and apprehension, even the slight fear of the unknown. Yeah and it would have been great if my support worker, or CPN even would have been there. But support worker obviously yeah. Somebody...somebody who could have support me through the process of the discharge.

I: Thank you for taking me through that part. Is there anything else in particular you wanted to say about the discharge process?

P7: Umm...Planned I think. Yeah and I think future like...discussing the future also, like what you gonna do in the community, what plans do you have. That input you know from the psychiatrist consultant. Yeah and even then, I was asked to fill in a questionnaire thing, to ask what I thought of the stay [smiles] and I just said five star, you know as if I was staying at a hotel maybe, but I know it’s a hospital. Staff are brilliant.

I: So to what extent would have it planned helped with what you needed at the time?

Poorly planned and chaotic discharge process.

Repetition of ‘a bit’ tentative - Just had to accept she was going.

No control, told discharged.

Mixed emotions, inner conflict excited but nervous.

Lack of emotional support, sense should feel pleased to leave. Trying to help interviewer understand ‘imagine’. ‘Dropped’ told to leave, sudden, no control, support system stripped away. Strong emotions inside—anxious, apprehension, fear of unknown about being discharged.

Support worker ‘obviously’ – they should have been there. Needed anyone to support with discharge so not alone.

Needed the discharge to be planned and preparation for discharge. Discussing the future to reduce uncertainty, to cope with emotions. Consultants view is important. Humour ‘smiles’ – didn’t give real opinion on care, like rating a ‘hotel’?

Ward staff are brilliant – contradicts discharge support – possibly view this as community services role?

Ward more comfortable than being in the community.
| Unprepared for transition to the community. | P7: A day or two, maybe even up to a week to hear the consultant say ‘I think you’re settled now. I think you’re getting better. I think in a week or two maybe we’re looking at...’ And I think they... do say that, but may be say a week or two ‘it’s not definite it depends on your behaviour’, but maybe a day or two before saying ‘right, I think...’ but that could then stress the patient maybe. I think...i’m sure they know the way they go about it is a good way, but then I’m thinking maybe if it was 24 hours thinking right tomorrow we plan on discharging you. Yeah.  

I: And how would that have helped you at that time with what you needed if you had had that planning?  

P7: Ermm...It would have helped me to may be ask for the support I needed, may be inform my partner or a family member if I had one, on that day could have said on that day the consultant is hoping to discharge, and if they want just give them a day or a date for that. That things are gonna change on that day. It is a change from being in here to being elsewhere.  

I: And would you have found that helpful if that had happened?  

P7: Yeah, I would have found it helpful. To help me plan.  

I: So I guess we’ve talked about the discharge process a little bit, but if you’re thinking about the time on the ward. Tell me a little bit about that. Tell me a bit about your care experiences on that ward at that time? |

| Consultants view important they make the decisions and give their view on readiness for discharge.  

Need for to be settled to be discharged  

Tentative language – suggested ways for consultant to help prepare – More staged approach needed.  

Confused at own experience vs discharge process being the best process. External language – making sense of what they needed during their discharge.  

Planning would have helped and given her opportunities to her express needs and ask for support. Can’t express needs as not involved in care decisions.  

Need to be made aware things are going to change, plan for this so less sudden, less unpredictable. Leaving the ward is a big change.  

More structured/planned discharge would help her plan. |
### Appendix K: Illustrative participant example of the analytic process.

<table>
<thead>
<tr>
<th>Quote</th>
<th>Exploratory Code</th>
<th>Emerging Theme</th>
<th>Individual participant superordinate (subordinate) theme</th>
<th>Final study superordinate (subordinate) theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Just being there and holding your hand really and saying ‘It’s ok to be emotional’, because we’ve always been taught hold it down, contain it you know. Don’t lose you’re composure you know. Don’t show your feelings. Don’t get overwhelmed.</td>
<td>Permission to express emotions.</td>
<td>Staff as an anchor, holding your hand through difficult emotions.</td>
<td>Trusting relationships &amp; emotional support</td>
<td>Knowing you matter (Compassionate, attuned and dismissive care)</td>
</tr>
<tr>
<td>It was there input to say ’right, you matter’. Important to me that they cared...that they were concerned to a certain extent.</td>
<td>Needing staff to be concerned about you.</td>
<td>Knowing you matter and have value.</td>
<td>Trusting relationships &amp; emotional support</td>
<td>Knowing you matter (Compassionate, attuned and dismissive care)</td>
</tr>
<tr>
<td>Speaking to me, and even the odd compliment to how well I’m doing, which was great you.</td>
<td>Need to feel empowered to keep progressing.</td>
<td>Encouraging and acknowledging progress.</td>
<td>Trusting relationships &amp; emotional support</td>
<td>Knowing you matter (Empowering and disempowering care).</td>
</tr>
<tr>
<td>Your doing something and you could just be doing your nails for all I care... but the fact that ‘Now [P7’s name]!’... ‘Now! You’ve got to see your consultant now!’...I’m saying ‘Well I’m sorry but I’m doing something’...you know ‘I realise that your time is valuable’.</td>
<td>Respect for patients preferences or time less valued than staffs’.</td>
<td>Intrusive/power imbalance.</td>
<td>Power imbalance in care.</td>
<td>Knowing you matter (Empowering and disempowering care).</td>
</tr>
<tr>
<td>Not planned properly, a bit...a bit up in the air...you know a bit you know there you go, gone.</td>
<td>Poorly planned and chaotic discharge process.</td>
<td>Unplanned discharge</td>
<td>Unplanned discharge</td>
<td>Adjusting to sudden shifts in care – Consistency, predictability and availability (The swift discharge process).</td>
</tr>
<tr>
<td>On one hand I’m thinking ‘yeah great! I’m released and I’m going back to my place’...on the other hand I was a bit apprehensive. I was thinking...’Am I ready for this’.</td>
<td>Inner conflict about readiness to leaving the ward.</td>
<td>Questioning readiness for discharge</td>
<td>Unplanned discharge (Readiness for discharge)</td>
<td>Adjusting to sudden shifts in care – Consistency, predictability and availability (The swift discharge process).</td>
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<tr>
<td><strong>It was a lot more to do with my cooperation and my involvement as in wanting to get on with my support worker. I think I kept putting them off, but then on the one hand I was thinking ‘Oh god they’re not supporting me and they’re not there for me’.</strong></td>
<td>Challenges cooperating and allowing support from staff in the community.</td>
<td>Inner conflict of wanting support vs. freedom from community services.</td>
<td>Unmet need in the community (Acceptance of care)</td>
<td>Adjusting to sudden shifts in care – Consistency, predictability and availability (Tolerating life in the community).</td>
</tr>
<tr>
<td>I spend so many days on my own. So if somebody was to knock on the door and say how do you do, come along with me I’d say yeah go on then...as in like with animals isolation you get. Alone, limited for so long.</td>
<td>Isolation and limited social networks in the community leads to vulnerability.</td>
<td>Isolation and need for human connection in the community.</td>
<td>Unmet need in the community</td>
<td>Adjusting to sudden shifts in care – Consistency, predictability and availability (Tolerating life in the community).</td>
</tr>
<tr>
<td>Reassurance, of feeling that I was safe, feeling that I wouldn’t be bothered, nobody would take anything from me that was mine, I was feeling like I was being given something that I could keep for myself, feeling like I wasn’t being pestered or harassed.</td>
<td>Needed the ward to provide a sense of safety from feeling vulnerable in the community.</td>
<td>Protection and safety of the ward.</td>
<td>Ward as a ‘cocoon’ (Place of safety)</td>
<td>Ward as a coping mechanism for unmet need</td>
</tr>
<tr>
<td>Just being there sometimes, you just having somebody be there. I’d spent an awful lot of time on my own. I spent time in four walls almost...days on my own.</td>
<td>Isolated and alone in the community someone always there on the ward.</td>
<td>Ward an escape from isolation in community.</td>
<td>Ward as a ‘cocoon’ (Escape from loneliness)</td>
<td>Ward as a coping mechanism for unmet need</td>
</tr>
</tbody>
</table>
Appendix L: Example participant map of superordinate and subordinate themes.

- **Zara**
  - Unmet need in the community
  - Power imbalance in care
  - Place of safety
  - Ward as a ‘cocoon’
  - Unplanned discharge
  - Readiness for discharge
  - Trusting relationships & emotional support
  - Escape from loneliness
  - Acceptance of care
**Appendix M: Illustrative participant t quotes relating to themes.**

### Theme 1: Knowing you matter

#### 1.1 Compassionate, attuned and dismissive care

<table>
<thead>
<tr>
<th>Participant</th>
<th>Quote</th>
<th>Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deborah</td>
<td>Just always having the time to talk to you. It would have just been better if everybody [the staff] could or wanted to give time for you. Talking to people, it’s been a big part. There is one person…she was lovely…whatever I needed she was there. There were lots of people that helped.</td>
<td>310-311, 643, 653-655</td>
</tr>
<tr>
<td>Aisha</td>
<td>I just need support at the end of the day. There are some things you can tell your family and some things you can’t. I don’t think the staff had time to talk to you in terms of to understand your problems. I don’t know how to say this; it helped me interpret how I felt.</td>
<td>395-396, 7-8, 100-101</td>
</tr>
<tr>
<td>Steven</td>
<td>Prior to that, very recent hospitalisations I didn’t cry and things like that for quite a number of years… Just the release of emotions. When I first entered the ward I got shown my room and they said they would come back, but nobody came back...All night...it’s like I was left to my own devices and then like...you do get low.</td>
<td>77-86, 146-148</td>
</tr>
<tr>
<td>Laura</td>
<td>When other people have been your named nurse and you talk to them it’s rigid. Care plans, all the time...that named nurse who I had, she’d talk to me about my care plans, but then we’d talk about other things, so it’s like we would bring up the past and talk about deep things, and then she wouldn’t just send me on my way, she would talk to me and make sure I was alright before she left. She understood and she didn’t judge...and she was just there to talk to...and she listened to everything that I had to say. I’d phone her up and the receptionist would say ‘Is it important, because she’s very busy’ and then I would just dismiss it and say ‘Oh I’ll be fine’...it made me struggle even more.</td>
<td>144-149, 320-321, 377-379</td>
</tr>
<tr>
<td>Jess</td>
<td>All I needed was probably just a friend. I pushed all my friends out, that’s why I didn’t have any. They just talk with concern...but they naturally care. You</td>
<td>322-323, 250-251</td>
</tr>
<tr>
<td>Know when someone just says ‘how are you’ you can get a feeling from it</td>
<td></td>
<td></td>
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<tr>
<td>--------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mary</strong></td>
<td>I felt as though I wasn’t wanted anymore. It made me feel…it hurt me.</td>
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<tr>
<td></td>
<td>It felt important to me that somebody was helping along the way.</td>
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<td></td>
<td>It helped a bit, because I’m usually all on my own out there.</td>
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<td></td>
<td>They were just nice people…I said ‘you believe me you know all I’ve been telling you?’ And she looked at me and she said ‘I do believe you’ and she gave me a hug. I thought yeah ‘that’s nice’. Having someone to listen and half believe me.</td>
<td></td>
</tr>
<tr>
<td><strong>Zara</strong></td>
<td>I wish there was always blue sky and fluffy clouds, but sometimes it’s not, it’s a grey day and that can get you down. But it’s helpful sometimes someone just saying ‘look listen I feel the same way. I can empathise with you’ and just knowing you’re not alone.</td>
<td></td>
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<tr>
<td></td>
<td>Just being there and holding your hand really and saying ‘it’s ok to be emotional’, because we’ve always been taught hold it down, contain it you know. Don’t lose you’re composure you know. Don’t show your feelings. Don’t get overwhelmed.</td>
<td></td>
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<tr>
<td></td>
<td>It was their input to say ‘right, you matter’…Important to me that they cared…that they were concerned to a certain extent.</td>
<td></td>
</tr>
<tr>
<td><strong>Karen</strong></td>
<td>It just made me feel like there was somebody there; on the outskirts concerned about me.</td>
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<tr>
<td></td>
<td>Just to know that they’re there for you.</td>
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<td></td>
<td>Just talk you through it like they do...like they’re professionals so they know how to talk you through everything. Ease your mind and that’s what...that’s the progress, process of getting better and back...As soon as you feel upset you see the staff are there and they sort everything out and help you through it.</td>
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</table>

### 1.2 Empowering and disempowering care

<table>
<thead>
<tr>
<th>Participant</th>
<th>Quote</th>
<th>Line</th>
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</thead>
<tbody>
<tr>
<td>Deborah</td>
<td><em>It was my choice.</em></td>
<td>158</td>
</tr>
<tr>
<td>Aisha</td>
<td><em>He just did things to make me get better. I think he believed in me that I was ok. He just...did what I asked, requested.</em></td>
<td>277-278</td>
</tr>
<tr>
<td></td>
<td><em>I’m just compliant with the rules, and I know if I comply with</em></td>
<td>242-243</td>
</tr>
<tr>
<td>Steven</td>
<td>I tried to readmit myself back into hospital, cos I knew that I wasn’t ok, and they gave me diazepam and said go.</td>
<td></td>
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<tr>
<td></td>
<td>The layout of the actual ward is basically like a prison. Like, you’ve got metal shutters, metal doors, and then…you know it’s a very…imprisonment environment…it’s like, they give you jam sandwiches and things like that. It’s a bit like stuck in the dark ages.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Laura</th>
<th>Not to always go to PRN if someone is struggling, because sometimes you just need to talk, rather than have medication thrown at you.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I saw the community psychiatrist about four weeks after I had been discharged and she was talking about getting me in to doing some volunteering or going to groups and things like that. So I went home and I organised my own volunteering.</td>
</tr>
<tr>
<td></td>
<td>Just being listened to because I was telling them before that my medication wasn’t working and nobody would dare change it or add anything else in or increase it, they just decided to reduce everything and then discharge me… I went to see my Psychiatrist, she put me back on everything that I was on, even though I told d her that it wasn’t helping.</td>
</tr>
</tbody>
</table>

| Jess     | It’s more about wellbeing. So the topics that they discuss and the people that…they’ve got a lot of experience…they speak to you about just things and life, how to better your life, but it’s not just about ‘you shouldn’t take drink, you shouldn’t do this and that’. It’s dead uplifting, powerful. |

<table>
<thead>
<tr>
<th>Mary</th>
<th>You know she said to me ‘you was on clozapine before for many years and it kept you alright, kept you well’ and ‘I thought it kept me quiet that’s what it did. It kept me quiet’. It would have made me feel a bit better. If they had listened to me in the first place the home treatment team I wouldn’t be sat here now.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>I was scared. That nobody would listen.</td>
</tr>
</tbody>
</table>

| Zara     | Your doing something and you could just be doing your nails for all I care [laughs] … but the fact that …’now, you’ve got to ...
see your consultant now’….I’m saying ‘Well I’m sorry but I’m doing something’…you know ‘I realise that your time is valuable’…

Frustrating and also having to ask time and time again, even without the illness if you had to keep going back and were a person that didn’t have an illness having to ask, ask, ask, ask. Then it leads to frustration, then it leads to anger, then it leads to behaviour that is unpredictable, that neither nor the staff or the patient like.

They were asking me about ways to move forward and may be make improvements and quality of life.

Speaking to me, and even the odd compliment to how well I’m doing, which was great you know.

Karen

They made me relaxed did the doctors, when they talk you through everything. They assess you then they look at what they feel is right for you and ask you what you think is right for you.

My CPN and me thought it would be fab! Just to get out the house a bit. I’ve never experienced [centre name] before. I think it was you know exciting to see, do something that I hadn’t done before.

Theme 2: Adjusting to sudden shifts in care – Consistency, predictability & availability

2.1 The swift discharge process

<table>
<thead>
<tr>
<th>Participant</th>
<th>Quote</th>
<th>Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deborah</td>
<td>I went out you know that quickly, nothing helped. It was lovely to come home don’t get me wrong, but after three weeks…I’m thinking ‘I shouldn’t have left’.</td>
<td>194-196</td>
</tr>
<tr>
<td>Aisha</td>
<td>In a way I think I rushed it, because they didn’t give me any home treatment care…</td>
<td>31-32</td>
</tr>
<tr>
<td></td>
<td>If they had started the home treatment team when I was on the ward, so I could have spoke about what I needed then, get a few things of my chest.</td>
<td>63-64</td>
</tr>
<tr>
<td></td>
<td>So I just asked [CPN name] whether he could ask if I could leave and they were fine at that time for me to leave, because the medication suited me…but it wasn’t helping me to get better and at the time I went home there were issues there as well.</td>
<td>202-206</td>
</tr>
<tr>
<td>Steven</td>
<td>It was basically, you come to the end of your section, then rescinded and then left to go home.</td>
<td>291-292</td>
</tr>
<tr>
<td></td>
<td>The state of play of what I was discharged in is why I’m back</td>
<td>336</td>
</tr>
</tbody>
</table>
I just found it like you’ve assessed me as healthy, like all the other times I’ve been in hospital.

And then when you’re discharged from hospital, you’re not discharged with any PRN, you’re not discharged with much at all. So it’s hard going from 24-hour care to next to nothing...

I told them that I was ready to go home, so they were letting me go. But deep down I knew I wasn’t ready.

You basically just get a piece of paper with your discharge plan, so it’s just got numbers of who to phone if you’re struggling.

They increased my leave, so I was going home a lot more, but they wouldn’t give me any overnight leave though, which sometimes helps...if you go on overnight leave sometimes that’s just instant discharge rather than coming back and talking to them about what’s going on and if you struggled or not.

They phoned me a taxi to take me home; it was a good few hours away.

It might have made a difference when I got home taking that stuff again...Maybe if it was my mum or something, someone I could have spoke to maybe. I wouldn’t have probably taken anything... but thinking now I wish I would have said something to someone.

No it wasn’t helpful at all. It was too quick.

‘The doctor wants you back in the ward round’ and I thought ‘what now’. So I goes in we’re letting you go home. He said you’re ‘8 hours out tomorrow to meet with your support worker’.

On one hand I’m thinking ‘yeah great! I’m released and I’m going back to my place’...on the other hand I was a bit apprehensive. I was thinking... ‘Am I ready for this’. I feel as though it’s just...kind of dropped on to you ...there you go; you can go now, instead of like a day or two.

The lady that helped me was the lady that usually does the clerical work...I think the emotional support wasn’t there...I think I needed somebody with me.
Not planned properly ...a bit up in the air...you know a bit you know there you go, gone.

I was sat there with my facemask on, not that it matters, then the consultant psychiatrist says ‘right [P7’s name] its discharge today’.

Karen
Everything is sorted out about me going home slowly for a few hours a day.

It’s a goal. It’s like I’d achieved something, like getting a bit stronger. Trying to help myself as well and get myself stronger slowly.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Quote</th>
<th>Line</th>
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</thead>
<tbody>
<tr>
<td>Deborah</td>
<td>Not really that helpful to be honest. You know, she only popped round gave me this and that and then she’s gone. And that was it.</td>
<td>448-449</td>
</tr>
<tr>
<td></td>
<td>Didn’t get very much support at all really.</td>
<td>453</td>
</tr>
<tr>
<td>Aisha</td>
<td>I mean I had seen him [CPN] in the hospital, at home and things like that, but he was only temporary staff.</td>
<td>279-280</td>
</tr>
<tr>
<td></td>
<td>Someone to come and see me more often. I know my [family] was there but it’s hard for him as well. So I don’t put pressure on him to talk about things.</td>
<td>346-347</td>
</tr>
<tr>
<td></td>
<td>I think I would have liked someone consistent, that I can talk to, because I’ve had a few CPNs.</td>
<td>404-405</td>
</tr>
<tr>
<td>Steven</td>
<td>I found my door was sealed up...I was financially, psychologically, geographically just all over the place...they said ‘stay in all day we will send a surveyor’. No surveyor came and I slept with no door on for 3, 4 days...</td>
<td>467-470</td>
</tr>
<tr>
<td></td>
<td>Basically, they [services] gave me medication and told me to get back and deal with the same problem.</td>
<td>524-525</td>
</tr>
<tr>
<td>Laura</td>
<td>Just people turning up when they say they would...my support worker...turns up two days early or just not turn up at all and not phone and explain why. You kind of look forward to it because you know you’re going to get the chance to talk to somebody about how you’re feeling...but then they don’t turn up and you’ve got all these feelings floating around and no one to talk to about it.</td>
<td>432-437</td>
</tr>
<tr>
<td></td>
<td>My structure and support was falling to pieces, so being left with limited care just sent me over the edge.</td>
<td>363-364</td>
</tr>
<tr>
<td></td>
<td>Just consistency.</td>
<td>391</td>
</tr>
<tr>
<td>Name</td>
<td>Quote</td>
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<td>-------</td>
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</tr>
<tr>
<td>Jess</td>
<td>My care-coordinator tried coming out to see me and I just ‘thought I don’t trust you. I don’t want to see you again, I’m fine’, and that’s what I thought at the time. I wouldn’t let them help. I didn’t trust anybody. That’s part of the illness, I can’t...don’t trust. I get really paranoid. So I didn’t trust her I thought ‘why are you coming round’.</td>
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<td>Mary</td>
<td>She only seen me once she was there for not two minutes. While I was at home I didn’t know what to do for the best...you know. And eventually I thought f**k it...and I went and...I smashed a window and they sectioned me off. It’s the worst! She said ‘we will send someone out’ and I said ‘umm no you’ll come tomorrow you’ll come everyday’...Only because I was kicking off... I said to them ‘I know all about you releasing patients in to the community and then you all disappearing off. Where they go off the radar and you don’t follow them up them up, but not with me! What would have happened if I had gone unconscious and nobody found me, nobody knocks on my door to check if I’m all right, unless they want something.</td>
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<td>Zara</td>
<td>I think I kept putting them off, but then on the one hand I was thinking ‘Oh god they’re not supporting me and they’re not there for me’...I was putting them off, because I just wanted to do my own thing. The community liaison officer I saw initially, but then it didn’t do much. We had a chat, we opened the can of worms, talked about certain incidences, undesirable things that had happened, but then we left it there. Then my CPN goes [leaves role]. I spend so many days on my own. So if somebody was to knock on the door and say how do you do, come along with me I’d say yeah go on then, but it’s that kind of...as in like with animals isolation you get. Alone, limited for so long.</td>
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Poor standard! You know... You know scruffy horrible, dirty... floorboards where you put cardboard carpet down, dust, dust getting in to my lungs... If they could just work on the basics.

Karen

You get your support worker coming to see you and... like every week or whenever they feel they need to be with you, you know, every two weeks or every week.

I have had a lot of shocks the last few months my [family member] couldn’t believe it, she said ‘your coping with this quite well, you were very poorly, you didn’t know whether you were ill or whether you wasn’t.’

Karen

You get your support worker coming to see you and... like every week or whenever they feel they need to be with you, you know, every two weeks or every week.

I have had a lot of shocks the last few months my [family member] couldn’t believe it, she said ‘your coping with this quite well, you were very poorly, you didn’t know whether you were ill or whether you wasn’t.’

Theme 3: Ward as a coping mechanism to escape unmet need

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<thead>
<tr>
<th>Participant</th>
<th>Quote</th>
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<tbody>
<tr>
<td>Deborah</td>
<td>Because...you can meet people...have a nice person to share things with here.</td>
<td>622</td>
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<tr>
<td>Aisha</td>
<td>I think I was too far gone to go to the [Crisis Team]. They look after you, but you have to take your medication on your own and I don’t think I was ready for that. Then I had to come back in to hospital to get better...the medical staff are watching you take your medication and things like that. My [family member] passed away this year... So I don’t know if that was the trigger for me to come to hospital or not.</td>
<td>270-273, 341-343</td>
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<tr>
<td>Steven</td>
<td>I’m not happy with my living place and I can’t magic the friends and family that come and visit me. So the isolation will kill you. I don’t really lean on A&amp;E and that, unless I need to. I don’t like to be in these places, but I only find these places...I don’t ask to get admitted, I get to a point where I cannot take it.</td>
<td>562-564, 537-539</td>
</tr>
<tr>
<td>Laura</td>
<td>I think my support network not being there that’s why I took the overdose at that time and then being admitted back into the hospital. Because when I’m around staff sometimes I feel safer than when I’m on my own...Just because I know if anything goes wrong, they’re there and they can help.</td>
<td>405-406, 115-118</td>
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<tr>
<td>Jess</td>
<td>At that time in my life, that’s what I needed to come away from my house and sit there, and just go out somewhere quiet, and it was perfect. Instead of the point where I lost the plot and ended up coming into hospital, but who was to know, no one. It’s a shame I would have needed that kind of restriction, as I didn’t have the will power. It is good when you come to the wards because you learn so</td>
<td>73-74, 194-195, 312-314</td>
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much. And having a laugh with the girls, because I don’t have like friends, I don’t see people, but when I go to the wards you’ve got a lot of people around you.

| Mary | One day [a nurse] was going home and I felt so alone! I used to put a chair out on the landing and just sit there right. They looked after me that well. I never met so many nice people in all my life as them staff. I said I would stay here forever. And I meant it.

They said ‘we can’t bring you in’ and I said ‘you’re bringing me in, you’ll have to find me a bed somewhere in the country’. I wanted to be monitored I was frightened! |

| 386-389 |

| Zara | I think I did get that kind of reassurance to say you’re in a place of safety. That the community can’t touch you. That people out there can’t take from you…I felt ok in [the ward] I got that kind of feeling that I could rest now, I can rest now.

You know it’s like I’m here [ward]...almost like a cocoon...it’s like you’re wrapped up in here.

Just being there sometimes, just having somebody be there. I’d spent an awful lot of time on my own. I spent time in four walls almost...days on my own. |

| 312-315 |

| Karen | I tend to come in when I’m very worried about something.

It’s just nice to know that they can help you through the bad stages that you’re going through at home, like losing my [family member], finding my [physical health condition]...that would have been more of a shock if the home treatment team hadn’t of got me to come in.

I’m in hospital and all of a sudden my [family member] dies so it’s a good job I wasn’t at home [sighs]. Because now I’m already in...they can keep a close eye on me to make sure I’m not going to get really upset and tearful. |

| 397 |

### Table: 3.1 Inevitable readmission

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<thead>
<tr>
<th>Participant</th>
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<tr>
<td>Deborah</td>
<td>I needed to come back.</td>
<td>637</td>
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<tr>
<td>Aisha</td>
<td>It’s sad that coming into hospital...I think it’s sad because I’ve been coming in and out of hospital for years and...I just want normality to come back in my life. I know I’ve a family. But for me its just loneliness.</td>
<td>330-337</td>
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<tr>
<td>Steven</td>
<td>The answer isn’t always medication or therapy, but people need to find a balance doing things they are passionate about. But its reocurrence</td>
<td>741-743, 302</td>
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I’ve been in this place years and years; I know this particular room inside out.

But my life is such that you never know when the next one’s coming and how you are going to get through it.

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<tr>
<th>Laura</th>
<th>The PRN you get given, when you’re discharged you don’t get it in the community, so you get reliant on it and when you’re discharged you’re discharged without it, so you have to find your own coping-ways.</th>
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<td>Jess</td>
<td>I don’t know where I would be if I didn’t have the hospital to come to... If I was at home all these admissions that I’ve had if I didn’t I probably wouldn’t be here now... If I didn’t have the hospital to come to I don’t know where I would be.</td>
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<tr>
<td>Mary</td>
<td>It didn’t. It didn’t. I’m still here fighting with the same stories I began with.</td>
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<tr>
<td>Karen</td>
<td>I’m just easy going I think because I’ve got older. Its good there are places like this for people you know going through bad times...</td>
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<td></td>
<td>Even if they think you need to come in to hospital many of times it had always been a long stay, but now it tends to be short stay with me.</td>
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