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Discharge planning and post-discharge follow-up care practice in psychiatry department at Jimma Medical Center, Ethiopia

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ABSTRACT

This study has explored discharge planning (DP) and post-discharge follow-up care (PDFC) practice at Jimma Medical Center. The purpose of the study was to understand the practice of DP, PDFC at JMC psychiatry department. The study used a cross-sectional qualitative case study research design with exploratory purpose. Participants were selected purposefully and their size determined based on the principle of data saturation point. Data were collected via in-depth interviews, focus group discussions (FGDs), document review, and observation. Thematic analysis was used for the data analysis. Securing the consent of the participants and reporting in aggregate fashion to conceal participants' identity were some of the techniques for research ethics. The finding revealed poor practice of DP and PDFC in the psychiatry clinic and gaps in having a standard PDFC program such as inadequate human power, absence of health education, inadequate medication and no community based mental health center. In addition, there is no linking strategy between DP and PDFC that exposed clients to experience non-stopping appointments, relapses, and readmissions. The hospital social worker has only very limited role in the process. We suggested interventions including further study to address the issues to come-up with quality services in DP and follow-up care.

KEY TERMS: *case-study, client/discharge-planning, post-discharge, psychiatry, social worker, Ethiopia*

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INTRODUCTION

The purpose of this study was to explore the practice of discharge planning and post-discharge follow-up care in psychiatry department of Jimma Medical Center (JMC), southwest Ethiopia. We employed a cross-sectional qualitative case study research design with exploratory purpose. The participants were selected purposely from the clients and the health providers including the social worker. We collected the data using qualitative data collection techniques and analyzed the data thematically. Trustworthiness of the data was enhanced through triangulation and member checking. Informed consent and reporting the finding in aggregate manner were the strategies to up-hold ethical issues in this study. This article includes background of the study, objectives, methodology, results, discussion, conclusion and recommendations.

BACKGROUND

The global trend on mental health problems shows that more than 300 million people suffer from depression and 260 million suffer from anxiety disorders (WHO, 2017). The proportion of people with mental illness who don't get treatment ranges from 75% in South Africa to more than 90% in Ethiopia and Nigeria (Lund, 2018). For instance, in the Ethiopian case, the prevalence of common mental disorders in Butajira, Addis Ababa and Hadiya district were 17.4%, 11.7%, and 11.2% respectively (Yimam, Kebede and Azale, 2014). These results revealed the need to pay attention to deal with mental health problems. Successful discharge planning has long been identified as the cornerstone of quality inpatient care and an effective transition of individuals from hospitals to their homes. But, there is a problem of allowing time to organize and plan the care and support required for successful restoration at home (Pellet, 2016).

Studies revealed that the transition from hospital to home has been identified as a time of heightened risk, particularly for those with complex healthcare needs (Naylor et al. as cited in Altfeld, 2013). The qualitative study by Bradway et al. (as cited in Altfeld, 2013) has revealed that complex care transitions can often result in readmission. In Ethiopia, the roles of the social workers are insignificant within the hospitals and the understanding of other professionals about social work is poor (Abate, 2014; Temesgen, 2016). And, hospital social work practice doesn't qualify the level of expectations of international standards. Fikreyesus (2014) has conducted a study on the prevalence of relapse and associated factors at Jimma Medical Center, Psychiatry Clinic. And, recognized that 65% of clients suffer from relapse cases and suggested establishing strong follow-up mechanisms on patients to deal with side effects and monitoring their adherence to medication.

Besides the efforts made, the aforementioned studies haven't identified and examined one specialized practice in the health setting where social workers' engagement is needed. For example, the psychiatry department is one of the settings where psychiatric social work is practiced with mentally ill clients. Thus, this current study came up with a new topic: discharge planning and post-discharge follow-up practice for this has not been studied before in the context of Ethiopia and in the study area Jimma in particular.

The general objective of this study was to explore the practice of discharge planning and post-discharge follow-up care at the psychiatry department of JMC. The specific objectives were to (1) explore the practices in the client admission process at the department (2) identify the process of DP practice in the psychiatry department (3) To explore the PDFC practice of the psychiatry department and (4) to identify the challenges in undertaking DP in the psychiatry department.

RESEARCH METHODS

Research design

This study employed a qualitative approach and case study research design to address the objectives of the study. This study was designed under the umbrella of exploratory cross-sectional research design due to the fact that the very nature of exploratory research is extending over the unknown or the phenomenon with we have little knowledge (Creswell, 2007).

Description of the study area

The psychiatry unit is one of the departments situated in JMC with both in and outpatient services with a capacity of 42 beds (retrieved: https://www.ju.edu.et/ -jush). The study area is delimited to this unit. The department had 42 beds for inpatient services. And, it involves different health professionals and caregivers to deal with the cases of the clients.

Study participants selection and size determination

Having obtained ethical clearance from Jimma University postgraduate and research ethical board of the College of Social Sciences and Humanities, the data gathering took place. Therefore, the study participants were health professionals, clients, and caregivers who were on their duties and business at the time of conducting this particular research. The study included both male and female individuals regardless of their backgrounds. However, clients who are not experienced or haven't gone through DP and PDFC practice weren't included in this study. Hence, we have employed non-probability purposive participant selection technique to choose research participants. We used the principle of data saturation point to determine the size of the participants. Consequently, seven key informants, four clients and two FGDs with eight members in each were involved in the study.

Data collection instruments

In-depth interview, key informant interview and FGD guidelines and observation and document review checklists were prepared and utilized as instruments of data collection. The guidelines were prepared and interviews were conducted with local languages: Amharic and Affan Oromo. The interview sessions took fifty minutes to one hour and one and a half-hour long was consumed for the FGDs. Note-taking with pen and notebooks have been undertaken properly.

Data analysis

The analysis is undertaken with thematic analysis of six phases via transcribing, reading, coding, categorizing, looking for patterns and bringing similar themes to produce the final findings (Neuman, 2014). Information from first-hand sources and document review have been converged to enhance the dependability and credibility of the data. Through thoroughly reading on the transcribed data, we found similarities and concepts in line with our study objectives. Enhancing trustworthiness of the data has been secured through triangulation, member checking, and peer debriefing. Consequently, the trustworthiness of the information has been improved via engaging the participants as partners and building trust during data collection time to generate genuine and honest information. Similarly, the consent of research participants has been considered before any attempt to obtain information from them (NASW, 2016, p. 8). For this reason, informed consent statements have been developed containing the following: the purpose of the study, voluntary participation, and the right to quit at any point in data collection time if participants feel discomfort, assurance on the confidentiality of the information and anonymity of the study participants. And this is done through presenting data only in an aggregate fashion as well as via providing pseudo names and codes for the participants during reporting.

FINDINGS OF THE STUDY

The analysis results obtained the main themes and subthemes as follows. Accordingly, related concepts are merged under eight themes and eighteen subthemes as indicated in the following table.

Table 1: Major themes and subthemes of the study findings

Themes	Subthemes
Admission processes	Orientation about the inpatient room Rights and responsibilities Health-related issues
Comprehension aspects	Limited knowledge about discharge planning
Discharge planning execution aspects	Discharge planning interval Focuses of discharge planning
Post-discharge follow-up care practices	Techniques used for PDFC practices
Actors and their roles	Multidisciplinary team
Features and facilities of the Psychiatry Clinic	Features Facilities
Challenges for implementing DP and PDFC aspects	Inadequate PDFC practices Shortage and absence of medication Absence of health education Shortage of human power

The admission processes

The admission process has different aspects that are undertaken among clients, caregivers and healthcare providers. Three subthemes emerged from the field data under the major theme admission process. The subthemes incorporated orientation about the inpatient room, rights and responsibilities of clients, and health-related issues.

Orientation to the inpatient room

Almost all participants and the results from observation and document review asserted that the professionals at the Psychiatry Clinic warmly welcome the clients with caregivers during their visiting times. And, after diagnosing the clients with the specified procedure and criteria they make the decision on the admission of the patients. The professionals use symptoms of emotional disturbance of the clients, attempts of suicide and homicide as criteria for admission. During admission time, no orientation and information is being provided regarding the rules and regulations of the psychiatry clinic, the roles, and responsibilities of the caregivers and direction about how to operate in the clinic as participants affirmed. However, caregivers are directed to be only one caregiver for a client and they were also oriented on the need to communicate health professionals when the needs arise. For instance, the key-informant V said:

> the criteria for inpatient health services at the psychiatry clinic are if the client is unable to control his/her situation, has suicide and homicide attempts and comes with very agitated and blowing mental health problems, and then he or she will be admitted and treated as inpatient client. And, if the discharged patient encountered with relapse of mental health disorder because of different factors, we will readmit him/her.

Rights and responsibilities of clients and caregivers

Through the observations and document reviews, we realized that the clinic simply lets the clients and caregivers know about their rights and responsibilities via posters on the clinic's wall with English, Amharic and Affan Oromo languages. And, except for the information provided during admission time to look after the clients and inform on-duty nurses if the client's situation gets worse, there is no detailed involvement of the caregivers in the helping process. For instance, CGII said: *"No one cares about us as caregivers; concerning the bed and mattress for sleeping on, food and even chairs to sit near to our relatives"*.

Health-related concerns

Participants from FGD I and II acknowledged that the psychiatry clinic was providing psychosocial education for both clients and caregivers during admission in the previous time in the waiting room. Currently, this good experience has not been existent in the psychiatry clinic at all. In addition, they said that sometimes the psychiatry professionals have advised them not to challenge the clients or yell at them following their misconduct since it is the characteristics of the disease. The response from CGIII strengthened the aforementioned notion "*no one care and talk to us as a caregiver and there is no education concerning the mental health problems of our relatives unless we report and seek their help"*. Results from document review and observation also confirmed this point.

Comprehension aspects

Limited knowledge about discharge planning

According to key informant interviewees, professionals lack clarity about the practice of DP in terms of contents and time of implementation. Concerning the knowledge of discharge planning, KII -IV, for example, replied that "*what do you mean by discharge planning?*" and KII- III also reacted for a similar question, "*please, explain the question, 'what do you know about discharge planning?' (He meant he did not understand)".* Therefore, based on the findings from key informants the practice of discharge planning was undertaken by intuition and not based on knowledge and planned procedures.

Discharge planning execution aspects

Discharge planning intervals

The result from key informants, focus group discussion and in-depth interview participants, as well as clinical record review and observation, assured that the discharge planning in the psychiatry clinic begun at the moment of discharge. All participants explained that the concept of discharge planning has begun when the client shows

progress and when they approach to be discharged. For instance, key informants (KII: I, II, and III) stated that if the clients' situation is promising, this medical progress of the patient will be written on the discharge summary chart. Other information such as his/her medication, admission and discharge date, diagnosis and progress, and appointment date will also be recorded.

Focuses on discharge planning

As to the participants, discharge planning focuses on admission of those who fit the disease classification such as suicidal and homicide attempts and highly blowing mental distresses. Advising caregivers, assigning individual nurses, put the client on medication and discharging the clients when they show improvement are the activities of DP. And, KIIs told us that the caregivers have a tremendous contribution to the clients helping process. For example, KII: IV: said that *"the caregivers are our right hands because they are with the clients for twenty-four hours and they have plenty of information concerning the clients' progress"*. KII: V: also explained the follow-up process as follows:

> We follow-up the clients' health situation at the psychiatry clinic with our students and they are allocated to every one of the clients and we do have a morning session from Monday to Friday from 8:30 to 10:00 am to discuss the progress of the clients and suggest a possible solution by senior staffs. On the other hand, seniors, students, nurses, and psychiatrists on their duties will have round for four days every week from 10:00 to 12:00 am.

Post-discharge follow-up care practices

Techniques used for PDFC practices

According to the explanation of all research participants, the major strategy to undertake post-discharge follow-up care practice by the psychiatry clinic is the outpatient follow-up care through an appointment. This can range from fifteen to thirty days depending on the health status of the clients. For instance, in our observation, one of the cold OPD psychiatrists was following-up on a client's case using the following questions. "*Who are you? And looking at the card for confirmation, when was your appointment date? And still watching the card, did you sleep well; eating properly, interact with relatives and friends? Have you experienced any side effects?"* The client was reacting with short responses like "yes" or "no". Finally, the psychiatrist prescribed additional medicine for two months because the client's residence was far away from the hospital. During our observation, the practitioner told us that he provides *"the follow-up care services to the minimum of 35 and a maximum of 80 clients per day."* He also reported that there is "*human power shortage and that of medication to render the maximum service for clients"*.

Actors and their roles

Multidisciplinary team

Study participants revealed the need for the multidisciplinary team to coordinate the healthcare services to clients with a mental health problem. Accordingly, one of the key informants (KII: V) explained that the treatment for mentally ill clients has three components such as medication, occupational therapy, and psychotherapy by the multidisciplinary team. Therefore, psychiatry specialists treat the biological needs of the clients, psychotherapists and clinical psychologists deal with the psychological needs of the clients and the occupational therapists tried to address the social needs of the clients. Hence, the psychiatry clinic has professionals such as psychiatry nurses, clinical nurses, students and instructors from the department, as well as janitors, runners, porters and guards to support the clients with mental health problems.

Features and facilities of the psychiatry clinic

Features and facilities

Based on the observation checklist, we found that the psychiatry clinic is not suitable for clients with mental health problems, caregivers and health services providers. The compound is not comfortable to reside and situate oneself. The waste disposal and deceased body storeroom of the hospital are nearby the clinics which create a distressful condition for clients, caregivers, and healthcare providers. Moreover, the narrowness of the compound and the inadequate services for the clients and caregivers hindered the services in the psychiatry clinic. And, participants have also complained about the problem of hygiene and sanitation of the clinic. One of the FGD participants (PIII)

said: *"my brother had asthma and he has experienced this seasonal disease last time when he was exposed to this bad smell of the toilet and the nearby unhygienic rooms; so it needs attention from responsible bodies of the psychiatry clinic"*.

Challenges for implementing PDFC practices

The participants assured that the inadequate PDFC practice, shortage, and absence of medications, absences of health education and shortage of human power have challenged the appropriate implementation of DP and PDFC practices for mentally ill clients in the clinic. For instance, KII-II explained that "*there is a shortage of human resources like social workers and there is no exclusive social workspace in the hospital*". CGI-II described the shortage and absence of medications by saying "*Because, of its shortage and absences, we are forced to buy from private pharmacies of the town. And, our relatives are forced to take replaceable medicines instead of the required one as a result of the shortage of the medications*". The key informants supported the idea of medication shortage. And, KII-V said that "*we have faced shortage and absence of medications like Divalproex Sodium (Depakote). It seems a miracle when it comes and gets finished at the same day; it just appears and shortly disappears immediately*."

The clinic didn't provide health education for clients and caregivers in its setting. Health service providers and caregivers agreed that of clients need great follow-up and counseling, as to their perception.

DISCUSSION

As the finding pointed out orientating clients and caregivers about the inpatient room, providing an explanation about the rights and responsibilities of clients and illustrating the health-related issues have been performed poorly in the psychiatry clinic during admission time. Beder (2006) explained that newly admitted clients to a psychiatric unit are typically disoriented due to their mental condition. In addition, they may be stressed with a sense of failure, the typical fears anyone experiences when admitted to a hospital, and a persistent sense of anguish over what will happen and what is happening to them. Responses to these issues have, however, been inadequately performed at JMC psychiatry clinic. Hager and Sara (2010) suggested that with shorter lengths of stay, clients and families need to begin the educational process within two to five days after admission so that they would have adequate time to begin to identify barriers and goals for hospital discharge. Bradway et al. (as cited in Altfeld et al., 2013) have identified information gaps and inadequate training for caregivers as key problem areas for clients and caregivers while they are transferred from hospital to home. Similarly, proper health education is not provided in the JMC's psychiatric clinic except for the irregular pieces of advice.

Comprehension aspects: as the finding of this study illustrated, all participants are confused about the concept of discharge planning. It has been understood as an activity that is undertaken at the point where the client shows improvement and approaches to be discharged from the hospital. And, others have requested for further explanation about discharge planning while they have been asked to state their understanding. But, stated the general rule is that discharge planning starts on admission (Pellett, 2016; Masumeh et al., 2018) to a health service though this is not usually what happens. The focuses of discharge planning: Yem et al. (2012) and Pellet (2016) stated that to mitigate preventable hospital readmissions, successful DP and appropriate post-discharge support care are major issues. Contrarily, the poor practice of DP and PDFC in the clinic can expose clients and caregivers for relapse and readmission. In our finding KIIs confirmed that DP is undertaken after symptoms are controlled and the client recovers his/her insight (when the clients have understood their situation). Hence, the current finding is incongruent with the aforementioned authors' illustrations. As Hager and Sara (2010, p. 92) stated *"post-discharge telephone follow-up allows clients to ask questions and to review any issues they may have regarding recommended treatments and restrictions"* however, JMC psychiatry clinic has no such programs of a home visit and phone call to look after the clients and caregivers' concerns. To make the recovery effective the client's families or guardians should be included under the services provided by the social work unit of the hospital as indicated in the Ethiopian standard for hospitals (Ethiopian Standard Agency, 2012). But, the clinic and the hospital have no qualified social worker to deal with such needs and to conduct client system assessment. PDFC practice is undertaken soon after the clients are discharged from hospital to home with home visit and phone call follow-up strategies by nurses or social workers according to the care transitional model's illustration (Carol et al., 2013). But, the finding from this study shows that PDFC is limited within the hospital (psychiatry clinic) by just giving discharge summary, medication, advice and appointment card without a home visit and phone call. And, the finding is not in harmony with the standards and requirements of PDFC.

Moreover, the coaching model facilitates new behaviors and communication skills, so that the client and family will know how to respond to common problems, which might arise during, and following transitions (Carol et al., 2013). The policies and procedures concerning the social work services shall address the following areas: counseling, discharge management and planning, social work assessment consultation and referral to support

groups, centers and/or organizations, client advocacy, community liaison and education (Ethiopian Standard Agency, 2012). But, this study indicates that the hospital's social worker's role is delimited to facilitate free medication, transportation and linking abandoned infants to NGOs in the locality. And, we have identified that the practices in the psychiatry clinic are not up to the requirements of the policy and the standards crafted for general hospitals of Ethiopia.

CONCLUSIONS OF THE STUDY

- The activities that should be in place during admission are practiced poorly in the psychiatry clinic with a simple focus on detecting the symptoms and suppression as well as looking for clients' insight about their situation.
- We understood that the professionals, clients, and caregivers had an unclear picture concerning discharge planning. They missed to acknowledge that discharge planning practice begins as soon as the client is admitted.
- The psychiatry clinic has no post-discharge follow-up care practice strategies except for the appointment and examining the progress and improvements clients demonstrate after discharge during appointment date at cold OPD.
- The psychiatry clinic is challenged with absences of PDFC program, human power shortage, absence of consistent health education, and resources to run the program. Hence, addressing them is crucial

RECOMMENDATIONS

Based on the findings of the study, we have recommended the following issues to be considered by concerned bodies.

a) The department of psychiatry at JMC has to advocate for the foundation of a vibrant hospital social work department and/or a specific psychiatric social work unit at the department in order to provide the necessary discharge planning and post-discharge follow-up care services to the clients.
b) Enriching the knowledge of health professionals at the psychiatry clinic of JMC regarding social workers and their contribution to the hospital in general and in the psychiatry clinic particularly may have a great contribution to improving the services. Moreover, arranging trainings for them concerning DP and PDFC practices can improve their knowledge level and hence can fill current gaps.
c) Similarly, provision of consistent and continuous health education for clients and caregivers at the waiting room has to be in place so as to mitigate the current knowledge gaps of the caregivers and clients about mental health problems.
d) The School of Social Work at Jimma University should have to aggressively work to use the psychiatry clinic as one of the destinations of its students for practicum courses. It has to also mobilize its instructors to integrate lessons from field education reports in to courses such as psychiatric social work, health social work, and counseling in social work.

CONCLUSION

Mental health problem is increasing alarmingly in the world and one of the cases to be considered in African context in general and in Ethiopia in particular. Though many studies have been undertaken at global, continental and local levels and states take the necessary measures, still mental health needs the attention of concerned bodies. This study suggested issues to address problems in mental health service provisions that should be considered by policy makers. Accordingly, social workers are the main actors to deal with those clients who have mental health problem and to run discharge planning and post-discharge follow-up care practice. It is the social workers' role to help clients recover from their mental health problem. Based on the outcome of this study, we can say that for clients' recovery well planned discharge and post-hospitalization follow-up care practices are essential. And, social workers should be there from the inception of the clients' case to their progress and recovery at their home environment.

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