Improving medication safety after discharge from mental health hospitals: co-developing recommendations with stakeholders

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Background: Discharge from mental health hospital presents patient safety risks due to a lack of care co-ordination and communication between stakeholders. A lack of patient/carer involvement in medication decisions and the implication of medicines in re-admission highlights them as a significant contributor to these safety risks. However, their impact in mental health care is limited as current research and clinical guidelines concerning care transitions do not focus on mental health or medicines specifically.

Objectives: This study aimed to create 'core statements' representing safe medication best practice following mental health hospital discharge in order to inform development of future interventions.

Methods: Three 2.5-hour consensus building workshops were held during July 2024 which were attended by community and mental health care professionals, people with lived experience of mental health hospital discharge with prescribed medication and the carers of these individuals. Social media, research team networks, and prior involvement in our research guided recruitment. A lived experience researcher and study advisory group supported all stages of the project, with the former being directly involved in data collection and analysis. Workshops (2xonline, 1xin person) each included: (a) presentation of findings from earlier research, (b) small group working to identify and discuss potential 'core statements', (c) whole group discussion of main ideas, and (d) whole group exercise to rank main 'core statement' ideas based on importance. Workshops were audio recorded and transcribed before undergoing thematic analysis alongside researcher field notes to identify best practice 'core statements' with supporting quotations.

Results: Workshops involved 23 participants including 10 lived experience/carers and 13 health professionals. Seventy five 'core statements' were identified and grouped into the following three themes: (a) discharge journey (n=54 statements, including care approach, medicines/general advice, medicines taking support and documentation), (b) consultation model (n=12; reflecting structure and behaviors of health professionals) and (c) the 'care coordinator' role (n=9; covering duties and training). The ranking exercises prioritized the need to personalise support with medicines, to openly communicate and work together around medication beyond discharge, and to identify key trusted individuals to actively support this process.

Conclusion: This study has developed 75 'core statements' describing safe practice with medicines in mental health discharge care, which focus predominantly around discharge processes and adopting patient-centered consultation models and capture the importance of psycho-social care elements. These statements should be developed and tested as part of clinical guidelines and improvement interventions.

Improving medication safety after discharge from mental health hospitals: co-developing practice recommendations with stakeholders

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BACKGROUND

- Poor care co-ordination and communication between stakeholders create safety risks following mental health hospital discharge.[1-2]
- A lack of patient/carer involvement in medication decisions [2] and the potential implication of medicines in causing re-admission [3] highlights them as a significant contributor to these safety risks.
- However, their impact in mental health care is limited as current research and clinical guidelines concerning care transitions do not focus on mental health or medicines specifically.

Scan this **QR code** to learn more about why this wider project was needed and what it involved → → → → → → → →

AIM AND OBJECTIVES

This study aimed to create 'core statements' representing safe medication best practice following mental health hospital discharge in order to inform development of future interventions.

METHOD/DESIGN

Who was eligible to take part?
People with lived experience of mental health hospital discharge with prescribed medication, carers of these individuals and community and mental health care professionals.

How were participants recruited?
Recruitment took place via social media, networks of the research team and involvement in related research [2].

What happened at the workshops?
Three 2.5-hour workshops held during July 2025 (one in person and two online). Workshops comprised four activity phases based on the Nominal Group Technique [4]: (a) presentation of findings from earlier research [2], (b) small group working to identify and discuss potential 'core statements', (c) whole group discussion of main ideas, and (d) whole group exercise to rank main 'core statement' ideas based on importance.

How was workshop data analysed?
Workshops were audio recorded and transcribed before undergoing thematic analysis alongside researcher field notes to identify best practice 'core statements' with supporting quotations. The study was approved by the University of Manchester Research Ethics Committee (ref: 2023-17915-32081).

Public and Community Involvement
Research team member FN supported project planning, co-facilitated workshops, independently read transcripts during coding and helped refine the coding framework. A Project Advisory Group supported each stage of the work.

RESULTS

Workshops involved 23 participants including 5 people with lived experience, 5 carers and 13 health professionals. Health professionals included 9 pharmacists, 2 nurses and 2 GPs from across primary care, mental health and drug and alcohol services.

Seventy five 'core statements' describing best practice were identified and grouped into three themes presented below: (a) discharge journey; (b) consultation model; and (c) 'care coordinator' role.

Discharge journey (54 statements)
- **Care approach** (shared care practices, lines of responsibility clear, discharge planning, follow up planning, third sector & carer involvement)
- **Medicines/general advice** (signpost to support, key info to cover, FAQs, meds review, who to call for advice, further tests required)
- **Medicines taking support** (timetable, build confidence on ward with use, adequate supply, support aids, key support person named)
- **Documentation** (explicit medication changes, named trusted person, justification for medication decisions, clear shared decision making, copies of documentation sent to patient and carers, who to speak to in future)

Consultation model (12 statements)
- **Content** (balanced, stigma, move beyond risk, partnership working, involving carers)
- **Professional behaviours** (patient centered, empathy, build rapport, motivational, mutual respect, acknowledge limitations, honesty)

Care coordinator role (9 statements)
- **Who could perform the role** (trusted person)
- **What they should be doing** (working with families, involvement in decision making)
- **How their involvement would be supported** (training, back-up person, meaningful role)

The ranking exercise revealed that participants consistently valued the following themes:

CONCLUSION

This study has developed 75 'core statements' describing safe practice with medicines in mental health discharge care, which focus predominantly around discharge processes and adopting patient-centered consultation models. These statements capture the importance of psycho-social care elements [1].

These findings could be integrated into future interventions guiding patient safety at transitions, such as bundles like SAFER-MH (**QR Code →**):

Other next research steps may include:

Tailor statements to different contexts
For example, young and older people

Deploy and test the statements in practice
Build documentation templates and new inclusive care models

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