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Improving discharge planning from acute inpatient mental health care settings: a realist review

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Abstract

Objectives

Discharge from acute inpatient mental health care is a known time of high risk, with elevated rates of suicide and readmission. Person-centred, collaborative approaches to discharge planning are recommended. However, these have received limited attention and there is little understanding about how to achieve this in practice. The dynamic interplay of personal, service and system factors impact when, how and if discharge planning with service users occurs. This review aimed to understand how and in what way discharge can be improved.

Method

A realist review was conducted across three iterative steps in collaboration with ten lived experience and five professional stakeholders to; 1) develop initial theories, 2) identify evidence, and 3) refine theories through analysis and synthesis. Documents reporting experiences of service users and staff and interventions related to discharge planning within adult acute inpatient mental health care settings were included. Data were extracted and analysed using realist logic.

Results

Evidence from 77 documents and discussions with ten people with lived experience and four staff refined initial theorising to five programme theories for how discharge planning worked and for whom. These theories, set out as context-mechanism-outcome configurations, defined relationships between factors across macro, meso and micro system levels. Macro level factors, such as ongoing lack of investment in mental healthcare, stigmatising social narratives about mental illness and organisational priorities on containing risk were found to reinforce meso level practices; entrenching risk-averse cultures and staff fears they would be blamed for poor discharge outcomes. Consequently, micro level relational care was impacted, inhibiting discharge planning with service users.

Conclusions

This review highlights how discharge planning occurs in acute inpatient mental health care settings. Drawing together evidence from across system levels demonstrated the necessity for a system-wide approach to designing interventions if person-centred, collaborative discharge planning is to be achieved.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- This realist review was guided by a systems engineering approach to programme theory development to explain how relationships between macro, meso and micro level factors influenced discharge planning and with what outcomes.
- We collaborated with experts with lived experience and clinical stakeholders to test the credibility of the assumptions of evolving programme theories.
- Despite longstanding inequalities in mental health services, there was limited evidence of how ethnicity intersected with the experience of discharge from mental health settings, potentially meaning an overrepresentation of the experiences of particular groups.

INTRODUCTION

Discharge from acute inpatient mental health care is a known time of high risk, with elevated rates of suicide and readmission in the initial weeks following discharge (1-3). Health system and service level factors, such as how continuity of care is organised and the availability of community support and resources required by the person, are known to contribute to variations in discharge outcomes (4, 5). For service users (see box 1), the challenges of accessing adequate support from mental health services can be coupled with feeling overwhelmed at managing mental health symptoms and returning to roles and day-to-day pressures of life (6). Discharge from acute inpatient mental health care settings often happen without sufficient preparation with limited involvement of the person being discharged or their supporters (see box 1 for definition). This can create or exacerbate negative outcomes (7). Discharge planning and preparation that is collaborative and person-centred is recommended in public policy and guidance (8, 9) but what this means in practice and how it is achieved is unclear.

Discharge planning is a process that takes place in acute inpatient mental health care settings, ideally between service users, supporters and a multi-disciplinary team. This process can set out components important for service users continued recovery following discharge, such as how people might continue their recovery with involvement from community mental health teams. However, there has been limited

attention about how discharge planning processes can be improved within the constraints of the ward. Discharge processes are impacted by ward characteristics and cultures and influenced by wider systemic factors (10). The complex interactions of factors operating across personal, interpersonal and service level have implications for how, when and with whom discharge planning is undertaken. Interventions to support discharge planning have often focused on supporting service users and their supporters to prepare for discharge (e.g. psychoeducational approaches) or relational components (e.g. peer support interventions to facilitate shared decision making and planning) (11). Consequently, wider consideration of the systemic issues is rare.

The decision to discharge from mental health wards is often led by mental health professionals. Timing is determined not only by the judgement of a person's readiness for discharge, but is also due to system pressures such as the need to free beds for other service users. Even when there is not an explicit need for beds, the lack of collaborative planning with service users and their supporters often results in a process that is disorientating and happens 'to' people rather than 'with' them (12). This can reinforce feelings of powerlessness and a lack of agency in the process. As a result, the experience for service users and their supporters is often that discharge is unexpected, unplanned and overwhelming. The complexity involved with discharge planning and preparation, particularly when considering factors operating at different levels, e.g. service user, staff and service/systems level, require consideration when developing interventions that are effective and balanced to meet the needs of the service user, staff and system (13). Contextual factors, such as limited resources, aversion to risk, and established ward practices, constrain the choices and actions of both those delivering and accessing interventions. These interactions can offer a useful explanation for the variations in outcomes and a foundation for complex intervention development. Realist research approaches are used to explain what works for whom in what circumstances and have been used in combination with systems approaches to understand factors operating at different levels of the system (14). This realist review built initial programme theories from existing literature and the iterative integration of stakeholder collaboration. These theories provided the foundation for a realist evaluation of current discharge planning and co-production of a systemic discharge intervention (in preparation). The review aimed to explain the factors impacting discharge planning and the active components for person-centred, collaborative discharge planning in acute mental health settings. The review asked 'What does the evidence suggest 'works', in terms of the key outcomes of and staff?'

Box 1: Terminology

We recognise there are multiple accepted ways to refer to people who have experienced admissions to acute inpatient mental health care settings and the people who are part of their non-professional support network. In line with the preferences and perspectives of authors and our advisory groups, the following terms are used throughout. 'Service users' refers to people who have been admitted to acute inpatient mental health care settings. 'Supporters' is used to refer to people that are significant within a service user's support network and may be involved in the discharge planning process. The terms 'mental health', 'mental illness' and mental distress' reflect their use in the literature.

METHODS

Realist reviews are theory-driven approaches to evidence synthesis that seek to explain how and why complex interventions work, or not, in different contexts and through which mechanisms (15). Discharge planning is a complex intervention undertaken with and by multiple stakeholders in a variety of ward settings and in different ways. We undertook a realist review (Prospero registration: CRD42021293255) with stakeholder collaboration guided by the Engineering Better Care framework (16). This framework brings together the perspectives of the People, Systems, Design and Risk across micro, meso and macro levels to support healthcare design and improvement (table 1). Firstly, the framework was used to define the system of interest with the MINDS project team which informed the scope of the review. This system of interest was revisited throughout the review to guide inclusion and exclusion criteria. It was agreed to focus on mental health ward practices and processes of mental health wards that could be modified through interventions delivered within the inpatient environment. These were considered in relation to external factors, such as policy drivers, and outcomes relevant to service users and their supporters beyond the inpatient environment. In this way, Engineering Better Care was used to explore the interdependencies of policy and operational pressures on ward processes and subsequent impact on service users and staff.

Table 1: Four perspectives of the Engineering Better Care framework

Perspective	Explanation
People	How people interact at personal, group and organisational levels
Systems	Understanding the complex interconnection of technical and social factors
Design	Improvements through identification of the 'right; problem to solve and how
Risk	Identifying risk to change, with management and mitigations planned for

Co-production of programme theories across the stages of the review

The study's Lived Experience Advisory Group (LEAG) were involved throughout programme theory development. Members of the LEAG were recruited via invitations circulated through personal and professional networks. Ten members supported the refinement of programme theories across three meetings. Two people provided additional, individual feedback. Four staff stakeholders representing psychiatrists, mental health nurses and ward managers, were recruited for consultation via professional networks. They provided comment and reflection on the evolving programme theories in one-to-one discussions with a member of the review team. Notes from discussions relating to agreement, disagreement or expansion of programme theories were recorded and used by the review team to revisit earlier understandings and adapt explanations. These discussions supported refinement and uncovered key contextual factors, mechanisms, and outcomes not identified in the literature. Both groups' contributions to programme theories are acknowledged below with reference to 'lived-experience stakeholders' or 'staff stakeholders'. Ethical approval was not required for this realist review as stakeholder engagement involved feedback on evolving programme theories and did not collect identifiable or sensitive data.

Stages of the review

The review was undertaken in three iterative cycles of searches, selection and analysis with embedded stakeholder consultation across each stage. Searches were conducted between January 2022 and August 2022 and updated to April 2026. *Stage one* focused on initial programme theory development, *stage two* identified evidence to test programme theories, and *stage three* refined programme theories. Programme theory development up to September 2022 informed the design of a realist evaluation of discharge planning in inpatient mental health wards. Additional programme theory refinement was undertaken to April 2026 for the purposes of publication.

Stage one: Development of initial programme theories

In stage one, we developed a series of initial programme theories related to discharge from inpatient mental health settings through discussions with the project team, lived experience and staff stakeholders and from theories identified in the literature. Initial programme theories deliberately sought factors operating across system levels (personal to organisational and policy level) to develop a comprehensive understanding of what discharge planning and processes could be improved and how.

Firstly, key papers that focused on interventions delivered in inpatient mental health wards and the range of experiences of the inpatient environment were identified from two systematic reviews (11, 17). Additional searches were undertaken in MEDLINE, CINAHL, EMBASE and Scopus using an approach to theory searching (18). These searches identified existing theories or ideas for collaborative, person-centred discharge planning processes that were articulated, for example, as logic models or explicit author explanations.

Twenty-four articles were selected and components suggestive of programme theories were extracted by eight members of the review team (MH, CH, LG, AS, CW, HZ, EK, SR). Some members live with severe mental illness (a term used to refer to experience of psychosis, bipolar disorder and either major depression with psychotic symptoms or treatment-resistant depression) and have experience of discharge from inpatient mental health care and brought these perspectives to discussions. Articles were annotated and initial programme theories recorded in tables as if... then… because statements. These were debated in team meetings and with lived experience and staff stakeholders to identify gaps and alternative explanations. Seventeen statements were reviewed, grouped and merged into eight initial programme theories that informed searches, data extraction and analysis in stage two.

Stage two: Identification of evidence to test initial programme theories

Searches

In stage two, systematic searches of evidence were conducted for evidence to test and refine the eight initial programme theories articulated in stage one. The focus of the review was to explain how the inpatient experience impacted discharge planning for service users, their supporters and staff and whether interventions delivered through the ward improved discharge planning outcomes and how. Searches conducted in stage one were iteratively supplemented with additional searches based on concepts from the initial programme theories (supplementary file 1). Electronic databases (PsycARTICLES, MEDLINE, CINAHL, EMBASE, HMIC, IBSS, Cochrane Library Trials, ASSIA, Web of Science and Scopus), Google Scholar and grey literature searches were completed. There were no restrictions on publication period. Lateral search techniques were employed through exploration of citations and bibliographies of included papers.

Selection

Papers were assessed for levels of relevance and classified as 'core content' (i.e. directly related to discharge) or 'generic content' (i.e. related to mental health inpatient environments) to assist prioritisation and manage the volume of evidence. Only papers published in English were included. Papers post 2005 were prioritised reflecting changes in mental health care policy (19) and relevance to current practice. International studies were included where evidence was judged to be transferrable to the UK context.

Search results were uploaded into Rayyan software (20) for screening. Title and abstract and full-text screening were completed by one member of the review team with the first 20% double screened by another member of the review team to check for consistency (MH, CH or CW). Disagreements were discussed and resolved by referring to the inclusion and exclusion criteria with another member of the review team.

The main inclusion criteria were:

- Theories and findings related to acute adult inpatient mental health care.
- Studies with evidence on the experiences and outcomes for service users, staff and significant supporters involved in the discharge process.
- Any type of study design related to discharge.

Documents were excluded if they reported:

- People under the age of 18 or only focused on older adult populations
- People receiving inpatient treatment solely due to learning difficulties, traumatic brain injury, substance use or eating disorders.
- Discharge from non-mental health (e.g. physical health) or community mental health services.
- Discharge from specialist forensic services and perinatal mental health units.
- Not published in English.

As the review continued, decisions for inclusion were revisited and revised to exclude discharge interventions that were administered only in the community. Discharge interventions delivered by the inpatient team that bridged ward and community locations were included if there was sufficient evidence relating to the role and/or impact of ward involvement.

Papers were assessed on their capacity to contribute to programme theory development and refinement. Judgements were iterative and revisited throughout the review process.

Data extraction and appraisal of documents

Data were extracted from included full-texts by four reviewers (AS, CW, MH, LG) as a two-stage process. Excel was used to record study citation information; settings; population and participant demographics; methodology; and information for assessment of quality. Full-text documents were uploaded into NVivo 13 (2020, R1) and coded both deductively (i.e. to the initial programme theories) and inductively (from data). Retroductive reasoning was used throughout to allow for continual realist theory building. Memo functions were used to record developments in understanding and changes to programme theories (21).

Individual studies were assessed based on: i) whether they contained data that were judged to be of both topic and theoretical relevance, ii) whether there was sufficient conceptual richness or contextual thickness for sources to meaningfully contribute to theory building, and iii) whether, by considering the trustworthiness of the evidence source and the coherence of the programme theories, data pertained to realist standards of rigour (22, 23).

Stage three: Refinement of programme theories: analysis and synthesis

Analysis and synthesis were led by MH, working closely with a core review team that included researchers with lived experience (CW, SR, HZ, EK, CH, LG, SD, AS) to debate the plausibility and credibility of developing programme theories. A realist logic of analysis that utilised retroductive reasoning was employed to code dyads and triads of context, mechanism and outcome (24, 25). Substantive theory identification and assessment took place throughout theory development and analysis to strengthen causal explanations. Two researchers (AS, CW) reviewed and distilled suggested theories for core concepts and adjudicated their potential to contribute to evolving programme theories.

As analysis progressed, mechanisms were subdivided into resources and reasoning in accordance with their conceptualisation in Pawson and Tilley's original work (26, 27). Analysis was regularly shared with the wider research team and the LEAG to ensure interpretations

resonated with experiences and resulted programme theories were credible. To support discussion of the developing programme theories with LEAG members, pen portraits were developed to offer 'real-world' illustrations of the evidence (28) (supplementary file 2). A narrative synthesis of findings was developed to assess the extent to which evidence supported the causal explanations within eight programme theories. This prompted further analysis which reconceptualised evidence in terms of contextual factors operating at different system levels and informed five refined programme theories. These theories articulated how key contexts and mechanisms relating to risk, uncertainty and expression of needs impacted discharge planning outcomes. Reporting followed RAMESES I quality and reporting standards (23). In line with standards for involving people with lived experiences and professionals as consultants in research (29), ethical approval was not required for this review.

FINDINGS

Findings are presented to show the evolution of the programme theories.

Stage 1: Development of initial programme theories

A total of 24 papers contributed to the development of 17 initial programme theories, across system levels (tables 2 and 3). Macro level theories (i.e. system and societal factors(1 - 4)) were: the influence of policies on discharge planning; system demands and priorities driving discharge decisions; perceptions of mental illness; whose knowledge is valued. Meso level theories (i.e. factors operating at service level (5-11)) were: tensions for what is valued as 'real work'; staff supervision to manage their working environment; structure and routines impacting when discharge needs are discussed; activities that prepare service users for leaving the ward; gradual return to community life; access to information; practices for capturing information to inform discharge. Micro level theories (i.e. factors at personal and interpersonal level (12-17)) were: coping with everyday activities and responsibilities; the role of peer support in discharge planning; building relationships while on the ward; increasing service user and supporter capacity to cope with discharge; the role of stigma in relationships; power in care planning (table 2).

Table 2: Initial programme theories by system level

#	Title	If… then… because
Macro level		
1	**Discharge procedures are formalised as standard practice**	IF trust policies set out requirements for notice periods of discharge, THEN this may prevent unplanned, sudden discharge BECAUSE there are standards are used to monitor quality through documented care
2	**Systemic / practical demands and priorities driving discharge decisions**	IF system demands and priorities drive the discharge process THEN service users are likely to experience a disorganised discharged with limited involvement BECAUSE staff consider service users' involvement will not influence discharge
3	**Perceptions of a 'worthy' service user affecting staff engagement with discharge discussions**	IF service users do not 'fit' medical/societal concepts of mental illness THEN they are likely to have poor experiences of discharge BECAUSE staff feel their admission is inappropriate.
4	**Whose knowledge is valued in discharge decision-making**	IF Staff exclude service users from decision making THEN service users will feel discharge has been 'done to them' BECAUSE their knowledge and opinions have not been valued
Meso level		
5	**Tensions between what staff and organisations value as 'real work'**	IF quality care is measured by target driven tasks THEN staff will make pragmatic decisions for what work they prioritise BECAUSE they feel that time getting to know service users is not valued. much as measurable, target driven tasks
6	**Regular supervision providing a space to work through secondary trauma**	IF Regular, protected clinical supervision is available and attended by staff to explore and reflect on their day-to-day experiences THEN they will be more effective in their work with service users BECAUSE they have considered and practised strategies for coping with secondary trauma
7	**The structure and routines of hospital impacting concerns for discharge**	IF service users adapt to and rely upon the hospital structure and routine of hospital life THEN they may feel anxious at the thought discharge BECAUSE they feel safe and/or have become used someone else taking responsibility.
8	**Preparation and developing skills as an opportunity to keep connected to life in the community**	IF Service users are supported to carry on with everyday tasks and activities during their admission THEN service users are less likely to feel 'shocked' by discharge BECAUSE they have retained their sense of self and self-efficacy.
9	**Gradual transitions to reduce anxiety for returning to the community**	If Discharge is undertaken gradually and prepares people for going back to their roles and their networks in the community THEN service users will be less anxious about returning to the community BECAUSE they have had the opportunity to trial returning to their roles and responsibilities
10	**Accessible, transparent information supports service users' to be involved in discharge planning**	IF service users and their supporters have information about their care and mental health THEN they are more likely to be actively involved in decisions BECAUSE they understand the reasons for and limits of plan.
11	**Capturing useful and timely information to inform an integrated approach to discharge**	IF ward processes are organised to consider discharge from the point of admission THEN discharge might be better managed BECAUSE there is an expectation to collect relevant and meaningful information throughout a service user's stay
Micro level		

12	**Coping with difficulties**	IF service users struggle to understand factors that cause them distress, THEN they may rely on past strategies avoid intense, uncomfortable, or negative feelings BECAUSE they have not been adequately equipped to cope with discharge
13	**Peer support and connection to build trusting relationships for discharge**	IF There are opportunities to access peer support as part of discharge planning THEN service users are likely to view discharge more positively BECAUSE they believe that recovery is possible.
14	**The impact of relationships with other people on the ward**	IF service users develop strong relationships with others during their stay THEN they might view discharge negatively BECAUSE they feel they will lose this support.
15	**Exploring self-management strategies and ways of dealing with challenging situations**	IF Service users and their supporters develop positive techniques for dealing with challenging situations THEN they may avoid severe distress that could lead to readmission BECAUSE they have a better understanding of how to live with their mental illness.
16	**Stigma and burden inhibiting collaborative discharge planning**	IF service users feel stigmatised by their mental illness and hospital admission THEN they might be less likely to involve people they know in discharge planning BECAUSE they feel shame and a sense of being a burden.
17	**Engaging with care plans to maintain a level of control in care and avoid involuntary admissions**	IF service users worry that non-compliance with care plans will lead to an involuntary admission THEN they will follow plans BECAUSE they fear losing control over aspects of their care.

Table 3: Studies contributing to initial programme theories

Author (year) *country*	Aim	Study design (methods)	Participants	Number of organisations / wards	Intervention / non-intervention study	Discharge or general focus
Ådnanes, M., et al (2020). *Europe (Austria, Finland, Italy, Norway, Romania, Slovenia)*	To explore mental health rehospitalisation from a service-user perspective, paying attention to how rehospitalisation can be avoided.	Qualitative (focus groups)	55 Service Users Female (33), Male (22) Diagnosis: Psychotic disorder (23), Depression (12), Bipolar (21), Anxiety (7), Other (11)	Mental health organisations in each country not specified	Non-intervention	General, including discussion of discharge
Birken, M., & Harper, S. (2017). *UK*	To explore the experiences of people with a personality or mood disorder regarding carrying out everyday activities following discharge from hospital	Qualitative (Interviews)	16 service users Female (11) male (5) White British (14) Black British (1) British Asian (1) Diagnosis: personality disorder (7), mood disorder (7), both personality and mood disorder (2) Previous admissions . one (4), more than two (12)	1 mental health trust	Non-intervention	Discharge
Clarke, D., & Winsor, J. (2010). *Canada*	To examine the impact of a young person's first hospitalization on his or her parents and to determine the parents' perspectives on their own emotional and practical support needs.	Qualitative (Interviews)	10 Family supporters (parents) Female (9) male (1) Age: 40 – 49 (5) 50 – 59 (5) Service user diagnoses (psychotic illness and major depression)	1 support group	Non-intervention	General
Crawford, M. J. (2004). *UK*	Discussion paper on reasons for risk of suicide post discharge.	Discussion paper	n/a	n/a	Non-intervention	Discharge
Cutcliffe, J., Links, P., Harder, H., Bergmans, Y., Balderson, K., Eynan, R., Ambreen, M., & Neibaum, R. (2012). *Canada*	To understand the experience of being discharged after being at risk for suicide	Qualitative (phenomenology, interview)	20 service users Female (10), Male (10) White (13), Black (1), Other (6) Diagnosis (Bipolar or Major Depression (7), Bipolar or Major Depression and borderline personality disorder (8), Bipolar or Major Depression and	Unclear	Non-intervention	Discharge

Author (year) *country*	Aim	Study design (methods)	Participants	Number of organisations / wards	Intervention / non-intervention study	Discharge or general focus
			schizophrenic disorder (1), Other (4)			
Cutcliffe, J. R., Links, P. S., Harder, H. G., Balderson, K., Bergmans, Y., Eynan, R., Ambreen, M., & Nisenbaum, R. (2012). (associated paper with above) *Canada*	To understand the experience of being discharged after being at risk for suicide	Qualitative (phenomenology, interview)	20 service users Female (10), Male (10) White (13), Black (1), Other (6) Diagnosis (Bipolar or Major Depression (7), Bipolar or Major Depression and borderline personality disorder (8), Bipolar or Major Depression and schizophrenic disorder (1), Other (4)	Unclear	Non-intervention	Discharge
Desplenter, F. A., Laekeman, G. J., Group, G. R., & Simoens, S. R. (2011). *Belgium*	To explore how patients evolved after hospital discharge and to identify factors influencing this evolution.	Mixed methods (quasi-experimental longitudinal design Questionnaires, researcher diaries)	99 Service Users Female (62) Male (37) Mean Age 46.1 (SD 11.1) Previous admissions 2 (1 – 3)	11 mental health hospitals	Intervention	Discharge
Everall et al. (2019) *Various*	To summarise the literature on patient and caregiver experiences with delayed hospital discharge	Qualitative (scoping review)	n/a	n/a	Non-intervention	Discharge
Gerson, L. D., & Rose, L. E. (2012) *USA*	To explore illness-related needs, coping, satisfaction with care, and social support of persons with SMI and their families post discharge.	Mixed methods (Pilot study Interviews, questionnaires)	!0 Service Users Female (4) Male (6) Age range 23 – 81 African American (10) Schizophrenia (5), Bipolar (3), Depression (2)	1 mental health hospital	Non-intervention	Discharge
Giacco, D., Dirik, A., Kaselionyte, J., & Priebe, S. (2017). *UK*	To explore views of staff and patients and carers with recent experience of inpatient mental health care on how to improve carer involvement in inpatient care.	Qualitative (Focus groups)	86 Total 31 Service users 22 Family supporters 33 Staff	1 mental health trust	Non-intervention	General
Hasson-Ohayon, I., Lerer, G., Tuval-Mashiach, R., Shamir, E., & Roe, D. (2016).	To understand the transition phase from mental health hospitalization back to the community,	Qualitative (Interviews)	15 Service users Female (3), male (12)	1 mental health rehabilitation agency and one outpatient unit	Non-intervention	Discharge

Author (year) *country*	Aim	Study design (methods)	Participants	Number of organisations / wards	Intervention / non-intervention study	Discharge or general focus
Israel			Age 45 (range 26-64) Diagnosis: schizophrenia			
Isobel, S. (2019). *Australia*	To gather voluntary and involuntary service users' experiences of care during hospitalization in two acute adult mental health inpatient units.	Mixed methods (Survey/interview)	67 Service users	1 service, 2 inpatient units	Non-intervention	General
Jansen, T.-L., Hem, M. H., Dambolt, L. J., & Hanssen, I. (2020). *Norway*	To explore the sources and features of moral distress as experienced by acute mental health care nurse	Qualitative (Interviews)	16 Mental health nurses Female (13) Male (3)	2 mental health hospitals	Non-intervention	General
Keogh, B., Callaghan, P., & Higgins, A. (2015). *Republic of Ireland*	To develop a grounded theory that explored service users' experiences of going home from hospital.	Qualitative (Grounded theory, interviews)	31 Service users Female (13) male (18) Age 45 (range 25 – 63) One previous admission (7), 2 – 33 (24)	1 area, (Community mental health services and voluntary organisations)	Non-intervention	Discharge
Manuel, J. I., Hinterland, K., Conover, S., & Herman, D. B. (2012). *USA*	To explores the experience of women with severe mental illness in transition from mental health hospital care to the community.	Qualitative (focus groups)	25 Service users Female (25)	2 mental health hospitals	Non-intervention	Discharge
McGuinness, D., Dowling, M., & Trimble, T. (2013). *Republic of Ireland*	To gain an understanding of what it means to have an involuntary hospital admission.	Qualitative (Interview)	6 Service users Female (4), male (2) Age (range 22 – 66)	1 mental health centre	Non-intervention	General
Nolan, P., Bradley, E., & Brimblecombe, N. (2011). *UK*	To explore service users' expectations and experiences of acute inpatient care and the early post-discharge period.	Qualitative (Interviews)	44 Service users Female (26), Male (18)	1 Mental health trust, 4 acute wards	Non-intervention	General, including discussion of discharge
Owen-Smith, A., Bennewith, O., Donovan, J., Evans, J., Hawton, K., Kapur, N., O'Connor, S., & Gunnell, D. (2014). *UK*	To investigate the lived experience of mental health discharge and explore service users' experiences following discharge.	Qualitative (interviews)	10 Service users Female (8), Male (2) White (9), Other (1) Diagnosis: Personality disorder (PD) (4), Psychotic (2),	2 mental health hospitals, 5 wards	Non-intervention	Discharge

Author (year) *country*	Aim	Study design (methods)	Participants	Number of organisations / wards	Intervention / non-intervention study	Discharge or general focus
			Bipolar (1), Depression + PD (1), Psychosis + PD (1), Schizophrenia (1)			
Redding, A., Maguire, N., Johnson, G., & Maguire, T. (2017). *UK*	To understand the lived experience of being discharged from a mental health unit.	Qualitative (Phenomenology, Interview)	8 service users Female (5), Male (3) White British (7), White Irish (1) Diagnosis: Personality disorder (2), Schizophrenia (3), Depression (1), Depression + PD (1), Adjustment disorder + anxiety (1)	3 community mental health teams	Non-intervention	Discharge
Rezaie, L., & Phillips, D. (2020). *Iran*	To determine the unique post-discharge needs of Iranian women diagnosed with severe mental illness.	Qualitative (Focus groups)	42 Service users Female (42) Diagnosis: Schizophrenia (10), Schizoaffective disorder (12), Bipolar (11), Depression (9) Age 40 (SD = 6.3)	1 mental health hospital, 2 wards	Non-intervention	Discharge
Simpson, A., Bowers, L., Alexander, J., Ridley, C., & Warren, J. (2005). *UK*	To explore relations between occupational therapists and other members of the multidisciplinary team	Qualitative (Interviews)	47 Staff Occupational therapists (11), Ward managers (13), Senior mental health nurses (14), Consultant psychiatrists (9)	1 Trust, 14 wards	Non-intervention	General
Tyler, N., Wright, N., Panagioti, M., Grundy, A., & Waring, J. (2021). *Various*	To investigate perceptions of safety in mental health transitions (hospital to community)	Mixed methods (Questionnaire)	93 Total 27 Service users 17 Family carers 39 Health care professionals 15 end users of research (policy, commissioners, charity workers) 37 Researchers	12 Countries (not reported)	Non-intervention	Discharge
Velligan, D. I., Roberts, D. L., Sierra, C., Fredrick, M. M., & Roach, M. J. (2016) *USA*	To explore views and experiences of transition between hospital and community services.	Qualitative (Focus groups)	10 Service users 8 Family supporters	Unclear	Non-intervention	Discharge
Wright, N., Rowley, E., Chopra, A.,	To explore the nature of service user involvement in	Qualitative (Focus groups)	52 total (included service users and health care	1 mental health ward	Non-intervention	Discharge

Author (year) *country*	Aim	Study design (methods)	Participants	Number of organisations / wards	Intervention / non-intervention study	Discharge or general focus
Gregoriou, K., & Waring, J. (2016). *UK*	the admission and discharge process into and out of acute inpatient mental health care.		professionals, breakdown not reported)			

Stage 2: Characteristics of included studies

Following deduplication, a total of 3601 records from empirical evidence searches were screened by title and abstract, the initial programme theories were tested against evidence from an additional 53 studies (see figure 1, PRISMA diagram). Studies (table 4) were conducted in the UK (n=13), Australia (n=8), United States (n=8), Canada (n=5), Norway (n=3), Denmark (n=2) Belgium (n=1), Brazil (n=1), Finland (n=1), Republic of Ireland (n=1), Iceland (n=1), Italy (n=1) Japan (n=1), New Zealand (n=1), Spain (n=1), South Africa (n=1), Sweden (n=1), Switzerland (n=1), Turkey (n=1), and multiple countries (n=1). Most papers were published since 2010 with 37 published between 2015 and 2025. The majority were qualitative (n=32). Twenty-nine reported findings from intervention studies. Twenty-one studies were conducted with multiple organisations, 24 conducted in single organisations and eight were unclear. Studies included total of 6341 participants, comprising 4975 service users, 1281 staff and 85 family supporters.

[Figure 1: PRISMA diagram of study selection process for initial programme theory development and refinement of theories through empirical evidence]

Table 4: Stage 2 included studies

Author (year)	Aim	Study design (methods)	Country	Participants	Number of organisations/ wards	Intervention / non-intervention study	Discharge or general focus
Attfield et al (2017)	To compare service users' length of stay, readmission rates and follow-up within 7 days of discharge for ICP and non-ICP care planning.	Quantitative (care record data)	UK	400 service users (200 experimental, 200 control)	2 mental health trusts	Intervention	Discharge
Barker, P. and Walker, L. (2000). [31]	To describe nurses' perceptions of the form and functions of care and treatment delivered by the multidisciplinary team (MDT) in acute mental health wards.	Qualitative (interviews)	UK	26 Senior nurses working on mental health wards	26 acute mental health admission wards	Non-intervention	General, including discussion of discharge
Bendall, C., O'Brien, M., & Williams, C. (2021).	To evaluate the provision of activities in a mental health inpatient setting from the perspective of patients.	Qualitative (service evaluation/focus groups)	UK	26 service users Female (8) male (18) Age range 20 – 63, white British (10) Black British (6) Asian or Asian British (6) Mixed White and Black African (2) 'Other' (2)	1 hospital, 6 wards	Non-intervention	General, including discussion of discharge
Bennewith et al. (2014)	To assess the usefulness and feasibility of a contact-based intervention for people recently discharged from inpatient psychiatric care .	Mixed methods (health care records, interviews)	UK	102 service users Female (35) Male (67) Mean age 38 (range 18 – 70) Schizophrenia (31), Affective disorders (24), Personality disorders (8) Substance related disorders (4) Other (4)	3 hospitals, 3 wards	Intervention	Discharge
Bora et al (2024)	To evaluate the effects of the Uncertainty Management Psychoeducation Program on reducing uncertainty and intolerance to uncertainty, improving	Quantitative (RCT, questionnaires)	Turkey	54 supporters (27 experimental 27 control)	1 hospital	Intervention	Discharge

	psychological well-being, and coping styles in caregivers of patients with schizophrenia.						
Botha, U. A., Coetzee, M., Koen, L., & Niehaus, D. J. (2018).	To assess the effect of a Transitional Care Service on readmission rates	Quantitative (Pilot study, notes review)	South Africa	60 service users Male (60)	1 hospital	Intervention	Discharge
Bradshaw, Butterworth and Mairs (2007)	To assess whether clinical supervision can enhance outcomes for mental health nurses and their service users.	Quantitative (questionnaires and staff assessment)	UK	23 staff (mental health nurses) (experimental 11, control 12)	1 training programme, 2 regions	Intervention	General
Cleary, M., Horsfall, J., O'Hara-Aarons, M., & Hunt, G. E. (2013).	To explore acute inpatient Mental Health Nurses understanding of recovery and how they incorporate a recovery paradigm in their day-to-day nursing practice.	Qualitative (Interviews)	Australia	21 Inpatient mental health nurses	4 inpatient mental health units	Non-intervention	General
de Oliveira, R. M., Júnior, A. C. S., & Furegato, A. R. F. (2016).	To investigate the perception of nurses, nursing assistants and patients about nursing care at a general hospital mental health unit.	Qualitative (Interviews)	Brazil	43 Total 27 Service users (Female (18), Male (9) Diagnosis: Schizophrenia (13), Mood disorder (6), Personality Disorder (8)) 10 nursing assistants 6 nurses	1 hospital, 1 unit	Non-intervention	General
De Ruysscher, C., Vandevelde, S., Tomlinson, P., & Vanheule, S. (2020).	To unravel the daily practice of an inpatient mental health ward that engages with persons with complex mental health needs.	Qualitative (Interviews)	Belgium	10 Service users Female (3), male (7) 10 health care professionals Female (7), Male (3) Psychiatrist (1), Social workers (1), Nurses (2) psychologists (2), Pedagogical (1), Occupational therapists (3)	1 hospital, 1 ward	Non-intervention	General

de Witt, P. A., Roestorff-Hambrock, N., Adams, F., & Franzsen, D. (2021).	To explore these challenges which Mental Health Care Users with Major Depressive Disorder perceived had contributed to their re-admission within a six-month period.	Qualitative (Interviews)	South Africa	11 Service Users Female (8), Male (3)	1 hospital	Non-intervention	Discharge
Delgado et al. (2022)	To explore how mental health nurse build and maintain their resilience in the face of high levels of emotional labour	Qualitative (Interviews)	Australia	11 mental health nurses	Not reported	Non-intervention	General
Doody et al (2024)	To explore perspectives of developing and establishing peer group clinical supervision	Qualitative (Focus groups and Interviews)	Republic of Ireland	24 staff	Not reported	Intervention	General
Drury, L. J. (2008).	To determine what homeless people experience during the transition from street life into community housing.	Qualitative (Ethnography)	USA	60 Service users	1 mental health hospital	Non-intervention	Discharge
Engstrom, P., Bolton, M., Bautista, C., & Barnes, T. (2022).	To describe common themes of worry experienced by individuals in mental health inpatient units in order to improve patient experience.	Qualitative (Quality improvement, survey)	USA	1800 Service users Female (864) Male (792) Transgender (36) No response (108)	1 mental health hospital, 5 units	Non-intervention	General
Forchuk, C., Gyamfi, S., Martin, M. L., Corring, D., Srivastava, R., & Harerimana, B. (2021).	To evaluate service users' perceptions of the benefits and potential adjustments to the implementation of a transitional discharge model	Qualitative (Focused Ethnography)	Canada	87 Service users	9 hospitals	Intervention	Discharge
Forchuk, C., Martin, M. L., Chan, Y., & Jensen, E. (2005).	To determine the cost and effectiveness of a transitional discharge model of care with clients with chronic mental illness	Quantitative (Randomised Clinical Trial, cluster design)	Canada	390 Service users (189 control, 201 intervention) [Intervention arm] Female (103), Male (98) Diagnosis: Schizophrenia (82), Mood disorder (91), Substance related (1), personality	4 mental health hospitals, 26 wards	Intervention	Discharge

				disorder (8), Anxiety (3), Development disorder (6), Schizo-affective disorder (2), Other (6)			
Forchuk, C., Martin, M. L., Sherman, D., Corring, D., Srivastava, R., O'Regan, T., Gyamfi, S., & Harerimana, B. (2020).	To understand healthcare professionals' perceptions of the effectiveness and sustainability of the transitional discharge model.	Qualitative (Focused ethnography)	Canada	216 health care professionals	9 hospitals	Intervention	Discharge
Fourie, W. J., McDonald, S., Connor, J., & Bartlett, S. (2005).	To compare the perceptions that registered mental health nurses have of their roles with their actual practice.	Qualitative (Observation, Focus groups)	New Zealand	Registered nurses (n=not reported)	3 wards	Non-intervention	General
Gillard et al (2022).	To establish whether peer support for discharge reduces readmissions in the year post-discharge.	Mixed method (RCT, patient records, interviews)	UK	590 service users (287 experimental, 291 control) Female (306), Male (267), transgender (3), not reported (2) Mean age 39.7 (SD 13.7, range 18-75) White (353), Black (94), Asian (68), mixed (48) other (13)	6 hospitals, 13 wards	Intervention	Discharge
Gonge and Buus (2014)	To test the effects of a meta-supervision intervention in relation to participation, effectiveness and benefits of CS to psychiatric nursing staff.	Quantitative (RCT, Questionnaire)	Denmark	83 staff (experimental 40, control 43)	1 hospital, 3 wards	Intervention	General
Greysen, S. R., Allen, R., Rosenthal, M. S., Lucas, G. I., & Wang, E. A. (2013).	To understand better the experience of acute care among homeless patients.	Mixed methods (note review, interviews)	USA	98 Service users Female (20), male (78) White (38), Black (39), Hispanic (15), Other (6)	1 Emergency shelter accommodation centre	Non-intervention	Discharge

Harris, Lechevallier, and Buhagiar (2021)	To investigate the perspectives of service users on barriers to engagement with a therapeutic group facilitated by assistant psychologists.	Qualitative	UK	16 service users Female (8) Male (8) Age range 18 – 66)	1 hospital, 2 wards	Intervention	General
Hattangadi, N., Kurdyak, P., Solomon, R., & Soklaridis, S. (2020)	To explore clinicians' and patients' experiences with PODS	Qualitative (Interviews)	Canada	6 Service users 10 Clinicians	1 mental health hospital, various wards	Intervention	Discharge
Hautala-Jylhä, P. L., Nikkonen, M., & Jylhä, J. (2005).	To describe and analyse the conceptions of patients, ward personnel, outpatient services personnel and administrative personnel in mental health units concerning the factors improving the continuity of care.	Qualitative (Phenomenology, interviews)	Finland	5 Service users 18 health care staff 5 Administrative staff	1 hospital district, 3 inpatient wards	Non-intervention	Discharge
Hegedüs et al (2018)	To determine the feasibility of the STeP, and gain insight into the effects of the STeP on improvements in coping during the week following discharge	(Pilot study Interviews and questionnaires)	Switzerland	29 service users (15 experimental, 14 control) Female (20) Male (9) Mean age 36 (SD 8.43) Schizophrenia (3), Affective disorders (14), Substance disorders (6) Neurotic disorders (3), Personality disorders (3)	1 hospital	Intervention	Prep
Jackson, K. P., Welch, A., & Hopkinson, S. (2020).	To understand the experience of re-engaging with life after a suicide attempt.	Qualitative (Phenomenology, interview)	Australia	8 Service users Female (4), male (4)	Various	Non-intervention	General
Keefe, K., Cardemil, E. V., & Thompson, M. (2020).	To elucidate barriers and facilitators faced by individuals with serious mental illness in establishing positive therapeutic relationships within state mental health hospitals	Qualitative (Interviews)	USA	22 Service users Female (8), male (13), other (1) White (12), Black (5), Asian (1), other (4)	3 mental health hospitals	Non-intervention	General
Kidd et al (2016)	To describe outcome and	Mixed methods (Pre-post	Canada	23 Service users	1 hospital	Intervention	Discharge

	feasibility findings for a peer support intervention.	Questionnaires, interviews)		Female (7) Male (16) Mean age 41.5 (SD 12.5) White (12), Black (4) Asian (2) Other (5)			
Klingemann et al (2020)	To explores the experiences of patients and clinicians regarding specialisation (SC) and personal continuity (PCC) of care in five European countries	Qualitative (Interviews)	Belgium, Germany, Italy, Poland and the UK	188 service users 63 Clinicians	57 hospitals	Non-intervention	General
Kular et al (2025).	To explores clinicians' perspectives on how service users come to be compulsorily detained in mental health hospitals and their suggestions for reducing these detentions in the future.	Qualitative (Interviews)	UK	23 Clinicians	Multiple, not specified	Non-intervention	General
Maguire et al (2025)	To explore perspectives of the Inpatient Aggression for mental health inpatient units model.	Qualitative (Focus groups)	Australia	15 Nursing staff various levels	14 wards	Non-intervention	General
Maguire et al (2025)	To explore how nurses can best enhance employment of a structured risk assessment instrument paired with an aggression prevention protocol.	Qualitative (Focus groups and interviews)	Australia	17 nursing staff various levels`	11 wards	Intervention	General
Matscheck and Piuva (2023)	To investigate CIP from the perspective of the professionals who participate in CIP meetings.	Qualitative (Interviews)	Sweden	20 staff Nurses (4) Social worker (5) Occupational therapist (1) Other (10)	7 social care and mental health providers	Intervention	General
Moreno-Poyato, A. R., El Abidi, K., Rodríguez-Nogueira, Ó., Lluch-Canut, T., & Puig-	To explore service user perspectives of people of an intervention model to improve therapeutic	Qualitative (Focus groups)	Spain	11 Service users Female (8), Male (3)	Various	Intervention	General

Llobet, M. (2021).	relationships with nurses.						
Niimura, J., Tanoue, M., & Nakanishi, M. (2016).	To elucidate patients' challenges immediately after hospital discharge following acute mental health inpatient care.	Qualitative (Interviews)	Japan	18 Service users Female (10), Male (8)	1 mental health hospital	Non-intervention	Discharge
Nordby, K., Kjønsberg, K., & Hummelvoll, J. (2010).	To explore and describe what facilitates active involvement for relatives in the treatment and rehabilitation of their family member.	Qualitative (Focus groups)	Norway	18 family carers 28 health care professionals	1 mental health hospital, 4 inpatient units	Non-intervention	General
Óladóttir, S., & Pálmadóttir, G. (2017).	To examine mental health clients' perceptions of the care they received in a hospital environment and how reflected the principles of client-centred practice.	Mixed methods (self-report instrument, interviews)	Iceland	30 service users Female (19), Male (11) Diagnosis: Bipolar (3), Depression (23), Anxiety (17), Personality disorder (2), Other (4)	1 inpatient ward	Non-intervention	General
Patrick, V., Smith, R. C., Schleifer, S. J., Morris, M. E., & McLennon, K. (2006)	To describe a group intervention for persons with long stays labelled as "resistant."	Qualitative (descriptive study)	USA	7 Service Users	1 mental health hospital, 1 ward	Intervention	Discharge
Quirk, A., Lelliott, P., & Seale, C. (2004).	To explore service users' strategies for managing risk in the volatile environment of an acute mental health ward.	Qualitative (Ethnography, survey)	UK	Not reported	Ethnography: 3 mental health hospitals, 3 wards Survey: 96 mental health units/wards	Non-intervention	General
Reid, R., Escott, P., & Isobel, S. (2018)	To explore how service users perceptions of how collaborative care planning with mental health nurses impacts personal recovery	Qualitative (Interviews)	Australia	12 Service users	1 hospital, 1 ward	Non-intervention	Discharge
Reynolds et al (2004)	To test the discharge model designed to assist patients discharged from acute admission wards to adjust to community living.	Quantitative (Pilot RCT, questionnaires)	UK	19 service users (11 experimental, 8 control)	1 hospital, 3 wards	Intervention	Discharge

Ryu et al (2025)	To describe the characteristics and perceived effectiveness of clinical supervision of mental health nurses.	Quantitative (survey)	Australia	422 nurses	4 mental health services	Intervention	General
Sather, E. W., Iversen, V. C., Svindseth, M. F., Crawford, P., & Vasset, F. (2019).	To explore former patients' views of pathways in transition between district mental health hospital centres and community mental health services.	Qualitative (Focus groups)	Norway	10 Service users Female (7), Male (3)	5 communities	Non-intervention	Discharge
Shaffer et al (2015)	To investigate the association between implementation of a brief critical time intervention (BCTI) model and occurrence of early and long-term psychiatric readmission of adults with serious mental illness.	Quantitative (questionnaire, patient records)	USA	373 service users (149 experimental, 224 control) Female (162) Male (211) Mean age 39.7 (SD 11.8) White (208) Black (158) Asian (1) Other (6) Anxiety (32) Bipolar (54) Schizophrenia (79) Co-occuring (71)	6 community based providers	Intervention	Discharge
Simpson et al (2014)	To explore whether peer support in addition to usual aftercare for patients during the transition from hospital to home would increase hope, reduce loneliness, improve quality of life and show cost effectiveness	Quantitative (Pilot RCT Questionnaires, activity diaries)	UK	46 service users (23 experimental, 23 control) Female (10) Male (36) Age range 20 – 57 White (14) Black (24) Mixed race (5) Asian (2) Schizophrenia (24) Depression (8) Bipoloar (10) Personality disorder (2) Unconfirmed (2)	4 wards	Intervention	Discharge
Smelson et al 2012	To establish the efficacy of the TLC intervention compared to a matched attention (MA) control condition on improving	Quantitative (RCT, questionnaires)	USA	102 service users (no additional detail)	1 hospital, 1 ward	Intervention	Discharge

	engagement in inpatient and outpatient treatment						
Stubberup et al (2025)	To explore which knowledge the municipalities need to assign appropriate assistance after discharge, the applicability of the knowledge delivered by the assessors and how they generated this knowledge	Qualitative (Interviews)	Denmark	19 staff Occupational therapists (11) Social workers (8)	5 services	Non-intervention	Discharge
Taylor et al (2016)	To explore the impact of a novel recovery-focused bridging strategy intervention administered prior to discharge	Quantitative (care records)	USA	195 service users (experimental 87, control 108) Female (87) Male (108) White (118) non-white (77)	1 hospital	Intervention	Discharge
Tucker, L., Moran, N., Naughton-Doe, R., Wakeman, E., Wilberforce, M., & Webber, M. (2025)	To explore carers' and mental health practitioners' experiences of leave following the implementation of practice guidelines for involving carers in planning and undertaking leave from hospital.	Mixed methods (interviews and surveys)	UK	13 Carers 13 Mental health practitioners	Six Trusts, 18 wards (nine implementation, nine usual care)	Intervention	Discharge
Vatne, M., Lohne, V., & Nåden, D. (2021).	To explore mental health personnel's experiences in the encounter with family members of patients at risk of suicide to develop an understanding of the content of caring.	Qualitative (Interview)	Norway	12 health care professionals Social educator (1), social workers (3), nurses (8)	2 mental health hospitals, 6 wards	Non-intervention	General
Virgolesi et al 2017	To explore the effectiveness of a nursing discharge plan to promote therapeutic adherence and patient satisfaction	Mixed methods (questionnaire, interviews)	Italy	135 service users Female (77) Male (58) Mean age 33.2 (SD 7.9) Schzophrenia (50) Mood disorder (85)	1 hospital	Intervention	Discharge

White et al (2023)* associate paper to Gillard	To identify pre-randomisation and pre-discharge predictors of engagement with peer support.	Quantitative (RCT, Questionnaires)	UK	265 service users Female (133), Male (125), transgender (1) White (144), Black (43) Asian (34) Mixed (29) Other (7) Psychosis (118) Personality disorder (51) Other non-psychotic disorder (96)	6 hospitals, 13 wards	Intervention	Discharge
White and Winstanley (2010)	To better understand CS through causal relationships with quality of care and patient outcomes.	Mixed methods (RCT, questionnaires, interviews, diary accounts)	Australia	268 Total 186 Staff (experimental 139, control 82) 82 Service users (experimental 82, control 88)	17 hospitals	Intervention	General

System pressures, practices and experiences related to discharge planning

Evidence from the literature and discussions with lived experience and staff stakeholders demonstrated how factors operating across policy, service, relational and individual levels shaped discharge planning practices and experiences (figure 2). Policy and service pressures, including chronic under-investment in acute and community mental health services and limited bed capacity, drove when and how discharge occurred alongside clinical assessments of service user readiness (30, 31). These pressures contributed to discharge planning that was sometimes rushed, incomplete or not possible, increasing the risk of rapid readmission or suicide (30). Communication gaps within multidisciplinary teams further undermined effective planning and service users were often excluded from discharge planning. This meant discharge could occur with little warning, leaving service users feeling shocked, abandoned and unsure about their ability to cope outside the ward.

[Figure 2: Factors operating across system levels]

Crisis management dominated ward practice, with extensive documentation of risks, behaviours and incidents as an established part of staffs' responsibilities (30, 32-35). . Staff and service users were routinely exposed to threats, aggression and secondary trauma of observing physical and psychological harm to others (30, 36, 37). The constant possibility of harm and fear of blame reduced staff capacity to engage with service users on an emotional level, limiting opportunities for open, honest conversations about discharge needs (30, 38). Training, supervision and emotional support appeared to be insufficient to deal with the emotional labour and responsibility of working with highly vulnerable and distressed service users. (30). Thus, psychologically defensive practices, such as task-focused, superficial interactions, were used to manage feelings of dissonance and secondary trauma. Service users recognised when staff were overwhelmed and less able to connect, meaning they themselves were less likely to engage.

Inpatient mental health services were poorly designed for service users with more complex needs, reflecting historical medical models of mental illness and treatment. Staff sometimes reacted negatively to service users whose needs could not be resolved primarily through medication (38, 39) (40). This could foster empathy for some service users but also contribute to a sense that others did not deserve to be on the ward (41, 42). Service users accessing inpatient treatment were more likely to have a history of interpersonal trauma, affecting their ability to understand their own internal experiences and associated needs (mentalisation), and trust others (40). While on the ward, service

users were acutely aware of staff expectations for their behaviour and often concealed, contained or exaggerated aspects of their identity and needs to secure support. This could involve behaving in ways they believed would either facilitate discharge or prolong their stay.

Stage 3: Programme theories

Below, five programme theories set out in relation to current experiences, processes and environmental factors. Evidence and contributions from lived experience and staff stakeholders are set out in table 5.

Table 5: Programme theory summaries and linked evidence

Programme theory summary statement	System level factors	Supporting evidence and stakeholder consultation
PT1: Self-efficacy for coping discharge IF service users can gradually experience and problem solve everyday activities with a key staff member, THEN they will be equipped to cope with potentially overwhelming situations BECAUSE they feel secure and supported.	Macro: Risk averse environment. Structured routines Meso: Staff become responsible for everyday tasks and activities Micro: Deskilled from escalation of illness and admission	Background evidence (31, 38, 43-51) Intervention evidence (33, 52-60) Lived experience contributions Some reported initial relief and feeling safe on the ward as they had structure to their day. Staff contributions Recognised service users lost confidence for managing everyday tasks. Considered that supported activities, such as shopping trips, were important to rebuild independence.
PT2: Enabling staff engagement in discharge planning conversations IF staff have experience and a framework for having discharge conversations with service users THEN they are more likely to explore service users' discharge related needs BECAUSE they know how to minimise provoking distress.	Macro: Discharge planning will not change some circumstances. Meso: Communication gaps in discharge agreements between members of MDT, particularly with nursing and health care assistants. Micro: Staff concerns about raising unrealistic expectations for discharge or causing anxiety.	Background evidence (30, 34, 38, 41, 42, 44, 61-64) Intervention evidence (60, 65-71) Lived experience contributions Conversations, therapies and practical support that could provide psychological and practical preparation for discharge but were often limited, unavailable or not utilised to their full potential Staff contributions Felt frustrated and powerless to influence the difficult situations some service users would be returning to.
PT3 Peer connectedness and mutual support IF service users develop a meaningful connection with a peer support worker THEN they are likely view discharge more positively BECAUSE they see that recovery is possible from someone who has lived experience of their situation.	MACRO: Shame and stigma around mental illness MESO: Ward environment and service user dynamics	Background Evidence (37, 39, 43, 49, 50, 70) Intervention (35, 53, 72-76)

	MICRO Connection through shared experience	Lived experience contributions Conversations and connections with other service users could help thinking through discharge needs. Service users with more experience of staying on the ward could help others to advocate for their needs. Staff contributions Recognised the complexities of service user relationships on the ward
PT4 **Involvement of external support network in discharge planning** IF consistent and reliable processes are established for supporter involvement THEN they will meaningfully contribute to discharge planning BECAUSE they feel that their concerns will be taken seriously.	MACRO: Confidentiality and rigid organisational practices MESO: Lack of clarity in the clinical team for who liaises with and involves supporters MICRO Quality of the relationship between service user and support	Background Evidence (30-32, 50, 52, 77, 78) Intervention (44, 79, 80) Lived experience contributions Examples of supporters excluded from discharge plans which often meant supporters were surprised when discharge occurred and felt ill-prepared to support the service user. Staff contributions Discussed challenges of including supporters but recognised the importance of their involvement when they were supportive.
PT5 Hearing discharge needs and responding meaningfully IF service users have information and opportunities to think about and capture their goals for discharge outside of formal meetings with staff THEN they will more fully express their needs BECAUSE service users feel they have control and agency for when they reflect on their discharge needs.	MACRO Service user needs are interpreted through the assessments of risk of harm. Inherent power imbalances in staff and service user relationships. MESO Current practices prioritise staff discussions around discharge and related risks. Service users do not have full access to information they need to inform decision making. MICRO Service users feel unable to express their needs in structured meetings	Background Evidence (32, 34, 39, 40, 43, 81-83) Intervention (59, 76, 84, 85) Lived experience contributions When discussing being an inpatient used language that suggested prison-like experiences. Staff contributions Views of service users could be influenced by how the trajectory of a person's diagnosis and their role in

	controlling relapse of symptoms were understood.

Programme theory 1: Self-efficacy for coping post-discharge

Background: Admission experiences that can erode confidence to manage following discharge

(31, 38, 43-51)

An escalation of difficulties that led to mental health hospital admission and subsequent treatment on the ward could result in service users feeling institutionalised and doubting they would cope once discharged. This was of particular concern for service users who had previously been admitted to inpatient mental health wards. These service users were aware of how difficult it could be returning to managing practical, emotional and social aspects of their lives once discharged. To overcome these concerns, service users needed to build confidence in their ability to manage and be safe once they left the ward. On admission, service users were often too ill to cope with the work and responsibilities associated with everyday tasks and self-care. Some reported an initial sense of relief and safety from the structure of inpatient care, although this structure could frustrate others. Regardless of the initial response, many adapted or conceded to the restrictions of ward life, which included a lack of privacy and agency as the responsibility for daily activities shifted to staff. This could foster dependence on ward routines and loss of confidence in managing independently outside the ward.

Building a sense of self-efficacy for everyday responsibility

(33, 52-60)

Intervention studies included periods of gradual, supported leave to service users usual living circumstances. These interventions enabled the reintroduction of everyday situations to help service users explore how they would manage post discharge (mechanism resource). Desired outcomes of these interventions were to increase service users' sense of self-efficacy and agency (outcome), with longer-term aims of reducing readmissions through sustained personal recovery (distal outcome). Gradual discharge that incorporated discussion of concerns, problem-solving and supported exposure to real-life situations with a staff member (context) provided reassurance that inpatient resources remained available (mechanism resource), that enabled people to build confidence in their capacity to self-manage and engage with potentially overwhelming situations (mechanism reasoning). However, activation of this mechanism depended on the relationship established between the service user and key worker and whether the ward environment was experienced positively (context). For some service users, the constant readjustment from ward to community and back to the ward could be difficult to manage. However, with these resources in place, it was more likely service users would experience the benefits of gradual discharge in ways that were psychologically safe and could potentially delay or reduce readmissions.

Programme theory 2: Enabling staff engagement in discharge planning conversations

Background: Staff fears around causing distress

(30, 34, 38, 41, 42, 44, 61-64)

Staff, particularly nurses and healthcare assistants, reported a range of concerns and experiences that led them to avoid engaging in discharge discussions with service users. Some service users became anxious when discharge was raised, leading staff to worry that discharge discussions might increase the risk of self-harming behaviours or disrupt recovery. In some cases, staff also felt frustrated and powerless to influence the difficult living situations service users would be returning to after discharge which were unlikely to change. These concerns, combined with communication issues between members of the multidisciplinary team (MDT) inhibited discharge conversations and undermined effective planning. Decisions made during MDT meetings were rarely shared with lower banded ward staff (i.e. those who often have more direct contact with service users) despite their daily contact with service users. Although these ward staff were well placed to build relationships and explore discharge needs, many were reluctant to do so due to uncertainty about discharge timelines, concerns about raising unrealistic expectations and their limited involvement in the process.

Developing skills for discharge conversations

(60, 65-71)

Interventions aimed at improving ward staff confidence in discussing discharge with service users involved role play and reflective exercises that addressed common concerns. These approaches were thought to provide staff with a rehearsed framework that they could draw on in conversations perceived as risky (mechanism resource), helping to reduce worries about saying the wrong thing, raising unrealistic expectations, or triggering anxiety and negative reactions to discharge (mechanism reasoning). Clinical supervision for mental health

nursing staff has been explored as an intervention to support staff to cope with the emotional and psychological demands of their work. Supervision that incorporates space for reflection on discharge conversations (context) may help staff to develop these skills and engage in discussions (outcome). In practice, organisational and individual staff factors influenced whether clinical supervision was implemented consistently (context). Many nursing staff viewed clinical supervision as difficult to achieve within existing workload pressures as it was not embedded within routine work or considered a contractual obligation. An alternate approach that drew on a structured conversational framework and reflective training in challenging discharge discussions was found to be acceptable and aligned with typical mental health nursing practices.

Programme theory 3: Peer connectedness and mutual support

Background: Learning from peers to navigate discharge planning

(37, 39, 43, 49, 50, 70)

Some service users found being apart from their usual support network difficult, but being on a ward with others who had similar experiences could be a comfort and elicit feelings of solidarity. This was particularly important for service users who felt misunderstood or excluded by their existing social network, who might be unable to relate to their admission and wider mental health challenges. Feelings of shame were reported when the people they knew avoided discussing or acknowledging their mental illness. Those service users with more experience of being on the ward and/or more confidence in advocating for their needs were often able to support those who were admitted for their first time and/or struggling with self-advocacy. This was achieved by sharing information about discharge processes and rights. However, not everyone experienced these supportive networks and others on the ward were not always a source of comfort of support. Some service users felt threatened, bullied and intimidated by other service users, and these individuals preferred early discharge as a result. Where friendships did form on the ward, this could become a source of motivation and support in ongoing recovery following discharge. While support was readily available on the ward from both other service users and staff, after discharge individuals often had to actively seek help, which required energy and effort that someone may not have. This made discharge distressing for some, especially those living alone, due to fears of increased isolation.

Meaningful connections through lived experience

(35, 53, 72-76)

Formal peer support worker interventions to support discharge drew on a shared lived experience of inpatient care (mechanism resource) to foster meaningful connections and demonstrate that personal recovery is possible (mechanism response). Outcomes of formal peer support have been mixed and largely depend on whether a strong relationship between the service user and peer support worker can be established (context). Limited availability of peer support workers (context) risks unequal access within the same service, particularly for underserved groups with high support needs (outcome). Evidence suggests peer support worker interventions have limited impact on readmissions, days in hospital and severity of symptoms (outcome). However, several studies reported improvements in service users' sense of hope (outcome), particularly for those who sustained peer support post-discharge (context). These benefits stem from the building empathic, meaningful relationships with peer support workers who model recovery through their own experience.

Programme theory 4: Involvement of external support network in discharge planning

Background: Operational and individual barriers to supporter involvement

(30-32, 50, 52, 77, 78)

Supporter involvement was complicated by issues of confidentiality and the capacity of service users to approve such involvement. Rigid organisational practices and a lack of clarity regarding how to involve supporters could mean they were not informed about admission details, treatment progress or discharge plans. Even when supporters were included, it was often brief and insufficient. Ad hoc involvement meant supporters were often unaware of a person's needs and how to support them upon discharge. This could lead to a sense of dread relating to discharge as supporters may not have processed the events leading to admission or anticipate the service user's progress during their inpatient stay. Where complex interpersonal or family dynamics were not addressed, service users could return to environments in which their needs were poorly understood or not accepted. In these contexts, staff ideally sought to understand service users' preference for supporter involvement and determine whether barriers stemmed from limited understanding, stigma, or more entrenched relational difficulties. Without such engagement, service users could continue to feel blamed for their illness. For both supporters and service users who were able and willing to have open discussions with staff about sensitive situations, such as self-harm, many reported this as beneficial, supporting a clearer expression of needs likely leading to more effective discharge planning.

Consistent involvement for effective partnerships

(44, 79, 80)

Interventions that actively included engaged supporters in care and discharge planning discussions aimed to gather a more comprehensive understanding of service user and supporter needs (mechanism resource) to improve outcomes. Consistent involvement of supporters prior to and during admission (context) was the basis for developing a collaborative partnership between staff, supporters and service users (outcome). Where this approach established a reliable route for contact with key staff members (mechanism resource) supporters were more likely to view these staff positively and engage in more open conversations their about concerns and needs (mechanism response). Some evidence suggested involvement of supporters was associated with reduced readmissions and supported continuation of treatment plans post-discharge (outcome). Beyond involvement, the use of psychoeducation that explored stigmatising views and uncertainties of mental illness recovery (mechanism resource) helped to increase supporters' capacity to cope with their caring responsibilities (mechanism response). This shift in perspective on managing uncertainty was a core mechanism for improving discharge outcomes. Improved knowledge about mental illness and strategies for supporting recovery helped supporters recognise the legitimacy of their concerns and initiate timely help seeking.

Programme theory 5: Hearing discharge needs and responding meaningfully

Background: Interpreting needs though risk and medical priorities

(32, 34, 39, 40, 43, 81-83)

Service users' priorities and individual circumstances needed to be clearly articulated as part of discharge planning discussions if plans were to be jointly agreed, meaningful and aid transition home and recovery. However, service users reported limited opportunities for involvement in the process, with most assessments of needs carried out through completion of checklists or in discussions between staff that focused on risk and medicalising behaviours. When service users were in attendance during discharge discussions, their involvement was often felt to be tokenistic. Existing processes, such as ward rounds, were reported by service users as reinforcing power imbalances between themselves and staff which led them to be silent or acquiescent. These meetings were rarely conducive for service users to correct discrepancies or provide a more comprehensive account detailing their needs. Information could also be withheld from the service user by staff in meetings. It was within this context, where service users had starkly limited input, that discharge plans were made; plans that were often agreed between professionals, not always shared with service users, or only shared in the moments before the point of discharge.

Discovering and integrating service users' perspectives

(59, 76, 84, 85)

Co-produced discharge planning tools were designed to give service users a space to record their goals for discharge and enable staff to tailor plans to their needs (mechanism resource). These tools provided a structured way for service users to reflect on and document their needs outside formal meetings, which were often brief and hierarchical. This was thought to support engagement in discharge planning by fostering a sense of control and agency over discussions (mechanism response). However, thinking about discharge could be distressing, particularly when it involved revisiting difficulties that led to admission (context). Designing tools that focused on strengths (mechanism resource) helped create a more positive reflective experience (mechanism response) leading to a clearer understanding of what would be helpful and meaningful to support discharge (outcome).

Summary and substantive theories related to work

These five programme theories demonstrate how discharge planning that is responsive to individual needs is influenced by a complex interplay of systemic, individual, and relational factors (figure 2). On the macro level this includes factors such as an ongoing lack of prioritisation and investment in mental healthcare, stigmatising social narratives about mental illness, risk oversight and inspection practices that reinforce risk-averse cultures and fear of blame, social adversity and inequality disproportionately affecting inpatient populations. These social factors impact inpatient wards and host organisations (meso-level factors). This includes under-resourced wards, fear of inspection and blame, staff pressure to manage complex needs and work in an environment with high levels of emotional distress with limited guidance, and a lack of protocols for collaborative planning as a complex intervention. These macro- and meso-level contextual factors were internalised by service users, their supporters, and staff, affecting the psychological and emotional processes involved in discharge planning. This manifests in interpersonal dynamics between service users and their support networks within and outside a ward, among staff (forming ward culture), and critically, between staff and service users.

To deepen understanding of these complex issues, several existing and substantive theories were explored to help define programme theory mechanisms. Early theorising drew on Goffman's total institutions (86) and attachment theory (87), but assessment of their contribution suggested they did not adequately characterise the concepts. More useful for evolving the programme theories was Corrigan et al's (2003) attribution theory (88) which provided a model for the causal factors of beliefs and responses to social narratives of mental illness. Explanations for interpersonal dynamics, dilemmas in decision making and lack of control over macro and meso level constraints of mental health services, such as pressures to discharge, were enhanced through revisions to Game Theory (89) and Impression Management (90), (for example: 91, 92, 93). Finally, Henshall et al's (2018) theory supported articulation of how macro level threats, such as sanctions for breaching targets and accountability for managing risk, impacted compassionate care (94).

DISCUSSION

This paper presents what is, to our knowledge, the first realist synthesis of discharge planning from acute inpatient mental health care. The synthesis developed programme theories that identify key contexts and mechanisms which either support or hinder effective discharge planning. These programme theories highlight numerous systemic barriers to the collaborative, person-centred discharge planning recommended by current guidance (e.g., (9)). In current practice, service users and their supporters are frequently de-centred, reinforcing feelings of powerlessness. System pressures and medicalised ward cultures can perpetuate stigmatising or dehumanising narratives and tend to generate a fear based environment, which inhibit the expression of needs and the formation of trusting relationships (88). Staff may feel unable to deliver collaborative discharge planning, and supporters are often excluded due to unclear guidance and lack of involvement protocols.

The programme theories identify resources that support effective discharge planning, including needs-based listening that can lead to clear discussions, constructive trust-building interactions between staff and service users, emotional and practical preparation for discharge, considered supporter involvement, opportunities for service users to share experiences with peers and friends on the ward, meaningful staff support, and team cohesion. These resources foster mechanism responses such as increased understanding and expression of discharge planning needs, and the relational and collaborative processes required to use this to develop person-centred discharge plans.

Implications and Future Directions

The combined contributions of the five programme theories points to an overall realist explanation that emphasises that discharge planning is a dynamic interpersonal process, which starts from admission and develops relationships that support collaborative discussions regarding needs and how these relate to discharge (95). Policy and guidelines emphasise the importance of timely and effective discharge that is planned from the point of admission (8, 9). There is also a clear expectation for services to ensure continuous improvement of the inpatient pathway, co-producing and reflecting on how to improve the discharge experience (95). Our findings show that this is not happening in practice. The consistent pressures, service constraints, and concerns around risk result in discharge that is happening to people rather than with people. This points to the need to target understandings of discharge planning that can accommodate for the wider system complexities and pressures. Similar to other realist reviews in the area (96), this review highlights the importance of interventions that recognise and work with the known inhibitors and enhancers/causal mechanisms of person-centred collaborative discharge planning to support positive change.

Future research that incorporates professionals' and service users' experiences, and observations of ward culture and interactions. is needed. This will allow for further testing and refinement of the programme theories, to enable a sophisticated construction of the discharge planning process to be understood.

Strengths and Limitations

The realist approach adopted for this review offers a rigorous and nuanced examination of the complexities surrounding discharge planning in complex inpatient mental healthcare systems, allowing for the development of applicable theories of what works for whom and in which circumstances. By considering different levels of the system, the review acknowledges that improving discharge planning cannot be fixed by focusing solely, for example, on discharge discussions between service users and staff. Instead, when designing a discharge planning intervention, wider system factors need to be considered in terms of what can and must change to facilitate its use. Collaborating with the LEAG, key clinical stakeholders and review team researchers with lived experience of discharge ensured robust critique and challenge to the evidence base and refinement of programme theories. The study selection process may have been impacted by bias (e.g. research examining successful interventions may have been more likely to be published). To mitigate this, lateral searching strategies were employed, and grey literature was included. In addition, the theory refinement process involved multiple stakeholders and representation of mental health staff, academic and lived experience expertise. There may nonetheless have been a bias towards certain theories and an

overrepresentation of particular groups. Notably, the specific or different experiences of minority groups did not emerge as a particular aspect to incorporate into the programme theories. Yet, inequality remains a long standing and stark problem for mental health services (97). People from some ethnic backgrounds, such as people of Afro-Caribbean heritage, have far poorer access and experience of services (with greater exposure to coercive and less exposure to more therapeutic pathways), resulting in poor outcomes and a lack of trust in services (98). It will be important for future evaluation of the programme theories to undertake specific equality analysis and ensure the mechanisms for discharge planning reflect the experience of racialised groups in the UK.

CONCLUSIONS

This realist review developed evidence-based programme theories about the causal pathway for improving discharge planning in inpatient mental health settings in collaboration with people with lived experience and key clinical stakeholders. Our overall realist explanation defined how national policies, existing social narratives about mental illness, interpersonal relationships and feelings of agency and control were core to how discharge planning was experienced and how discharge processes were enacted. If the outcomes of discharge that are important to service users, their supporters, staff and services are to improve, then interventions need to attend to organisational climate of mental health inpatient wards. The programme theories of this review provide the basis for future primary research and development of systemic discharge planning approaches that attempt to mitigate the multiple, interconnected challenges to collaborative, person-centred discharge planning.

Declarations

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CONTRIBUTORS

MH, CH, EK, HZ, SD, AG, CaH and SR are co-investigators on the wider project and were involved in the conceptualisation of the study. MH, CH, LG, EK, CW, HZ, AS, SD and SR were core review members, meeting fortnightly between January to December 2022 and contributed to data analysis and development of programme theories. MH, CH, LG and CW led analysis with input from SD. CaH devised, ran and recorded searches. CW and AS conducted the database searches. MH, CH, LG, AS and CW extracted data and were involved in the synthesis process, discussing findings with the review team. MH prepared the first draft of the manuscript which was reviewed and critically appraised by all authors, who approved the final version and agree to be accountable for this work.

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COMPETING INTERESTS

None declared.

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Patient and public involvement

Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

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Figures

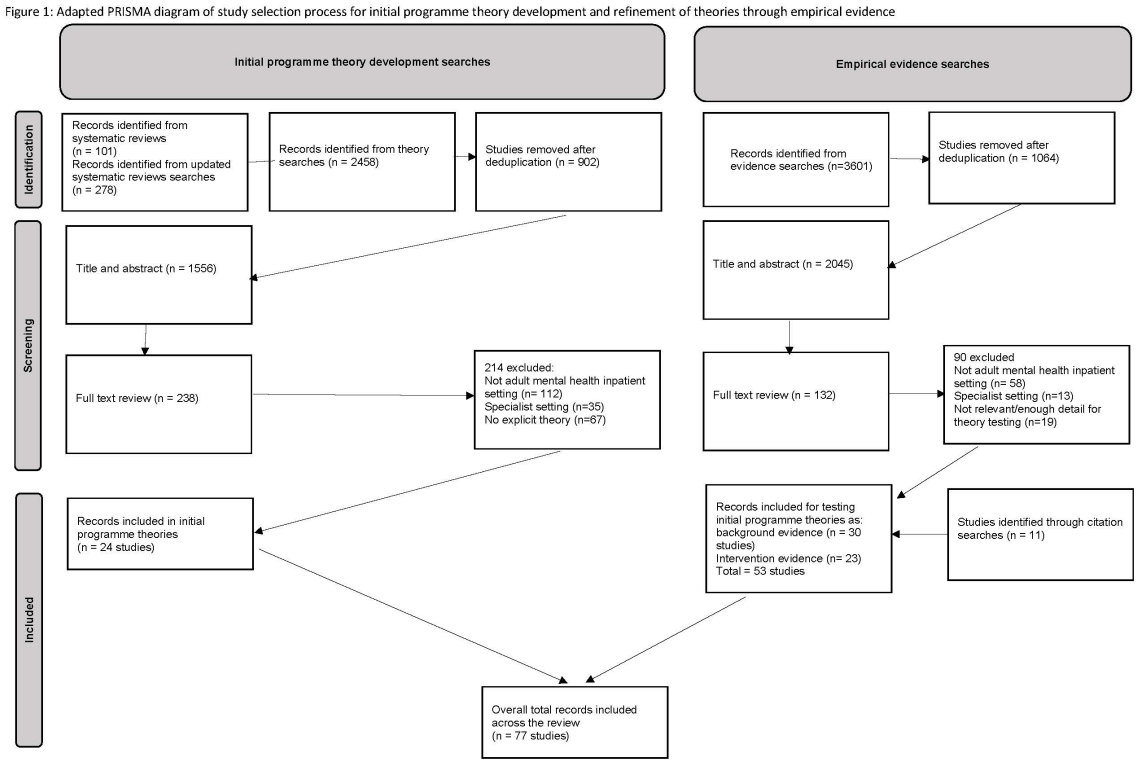


Figure 1

PRISMA diagram of study selection process for initial programme theory development and refinement of theories through empirical evidence

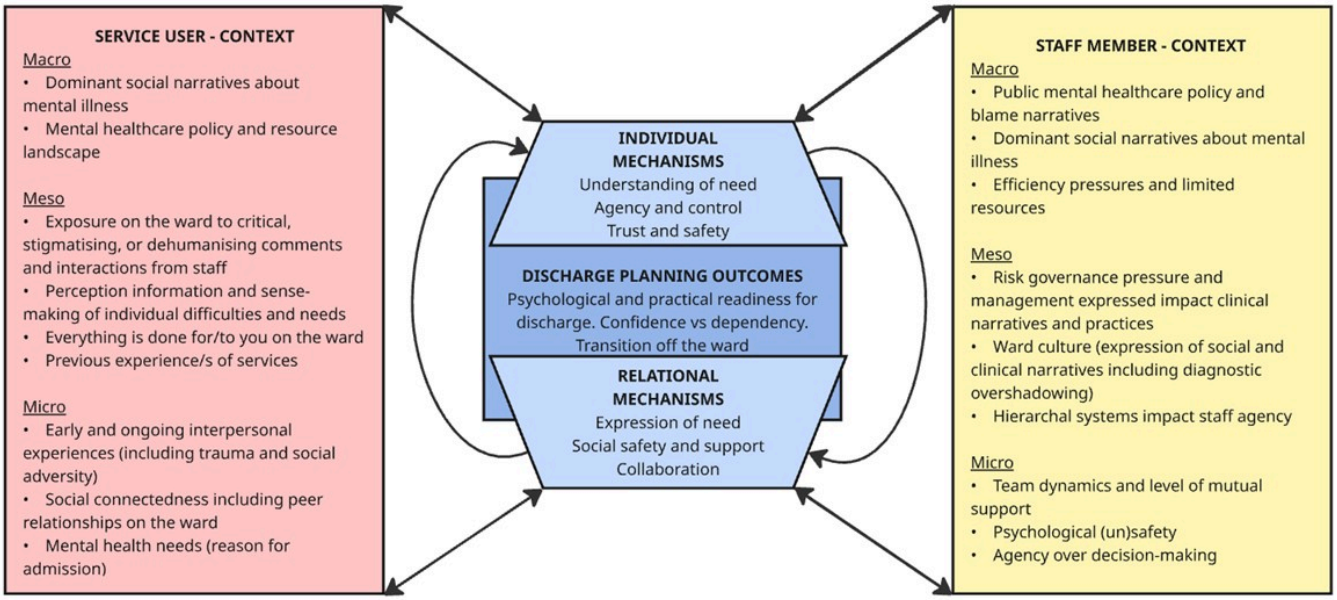


Figure 2

Factors operating across system levels

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