Medicines Safety in the Community Following Mental Health Hospital Discharge: A Qualitative Interview Study

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Background: For those with mental illness hospitalisation can lead to challenges following discharge, as treatment may change and patients often find the transition disruptive and emotionally difficult. As medicines are the most common treatment intervention for those with mental illness, related safety issues may be common at, and following discharge, particularly since medications often change from those taken pre-admission. There is little research exploring medication safety issues, and the lived experiences of patients, and their carers, in the community following discharge.

Objectives: This study aimed to explore medicine taking, continuity and care following mental health hospital discharge from the perspectives of people with lived experience, their carers and community based health professionals.

Methods: Participant recruitment was via social media and the professional networks of the research team. Semi-structured online interviews were conducted with people with mental illness, carers, and health professionals (including pharmacists, doctors, and nurses in hospital, primary care, and community settings) involved in medication use and safety after hospital discharge. Questions focused on medication related activities, knowledge transfer practice, support needs and key challenges and facilitators of medication safety in the community following discharge. Reflexive thematic analysis involved independent reading and coding across the research team.

Results: Analysis of 34 interviews conducted with 17 healthcare professionals, 10 people with lived experience and 7 carers suggested a fragmented and disrupted network of care provision following discharge. Participants described poor communication and noted that time pressures, disconnected record systems, and limited information sharing with GPs contributed to unclear care planning. Continuity of care was disrupted due to unclear responsibilities for patient review and follow-up, causing service disconnects and patients falling through gaps. Participants reported delays in prescribing, providing, and reviewing medications, with inconsistent information given to patients. Patient and carer voices were often unheard, leaving them disempowered, and shared decision-making was unclear—sometimes involving patients, other times placing responsibility on them without their input.

Conclusion: This study has revealed the system level challenges associated with maintaining safety with medicines following mental health hospital discharge, particularly around the continuity of care and disempowerment of patients. We suggest that clearer pathways and the organisation of care services based around collaborative working would benefit medicines management post discharge. Further attention is needed to developing care provision that is holistic and person–centred.

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BACKGROUND

For those with mental illness hospitalisation can lead to challenges following discharge.

Medicines are the most common treatment intervention for those with mental illness.

Related safety issues may be common at, and following discharge, particularly since medications often change from those taken pre-admission.

There is little research exploring medication safety issues, and the lived experiences of patients, and their carers, in the community following discharge.

Aims and Objectives

We aimed to explore medicine taking, and continuity and care, following mental health hospital discharge from the perspectives of people with lived experience, their carers and community-based health professionals.

METHODS

Participant recruitment was via social media and the professional networks of the research team.

Thirty–four semi-structured online interviews were conducted with people with mental illness (10), carers (7), and health professionals (17) involved in medication use and safety after hospital discharge.

Questions focused on medication related activities, support needs and key challenges of medication safety in the community following discharge.

Reflexive thematic analysis involved independent reading and coding across the research team and the interpretation of three main themes.

RESULTS

"There needs to be a collaborative approach, there needs to be an understanding that we all have a part to play in this, and that we all have equal accountability, and the consequences of not working collaboratively within a team, ultimately does impact patient care" ***P14 Pharmacist.***

Collaborative work in the co-ordination of care and medicines

Participants described a fragmented network of care provision following discharge with poor communication. Time pressures, disconnected record systems, and limited information sharing with GPs contributed to unclear care planning.

*"And I still struggle, like, on many days, you know, to manage because of the dosage of the medication. And I have brought this across many times, you know, with my team, my CPN [community psychiatric nurse]. I've told them many times but I think the problem with all these experiences that...they do not want to listen to me. Like, I try, I try, I try, I explain my situation, even with my mental health advocate. But they don't really pay any attention to what I'm explaining to them or they're not listening to me. "****P30 Lived Experience.***

Disruption, fragmentation and lack of continuity of care with medicines.

Continuity of care was disrupted due to unclear responsibilities for patient review and follow-up. Participants reported delays in prescribing, providing, and reviewing medications, with inconsistent information given to patients.

"I'm on weekly [supply of] medications, so it can cause quite a problem if they're sort of delayed, especially over the weekend, 'cause I don't have like a back-up, you know? So it's kind of like, if they don't give me the medication on the date that I'm asking for is, then I don't have anything to keep me, [...] and of course, I do ring up the surgery if they make this mistake [...] it causes me a lot of stress and anxiety." ***P28 Lived Experience.***

Patient and carer voice

Patient and carer voices were often unheard, leaving them disempowered, and shared decision-making was unclear—sometimes involving patients, other times placing responsibility on them without their input.

CONCLUSION

This study has revealed the system level challenges associated with maintaining safety with medicines following mental health hospital discharge, particularly around the continuity of care and disempowerment of patients.

We suggest that clearer pathways and the organisation of care services based around collaborative working would benefit medicines management post discharge.

Further attention is needed to developing care provision that is holistic and person–centred.

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