



HIGHLAND USERS GROUP

DISCHARGE FROM HOSPITAL

The views of the Highland Users Group on what discharge from a psychiatric hospital is like and what would improve it.

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Highland Users Group can be contacted through Graham Morgan, Highland Community Care
Forum, Highland House,
20 Longman Road, Inverness IV1 1RY

Telephone: (01463) 718817 / Fax: (01463) 718818
e.mail hug@hccf.org.uk
www.hug.uk.net

INDEX

WHAT IS HUG?	3
INTRODUCTION: WHY WE LOOKED AT THE SUBJECT OF DISCHARGE FROM HOSPITAL	4
HOW PEOPLE FEEL WHEN THEY HEAR THEY ARE GOING TO BE DISCHARGED	4
THE GOOD BITS ABOUT DISCHARGE	5
THE BAD BITS ABOUT DISCHARGE	6
Being involved in the process	6
The lead up to discharge	6
The day of discharge	7
The journey home	7
Getting home	7
People who are on section	8
Families and carers	9
Benefits	10
The positive again	10
HOW WE MAY IMPROVE DISCHARGE	10
When should the idea of discharge first be raised?	10
How involved should people be in the decision to discharge them? ..	11
What preparation do people need when they know they are going to be discharged?	12
Who should be informed that we are going to be discharged?	12
What information do people need?	13
What should the criteria for discharge be?	13
When should people be discharged against their will?	14
What should happen when we get home?	14
ADDITIONAL POINTS	15
CONCLUSION	17
ACKNOWLEDGEMENTS	18

WHAT IS HUG?

HUG is the Highland Users Group, a network of users of mental health services in the Highlands.

At present (January 2003) HUG has approximately 272 members and 14 branches in:

- Caithness
- Sutherland
- Easter Ross
- Wester Ross
- Nairn
- Inverness
- New Craigs
- Lochaber
- Skye & Lochalsh
- Badenoch & Strathspey

Our main aim is to improve the way in which we, as users of mental health services, are treated. HUG campaigns to improve the rights, services and treatments of people with mental health problems and strives to challenge the stigma of mental health.

HUG works on a local, Highland and national level to influence policy and planning, and to encourage improvements in the management and delivery of mental health services.

Where there are other groups such as the New Craigs Patients Council or the Members Group in Skye (formerly "slug") we try, as far as possible, to work in partnership with them when we hold meetings.

Between them, members of HUG have experience of nearly all the mental health services in the Highlands.

HUG AIMS:

1. To represent the interests of users of mental health services living in the Highlands, and to provide information on mental health issues.
2. To identify gaps in services and to find ways of improving services for users.
3. To participate in the planning and management of services for users.
4. To pass on information and news amongst mental health user groups in the Highlands and interested parties.
5. To increase knowledge about resources, alternative treatments and rights for users.
6. To promote co-operation between agencies concerned with mental health.
7. To promote equality of opportunity and to break down discrimination against users of mental health services.

INTRODUCTION: WHY WE LOOKED AT THE SUBJECT OF DISCHARGE FROM HOSPITAL

There were a number of reasons for choosing this subject as a topic of discussion in the HUG branches.

In 2001 we produced a report on Admission to Hospital that was born out of the developing admissions policy in New Craig's Hospital and also people's frustration at not always being able to be admitted when they felt they needed to be. At the time HUG members said we should follow this up with a focus on discharge from hospital.

This report is that follow up, but was also used during its creation as a way of helping HUG members play a part on the committee that was developing a discharge policy for New Craig's.

It was also a response to the anxiety and trauma that members of HUG had expressed about being discharged from hospital. People had commented on the abrupt contrast between being a patient in hospital, subject to care and protection, and leaving hospital and having to resume the life they had left behind. For some this was greatly welcomed but for others the transition between the two experiences was on occasion very hard to cope with. In fact for some people it was too much to manage and they ended up being re-admitted because their home environment was too fragile.

We are keen that this report is used to help make discharge from hospital in the future as easy, smooth and joyful as it should be.

The report was produced after a series of meetings in the network of HUG branches in the Autumn of 2002.

We held discussions in most branches of HUG, which were guided by a series of questions set by the workers and HUG members. These were written up and then combined into this report which was then in turn checked and cleared with the HUG Round Table (the HUG committee through which decisions and policy are made.)

In total 64 people with experience of mental health problems participated in the meetings that created this report.

HOW PEOPLE FEEL WHEN THEY HEAR THAT THEY ARE GOING TO BE DISCHARGED

We had mixed feelings on this subject.

Some of us felt great, we felt elated and happy that we were now able to go home.

Others felt very frightened and apprehensive, even terrified. We had felt safe in hospital but were now very nervous about returning to our homes.

Many of us felt a combination of both feelings. Although we were glad to be leaving we were still not fully confident that we could manage at home, especially if there was little support there or if we did not really know what to expect.

Some of us had felt particularly worried about how we would face our community, friends and family now that it was known we had been in a mental hospital.

Others of us, whilst pleased we were leaving, felt sad that we would be leaving newly made friends behind.

Leaving hospital can be particularly difficult for those of us who have spent a long time there.

We can have a pressing need to talk about what will happen. The anxiety and fear of leaving can disrupt what should be a smooth process.

Ideally discharge from hospital should be turned from a time of worry and anxiety into one of congratulation and celebration to mark a new and happier stage in a person's life.

THE GOOD BITS ABOUT DISCHARGE

Some of us felt that we had been involved as much as we wished in the decision to be discharged and were happy with the whole process. When staff take time to be with us, and talk through what we may expect and demonstrate that they care for us, we can feel much happier.

Having our support needs in the community discussed and organised in advance by people such as key nurses or social workers can make the process a very positive one.

Seeing that our care continues at the same level, even though everyone knows we will soon leave, is also very reassuring.

Some of us were contacted or phoned at home very soon after discharge, which felt very good.

For others the process was uneventful. We left hospital when we were ready to go, we felt no pressure at all:

"I felt OK, I knew I was up for it and it felt really good."

A comment made by some of us was the information given in advance about medication:

"There was a visit from the pharmacist to chat about the medication - to let me know what it does and what the side effects are. It was really helpful as many of the GP's do not have clue."

One of us, discharged in a different area of the country, was given a card with details of how to contact services at any time of the day. Being given this information when we may be panicky and not up to trusting other people was very welcome.

On occasion we have been able to contact people on the hospital ward in the first few days at home. This has been very welcome.

Good communication and preparation is often the key to successful discharge.

THE BAD BITS ABOUT DISCHARGE

Whilst many of us had had positive experiences around our discharge, there were also a substantial number of us who had had a bad time.

BEING INVOLVED IN THE PROCESS

Some of us felt that we had no involvement in our discharge. We felt we had no say in when we should leave, and were discharged from an environment providing 24-hour care into one of minimal support.

For some of us the lack of preparation caused a lot of resentment with one of us saying it felt like they were "booted out".

Some of us reported being discharged whilst out on pass, or very shortly after returning from being on pass. We had not realised this would happen and the abruptness of the process had been very disconcerting.

We should have an involvement in the decision to be discharged and have some indication about when this is likely to be.

THE LEAD UP TO DISCHARGE

We had a feeling that sometimes staff attitudes change when they know that we will be leaving. They seem to react as though there is less need to bother with us anymore. This can have a bad effect on us - in fact it can encourage some of us to leave earlier than planned.

Sometimes we feel so frustrated in hospital that we leave early. We can be very sensitive to the way in which staff are acting and very aware of the pressure on beds. All of this may combine to make us leave before we feel ready to do so. Sometimes we say to staff that we feel ready to leave when in fact we don't, but feel that there are probably people in greater need than us.

This made us keen that the decision to discharge someone should solely rest on their condition, rather than the pressure on the hospital.

Some of us felt that a hospital's need for beds also contributed to the decision to discharge us. This was felt to be a greater problem in New Craig's than it had been in Craig Dunain.

People's attitude can be a big factor. Some of us may be so keen to leave that our need to leave outweighs our ability, and knowledge of our ability, to cope at home.

"Our need to be discharged may be outweighed by the symbolism of hospital or our attitude to it and ideas about professionals. Our anger about our treatment may cause us to leave early."

Sometimes we leave hospital for purely practical reasons unconnected with our health. The reduction in benefits after a time in hospital, and maybe debts that we have incurred, can cause us to return home.

The decision to leave should be taken purely because we are ready for it. It should not be influenced by staff attitudes, bed shortages or perceived ill treatment.

THE DAY OF DISCHARGE

The main concerns we had about this were:

- ◆ The wait for medication and paperwork. Although we were often ready to leave we sometimes had to wait for many hours to get our medication and for the final arrangements to be made. This could be very annoying.
- ◆ Sometimes we returned to the hospital to find our bed stripped and our possessions piled into plastic bags. This made some of us very angry. We felt that it signalled a complete lack of respect for us, as though we didn't really matter.

If there is going to be a delay in discharge we should know about it. Staff should always be aware of the effect that their actions may have on people who may be feeling very fragile.

THE JOURNEY HOME

Many of us said that the journey home from New Craigs was particularly traumatic. We often felt very vulnerable. We could not face the mechanics of public transport or the people on the buses:

"You can pick up your bag and get the bus home. You can feel cast out without even a goodbye and you can feel very apprehensive. A lift home can be very good, as would company to help you at home. What if you get home and you have no money, there is no shopping in, nothing in the cupboards, no money and no electric and these need sorted out?"

There was a feeling that the stress of travelling long distances when very vulnerable had contributed to some of us being re-admitted.

We talked about the benefit that could be had in having transport home or a companion to help us with our journey.

The Good Companion's Scheme, that was established for a short time in Caithness to provide an escort home, was mentioned as a very good idea.

The delay in getting discharged can disrupt prearranged lifts home, and our difficulty in travelling has on rare occasions meant that we have not been able to make it to the destination that we set out for.

If a patient is anxious about travelling home they should have help in finding a companion for the journey or they should be escorted home.

GETTING HOME

Many of us have returned home with no information or minimal information. We have not known who to contact or where to go. It has on occasion taken months to learn about the community facilities that we could have accessed.

We can be returning to unpleasant environments that have sometimes prompted our initial admission:

" Sometimes people do not want to come out of hospital as they feel safe there. It can be a great upheaval. They can end up back in a harsh environment and this can be hard to cope with. They can feel as though they are back at square one and end up quickly back in hospital"

We can also feel very alone and isolated:

"Not having anyone there for you when you are coming home. You need help when you get into a wobbly patch with access to someone to talk to."

We can also feel that people will be apprehensive about welcoming us home:

"There is also a lot of stigma. Friends may not know much about hospital and people may worry about what to say and think."

" We can be very scared to come home, we may not know how to face coming home and how people may react. The worry of returning home and seeing people can cause all sorts of anxiety which, if we are ill, gets all out of proportion."

"People can treat you differently, as if you have become unhinged. Its so sad that this is how people react."

The environment can also be crucial:

"If you are going to undesirable accommodation it can be very hard. You need to plan for your return especially if you feel vulnerable and are mixing with unhelpful people."

Adjusting to life back in the community can be hard:

"It's like you have been wrapped in cottonwool, because you are looked after you don't have to think about keeping yourself strong as everything is done for you, but when discharge comes along you need help, but you are used to all the protection round you. It is then taken away, you are shoved out of the door. You have to learn how to protect and look after yourself again."

"Being in hospital I felt secure but as soon as I got out I panicked. It was horrendous. What kept me going was seeing the doctor. You can want to go back to hospital and also to remain in the community and end up feeling trapped. We all need to be able to use varying crutches in the community to keep going."

Who helps us depends on the individual and our culture. You may want an expert to contact or supportive friend. I especially wanted (access to) someone with medication and the ability to re-admit."

At home we can be very isolated and may feel lonely, lack confidence, lack motivation, worry about what to expect and whether we can cope, we can fear the attitudes of others and possible discrimination at home or work.

People returning home should know before they leave that they have an adequate support package, that their home environment is acceptable and that they have sufficient information to help them cope in the community.

PEOPLE WHO ARE ON SECTION

This situation can pose different problems for us.

- ◆ We may be very ill and yet are unable to accept it. We may see the whole process as an infringement of our liberty and autonomy.
- ◆ We may find it very hard to trust the staff who are responsible for our detention or who prevent us from leaving hospital.

In this situation it can be common for us to have, as our sole aim, getting away from hospital. We may feel that a great injustice has been done to us, and not be very worried about what to expect when we return to the community. Almost anything would be better than the injustice that we feel has been done to us.

Over time some of us may come to accept a need to be in hospital and to plan discharge carefully. Often this can be achieved by sensitive and tactful nursing. At other times a connection is not made and we are left feeling betrayed and neglected, which can only serve to make discharge and continuing treatment an area ripe for confrontation.

Because of the trauma of what we are going through we may come to see the psychiatric system as the "enemy" and refuse to co-operate with it, which may make it very hard for us to discuss issues like discharge calmly.

The anger and trauma a person who has been sectioned may feel must be acknowledged and responded to as sensitively as possible. Every effort should be made to understand the patient's point of view and to help them come to terms with their situation.

FAMILIES AND CARERS

Families are sometimes the last to know what is happening but may often be the main source of help. They have their own needs around discharge.

They may believe that discharge will mean the person is well again, when often this is not the case.

They may wish to help but may, through lack of information, be unsure of what to do.

Sometimes because of the lack of support that they get they can become part of the problem. They may be terribly anxious and traumatised by the whole situation and may be overprotective.

In a few rare instances they are in part responsible for the problem we are experiencing (some people have been abandoned and ignored by their families after admission to hospital).

They are often the key to a person's successful transition back home, and yet the feeling is that they often have very little support for this.

Sometimes they only find out at the last moment that their relative is being discharged home.

Families are often key to the discharge process, but it is easy to lose links with family if they live a long distance away. There is a need for facilities for families to meet in, and stay at, when visiting New Craigs.

Families may need emotional and practical support to prepare for the return of their relative.

BENEFITS

As mentioned elsewhere, the benefits we are entitled to can get very mixed up when we are in hospital and when we leave it. At times of change our entitlements can change rapidly and, with differing needs and home costs as well as hospital costs, debt can become a real issue.

We can also be too vulnerable to know how to deal with all of this. Quickly repeated admissions and discharge can cause great problems when we are claiming benefits.

On discharge we may arrive home to find "threatening" letters about our benefits and housing which can be very hard to cope with.

Ideally we would have access to a Welfare Rights Officer with expertise in mental health to deal with these problems before we leave hospital.

People's benefits should be sorted out and any debt taken in hand before they leave. There should be Welfare Rights Workers with a specialism in mental health.

THE POSITIVE AGAIN

Although many negative points were made about discharge, a number of groups were keen to point out that they felt that hospital services in the Highlands were a great deal better than many other services further south, especially those in England.

HOW WE MAY IMPROVE DISCHARGE

WHEN SHOULD THE IDEA OF DISCHARGE FIRST BE RAISED?

Nowadays it is commonly accepted that best practise would mean that planning for discharge starts as soon as we are admitted to hospital.

Within HUG we had a variety of opinions that are best expressed by the following two quotes:

"You need to forget the problems at home first. You need to feel safe and secure to start with. You need to fold up the possibility of discharge and put it into the back of the drawer and forget about it. Don't make the decision pressurised to start with, especially when you are feeling vulnerable - you need a safety net. Staff should only broach the subject when you are ready to accept the idea, and this will vary from individual to individual."

and in contrast:

It should be considered "Right at the start, because if you do not look forward to going back to the community then you look forward to hospital and staying there. You need to maintain hope. Admission can mean that you feel as though your life is being taken away. You need to be able to look forward to discharge and being well."

The feeling amongst most of us is that the subject is a highly individual one, and should only be broached when it is clear that we are ready and able to face it. For some of us (especially those on section) getting out of hospital is our main goal and we are very willing to look at the idea as soon as possible. For others of us there is a need for sanctuary and respite which will be disrupted if the idea of going back home is raised too soon.

We had no problem with staff members starting to consider the idea early on and then raising it with us when it was clear we were ready and able to cope with it.

However, at some point we do need a clear idea of when we will be leaving. This will allow us to prepare ourselves and plan for life back at home. Some of the hardest times are when we are given little notice that we will be leaving - this can be quite shocking.

We should be involved in these decisions when it is clear that we are likely to be able to cope with them. We should have advance warning of when we are likely to leave.

HOW INVOLVED SHOULD PEOPLE BE IN THE DECISION TO DISCHARGE THEM?

Some of us felt that we hadn't had a say in when we should be discharged and some that our views were not listened to at all. However most of us felt that we should be a part of this process:

The decision to discharge "should rest with us - it's our lives and we know what we need ... we need to aim for independence not dependence - however we need to accept the support that will get you there without you having to give away your autonomy."

However we were also aware that we are not always fully aware of what helps. For instance, we may feel very well when in hospital and ready to leave but when we do so find, to our surprise, that we are not up to life at home after all.

The general feeling was that as soon as we were able we should be involved in the decision and as far as possible as equal partners, although for many the final decision should rest with the doctor.

Some of us said that we felt intimidated by doctors and that we would trust the decision to discharge us more if it was made by people with whom we had a close relationship, or who were closely involved in our care.

Even those who may be very ill need to feel a part of what is happening:

"They should reason with you and help you work out why you were taken in against your will, and why it might be a good idea to stay. Our feelings need recognised too - if they listen to you and if they hear you then half the battle is done."

Some of us may have difficulty in participating, or in expressing our views, and may need access to an advocate to help make sure our opinions are heard and respected.

We should be involved in the process as much as we seem willing to be. Ideally we would be equal partners and those that know us well should be fully involved.

WHAT PREPARATION DO PEOPLE NEED WHEN THEY KNOW THEY ARE GOING TO BE DISCHARGED?

Proper preparation can be the key for a successful and positive move from hospital back into the community. For some of us the absence of any significant preparation has caused us to be re-admitted or to struggle at home.

We need to:

1. Know what will happen when we get home.
2. Have adequate information about community facilities.
3. Know where we can go for help and who will see us and provide support.
4. Know that our family and friends are ready for our return.
5. Have been introduced to carers such as CPN's or social workers prior to leaving.
6. Have someone to talk to about our fears, expectations and wishes about what may feel like a new life.
7. Be reassured, comforted and counselled.
8. Have been involved in drawing up, and have to hand a discharge plan giving details of the people dealing with us and times and places of appointments in the community, which have been made before discharge.
9. Have a chance to consider a range of different options relating to our care.
10. Have a little cajoling to help us realise it's a good idea.
11. Have contacts arranged in the community - perhaps a friend to visit or a "buddy".
12. Have our benefits, including housing benefit and council tax, sorted out prior to discharge. Money worries such as debt and reclaiming benefits can be particularly traumatic and also very important when leaving hospital.
13. Perhaps we should have a link with people who have already successfully gone through discharge themselves.
14. Accommodation also needs to be adequate and arranged prior to discharge.
15. It can be good to make lists of the things that need to be done before we leave.
16. Make sure that our everyday life skills are back, perhaps with help from the Occupational Therapy Department. There could be a series of tests that show we can look after ourselves at home.
17. Go through normal activities such as cooking, dealing with paper work, going into the city, buying clothes, etc.
18. Try some trial days at home and out in the community first.
19. Be clear about our medication, how it works, its importance, when to take it and how to reorder it.
20. It is important that we have appropriate clothing.
21. We should be registered with the appropriate services, such as GP's.

The degree of preparation that we need will vary from individual to individual, but may be particularly important for those of us who have been in hospital for some time.

These factors should be taken into account when preparing people for leaving.
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WHO SHOULD BE INFORMED THAT WE ARE GOING TO BE DISCHARGED?

- The main workers such as the Community Psychiatric Nurse, any support workers and the GP.
- Family and carers need informed (if we wish) and should be told anyway if we are returning to live with them.
- If we go to Drop-in-Centres it may be good to let them know too.
- It can be good to let friends and neighbours know if we wish (we might need some support to do this).

- It is important that the various agencies dealing with things like benefits and accommodation know we are being discharged (and that we have help in dealing with these problems).
- Some of us may need access to an advocate. We should be given the contact details.

Although some of us have been asked who we would like contacted, others haven't. Ideally each of us would be asked who we would want to contact and if we want help in doing so.

A range of people should be informed that we are leaving. We may need some help in letting people know this.

WHAT INFORMATION DO PEOPLE NEED?

The main things we need to know about on leaving hospital are:

1. Our diagnosis.
2. Our medication.
3. Self-help possibilities.
4. Community facilities.
5. The help we can expect to receive.
6. How to get help in crisis.
7. Information about our rights, such as how to get access to our medical records.
8. Information about how to deal with benefits and how to contact the C.A.B. or Welfare Rights Agencies.

Staff should take time to go through this information with us before we are discharged. Ideally it would then be passed on to us in an information pack.

Carers also need access to appropriate information if they are expected to help the person being discharged.

Carers and users should be provided with information packs on discharge from hospital.

WHAT SHOULD THE CRITERIA FOR DISCHARGE BE?

1. Being able to cope at home.
2. There is adequate support available in the community and/or at home.
3. We are able to carry out everyday tasks such as cooking.
3. We can face the public and our friends.
4. We can get out of the house and into the community.
5. We have enough confidence to face life at home.
6. We have an appropriate home to go home to.
7. Everyone providing our care has been involved in the decision to discharge us.
8. We are fit enough mentally and physically to return to the community.
9. Our medication has been arranged.
10. Our benefits have been sorted out.
11. We have enough money to manage the first few days at home.
12. We feel ready to leave and want to.
13. We know what support we will get and agree with it.
14. We have had time to prepare for discharge.
15. We have had the chance to try a few days at home first.

16. There has been a risk assessment carried out to ensure that we are not unreasonably dangerous to ourselves or other people.
17. We have been given appropriate information for our return.
18. We can travel alone.
19. There is food and heat at home.
20. We have enough motivation to manage at home.

These criteria should be taken account of when making the decision for a patient to leave.

WHEN SHOULD PEOPLE BE DISCHARGED AGAINST THEIR WILL?

We felt there were three main reasons which would justify us being discharged against our will:

- 1) Some of us may get so used to hospital and the security it provides that we lose the will to leave, even though it is obvious to other people that with support and encouragement we can manage at home. In these situations it may be justified to encourage us (with tact and sensitivity) to leave despite our own reluctance.
- 2) Some of us may misuse drugs or alcohol in hospital and may even be involved in dealing in drugs. In these circumstances it may be justified to discharge us, especially if we are "dealing". However the issues of drugs and alcohol need to be dealt with sensitively as they are so often bound up with our emotional and mental health.
- 3) Our behaviour may be threatening or dangerous to other patients. This may justify discharge, although if it is caused by our illness it may not. Ideally there would be facilities and strategies for dealing with patients whose behaviour is damaging to other people.

On occasion it would be acceptable to discharge a person against their will. The seriousness of this decision and the need to seek alternatives needs taken account of.

WHAT SHOULD HAPPEN WHEN WE GET HOME?

- Ideally we will leave hospital in a positive frame of mind having dealt with some of the problems at home while in hospital. We will be prepared emotionally and practically for our return. We will have said our good-byes to fellow patients and key members of staff and know how to get help and manage at home.
- If necessary we will have been given a lift home, or a friend or relative will have come in to accompany us home.
- Some of us find early mornings hard because of the effects of our medication and therefore we will not have been discharged whilst still groggy.
- We will have been discharged at a time when we have access to our benefits rather than at a time when they are running out. We will have also been discharged at a time of the week when sufficient support is available. For some people (especially those living alone) weekends can be particularly difficult as many community facilities close for the weekend.
- At home the house will ideally be stocked with basic essentials, such as bread and milk and hopefully it will be warm or the fire set.

- Within a few hours of getting home we will have been contacted by professionals to check how we are, and we will be looking forward to the first prearranged appointment with those responsible for supporting us at home.
- Some of us would benefit from company, either a friend to stay for a few days or a visit from a community psychiatric nurse or support worker as soon as possible.
- We will have access to community facilities and know about the range of services through our information pack and if possible (and if we wish it) have been linked up to a “buddy” who knows what we are going through and can offer support from the perspective of one who has been there.
- The support we can get from people at Drop-in-Centres can be very welcome at this delicate time. It can be very hard to talk to those we are close to as the pain of our experience can put a lot of pressure on them. However meeting people who understand the experience of mental illness can be a great release.
- Some of us will not be up to the everyday tasks of keeping the house running. In these circumstances the help of a support worker or home help could be very valuable.
- Some of us are very unwilling to ask for help. Services will be aware of this and will not take silence to mean we are all OK.
- Others of us will have discharged ourselves against the advice of the hospital. This will not mean that we are abandoned, rather that the services make sensitive attempts to contact us until it is apparent that we genuinely no longer wish to have any contact with them.
- We will have a worker designated to co-ordinate the sometimes intensive support that we need for the first few days or weeks. We will also have access to the ward we have left, if only for the sound of a familiar and supportive voice.
- Some of us won't be able to manage at home to start with. In these circumstances access to a half-way house, rehabilitation ward, supported accommodation or a day hospital may bridge this gap.
- Some of us can be very lonely and isolated and access to a befriender can offset this for some people.
- As we regain confidence we may still need help. We may need access to respite care but certainly need to know that there are people around that we know we can trust and who we know care for us. Access to self-help strategies to avoid re-admission may also be very good, for instance help to stop us getting bored and to stop "thoughts" growing again.

The period when we have been discharged can be critical to our wellbeing. All the above factors should be considered to make it as smooth a move as possible.

ADDITIONAL POINTS

There was a feeling amongst some groups that the length of stay in hospital was constantly decreasing. They felt that this was damaging for some people and that the benefits of sanctuary and peace were being lost with this change.

The existence of alternatives to hospital may partly offset this problem.

Some groups were keen to see local facilities that provide:

- ◆ Accommodation, access to a drop-in-centre, support with everyday skills such as shopping, cooking and personal care as well as social support and company.
- ◆ Equally some local beds in remote areas could make the process of hospitalisation a much smaller event.
- ◆ Early intervention may also take away the need for hospital and reduce the trauma of admission or discharge.
- ◆ Many groups, having seen the positive effect of the Braeside Resource Centre, have called for an equivalent in their area.

Comments on it include:

"Braeside was my support. A psychiatrist suggested admission to hospital and then offered an alternative of the day hospital. I jumped at the chance to sort my life out. It was a change from hospital and a way of giving me space to sort my life out but not within the restriction of hospital"

However it still has its own problems over discharge:

"I have had back-up which has been good. However it does still feel that being discharged from Braeside, if you do not have support lined up, is still a great shock and even with support it is a shock - you have been depending on crisis support and then suddenly it goes."

"It focuses the mind and helps with healthy living. You get to do things and to keep going and suddenly this stops."

Some of us need access to enhanced community services when we are discharged. These may be places to go such as drop-in-centres or day hospitals or they may be places we can stay in as we get used to the idea of regaining our independence.

CONCLUSION

Whilst many people may have a smooth and comfortable stay in hospital, and an uneventful departure, discharge from a psychiatric hospital is for some of us a time of fear and trauma. We are ill prepared to resume a life back at home and may feel damaged by our time in hospital.

It can feel as though we are making a great leap at a time when we are feeling particularly vulnerable.

This experience should be avoided and the positive experiences other people have had should become the norm.

We hope that this report indicates how unpleasant a badly managed discharge can be and equally what changes can be made to improve the experience.

With thanks to all the users of mental health services who contributed to this report and to the professionals who provided information.

For more information on HUG, or an information pack, please contact:

Graham Morgan
Highland Users Group
Highland Community Care Forum
Highland House
20 Longman Road
Inverness
IV1 1RY

Telephone: (01463) 718817

E-mail: HUG@hccf.org.uk

www.hug.uk.net

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