



Transition Experiences Following Psychiatric Hospitalization: A systematic Review of the Literature

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Abstract

The period immediately following discharge after inpatient stay for mental illness has been found to be the time of greatest risk for adverse outcomes (e.g., rehospitalization, relapse, suicide). However, the experiences of patients as they transition from the hospital to the community are not well understood. The purpose of the present review was to systematically search and synthesize the literature examining the transition experiences of individuals following inpatient psychiatric stay. A systematic search was conducted for studies examining the experiences of patients as they transition back into their communities, using qualitative or quantitative methods. Qualitative articles were analyzed using thematic content analysis. Quantitative articles were extracted and summarized. The search identified 1614 abstracts, of which 27 (18 qualitative; 9 quantitative) were included in the review. The results of the analysis identified themes necessary for transition including safety, supported autonomy, and the opportunity to engage in a number of reintegration activities. A number of barriers were found that prevent integration, such as poverty, interpersonal difficulties, and stigma. The results highlight the disconnect that occurs for patients as they transition from hospital, pointing to the need for effective transitional interventions that target these challenges.

Keywords Transition · Psychiatric hospitalization · Recovery · Systematic review

Introduction

The period immediately following hospital discharge has consistently been found to be time of greatest risk for adverse outcomes including rehospitalization, relapse, and suicide (Canadian Institute for Health Information 2011; Chung et al. 2017). Recent reviews have documented a number of patient characteristics that may lead to these negative outcomes, such as severity of illness, gender, age, and engagement in outpatient treatment (Hawton et al. 2005; Hor and Taylor 2010). However, no review to date has examined the experiences of patients during the transition period.

In order to reduce the instances of adverse outcomes, a small but promising number of trials of transitional interventions have been developed that have shown effectiveness in reducing adverse outcomes (Vigod et al. 2013). Transitional interventions involve integrating a number of supports into the typical discharge as usual, in order to create better continuity of care from inpatient stay, to the community. The supports used in transitional interventions may include home visits, psychoeducation, telephone follow-up, and peer support (Vigod et al. 2013). However, transitional intervention models remain poorly articulated and investigated despite their important implications from systems and health economics perspectives. There are also bodies of literature that describe programming designed to support community integration (Gibson et al. 2011) experiences of community integration broadly (Yanos et al. 2007), and literature describing interventions for individuals experiencing frequent hospitalizations such as Assertive Community Treatment (Coldwell and Bender 2007) and Intensive Case Management (Burns et al. 2007).

However, despite the body of research on transitional and community-based programs and support, individuals' actual experiences as they transition from inpatient care into the

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community are not well captured or synthesized in the literature. This is an important omission, given the evidence of particularly heightened risk and challenges in the first weeks and months following hospitalization—indicating something distinct about this time period as opposed to broader inquiry into community integration at other times. Lacking a synthesis of the literature on individual experiences in the period immediately post-hospitalization increases the risk of misinformed policy and intervention design. Having better evidence in this area might help with the effort to reduce suicide, rehospitalization, and other crises in this high-risk period. Therefore, the purpose of the current review was to systematically search the literature to capture and consolidate the current understanding of the experiences of individuals post-discharge who are transitioning back into their communities. This is, to the best of our knowledge, the first systematic review of this kind.

Method

Search Strategy

A systematic literature search, following PRISMA guidelines (Moher et al. 2009) was conducted for all eligible published studies up to June 2017. The purpose of the review was to answer the following questions: What are the experiences of mental health patients as they transition from inpatient care back into their communities? What are the needs of these patients and how can these needs be met? The review strategy, extraction, and thematic synthesis of qualitative studies, followed the guidelines outlined by Thomas and Harden for systematic qualitative reviews (Thomas and Harden 2008).

This systematic review included studies that examined the experiences of mental health patients as they transition from an inpatient treatment setting back into their communities. Transition was defined as the physical and psychological move from inpatient services to independence in the community or reliance on outpatient services. Studies that were included in the systematic review were empirical papers, both qualitative and quantitative, in order to provide an extensive review of the current state of the literature on our focal research questions. Abstracts were excluded if they failed to meet one or more of the inclusion criteria (i.e., not being focused on mental health outcomes, not examining patient's experiences, or only focusing on inpatient experiences). Finally, studies had to be published in English. Relevant studies were identified through online searches of several relevant databases (i.e., PsychINFO, Medline, Healthstar and Google Scholar). Search terms that were used to search the literature included: (1) Psychiatric OR psychological OR mental health OR mental illness OR mental

disorder OR schizophrenia OR depression OR bipolar OR mood disorder AND (2) transition OR discharge OR deinstitutionalization OR transfer OR post-discharge OR post discharge AND (3) experience OR perspective AND (4) inpatient OR patient OR service user OR client. In addition, reference lists from review articles were examined for any other potentially eligible studies.

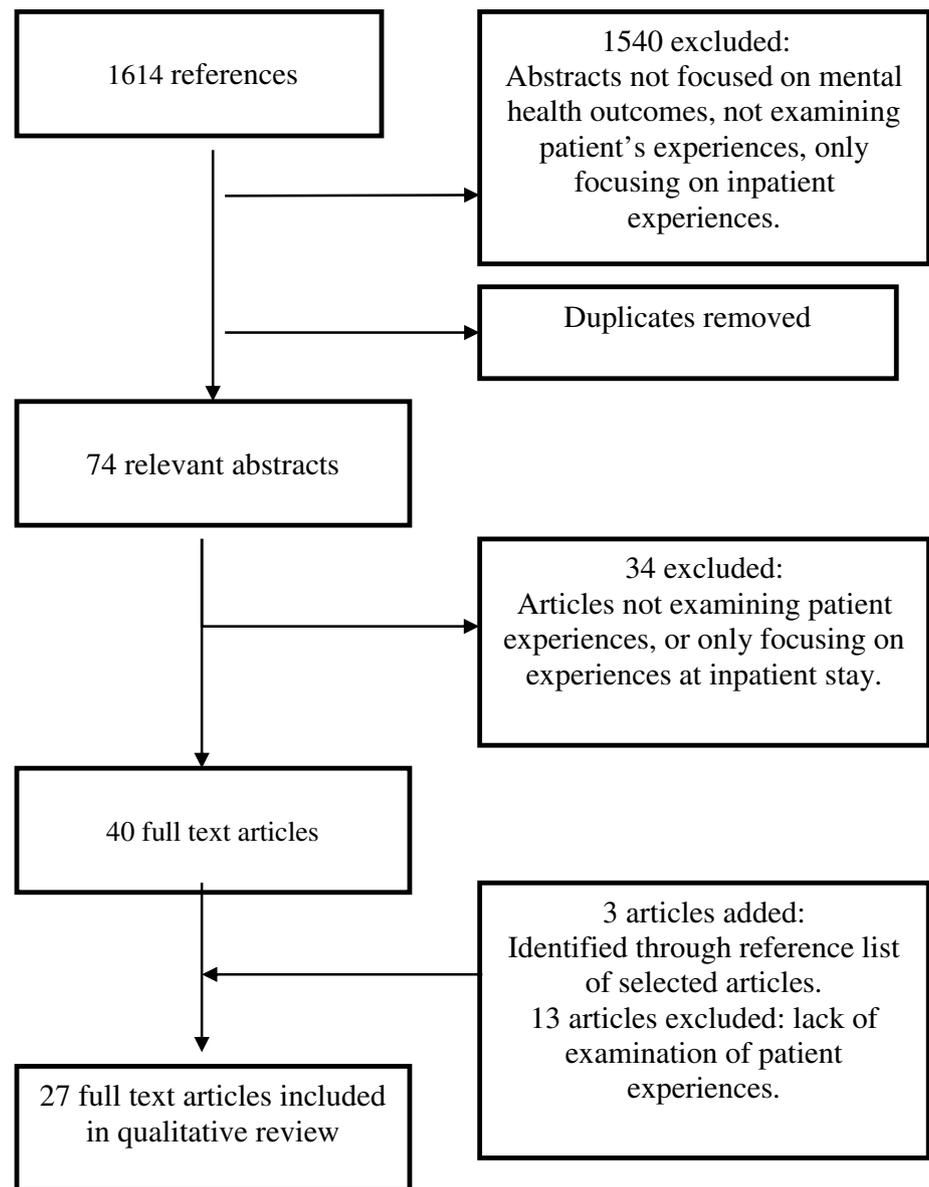
The search strategy generated a total of 1614 abstracts that subsequently underwent review. Two authors independently reviewed the list of abstracts and initial decisions were made on whether to include the abstract. In the case of disagreement, discrepancies were resolved through discussion with a third research team member. Duplicates were removed at this stage. Selected relevant abstracts ($n = 74$) were then retrieved and two members of the research team independently reviewed every article to confirm inclusion and extract study information. At this stage, articles were removed from analysis primarily for lacking examination of patient experiences or for only focusing on inpatient experiences. As a result, the full text for 24 articles (18 qualitative; 9 quantitative) were retrieved and coded for relevant information. Three additional studies were added from the reference lists of the coded studies (see Fig. 1).

Quality Assessment

Two independent raters assessed the quality of articles, including rigor and relevance of the study, ranging from low, medium, to high. Quality was assessed based on the clarity of the research question, the data collection methods used, the type and applicability of qualitative analysis, validity of findings, and relevance of the results and conclusions. Previous qualitative systematic reviews have emphasized that all studies should be included regardless of their quality, although poorer quality studies may not contribute as much to the synthesis as higher quality studies (Thomas and Harden 2008). Therefore, all studies were included in the qualitative review, regardless of the ratings in the quality assessment phase.

Analysis

After the full text review of relevant articles, all qualitative article text was uploaded into NVivo in order to analyze the results of each article qualitatively using the method outlined by Thomas and Harden (2008). The qualitative approach that was used was thematic content analysis. The first author began by sorting phrases and words in QSR's NVivo software that were reflective of different categories of patient's experiences (e.g., social relationships). The highlighted words from each article were then grouped together by category and analyzed further in order to refine each category (e.g., family relationships, peer relationships). The categories were combined or

Fig. 1 Flowchart of search strategy

eliminated if they appeared to be redundant. Two additional members of the team were asked to verify the accuracy of the categories and after discussion with them, minor modifications were made to the categories. Information from quantitative articles was extracted into a table and summarized. Extracted information included methodology, study population, and primary outcomes. The outcomes of the quantitative data were used as further support for the themes found within the qualitative analysis.

Results

The search strategy resulted in 27 full text articles (18 qualitative; 9 quantitative) retrieved for review. Of these, articles were from the United States ($n = 10$), Canada ($n = 4$), United Kingdom ($n = 4$), Sweden ($n = 2$) and Australia ($n = 2$), and one article each from Austria, New Zealand, South Africa, Japan, and Nigeria. The articles

Table 1 Description of included studies

References	Population characteristics (sample size (N); condition; ethnicity; gender; age)	Study design (cross-sectional, case study, semi-structured interviews, focus groups)	Analysis method (grounded theory, content analysis, etc.)	Primary outcomes	Quality assessment (high, medium, low)
Caton et al. (1985)	119 patients with chronic schizophrenia in New York City, USA. 80.5% non-white ~ 50% female	Cross-sectional	Regression analysis	External stressors (interpersonal conflict) Adherence to aftercare Social support Transition supports	Medium
Connerty et al. (2016)	8 women (mean age 33.3) who had been discharged from a mother-baby psychiatric unit in Australia	Semi-structured interview	Interpretive phenomenological analysis	Independence and autonomy External stressors Normalization (responsibilities) Transition supports	High
Davidson et al. (1997)	12 recidivist patients with severe mental illness from USA. No stats on age or gender	Semi-structured interview	Phenomenological and participatory research methods	Transition supports Independence and autonomy Self-efficacy External stressors Social support	High
Duhig et al. (2017)	13 people (4 women) readmitted to inpatient care within 28 days of discharge. Participants, including eight men, were recruited in 2013 from three psychiatric wards at a metropolitan hospital in Australia Duration of admission at interview ranged from 7 days to more than 3 months	Semi-structured interviews with individuals readmitted	Grounded theory	Independence and autonomy Social support External stressors (financial) Coping strategies Self-efficacy Transition supports	High
De Falco (1975)	31 men and 33 women: within 6 months, 12 men and 7 women were readmitted. Pittsburgh, USA Additional information was obtained from the current hospital record, interviews with family members, and from professionals	Interviewed the readmitted patients in four weekly sessions	No analysis mentioned. Case studies of patients	Transition supports Independence and autonomy Social supports	Low

Table 1 (continued)

References	Population characteristics (sample size (N); condition; ethnicity; gender; age)	Study design (cross-sectional, case study, semi-structured interviews, focus groups)	Analysis method (grounded theory, content analysis, etc.)	Primary outcomes	Quality assessment (high, medium, low)
Gerson and Rose (2012)	N = 10; 23–81 years of age All participants were African American N = 6 males and N = 4 females Diagnoses: schizophrenia, bipolar disorder, and major depressive disorder or major depressive disorder with psychotic features Recruited from one inpatient psychiatric treatment unit in USA	Semi-structured, exploratory interviews to assess patients' and families' perspectives of the transition to community Interviews were then conducted 1 week after discharge (time 1) and again 3 weeks after discharge (time 2) Quantitative measures also included	Interviews were transcribed verbatim and then analyzed using a process of manifest and latent content analysis Patient and family interviews were analyzed separately and then compared	Normalization Independence and autonomy Meaningful activity Social support Transition support	Medium
Harper et al. (2008)	Thirty participants (83% female) were selected for this study from the larger study sample of 163 adults with self-reported histories of child abuse. All had completed the six-week inpatient treatment program between September 1998 and February 2000 Canada	The interviews were conducted at approximately 6 months post-discharge	Ethnographic approach	Normalization (responsibilities) Self-efficacy Social support Coping strategies Transition support	Medium
Hebblethwaite and Pedlar (2005)	Adults diagnosed with a psychiatric disorders, had received inpatient treatment at a geriatric psychiatry unit, and had returned to their homes in the community after discharge N = 5 Canada Ages 68–80 years old	Interviews guided by phenomenology Interviews began 3 months following discharge and accompanied by a follow-up phone later to discuss the interview and the themes of the interview	Grounded theory	Social support Transition support Meaningful activity Independence and autonomy	High
Heron et al. (2012)	5 white female participants who all experienced post-partum psychosis from the United Kingdom	Semi-structured interview study exploring recovery was designed and conducted by service user researchers (SURs) in collaboration with academics	Grounded theory	Normalization (responsibilities) Social support Self-efficacy Stigma Meaningful activity Independence and autonomy Transition support Medication	High

Table 1 (continued)

References	Population characteristics (sample size (N); condition; ethnicity; gender; age)	Study design (cross-sectional, case study, semi-structured interviews, focus groups)	Analysis method (grounded theory, content analysis, etc.)	Primary outcomes	Quality assessment (high, medium, low)
Herrera et al. (1974)	Consecutive hospitalization, between 1958 to 1961, for mental illness in adult wards in the USA N=55 Ages 25–29, 50% women 44% schizophrenic, 25% adjustment reactions of adolescence, 16% psychoneurotic, 11% character disorders, 4% manic-depressive	Longitudinal Personal interviews with patients, parents, and therapists 10 years after discharge Loosely structured interviews focused on family relationships, school-work adjustment, and social relationships	Chi square analysis	Social support Parental involvement	Low
Hodgins et al. (2009)	N = 225 All male participants n = 181 with Schizophrenia or Schizo-affective disorder, the remaining participants had a SMI (bipolar disorder, major depression or non-toxic psychosis) Recruited from general and forensic psychiatric hospitals in: Southern British Columbia, Canada, Finland, the state of Hessen, Germany, and Southern Sweden Age M = 38.36 57.8% had comorbid alcohol abuse and/or dependence, 43.6% had comorbid drug abuse and/or dependence, and 22.7% had comorbid anti-social personality disorder	Structured interviews conducted at discharge from hospital and at six-month intervals during a two-year period post-discharge Interviews with: participants, family members, and treatment staff Also collected: records of psychiatric treatment, social service files, and official criminal records. Symptoms assessed using the Positive and Negative Symptom Scale and the Hamilton Rating Scale for Depression Substance misuse was measured by self-report and hair and urine analyses	Regression Model	Substance abuse Victimization Meaningful activity	High
Hofer et al. (2004)	80 patients with schizophrenia disorder from Austria, whose discharge from inpatient had been at least 6 weeks earlier	Cross-sectional	Regression model	Meaningful activity (employment) Medication	High

Table 1 (continued)

References	Population characteristics (sample size (N); condition; ethnicity; gender; age)	Study design (cross-sectional, case study, semi-structured interviews, focus groups)	Analysis method (grounded theory, content analysis, etc.)	Primary outcomes	Quality assessment (high, medium, low)
Johnston (2013)	<p>KwaZulu-Natal, South Africa Inpatient psychotherapeutic unit in a public mental health facility N=72, 45 female participants, and 27 male participants Includes: mood disorders, personality disorders, substance abuse disorders, and first-episode psychosis Length of time since discharge: 1–35 months (mean = 8.81 month, SD = 6.88 months)</p>	<p>Structured questionnaire containing closed-ended questions about the subjective well being and mental health status Preliminary survey conducted in inpatient psychotherapeutic unit over telephone by a registered clinical psychologist and trained intern psychologist</p>	<p>Frequencies recorded to analyze trends and experiences reported by participants Themes identified were coded by the researcher and an independent rate</p>	<p>Meaningful activity (employment) Autonomy Transitional support</p>	Low
Manuel et al. (2012)	<p>N = 25, 100% female, mean age = 38 years Living in transitional residences on the grounds of two state-operated psychiatric hospitals in the New York City, USA metropolitan area, awaiting discharge to both supervised and independent housing Diagnosed with SMI and hospitalized for at least 1 month before discharge 76% African American</p>	<p>25 women were split into three focus groups Focus groups consisted of 2 h semi-structured group discussions guided by a protocol of questions and probes developed by the research team Focus group transcripts and notes were coded</p>	<p>Audio recordings of the discussions were transcribed and then analyzed using an open-coding approach</p>	<p>Normalization (responsibility) Self-efficacy External stressors Independence and autonomy Social support Transitional support Medication</p>	High

Table 1 (continued)

References	Population characteristics (sample size (N); condition; ethnicity; gender; age)	Study design (cross-sectional, case study, semi-structured interviews, focus groups)	Analysis method (grounded theory, content analysis, etc.)	Primary outcomes	Quality assessment (high, medium, low)
McIntosh and Worley (1994)	Mixed population: substance abuse, eating disorders, general psychiatric problems from USA Patients from state mental health facilities or other medical facilities as well as those discharged against medical advice were excluded N = 127. 25 completed the 6 month follow up, 53 completed the 3 month follow up, 31 will be contacted in 3 months, 18 were recently discharged and on weekly follow ups	Semi-structured phone interview Patients called within 72 h of discharge as well as the second and third weeks post-discharge If the patient doing well, follow up calls done at 3 and 6 months post-discharge then calls are terminated If the patient is having difficulties the nurse may make additional recommendations Four cases are reported	Cross-sectional Frequencies distribution of post-discharge patient reported problems	Transition supports Meaningful activity Social support Normalization (responsibilities) Medication	Medium
Mgutshini (2010)	Multidisciplinary admission records (n = 59) of randomly selected patients (30 with multiple admissions and 29 with less than two admissions) from USA. The multiple-admission (MA) group was made up of 17 males and 13 females while the single-admission (SA) group had 10 males and 19 females From the group of frequently admitted patients, 23 patients were interviewed	Phenomenological study Methods included a retrospective review of multi-professional case notes, clinician and service user semi-structured interviews, and focus groups	Data were collected using multiple approaches including a retrospective review of multi-professional case notes, semi-structured interviews and focus groups with both clinicians and service users	Transition support External stressors Social support Medication	High
Miedema and Stoppard (1994)	27 women who had been hospitalized at least once for psychiatric treatment in New Brunswick, Canada Recruited from self-help groups. 21–61 years of age Diagnosis not assessed	Semi-structured interviews (1 h in length) Interview consisted of 19 questions focused on admission, treatment, discharge, and demographics	Interview transcripts analyzed using Kirby and McKenna (1989)	Normalization (responsibilities) Social support Transition support	Medium

Table 1 (continued)

References	Population characteristics (sample size (N); condition; ethnicity; gender; age)	Study design (cross-sectional, case study, semi-structured interviews, focus groups)	Analysis method (grounded theory, content analysis, etc.)	Primary outcomes	Quality assessment (high, medium, low)
Niimura et al. (2016)	N = 18 patients with diagnosis of Schizophrenia Spectrum disorder who were involuntarily admitted in Tokyo, Japan 1–6 months into discharge period while receiving outpatient treatment 8 males and 10 females; Ages 17–68	Qualitative descriptive study design Semi-structured patient interviews post-discharge	Inductive qualitative content analysis	Social support Normalization Meaningful activity Independence and autonomy Transition support	High
Nolan et al. (2011)	Four acute care wards in a large NHS Mental Health Foundation Trust in the West Midlands UK Participants admitted over a 9-month period and received inpatient care for a minimum of 2 weeks N = 44 for the first phase of interviews (n = 18 men and n = 26 women, ages 18–71 years, n = 4 ethnic minority backgrounds) N = 18 for the post-discharge interviews (n = 10 men and n = 8 women)	Semi-structured interviews First interview: prior to discharge and focused on experiences as an inpatient Second interview: 2–4 weeks post-discharge and participants discussed/reflected on the discharge process, their concerns at the time and their subsequent experiences	Data put into SPSS and analysed descriptively. Interviews transcribed, read independently by the authors and then together to identify key themes and the frequency with which they occurred	Social support Transition support External stressors Medication Normalization Self-efficacy Meaningful activity Coping strategies	Medium
Olusina and Ohaeri (2003)	Psychiatric patients (n = 118, aged 18–60, 62.7% female) with schizophrenia and major affective disorders South west Nigeria	Cross-sectional Assessed with the 26-item WHOQOL instrument, 2 weeks after discharge	Cross-sectional	External stressors (financial) Meaningful activity (leisure) Autonomy	High
Proctor et al. (2006)	199 older adults hospitalized for depression on a 34-bed geropsychiatric unit of a large urban hospital in USA and discharged to home settings between March 1997 and May 2000 Mean age = 76; 86% white 70% female	Observational, prospective study	Cross-sectional	Social support Severity of illnesses	High

Table 1 (continued)

References	Population characteristics (sample size (N), condition; ethnicity; gender; age)	Study design (cross-sectional, case study, semi-structured interviews, focus groups)	Analysis method (grounded theory, content analysis, etc.)	Primary outcomes	Quality assessment (high, medium, low)
Redding et al. (2017)	Eight participants were interviewed to explore their experiences of discharge 5 female, 3 male 100% white Aged 26–65 years Time since discharge (to interview) ranged between 6 and 29 months, with a mean time of 20 months United Kingdom	Semi-structured interviews	Interpretative phenomenological analysis	Self-efficacy Meaningful activity External stressors Coping strategies Social support Stigma Medication Independence and autonomy Transition support Normalization	High
Skärsäter et al. (2003)	13 Swedish-speaking women, who had been diagnosed suffering from major depression using DSM-IV and had received inpatient care at some time during the period 1997–1998, in two psychiatric departments situated in the south-western part of Sweden	Interview guide created by the authors. Conducted interviews in a conversational style	Phenomenographic approach.	Self-efficacy Stigma Normalization (responsibilities) Independence and autonomy Meaningful activity Coping strategies (self-care) Social support	High
Harper et al. (2005)	30 participants from an inpatient trauma treatment program in Canada 83% female 9% non-white	Open-ended, semi-structured interviews approximately 6 months after discharge	Ethnographic approach	Normalization Transition support Social support Coping strategies Meaningful activity	Medium
Svensson and Andersson (2012)	35 people, with a long history of heroin addiction, including ten women from Sweden Ethnicity unclear. Recruited visitors with discharge experiences at the local needle exchange programme The average time span since the last discharge was 30 months	Interviews were conducted by a social worker at the Infection Clinic's needle exchange programme (NEP)	Analysis focused on identifying key themes and individual markers in their stories	Transition support External stressors Social support Coping strategies	Medium

Table 1 (continued)

References	Population characteristics (sample size (N); condition; ethnicity; gender; age)	Study design (cross-sectional, case study, semi-structured interviews, focus groups)	Analysis method (grounded theory, content analysis, etc.)	Primary outcomes	Quality assessment (high, medium, low)
Tregoweth et al. (2012)	4 men and 4 women discharged from a forensic inpatient setting for at least six months in New Zealand 6 non-white, 2 white Within the last decade, they have returned to part or full time employment for a period of at least 6 months DSM-IV Axis I clinical disorder including schizophrenia, bipolar affective disorder or schizoaffective disorder	Unstructured interviews were used to gather and explore the participants' stories via a 45 to 90 min audio-taped in-depth conversation	Van Manen's description of analysing lived experience informed the thematic analysis of the text	Transition support Self-efficacy Normalization External stressors Stigma Independence and autonomy Social support Meaningful activity	High
Wright et al. (2000)	N = 88, recently deinstitutionalized long-term state hospital patients (~8 years institutionalized) Indianapolis, Indiana, USA 20 females; 37 African Americans; M age: 43.8	Three wave longitudinal design 2 h, semi-structured interview Interview also asked self-esteem using the Rosenberg Self-Esteem scale and a quantitative measure of respondents' sense of personal control, and experiences of social rejection Global Assessment of Functioning (GAF) scale to assess patients' overall mental health status	Time-lagged OLS regression analyses Structural equation path modeling techniques	Interpersonal difficulties Stigma Self-worth	High

ranged in publication dates from 1974 to 2017. The total number of participants in the studies was 1497, with 622 women and 651 men. Four studies did not report gender. Ten articles reported the ethnicity of their participants and of these, 38% participants identified as ethnic minorities. A full description of articles identified can be found in Table 1.

Qualitative Results

Eighteen qualitative articles were included in the review. Sixteen of the articles reviewed utilized an interview format, while the two remaining used a structured questionnaire and a focus group. In terms of the analysis of qualitative data, the most common method used was content analysis ($n=6$), followed by phenomenology ($n=5$), grounded theory ($n=3$), frequency analysis of phrases and words ($n=3$), and one study did not note the analysis method used. The majority of studies were of high rigor and relevance ($n=11$), seven studies were of medium quality, and two studies were of low quality.

Independence and Autonomy

A number of studies ($n=12$) discussed the lack of autonomy that patients felt over their lives when leaving inpatient wards. When asked about what she could do to cope with her illness one patient responded, “Just take my medicine and pray” (Davidson et al. 1997). The authors reported that the majority of the patients felt they had no control over their illness, and they could be “talking to you today and end up back in the hospital tomorrow” (Davidson et al. 1997). Other participants noted that they wanted to have their independence and autonomy, but recognized they needed consistent support. A patient stated, “I want to get my own apartment, [and] do things on my own. But I need supervision, too, [and] support” (Manuel et al. 2012). Participants also discussed the changes they experienced in their independence over time:

I remember one day going out with my parents and [my husband] over to the café for a cup of coffee and back and thinking “oh the day I can do that on my own would be amazing” and I did do it one day and it felt so good, but it was little bits at a time, piece by piece, building yourself back together again. And I kept setting myself goals to achieve and I found that helped tremendously (Heron et al. 2012).

Self-Efficacy

Ten papers discussed that patients had a belief that they lacked the coping skills necessary to transition into the community. There was a lack of self-efficacy in a number of areas, including fulfilling roles the patients had before going

to hospital, as well as more day-to-day activities like taking care of themselves and their home. The lack of self-efficacy to cope in the community often led patients to seek further hospitalization. One participant stated:

When I got back I had to start work again um and you know get back to doing you know worrying about tea and shopping and cleaning and you know all of those other things. So it was just kind of really daunting you know about how am I going to keep on top of all of this (Connerty et al. 2016).

Patients also discussed the lack of self-efficacy in their ability to remain in the community while avoiding future re-hospitalizations. One participant stated:

I dread my discharge probably more this time than I have done on previous occasions. In the past, I had high expectations of what could be achieved but I know now that admission itself causes many problems. Admission offered only temporary respite in the past, and I see no reason why it should be different this time or in the future. I feel on a merry-go-round and very negative about the future (Nolan et al. 2011).

Duhig et al. reported that when patients had a perceived inability to cope, a stressful event often led them to seek re-admission immediately by accessing emergency services (Duhig et al. 2017). In contrast, patients who did have self-efficacy about their ability to cope in the community often had successful recovery outcomes. One participant stated, “you’ve got to do a lot yourself erm, it’s got to come from you really. You’ve got to want to get better, it’s got to come from you” (Redding et al. 2017).

Transition to Outpatient Supports

A major theme that was covered by 17 of the articles reviewed was related to the inadequate transition to outpatient supports. Many articles discussed that participants received the care they needed in the hospital, but were often left to find their own supports as they were discharged into the community. Individuals who were given a comprehensive discharge plan reported that their transition into the community was much easier.

Participants described the transition out of the hospital to be quite emotional for them. One participant stated, “I remember driving off the [hospital] property... and I just started crying. It was like I was leaving home or something—something so secure...It was a combination of leaving something that was very secure and going into the unknown, going right back to [an unsupportive environment]” (Harper et al. 2008). This participant is reflecting on the lack of support that they had from outpatient care. Another participant echoed this sentiment by describing the

difficulty leaving hospital when he felt he did not have the proper supports in place:

I wasn't stable enough in myself. It was tough to get established. Not functioning as well as I normally do. I left here pretty much without a follow-up plan in place and just being out set things off again (Duhig et al. 2017).

Participants discussed a lack of support after they left inpatient care and the outcomes that followed. One woman stated, "if you don't get help and are not followed in everyday life, you just end up in the ward" (Miedema and Stoppard 1994). Although a few individuals did access some form of outpatient care, some did not have access to any services: "Erm, no I, I had no home treatment, I had, nothing except a prescription" (Redding et al. 2017).

Patients who did receive outpatient support reported varying levels of quality and quantity of the supports:

I saw my psychiatrist once every two weeks to check on my medication. It would have been good to have somebody who knew something about it, like a sort of social worker or community mental health worker or something, to visit and just ... give you some help and encouragement. I mean that's why it's great if they can come to your home because, as somebody who has been to visit psychiatrists quite a lot in their offices, it's quite daunting and you tend to, especially as a female, you're always eager to please and 'oh I'm doing fine' and put your best face on it (Heron et al. 2012).

Social Support

A number of articles ($n=7$) discussed the lack of social support that is felt by patients as they transition into the community. Due to the lack of support, patients often resorted to previous harmful coping strategies, which then resulted in further hospitalizations. One patient who reflected on her previous discharges stated, "They have no idea what my situation is like at home, the endless boredom, lack of social contact, it's intolerable at times" (Nolan et al. 2011). One patient from Davidson et al. discussed his lack of friendships and social support and that his outpatient workers were all he had to rely on for support: "Like there's a number and I like call... from I think it's 8:30'ti1 4:30, something like that. And that's helpful that I can call and talk to someone when I have problems. That's a big thing; sometimes I just need somebody to talk to" (Davidson et al. 1997).

Another participant noted the need for social interactions to support recovery:

No, I don't think that one should be alone in a situation like that. Even if one's whole being and emotions... just wanting to be left alone... and retire still further

into one's own shell. Nevertheless, I do believe that I needed to have people around me who said "hello, there's a world outside, you know"... I think it's a help or a way to recovery (Skärsäter et al. 2003).

This quotation is echoed by another patient in DeFalco (1975) who commented on his living situation by stating, "I'm not a recluse; I can't live by myself". DeFalco reported that 3 months after hospital discharge, this patient quit his job, began living with his mother, and 2 months later he was readmitted to the hospital. Duhig et al. reported patients were "lacking social support and seeking to escape distress rather than solve problems..." which led to "substance use and self-harm in attempts to alleviate difficulties" (2017). Another participant described his inadequate coping strategies due to lack of social support: "I felt lonely and depression creeps in and [I] had suicidal tendencies."

Need for Peer Support

A number of studies ($n=17$) discussed the importance of the relationships that were made during inpatient stay, with patients discussing the importance of shared experiences. An examination of experiences after an inpatient trauma program indicated that the friends who were made while in the inpatient program were seen as being more emotionally supportive due to their similar experiences (Harper et al. 2005). In addition, friends who were not from the inpatient program, but who had similar experiences, were also perceived as more emotionally supportive by patients. Paralleling this result, a participant from the study by Nolan et al. stated:

I have made some great friends during my time here and I hope people will maintain contact with me after discharge. Following previous discharges my biggest regret was not just the isolation, but the fact that I had no one to talk to about my stay in hospital (Nolan et al. 2011).

Ten studies discussed the need to talk about mental health experiences with people who had gone through similar experiences and the lack of understanding of the experience by close others: "My mom has a particularly hard time dealing with this. She just does not understand it. She's never been depressed a day in her life and she really doesn't understand why [I get depressed]" (Skärsäter et al. 2003). A patient from Heron et al. (2012) stated:

If I'd have met people with similar experiences or could have had a conversation with somebody who'd been through the same thing...I didn't know of anyone at that time, so that would have been a big help... So other people just, walking the journey with you and kind of saying 'I've done it too, I know how you feel'...

Another participant stated, “I would have liked someone who had experienced being depressed to have visited me in the hospital and told me his/her story and that ‘you will recover’” (Skärsäter et al. 2003). A patient from the study by Manuel et al. (2012) suggested a “peer advocate phone line for [when] you’re feeling anxious or if you’re not sure how to handle something...when you leave the hospital.”

Self-Care as a Coping Strategy

Developing self-care practices was noted in 5 studies as part of recovery after inpatient stay. Skärsäter et al. (2003) discussed a variety of self-care practices that patients used to deal with their depressive symptoms including exercise, massage, music, reading, and painting. Harper et al. also noted participant’s use of self-care: One woman stated, “When I can’t talk, I can often paint, because words don’t come out and I can’t write it sometimes. But I can paint it or draw [it]” (Harper et al. 2005). Another woman said, “Journaling is very helpful ... It’s a private thing and it takes all the crap that’s in me and puts it on paper and I put it away. That’s crap I don’t have to carry around at night before I go to bed. And I always say, ‘Okay, now I’ve done this ... I’ll sleep well tonight’” (Harper et al. 2005).

Some participants used self-care to take a break from social interaction. One woman remarked: “So, I’m swimming 3 days a week, and it’s excellent. It’s really good because I’ve noticed different things when I’m there, like I don’t have to socialize with anybody and that’s fine” (Harper et al. 2005). Another participant stated that having choice in participating was part of her recovery: “but I’m increasingly doing the things I want to do... and I say “No” when I don’t feel like doing something... if I don’t feel like going to a certain place, then I won’t...” Another woman speaking about gardening, sewing, and reading stated, “It lets me isolate without having to say ‘Oh, I’m isolating in a bad way.’ I think it’s a good thing for me” (Harper et al. 2005).

Normalization

A number of studies discussed the idea of normalization as a key theme for individuals who are integrating back into the community. Patients discussed both the challenges and triumphs with taking back their role in society before being hospitalized. Specifically, patients discussed engaging in previous responsibilities ($n = 11$), pursuing meaningful activity ($n = 10$), and the idea of attaining “normalcy” ($n = 9$). One participant stated, “The excitement that I could look after my girls again and start living a normal life again” was a positive change for her returning from hospital (Connerty et al. 2016). Another participant reflected on their feelings being discharged and stated, “I wanted to move forward, feel more normal” (Connerty et al. 2016).

While many patients stated that they wanted to integrate back into a normal lifestyle, a number of participants found this to be very difficult. One said, “I’m never going to be normal like everybody else and never going to have this health that they say is possible” (Harper et al. 2008). Many participants found that they were never able to attain what they believed to be back to normal: “er, I was quite a high achiever getting all those bonuses all the time...so erm I’ve tried to get that thing back in my life again and try and go for different jobs and never found it” (Redding et al. 2017).

Engagement in Responsibilities

Returning to normal life brought about many challenges for patients, especially re-engaging in responsibilities. Many participants discussed responsibilities such as chores or taking care of children to be quite difficult. One woman stated, “I was expected to run my house, enter the community on my own” (Miedema and Stoppard 1994). Others mentioned much more basic responsibilities such as making decisions throughout the day that were particularly difficult for them. Another participant stated, “Deciding whether to get something out for dinner or not was even challenging for me so to make a decision about like saying I need help was a huge thing for me” (Miedema and Stoppard 1994). Said another:

When I got back I had to start work again um and you know get back to doing you know worrying about tea and shopping and cleaning and you know all of those other things. So it was just kind of really daunting you know about how am I going to keep on top of all of this (Connerty et al. 2016).

Meaningful Activity

Individuals described the need for meaningful activity in their transition from an inpatient unit. Ten papers discussed the need for structure throughout the day, however, the structure needed to be filled with activities that the clients actually enjoyed. One individual described her involvement in her religious organization and a variety of other activities she is involved in: “Then I come home and make myself something to eat and I read. I’m going back to sculpting. I’m pretty peaceful with myself now” (Hebblethwaite and Pedlar 2005).

Participants described that finding meaningful activity was sometimes difficult due to their mental health status. One woman stated, “Going out with friends, like going swimming and just making myself do stuff that I didn’t really want to do with [my baby] but doing it anyway. And then I started to enjoy it” (Heron et al. 2012). Nolan et al. stated that all of their participants endorsed wanting help filling their days and finding useful activities to participate in such

as voluntary work, hobbies, and making social contacts, but many lacked the confidence to seek them out themselves (Nolan et al. 2011).

Participants also discussed the importance of returning to some form of work after their inpatient stay. One patient stated, “Well, today I have prospects for the future, which I didn’t have before. So I have this goal to return to work, and I see myself as having a lot to give. So today, my future looks bright, which was not the case before” (Skärsäter et al. 2003).

Participants described the experience of returning to work as something that contributed to their self-confidence: “It’s gained me respect off everybody, and if everybody is wanting you to do work, you know I must be doing something right” (Tregoweth et al. 2012). Although work as a meaningful activity proved to be quite beneficial for some, others said that it took quite some time before they felt they were able to transition into this role. One participant stated, “My stamina wasn’t really that great and I had to build it up gradually. It took about 3–6 months before I was ready for real work and then I couldn’t just jump into full-time work” (Tregoweth et al. 2012).

External Factors

A common theme in the papers reviewed was external factors that hindered recovery and successful transition. Participants discussed issues related to poverty, such as lack of housing and an inability to find a job that prevented them from transitioning into the community. Due to these harsh environments, participants often were unsafe in the community in which they were living. The lack of resources and difficult environments made coping with interpersonal stressors and stigma very difficult for clients, which often led them to readmission.

Poverty

A number of studies ($n=5$) discussed issues related to poverty for those transitioning back into the community. One participant described his life outside the hospital: “My living situation? I was homeless, broke, unemployed. The same harsh feeling everyday” (Davidson et al. 1997). Many participants echoed this statement, “like living in poverty all your life, being oppressed, no income, unemployment, no good jobs... drugs, and all of that” (Davidson et al. 1997). Due to poverty and lack of adequate housing, participants spoke of an elevated exposure to violence. “The worst thing is walking [in the] streets late at night. [You can] get robbed...” (Redding et al. 2017). Said others:

At the same time as I was discharged from treatment I also lost my home and became homeless. I hung in

there for three weeks. From the day I was discharged, I made it for three weeks, and only took illegal methadone, but then it went on to heroin (Svensson and Andersson 2012).

Just walking down the street is a challenge you know because you know, you tend to find, especially in the area that I live you tend to find a lot of people there are on the corners drinking, there’s a lot of people around that area that are either using or have been using psychiatric services. There’s a few erm, houses along the street I live that are dry house for alcoholics and drug addicts so the area is quite a um, colourful mix of people (Redding et al., 2017).

Interpersonal Difficulties

In 8 studies, participants spoke of recurring interpersonal difficulties that they encountered, specifically living in supportive housing units where other tenants had mental health or substance use problems. One individual stated “my neighbours, the one directly opposite me becomes very violent when she doesn’t get her own way and all I was doing was kicking the football and she hit me in the head with the cricket bat” (Duhig et al. 2017). Said another:

On admission I was told that I was a risk to myself and others and my well-being seemed to be everybody’s concern. On leaving, however, nobody thought about how much risk I was at from others, especially my landlord and the neighbors and the police. I live in fear of a knock on the door from someone warning me that I am being observed and suspected of causing a nuisance (Nolan et al. 2011).

Stigma

Five articles discussed the experience of stigma that patients felt as they transitioned from the hospital into the community. One participant stated, “When you tell people you have a mental illness, they think they can catch it like it’s contagious” (Manuel et al. 2012). Others discussed that their experience of stigma was associated with isolation and a lack of engagement with others: “...I feel that, previously, I could have just vanished... nobody would have noticed anything... I think I was invisible” (Skärsäter et al. 2003). Said another:

It was with er, my workplace, as soon as they found out I was schizophrenic, they dropped me like a ton of bricks. Erm, my manager got scared of me, she was scared that I might follow her, which I’d never done before (Redding et al. 2017).

Quantitative Results

Nine quantitative articles were included in the review. The majority of studies utilized a cross-sectional design ($n=8$) and one study used a prospective design. Studies ranged in quality, with the majority of studies at high quality ($n=5$), two of medium quality, and one study being of low quality.

Social Support

A cross-sectional study of 119 patients with schizophrenia by Caton et al. (1985) found that interpersonal stressors, adherence to aftercare treatment, social supports, and lack of transition to community supports were all predictors of readmission. A 10-year follow-up study of hospitalized adolescents by Herrera et al. (1974) found that 67% of participants had insignificant relationships or none at all and no participants were involved with community resources. Participants who had experienced leadership or friendship before hospitalization had better long-term adjustment compared to those who had not. Additionally, parents' positive involvement was necessary for success of adolescents, whereas negative involvement was associated with poorer functioning. These results provide further support for the qualitative themes that were presented, underscoring the importance of social support in the transition from hospital to community.

Proctor, Morrow-Howell, Lee, Gledhill, and Blinne studied 199 older adults (mean age = 76) who were hospitalized for depression and discharged into home settings (2006). The authors analyzed services received by the patients after they were discharged and found that only 27% of individuals reported that after discharge their needs for socialization services were met. In addition, discharged patients were more likely to have their needs met if they were living with others, had more severe mental illness, or poorer physical health.

Engagement in Responsibilities

Hofer et al. (2004) studied the predictors of quality of life of 80 patients with schizophrenia, whose discharge from inpatient care had been at least 6 weeks earlier. These authors found that those who were employed had higher quality of life than those who were unemployed and mental health status (i.e. depression, anxiety) as well as negative feelings toward antipsychotic medication had a negative influence on quality of life. The results of this study show the importance of meaningful activity, echoing the results found in the qualitative analysis. Johnston (2013) studied patients discharged from an inpatient unit in South Africa. They found that those who felt anxious one month after discharge were dissatisfied with their current work situation, including their

performance, maintaining a job, and job availability. Further, several participants in the study wanted more input into their discharge planning and overall results suggest that inpatient services need to manage transitions with outpatient services more effectively. This result parallels the importance of transitional supports that was noted in the previous qualitative analysis.

Olusina and Ohaeri (2003) assessed the quality of life of patients with schizophrenia and major affective disorders from South West Nigeria 2 weeks after discharge. The highest rating of satisfaction was overall subjective quality of life, with 81.8% of scores being positive. The least satisfaction was for financial ability, with only 22.4% of ratings being positive. Patients also had dissatisfaction about dependence on treatment for daily functioning, opportunity for leisure, inadequacy of information for daily life, and sex life. This study provides further evidence for the importance of meaningful activity, relationships, and autonomy for individuals after discharge.

External Stressors

Hodgins et al. (2009) studied community functioning among 181 men with schizophrenia or schizoaffective disorder. An absence of substance abuse was significantly correlated with life functioning. In addition, the absence of substance abuse was negatively associated with social and leisure activities. Lastly, the number of victimizations was positively associated with aggressive behavior and substance abuse, and negatively associated with independent living and occupational functioning.

Wright et al. (2000) investigated the impact of social rejection and stigma following discharge for long-term mental health patients. At 1 year post-discharge, feelings of self-worth were found to increase unless the patient experienced social rejection. Rejection was also found to be associated with lower levels of mastery at 1 year post-discharge. Patients who formed negative feelings of self-worth and mastery after 1 year tended to maintain this negative self-image 2 years post-discharge. The authors state that the impact of new social rejections on client's feelings of self-worth persists over time. Exposure to stigma presents a chronic source of stress for mental health patients as they are discharged from hospital.

Discussion

The qualitative systematic review performed in the present paper provides an in-depth review of the experiences of patients as they transition from inpatient care back into their communities. This review is the first of its kind and provides invaluable information about the need for transitional

interventions for patients with severe mental health conditions. The review combined qualitative and quantitative research in order to fully describe the current state of the literature. Both the qualitative and quantitative studies focused on similar themes and outcomes in illustrating the difficulty faced by individuals as they transition from psychiatric hospital stay back into their communities.

While research on community integration considered broadly has addressed issues that have overlap with those raised in this review, such as discrimination, stigma, and exclusion (Corrigan and Phelan 2004; Mezzina et al. 2006; Prince and Prince 2002), the current review highlights several factors that are specific to the transition from hospital period. This period is of specific interest due to the heightened risks that are associated with the weeks immediately following discharge from hospital (Chung et al. 2017).

A number of themes were found that either led to successful or unsuccessful transition. Participants noted that independence and autonomy were factors that they were striving for throughout the transition and patients wanted autonomy in the discharge process. Conversely, many patients also noted a lack of autonomy and self-efficacy in their ability to cope outside of the hospital. Mental health practitioners and service planners need to take into consideration the autonomy needs of the patient while also balancing the lack of skills that some patients may have. A number of community-based interventions have been developed that support patient autonomy while increasing day-to-day functioning and skills including Cognitive Adaptation Training and the Clubhouse model (Draper et al. 2009; Rouse et al. 2017). These supports may be offered to patients in order to increase self-efficacy while supporting integration back into their communities.

Patients want the opportunity to choose what services and relationships they would like to engage in and the ability to say no if they would rather engage in self-care activities on their own. Recent literature has discussed the lack of recovery-oriented care on inpatient mental health wards, which often leads to a lack of autonomy and self-efficacy for patients (Kidd et al. 2014). Other medical conditions, including diabetes and cardio-vascular conditions, have utilized the concept of patient autonomy, leading to more illness self-management, rather than reliance on providers (Kidd et al. 2014). The present review has highlighted that patients want to be active participants in their illness management and to feel less dependent on the mental health system in their recovery.

Unsuccessful transition was often due to external factors such as poverty, interpersonal difficulties, and stigma. The risks of these external factors were triggered when patients did not have adequate transitional outpatient supports or a significant social network to turn to. The resources they did have often became exhausted, leading patients to turn to

previous coping strategies such as substance use or readmission. Previous research has indicated that those who have more control in their choice of housing have been found to have higher levels of subjective quality of life (Nelson et al. 2007). In the present review it was noted that housing is an important factor for successful transition, but patients also wanted the autonomy to choose their housing units, because for some, supportive housing brought about interpersonal conflict resulting in rehospitalization.

Patients described the lack of social support they received upon leaving the hospital. Although some patients turned to family members for support, many noted a lack of understanding in these relationships. Patients described support groups as helpful, in that they were able to talk about their experiences with people who had gone through similar situations. This theme highlights the importance of peer support in the recovery process for individuals with mental health problems. Recent research has found peer support to be a successful intervention for patients transitioning into the community (Kidd et al. 2016a), and the present review touches on the lack of peer supports currently available to patients. Although social support was highlighted as a vital factor in successful transition, individuals also noted the importance of self-care and taking a break from social interactions. Importantly, social support and peer support interventions need to allow for autonomy and flexibility in their delivery, as some patients may prefer to use independent self-care strategies to support their transition and recovery.

Previous research examining community participation has also suggested that similarity of the community with the individual, such as perceived values and ethnicity, is predictive of engagement in the community (Kidd et al. 2016b; Yanos et al. 2004). Having a peer who has experienced the mental health system may provide an added connection as they transition into a community setting. Importantly, it may be necessary for peers to also be similar to patients in their values and ethnicity in order to fully meet the integration needs of patients.

Participants noted that once external stressors and social support needs were met, a number of normalizing activities were pursued. Patients wanted to engage in day-to-day responsibilities as well as meaningful activity (e.g., employment, volunteer work, hobbies, self-care). Previous research on supported employment has noted the effectiveness of paid and volunteer work in increasing functioning (Bond et al. 2008). Research has also found the importance of engagement in meaningful activities, with the specific type of activity being irrelevant to recovery outcomes (Hendryx et al. 2009). Research has shown that engagement in meaningful activity is particularly important for individuals who lack significant social support (Hendryx et al. 2009). Noted in the present review, some mental health patients may lack the self-efficacy to seek out meaningful activity on their own.

Therefore clinical teams need to provide resources to clients who may benefit from these normalizing activities. Further, it is necessary to respect patient autonomy in the choices about what activities they would like to engage in. It was noted that individuals might also benefit from engaging in self-care activities and rather than coercing discharged clients into specific programming, individuals should be active in the decisions around their care.

Limitations

A number of limitations exist in the present systematic review. First, the review is limited in the number of publications found that span over a period of approximately 40 years. Although this provides an in-depth analysis of experiences of patients, the contextual differences that have occurred post-deinstitutionalization may impact the relevance of the older articles to the state of current mental health practices. In addition, due to the limited number of publications on the experiences of mental health patients, it was not possible to organize patient's experiences by disorder. Future research should also explore the transition experiences of different populations including youth, seniors, and ethnic minorities as these populations were found to be under-studied in the present literature. The number of articles, specifically the number of articles that reported on gender and ethnicity of their participants, also limited the review. The difficulties that patients encounter are exacerbated by ethnic minority status and gender (Chernomas et al. 2000; Kidd et al. 2013). Ethnic minority women in particular face both discrimination and a lack of relevant resources such as housing and health services (Chernomas et al. 2000). Future research needs to examine diverse populations in order to better target services to those who have difficulty accessing care. The systematic review is also limited in that the authors included all articles regardless of their quality. This has been recommended by researchers using qualitative systematic reviews (Thomas and Harden 2008), and due to the limited number of qualitative studies on the present topic, was utilized in order to provide a rich synthesis of the literature. As more research is done in this area, it may be necessary to remove articles of poor quality in order to provide a more concise narrative.

The results of the present review provide insight into the disconnect that occurs for patients as they transition from hospital into their communities. The themes identified have important clinical and policy implications, as novel interventions are developed, in order to lessen the societal burden of rehospitalization and relapse. The present review noted external factors such as poverty, interpersonal conflict, and stigma as ones that can prevent successful transition. Novel transitional interventions, including peer support or community-based programs, are ones that may reduce the negative

experiences of patients during the transition period, as social support and normalizing activities appear to be an important factor in recovery. It should be noted, however, that patients should be allowed to practice autonomy in choosing what activities or supports they would like to access. The present review illuminated the challenges of patients and provided essential information that will inform the development of future transitional interventions.

References

- Bond, G. R., Drake, R. E., & Becker, D. R. (2008). An update on randomized controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal*, 31(4), 280.
- Burns, T., Catty, J., Dash, M., Roberts, C., Lockwood, A., & Marshall, M. (2007). Use of intensive case management to reduce time in hospital in people with severe mental illness: Systematic review and meta-regression. *BMJ*, 335(7615), 336.
- Canadian Institute for Health Information and Statistics Canada. Health Indicators 2011. CIHI, 2011.
- Caton, C. L., Koh, S. P., Fleiss, J. L., Barrow, S., & Goldstein, J. M. (1985). Rehospitalization in chronic schizophrenia. *The Journal of Nervous and Mental Disease*, 173(3), 139–148.
- Chernomas, W. M., Clarke, D. E., & Chisholm, F. A. (2000). Perspectives of women living with schizophrenia. *Psychiatric Services*, 51(12), 1517–1521.
- Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. *JAMA Psychiatry*, 74(7), 694–702.
- Coldwell, C. M., & Bender, W. S. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. *American Journal of Psychiatry*, 164(3), 393–399.
- Connerty, T. J., Roberts, R., & Williams, A. S. (2016). Managing life, motherhood and mental health after discharge from a mother-baby unit: An interpretive phenomenological analysis. *Community Mental Health Journal*, 52(8), 954–963.
- Corrigan, P. W., & Phelan, S. M. (2004). Social support and recovery in people with serious mental illnesses. *Community Mental Health Journal*, 40(6), 513–523.
- Davidson, L., Stayner, D. A., Lambert, S., Smith, P., & Sledge, W. H. (1997). Phenomenological and participatory research on schizophrenia: Recovering the person in theory and practice. *Journal of Social Issues*, 53(4), 767–784.
- De Falco, M. L. (1975). The rehospitalization of discharged schizophrenic patients. *Perspectives in Psychiatric Care*, 13(3), 130–135.
- Draper, M. L., Stutes, D. S., Maples, N. J., & Velligan, D. I. (2009). Cognitive adaptation training for outpatients with schizophrenia. *Journal of Clinical Psychology*, 65(8), 842–853.
- Duhig, M., Gunasekara, I., & Patterson, S. (2017). Understanding readmission to psychiatric hospital in Australia from the service users' perspective: A qualitative study. *Health and Social Care in the Community*, 25(1), 75–82.
- Gerson, L. D., & Rose, L. E. (2012). Needs of persons with serious mental illness following discharge from inpatient treatment: Patient and family views. *Archives of Psychiatric Nursing*, 26(4), 261–271.
- Gibson, R. W., D'Amico, M., Jaffe, L., & Arbesman, M. (2011). Occupational therapy interventions for recovery in the areas of community integration and normative life roles for adults with serious

- mental illness: A systematic review. *American Journal of Occupational Therapy*, 65(3), 247–256.
- Harper, K., Stalker, C., Palmer, S., & Gadbois, S. (2005). Experiences of adults abused as children after discharge from inpatient treatment: Informal social support and self-care practices related to trauma recovery. *Families in Society*, 86(2), 217–225.
- Harper, K., Stalker, C. A., Palmer, S., & Gadbois, S. (2008). Adults traumatized by child abuse: What survivors need from community-based mental health professionals. *Journal of Mental Health*, 17(4), 361–374.
- Hawton, K., Sutton, L., Haw, C., Sinclair, J., & Deeks, J. J. (2005). Schizophrenia and suicide: Systematic review of risk factors. *British Journal of Psychiatry*, 187(1), 9–20.
- Hebblethwaite, S., & Pedlar, A. (2005). Community integration for older adults with mental health issues: Implications for therapeutic recreation. *Therapeutic Recreation Journal*, 39, 4.
- Hendryx, M., Green, C. A., & Perrin, N. A. (2009). Social support, activities, and recovery from serious mental illness: STARS study findings. *The Journal of Behavioral Health Services & Research*, 36(3), 320–329.
- Heron, J., Gilbert, N., Dolman, C., Shah, S., Beare, I., Dearden, S., et al. (2012). Information and support needs during recovery from postpartum psychosis. *Archives of Women's Mental Health*, 15(3), 155–165.
- Herrera, E. G., Lifson, B. G., Hartmann, E., & Solomon, M. H. (1974). A 10-year follow-up of 55 hospitalized adolescents. *American Journal of Psychiatry*, 131(7), 769–774.
- Hodgins, S., Lincoln, T., & Mak, T. (2009). Experiences of victimisation and depression are associated with community functioning among men with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 44(6), 448–457.
- Hofer, A., Kemmler, G., Eder, U., Edlinger, M., Hummer, M., & Fleischhacker, W. W. (2004). Quality of life in schizophrenia: the impact of psychopathology, attitude toward medication, and side effects. *Journal of Clinical Psychiatry*, 65(7), 932–939.
- Hor, K., & Taylor, M. (2010). Suicide and schizophrenia: a systematic review of rates and risk factors. *Journal of Psychopharmacology*, 24(4_suppl), 81–90.
- Johnston, E. R. (2013). A preliminary follow-up study of patients treated at an inpatient psychotherapy unit. *South African Journal of Psychology*, 43(3), 370–378.
- Kidd, S. A., Virdee, G., Krupa, T., Burnham, D., Hemingway, D., Margolin, I., et al. (2013). The role of gender in housing for individuals with severe mental illness: a qualitative study of the Canadian service context. *British Medical Journal Open*, 3(6), e002914.
- Kidd, S. A., McKenzie, K. J., & Virdee, G. (2014). Mental health reform at a systems level: Widening the lens on recovery-oriented care. *The Canadian Journal of Psychiatry*, 59(5), 243–249.
- Kidd, S. A., Frederick, T., Tarasoff, L. A., Virdee, G., Lurie, S., Davidson, L., et al. (2016a). Locating community among people with schizophrenia living in a diverse urban environment. *American Journal of Psychiatric Rehabilitation*, 19(2), 103–121.
- Kidd, S. A., Virdee, G., Mihalakakos, G., McKinney, C., Feingold, L., Collins, A., et al. (2016b). The welcome basket revisited: Testing the feasibility of a brief peer support intervention to facilitate transition from hospital to community. *Psychiatric Rehabilitation Journal*, 39(4), 335.
- Kirby, S. L., & McKenna, K. (1989). *Experience, research, social change: Methods from the margins*. Toronto: Garamond Press.
- Manuel, J. I., Hinterland, K., Conover, S., & Herman, D. B. (2012). “I hope I can make it out there”: Perceptions of women with severe mental illness on the transition from hospital to community. *Community Mental Health Journal*, 48(3), 302–308.
- McIntosh, J., & Worley, N. (1994). Beyond discharge: Telephone follow-up and aftercare. *Journal of Psychosocial Nursing and Mental Health Services*, 32(10), 21–27.
- Mezzina, R., Borg, M., Marin, I., Sells, D., Topor, A., & Davidson, L. (2006). From participation to citizenship: How to regain a role, a status, and a life in the process of recovery. *American Journal of Psychiatric Rehabilitation*, 9, 39–61.
- Mgutshini, T. (2010). Risk factors for psychiatric re-hospitalization: An exploration. *International Journal of Mental Health Nursing*, 19(4), 257–267.
- Miedema, B., & Stoppard, J. M. (1994). I just needed a rest’: Women’s experiences of psychiatric hospitalization. *Feminism & Psychology*, 4(2), 251–260.
- Moher D, Liberati A, Tetzlaff J, Altman DG, Group P. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, 6(7), e1000097.
- Nelson, G., Sylvestre, J., Aubry, T., George, L., & Trainor, J. (2007). Housing choice and control, housing quality, and control over professional support as contributors to the subjective quality of life and community adaptation of people with severe mental illness. *Administration and Policy in Mental Health and Mental Health*, 34(2), 89–100.
- Niimura, J., Tanoue, M., & Nakanishi, M. (2016). Challenges following discharge from acute psychiatric inpatient care in Japan: patients’ perspectives. *Journal of Psychiatric and Mental Health Nursing*, 23(9–10), 576–584.
- Nolan, P., Bradley, E., & Brimblecombe, N. (2011). Disengaging from acute inpatient psychiatric care: A description of service users’ experiences and views. *Journal of Psychiatric and Mental Health Nursing*, 18(4), 359–367.
- Olusina, A. K., & Ohaeri, J. U. (2003). Subjective quality of life of recently discharged Nigerian psychiatric patients. *Social Psychiatry and Psychiatric Epidemiology*, 38(12), 707–714.
- Prince, P., & Prince, C. (2002). Perceived stigma and community integration among clients of assertive community treatment. *Psychiatric Rehabilitation Journal*, 25, 323–331.
- Proctor, E., Morrow-Howell, N., Lee, M. J., Gledhill, J., & Blinne, W. (2006). Quality of care for depressed elders in post-acute care: Variations in needs met through services. *The Journal of Behavioral Health Services & Research*, 33(2), 127–141.
- Redding, A., Maguire, N., Johnson, G., & Maguire, T. (2017). What is the lived experience of being discharged from a psychiatric inpatient stay? *Community Mental Health Journal*, 53(5), 568–577.
- Rouse, J., Mutschler, C., McShane, K., & Habal-Brosek, C. (2017). Qualitative participatory evaluation of a psychosocial rehabilitation program for individuals with severe mental illness. *International Journal of Mental Health*, 1, 1–18.
- Skärsäter, I., Dencker, K., Bergbom, I., Häggström, L., & Fridlund, B. (2003). Women’s conceptions of coping with major depression in daily life: A qualitative, salutogenic approach. *Issues in Mental Health Nursing*, 24(4), 419–439.
- Svensson, B., & Andersson, M. (2012). Involuntary discharge from medication-assisted treatment for people with heroin addiction—patients’ experiences and interpretations. *Nordic Studies on Alcohol and Drugs*, 29(2), 173–193.
- Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8(1), 45.
- Tregoweth, J., Walton, J. A., & Reed, K. (2012). The experiences of people who re-enter the workforce following discharge from a forensic hospital. *Journal of Vocational Rehabilitation*, 37(1), 49–62.
- Vigod, S. N., Kurdyak, P. A., Dennis, C.-L., Leszcz, T., Taylor, V. H., Blumberger, D. M., et al. (2013). Transitional interventions to reduce early psychiatric readmissions in adults: Systematic review. *British Journal of Psychiatry*, 202(3), 187–194.
- Wright, E. R., Gronfein, W. P., & Owens, T. J. (2000). Deinstitutionalization, social rejection, and the self-esteem of former mental patients. *Journal of Health and Social Behavior*, 1, 68–90.

- Yanos, P. T., Barrow, S. M., & Tsemberis, S. (2004). Community integration in the early phase of housing among homeless persons diagnosed with severe mental illness: Successes and challenges. *Community Mental Health Journal, 40*(2), 133–150.
- Yanos, P. T., Felton, B. J., Tsemberis, S., & Frye, V. A. (2007). Exploring the role of housing type, neighborhood characteristics, and lifestyle factors in the community integration of formerly homeless persons diagnosed with mental illness. *Journal of Mental*

Health, 16(6), 703–717. <https://doi.org/10.1080/09638230701496378>.

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