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Provider Opinions on Frequent Mental Health Hospitalizations

by

Courtney J. Funke, B.S.; B.S.W.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
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St.Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members
Andrea Nesmith, Ph.D., MSW
Karen Cooper, MSW, LICSW
Mary Larson, LSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Provider Opinions on Frequent Mental Health Hospitalizations
By: Courtney Funke

Research Chair: Andrea Nesmith, Ph.D., MSW

Committee Members: Karen Cooper, MSW, LICSW; Mary Larson, LSW

Frequent mental health hospitalizations are contingent on many variables. The purpose of this study was to gather provider opinions on frequent mental health hospitalizations. A qualitative design was utilized; ten providers participated in this study which explored factors of frequent mental health hospitalizations. Data were analyzed using content analysis. The findings indicated that all providers view medication management as a precipitating factor to psychiatric hospitalization. Findings indicate that support at discharge will greatly influence the success of the patron. The findings of this study indicate further need for education and advocacy in mental health. Findings suggest that stigma and limited community resources are key variables to frequent mental health hospitalizations. This study parallels data from previous research on this subject; however, patient opinions on frequent mental health hospitalizations are still absent.

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Table of Contents

Introduction p.5

Literature Review p.8

Conceptual Frameworkp.19

Methodsp.21

Findingsp.24

Discussionp.36

Referencesp.43

Appendix A: Interview Questionsp.47

Frequent Mental Health Hospitalizations

One in every four adults endure a mental disorder in a given year (National Alliance on Mental Illness [NAMI], 2012). Suicide is the eleventh leading cause of death in the United States (NAMI, 2012). Psychiatric hospitalization is a necessary intervention needed for those who are experiencing a mental health crisis. There are many factors that lead to an inpatient mental health hospitalization. Previous studies have focused on gathering quantitative data aimed at readmission reduction; there is no clear consensus on what variables affect frequent hospitalization. Furthermore, there is very little qualitative data available that would allow a greater understanding of those frequently utilizing mental health hospitalizations. This study will strive to answer the following question, what are provider opinions on frequent mental health hospitalizations?

To some, psychiatric hospitalization may be a misunderstood intervention and a concerning factor is the concept of frequent mental health hospitalizations. Montgomery and Kirkpatrick (2002) found that forty to fifty percent of those with a severe and persistent mental illness were rehospitalized within one year post discharge. Understanding patients who seek frequent mental health hospitalization may provide the necessary information to reduce rates of recidivism.

Predictors of mental health hospitalizations have included patient demographics and diagnoses; however, many studies are retrospective chart reviews and fail to gather qualitative data (Brunero, Fairbrother, Lee & Davis, 2007; Ledoux & Minner, 2005; Novak-Grubic, Zalar, & Saje, 2006). Common themes have been identified in research in the hope of reducing the rates of frequent mental health hospitalizations; the only variable consistently found throughout

the literature related to rehospitalization is the number of previous admissions (Miller & Willer, 1976; Montgomery & Kirkpatrick, 2002; Novak-Grubic et al., 2006). Inpatient mental health units were designed for crisis stabilization. Frequent mental health hospitalizations may indicate that a need is not being met for those who are hospitalized.

Researchers suggest conflicting definitions and factors that lead to frequent hospitalizations (Ledoux & Minner, 2005; Lichtenberg, Levinson, Sharshevsky, Feldman, & Lachman, 2008; Novak-Grubic et al., 2006). Recurrent hospitalizations are of concern as they utilize money, time, and resources. Yet as Montgomery and Kirkpatrick (2002) state, “instead of trying to minimize the number of hospitalizations, a more effective alternative may be to investigate optimal rates, rates that are reflective of an individual’s unique path of illness” (p.22). It is recognized that frequent mental health hospitalizations are contingent on a combination of variables. Research regarding those who are frequently hospitalized is not lacking, but qualitative data is. The voice of those utilizing psychiatric hospitalizations and the providers that assist these patients is still absent.

Studying additional information rather than limited patient demographics and diagnoses would suggest a more comprehensive assessment of characteristics for those frequently hospitalized. Additional variables studied have included patient’s interpersonal skills, social support, and quality of life (Miller & Willer, 1976; Montgomery & Kirkpatrick, 2002; Morin & Edward, 1986). Further information on the topic also includes the experience of being named chronically ill and systemic interventions aimed at reducing frequent hospitalizations (Corrigan, 2007; Fleury, Greiner, Barnvita & Caron, 2010; Hayne, 2003; Hillman, 2000; Lichtenberg et al., 2008; Montgomery & Johnson, 2002). Comprehensive studies are limited and it is rare to find research that gathers this information through a qualitative method.

The social work profession has achieved vast success in adopting professional standardization and legitimacy in the field of mental health. This study is important to the profession as further understanding of frequent mental health hospitalizations will equip social workers to successfully implement change in the mental health system. The purpose of this study is to gather mental health provider opinions to increase the understanding of mental health hospitalizations.

Literature Review

Deinstitutionalization began in 1955 and aimed at community reintegration for persons with mental illness and disabilities. Concerns regarding the efficacy of this movement have been examined (Greenblatt & Norman, 1983; Public Broadcasting Service, 2005). Bradshaw and colleagues (2007) state that the deinstitutionalization policy was made with well intent, however unintended consequences have included revolving door rehospitalizations, homelessness and victimization of persons with mental illness. Further exploration suggests that revolving door hospitalizations are a derivative of deinstitutionalization and scarce social welfare services (Oyffe, Kurs, Gelkopf, Melamed & Bleich, 2009). The concerns indicated above still remain widespread; the World Health Organization reports that approximately 450 million people suffer with mental or neurological disorders, which places these conditions among the leading cause of ill-health and disability (World Health Organization, 2001).

Psychiatric hospitalization is a service needed to care for those who are experiencing a mental health crisis. “A crisis can refer to any situation in which the individual perceives a sudden loss of his or her ability to use effective problem-solving and coping skills” (Encyclopedia of Mental Disorders, 2012, para.1). A mental health crisis may include the following: feeling suicidal, threatening to harm self or others, experiencing out of control behavior or experiencing psychotic symptoms. While the need for hospitalization may not be challenged, the frequent need for this service has been scrutinized. Studies have attempted to determine predicting factors for those who frequently require hospitalization.

Defining Frequent Hospitalization

Researchers differ on defining frequent hospitalizations and what constitutes frequent. Revolving door patients and frequent repeaters are terms that have been used to describe those

needing multiple psychiatric hospitalizations. Revolving door patients have been defined as those with at least three admissions in two years (Lichtenberg et al., 2008), those who have been admitted three or more times in a two year span (Oyffe et al., 2009), and patients who have been admitted at least three times to a psychiatric unit over a lifetime (Langdon et al., 2001). Frequent repeaters have been defined as those with four or more contacts to a psychiatric emergency room in a sixteen month period (Ledoux & Minner, 2006). A study on patients with schizophrenia defined this group of heavy users (frequent) or revolving door patients as those hospitalized three or more times in a twelve month period (Novak-Grubic et al., 2009). Rapid admission has been defined as readmission within thirty days of a psychiatric hospitalization (Hillman, 2000). The terms recidivism and recidivists also appear in the literature to classify frequent mental health hospitalizations. Miller and Willer (1976) classify recidivists as those readmitted to a psychiatric hospital within six months of discharge. Research has been conducted to determine predictors of readmission and possible interventions aimed at the reduction of rehospitalization.

Admission Predictors

In order to better understand frequent psychiatric hospitalizations Montgomery and Kirkpatrick (2002) critically examined conceptual and methodological issues published in research that predict risk of psychiatric hospitalization. A number of common variables have been studied to predict hospitalization. “Differing results in the relationship between such predictor variables and rehospitalization have been found, many of which are mutually contradictory” (Montgomery & Kirkpatrick, 2002, p.19). In reviewing literature on mental health recidivism the previous statement by Montgomery and Kirkpatrick (2002) becomes convincingly understood.

Mutually contradicting findings are present throughout this literature review. Authors Langdon and colleagues (2001) and Oyffe and colleagues (2009) studied similar admission predictors. Langdon and colleagues (2001) collected data on 128 patients admitted to a psychiatric hospital during a one year time period and classify revolving door patients as those who were readmitted at least three times. Oyffe and colleagues (2009) studied 183 patients who were admitted three or more times during a two year span. Similar client demographics studied included gender, age, religious affiliation, ethnicity, marital status, employment status and social living status. Among the previous listed factors Oyffe and colleagues (2009) did not find any variables to be of significance. Langdon and colleagues (2001) found that living status was the only variable of significance, reporting that revolving door patients were more likely to be living alone.

Additional findings found by Langdon and colleagues (2001) concluded that revolving door patient's have been referred to psychiatric services at an earlier age, were more likely to be readmitted due to relapse in psychosis and to have a primary diagnosis of psychoactive substance misuse. Additional data retrieved by the authors to support these findings included: primary diagnoses, prescribed medication, source of admission, type of accommodation upon discharge, age of patient's when they were first referred to psychiatric services, as well as number of previous admissions. These authors also utilized a questionnaire on reasons for admission. The questionnaire included fourteen possible reasons for readmission to the hospital and was completed by the psychiatrist assigned to the patient's care. Examples of reasons for admission include: non-compliance with medication, substance misuse, impairment in self-care and personality disorder (Langdon et al., 2001). Langdon and colleagues (2001) cite the limitations

of their study to the size of respondents and generalizability regarding the socio-economic conditions of the studied area.

Additional data studied by Oyffe and colleagues (2009) included: diagnosis, number of previous admissions, duration of first hospitalization, duration of time between first and second hospitalization, place of discharge, type of outpatient treatment, type of medication, suicidal behavior, use of illegal drugs and alcohol and type of discharge (i.e. by physician, against medical advice). The authors found no difference in clinical diagnoses between revolving door and non revolving door patients. The most significant differences found between these two groups are revolving door patients had shorter intervals between their first and second hospitalization, and had a tendency to leave the hospital against medical advice.

Hodgson, Lewis and Boardman (2001) found similar and contrasting results. The authors studied admissions from four acute psychiatric units in the United Kingdom between the years of 1987-1993; only patients age sixteen to sixty-four were considered. Findings from this study indicate that a psychotic diagnosis was a strong predictor of readmission. Marital status was also found to be a strong predictor of readmission; those who were not married were at a higher risk for readmission. The authors found that discharge against medical advice failed to reach statistical significance. Hodgson and colleagues (2001) indicate that patients were at highest risk for admission in the subsequent year following discharge.

The authors Novak-Grubic and colleagues (2009) conducted a retrospective chart review of patients with schizophrenia to determine possible risk factors for frequent hospitalization. Socio-demographic, diagnoses and therapy interventions constitute the data that was used; frequent repeaters were compared with a control group. The authors found the prominent differences between groups included higher suicidality risk, previous hospitalizations, marijuana

use, and co-morbid somatic illness. The authors state their sample was relatively small, as they used strict criteria to identify heavy users, they also state that a longer observation period or a prospective design may affect the results.

Psychiatric Emergency Room Predictors

Successful treatment for those who present with psychiatric concerns proves difficult when the symptom profile is unclear (Ledoux & Minner, 2006). Ledoux and Minner (2006) compiled a retrospective study of occasional and frequent repeaters in a psychiatric emergency room over a sixteen month period. The goal of this study was to identify admission predictors that would aid staff in the treatment of those who were frequently admitted. Occasional repeaters (OR) consisted of those with two-three contacts while frequent repeaters (FR) consisted of four or more contacts within the sixteen month period. Diagnostic profile included a mixture of severity including alcohol dependence, adjustment disorder, active psychosis or schizophrenia, major depression, or non active psychosis. Univariate and logistic regression techniques were used to compare the two groups. Significant variables differing frequent repeaters from occasional repeaters indicate that frequent repeaters are likely to be younger males and socially disabled (low income status). The authors also found that half of the patients had experienced a specific stressor. The two stressors differentiating occasional repeaters and frequent repeaters were grief and cravings (related to substance use), leading to the conclusion that the trigger of grief may reveal a specific fragility and cause of suffering for frequent repeaters.

Client Identified Admission Predictors

There are few studies designed to investigate patients' subjective meaning on frequent hospitalizations. Montgomery and Kirkpatrick (2002) present findings that state patients return

to the hospital seeking help to manage their illness, and that rehospitalization is not viewed as an entirely negative event by either patients or their families. The authors discuss a study in which patients attribute rehospitalizations to internally-oriented reasons; patients believe rehospitalization is out of their control. This study also gathered staff opinions on rehospitalizations for these patients. Outcomes state that staff differ on the view of controllability of hospitalization and attribute admissions to a lack of patient effort and non-adherence to medication and treatment regimens. Montgomery and Kirkpatrick (2002) suggest that being labeled chronically ill supported by recurrent hospitalizations may manufacture the need for future hospitalizations.

Like Montgomery and Kirkpatrick (2002), Hillman (2000) also states that client identified reasons for readmission are very limited in the literature on recidivism. Hillman (2001) presents a study in which fifty case records were examined in a Southern Australian hospital to identify precipitating psychiatric admission factors. The fifteen factors were reduced to four broad categories and are reported here, followed by the percentage of study participants who reported such factors: social factors (38.9%), physical or mental illness related factors (31.1%), danger to self or others (20.3%), and substance abuse problems (9.7%).

Stigma of Mental Illness

Research on the experience of being named mentally ill has been conducted. Hayne (2003) interviewed persons who had the experience of being diagnosed with a 'severe and enduring mental illness.' Hayne (2003) identified four essential themes regarding the knowledge a diagnoses provided and how this information affected the subjects. The author suggests providers utilize sensitivity to the process of how medical terminology is experienced. "...receiving a psychiatric diagnoses goes much beyond acquiring knowledge about functioning

in that the diagnostic label becomes a transforming influence to actually shape present and future life expectations” (Hayne, 2003, p.723).

An article by Corrigan (2007) examines clinical diagnosis and the potential exacerbation of the stigma of mental illness. Corrigan (2007) states that the stigma of mental illness impairs people in three ways: label avoidance, blocked life goals, and self-stigma. The author discusses diagnoses as a stereotype and explores the idea that overgeneralization of the ‘groupness’ of a diagnoses may be detrimental to the individual’s with the diagnoses. “Rather than assign someone to a class of people with similar symptoms, course, and disabilities, dimensional diagnoses seeks to describe a person’s profile of symptoms on a continuum” (Corrigan, 2007, p.36).

Social Factors

Current research on psychiatric recidivism encompasses the understanding that many factors influence hospitalization rates. The following authors suggest social factors are significant rehospitalization determinants. Miller and Willer (1976) used a multiple linear regression analyses to compare predictors of rehospitalization of former mental health patients. Subjects included 108 patients with a diagnosis of psychotic, neurotic or character disorders. The number of previous admissions to a psychiatric facility and patient sex were recorded along with completion of the Self-Assessment Guide. The Self-Assessment Guide covered seven content areas including physical health, general affect, interpersonal skills, personal relationships, use of leisure time, control of aggression and support (Miller & Willer, 1976). Results of this study indicate that the number of previous admissions was significantly related to readmission at six months, however the number of previous admissions overall was not found to be a good predictor as the amount of variance was small (Miller & Willer, 1976). Miller and

Willer (1976) suggest that “social factors are important determinants of recidivism as supported by the observation that six of the seven subscales on the Self-Assessment Guide are significantly related to return to the hospital” (p.900).

Findings by Morin and Seidman (1986) suggest a social network approach to the revolving door patient. These authors indicate that key network characteristics, such as size and flexibility of members, can be modified and anticipate that hospitalizations will decrease.

Holmes-Eber and Riger (1990) also discuss the composition of social networks for those who utilize psychiatric hospitalization. They report that frequent hospitalizations lead to higher rates of short term relationships, a decrease in the social network size, and to higher numbers of members met within the hospital or during subsequent mental health treatment (Holmes-Eber & Riger, 1990).

Hillman (2000) presents a literature review of social networks of those frequently hospitalized. The following are similar themes found in these social networks:

- 1) Social networks are smaller among recidivists, 2) recidivism rates were higher among those involved in higher percentages of conflictual relationships or family atmospheres in which there is high levels of expressed emotion, 3) involvement in leisure activities is associated with non-recidivists, 4) the depth and breadth of one’s social network is differently associated with community tenure length, 5) when families received behavioral and educational interventions, fewer rehospitalizations occurred, and 6) family meetings or frequency of familial contact during the course of hospitalization does not result in decreased recidivism rates (Hillman, 2000, p.19).

Social factors have found to be admission predictors for those who are frequently hospitalized, and common themes have been identified in the social networks of these patients.

An intervention for those frequently hospitalized may include modifiable solutions to social factors and further assessment of their social networks.

Systemic Interventions

“Case management is the most commonly researched systemic intervention and has been the method most often utilized by mental health systems to monitor patients’ psychiatric status and to decrease recidivism” (Hillman, 2000, p.19). The following studies present systemic interventions and case management of those with a severe mental illness. Montgomery and Johnson (2002) conclude that provider’s understanding of community integration will aid in the preparation of chronically ill patients discharge from the hospital. Fleury and colleagues (2010) suggest that care access, continuity, and a diversification of services will increase the success of quality aftercare for chronic patients.

Findings by Lichtenberg and colleagues (2008) concluded that clinical case management did not reduce the number of hospitalizations, nor did they find an improvement in psychosocial functioning for the patients placed in clinical case management. However, these authors report that an improvement in patients’ individual sense of well-being may be marginally improved through clinical case management. Lichtenberg and colleagues (2008) constructed a semi-randomized study of clinical case management of revolving door patients; subjects had at least three admissions in the previous two years. Subjects were placed in two groups, clinical case management or standard care. Basic demographic information was gathered as well as interviews with patients regarding their psychosocial functioning and support, life satisfaction and emotional health (Lichtenberg et al., 2008). Interviews were conducted at the beginning of the study as well as one year later. Also assessed at the one year mark were participant scale assessments of how their situation compared at that moment to how it was one year ago.

Lichtenberg and colleagues (2008) cite that their study may have limited applicability to other regions.

Reducing Readmission Rates

No clear consensus is reached in the literature as to what factors influence rehospitalization rates or which variables accurately predict readmission (Montgomery & Kirkpatrick, 2002; Langdon et al., 2001). Ashcraft and Anthony (2010) describe the revolving door as a term applied to distressing situations of unresolved treatment efforts in behavioral health.

Characteristics and variables linked to patients needing frequent hospitalizations have been the focus on reducing readmission rates, Ashcraft and Anthony (2010) state that perhaps a change in focus on rehospitalization is needed. Montgomery and Kirkpatrick (2002) state that research on predictors of rehospitalization has provided empirical data of varying quality and usefulness; they suggest that factors concerning the patient's quality of life, employment status and/or level of functioning are a more relevant indicator of mental health program success.

Conclusion

The care of those with disabilities and mental illness has become community orientated since the deinstitutionalization movement. Insufficient funding and inadequate services have led to a phenomenon known as mental health recidivism and revolving door patients. The frequent use of mental health hospitalizations has been scrutinized and found to be a burden by many. There are many factors that affect the rates of psychiatric rehospitalization. Research on this subject yields varying results and finds no clear consensus. Additional research has been suggested on such variables as modifiable factors, clear and concrete methodology, and further research on variable interaction. Data from clients and providers is lacking in the literature on mental health recidivism. To better serve clients utilizing mental health hospitalizations and to

increase provider knowledge on the epidemic of frequent hospitalizations, further research is needed. The purpose of this study is to gain provider opinions on frequent mental health hospitalizations.

Conceptual Framework

The conceptual framework used in this study is intended to be reflective of empowerment theory. Empowerment theory in social work is used to identify strengths and resources. Empowerment is a key concept in the strengths perspective in which all clients are thought to possess strengths that will contribute to the achievement of their personal goals. “The primary mission of the social work profession is to enhance human well-being and help meet the basic needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW Code of Ethics Preamble, 1998).

Strack, Deal and Schulenberg (2007) discuss the concept of empowerment in the treatment of those with mental illness. “Promoting the empowerment of individuals with SMI [serious mental illness] has also arisen as a possible solution to frequent rehospitalizations. Empowerment focuses attention on the degree of control individuals can assume over their own lives and improvements in quality of life” (Strack, Deal & Schulenberg, 2007, p.97). The authors in this article suggest that after psychiatric stabilization has occurred, the notion of empowering individuals in their treatment and recovery will promote gains in self-confidence, social support, self-esteem, quality of life improvements, and the development of skills in a variety of areas (Strack, Deal & Schulenberg, 2007).

Carpenter (2002) discusses the mental health recovery model and its applicability to the profession of social work. This article proposes key concepts in the recovery movement are closely linked to the National Association of Social Worker Code of Ethics noting specifically: consumer empowerment, self-determination, worth of the individual, and person-in-environment (Carpenter, 2002).

Carpenter (2002) further examines how the medical model has influenced the view of those with a mental illness. “Ultimately treatment too frequently focuses on symptoms and deficits, failing to recognize or engage the whole person and as a result dehumanizes the client” (Carpenter, 2002, p.87). This author also discusses the concept of chronicity of psychiatric disabilities; arguing that research does not consistently support the model of chronic degenerative mental illness. “The most fundamental premise of the recovery models is that people with psychiatric disabilities can and do recover” (Carpenter, 2002, p.88). This can be achieved through empowerment and by instilling hope that a life worth living is possible.

The conceptual framework used in this study is based on the notion that frequent mental health hospitalizations are contingent on many factors in a person’s life. Montgomery and Kirkpatrick (2002) suggest that the acceptable number of psychiatric hospitalizations needs to be based on the individual, and not deemed a tool for program success or used to label a consumer of mental health services. “Rather than attempting to reduce the risk of relapse, the individual in recovery works to achieve personal success. The vision describes a life beyond psychiatric diagnosis that is both vital and valuable, whether or not symptom relief is ever achieved” (Carpenter, 2002, p.88).

Methods

Design

This purpose of this study was to gather provider opinions on frequent mental health hospitalizations. The study design was an exploratory qualitative study. This study obtained interviews with providers who work on mental health hospital inpatient units. The participants were asked to share their opinions on frequent mental health hospitalizations. The qualitative design for this study was chosen in order to add provider voice to the conversation on frequent mental health hospitalizations. The data on mental health recidivism is mostly quantitative in nature; there is a need for qualitative data regarding frequent mental health hospitalizations.

Sampling

The sample for this study was recruited from providers who work on mental health hospital inpatient units. Convenience sampling was used to attain participants; this researcher has worked with staff on the mental health inpatient units. A memo inviting providers to participate was distributed by a supervisor of the mental health inpatient units. Participants were gathered from two Minnesota hospitals. Participants included five social workers, three nurses, one chaplain, and one behavioral health associate. Those who participated met the following participant inclusion criteria:

1. Participants must have at least 3 years of psychiatric hospital experience.
2. Participants must currently provide direct care for mentally ill patients.

Protection of Human Subjects

Protection of those participating in the study was secured through approval from the Institutional Review Board at the University of St. Thomas. The Institutional Review Board was supplied with the following: the initial participant memo that was sent out to potential participants, the research consent form, and letters of support from participating hospitals. Participants were part of an informed consent process which allowed withdrawal of involvement at any point in the study. Participants were provided with background information on the research study, procedures, risks and benefits of participation in the study and protection of confidentiality. Those who participated in the study were assured that participation was voluntary and that involvement in the study would not affect their job status. Interviews took place at the convenience of the study participants and a confidential setting was located prior to the interviews. Interviews were audio recorded and transcribed. Upon completion of this study all audio and transcribed information gathered in the interviews has been destroyed.

Measurement

This study utilized in person interviews with providers to answer open ended questions regarding frequent mental health hospitalizations. A focus group was conducted with five of the participants as their availability best suited this type of interview. One participant responded to the interview questions by written response. Appendix A includes the scheduled interview questions that participants in this study were asked. The nature of the interview questions focused on provider opinions on frequent mental health hospitalizations. Questions were formed after a review of literature on frequent mental health hospitalizations. The conceptual framework

of empowerment and the desire to capture the story of those frequently hospitalized is reflected in the questions that those participating in the study were asked.

Analysis

For this qualitative study content analysis was used. Berg (2009) states that “content analysis is a careful, detailed, systemic examination and interpretation of a particular body of material in an effort to identify patterns, themes, biases, and meanings” (p.338). Open coding was used to deduct themes from the transcribed interviews. Content analysis was used to present themes from this qualitative study on frequent mental health hospitalizations.

Findings

This study was conducted with the contribution of ten participants. All participants were currently working in a hospital on a mental health inpatient unit. Five participants were social workers; four of these social workers were licensed independent clinical social workers (LICSW) and one was a licensed social worker (LSW). Three participants were registered nurses. One participant was a chaplain and one participant was a behavioral health associate. Participants were asked eleven open ended survey questions in regards to frequent mental health hospitalization. A research prelude was read to each participant before each interview began. This prelude was utilized to ensure that each participant was aware of the phrase revolving door patient.

This section will present themes found by content analysis of the transcribed participant interviews. Revolving door patient will be defined. The themes presented here are: medication management, persistent stigma, support for mental health stability, community resources, socio-demographic influences, inpatient factors, and utilizing psychiatric hospitalization.

Defining Revolving Door Patient

Participants were asked to give a definition of the term *revolving door patient*. Participant answers are summarized as follows: two to four admissions in one year, more than one admission a year, frequent admission within a year's time [even within a couple months], multiple admissions [not just two], and patients requiring multiple psychiatric inpatient hospitalizations within a shorter period of time.

Medication Management

Medication management was reported by all participants in this study. This theme was found to be a precipitating factor to frequent psychiatric hospitalizations. Medication management was reported when participants were asked what difficulties frequently hospitalized patients face and it was also reported in regards to reducing frequent hospitalizations.

The following statement is in regards to precipitating factors that lead to hospitalization:

Often times people go off their meds because they can't afford them, that's a big factor. They have side effects while they're on their medications. They don't think they need their medications anymore because they are feeling so good, they don't think that they are necessary anymore. And of course the longer they're off their medications the more they lose their insight.

Medication management was identified when asked what difficulties frequently hospitalized patients face:

Mainly medication management. They are either having issues revolving around finding the right medications that work for them and are covered by insurances or the medication works so well that they become hopeful of not needing to be medicated and they come off, leading them to decompensate.

Medication monitoring and education were identified in regards to reducing frequent hospitalizations:

<p>“I think if more people could have home med monitoring.”</p>
<p>“Education. Personal information that speaks to their situation, such as what their diagnosis means and what medications they are being prescribed and for what and why. These individuals are not always aware of these issues.”</p>

Findings from this study indicate that medication management is a significant precipitating factor to psychiatric hospitalization. Findings indicate that education and medication monitoring could assist patrons with medication management after discharge.

Persistent Stigma

The theme of persistent stigma was found in factors that are missing for frequently hospitalized patients, difficulties frequently hospitalized patients face, factors to reduce frequent hospitalizations and positive factors of utilizing psychiatric hospitalization.

Stigma can persist when awareness and education are not instilled; the following quote is an example of this: “I think the other thing that is missing for some people is family awareness, or education, the stigma is still there in some families, so they don’t get supported from family here.”

The following is an example of burden and stigma: “I think for some of them, being ostracized, by family or friends who are tired of frequent hospitalizations. Financially it certainly is a burden. The stigma I think is huge.”

Education on mental illness was identified in factors to reduce frequent hospitalizations. In regards to this, one participant stated: “I think that we need to pass that education on to the patients and try to decrease stigma.”

The following are examples of what can be positive about utilizing psychiatric hospitalization: “And I think hopefully the more families that deal with family members having psychiatric hospitalizations, it will become less stigmatized.”

And then decrease the stigma of mental illness so that having a mental illness is just as common as having diabetes or something like that, where you don’t feel different from other people because you have it, it’s accepted as a medical disorder that is treatable.

The findings in this study indicate that stigma is a perpetual issue for those utilizing frequent mental health hospitalizations; proving that awareness and education will benefit those in need of mental health services.

Support for Mental Health Stability

The theme of support for mental health stability was found in regards to factors that reduce frequent hospitalizations and traits of patients who stabilize with one inpatient hospitalization.

Participants stated the following after being asked about the traits of patients who stabilize with one inpatient hospitalization versus those who are frequently hospitalized:

<p>“If they have good family support, good psychiatrist, again back to the community, those are the ones we don’t see as often.”</p>
<p>“Patients who typically stabilize have insight into their needs and often a plan to obtain and sustain those needs.”</p>
<p>“People that just don’t always care enough about them or support people enough, they’re out there on their own, and trying to live independently and just don’t have any support system to help stay stable in their environment.”</p>
<p>“Being in unsafe situations when they get out there again, lack of support from family and in the community, that can be problematic.”</p>

Stabilization with one hospitalization was attributed to having better resources and education in regards to mental health:

I think that people who are able to stabilize with one hospitalization are probably people who have better resources at their disposal. Whether it be finances, or family, or I think even educational level plays a part unfortunately because I think maybe people who aren't as educated just don't get the biological nature of what they are dealing with. It's not a matter of, oh if I just try harder my depression will go away, it's a physiological issue.

Early symptom detection was identified as a factor to reduce frequent hospitalizations:

I think that for number one, for a good part of people that come back to the hospital, have very poor family and friends support. I think that's number one. And you can only do so much, but having strong family ties, and good friends that recognize the problems early on so they can be more easily addressed in an outpatient type setting. Someone to be able to watch that and catch symptoms of things going back for these folks earlier on, rather than later, I think there is a way of having more of that, I think that there would be less repeat to the hospital.

The findings in this study indicate that support for mental health stability is of great importance.

The findings also indicate that success after discharge is dependent on the amount of support a patient receives.

Community Resources

The theme community resources was found in regards to factors to reduce frequent hospitalizations and what is missing for patients that are frequently hospitalized.

Resources and stability in the community were identified as factors to reduce frequent hospitalizations:

I think if we could get people connected to appointments to outpatient providers and somehow ensure that they would get there. And wish list, there would be less homelessness and more resources out there in the community. People to have stable homes, environments, communities.

Appropriate housing and support services in the community were identified as specific resources:

I would hope for more funding to get more community resources out there. I actually feel like the regional treatment center needs more beds opened, not less shut down. I think that the chronic people that really need to remain in a regional treatment center should be there, I'd like to see the regional treatment center go back to more what they were years ago where the patients are more involved in their care and they learned some skills there whether it be cleaning, or gardening, or something like that, ya know where they can live there and be supervised long term, but yet feel real productive and have skills. And then for people that can be in the community and maintain themselves out there I think we need lots of resources, more support services to keep them in the community which is ultimately the goal, if they're able to maintain out there.

A well functioning mental health system was identified as a factor that is missing for patients that are frequently hospitalized:

A good mental health system. [participant chuckles] Like I say, back to kind of what I mentioned in the first thing it starts with funding and it seems like the system is broken all the way, from the top on down, there isn't the money to have the appropriate community resources for people with mental illness. We're always looking for resources, and the facilities that are out there are full, there's waiting lists, you can't get in in a timely manner, that kind of thing, so that really back logs people in a hospital setting. I think that the newest medications are very expensive, so sometimes we have really good options but people can't afford them, insurance companies won't cover the cost. Again, there is not enough psychiatric staff in the community overseeing the mentally ill that are out in the community. It's hard for them to get in to a psychiatrist, to have follow up appointments, a lot of psychiatrists are booked two to three months out.

Findings from this study indicate that community resources are needed to ensure mental health stability. Findings from this study indicate that these resources are scarce; to reduce frequent mental health hospitalizations additional community resources are required.

Socio-demographic Influences

Such factors found in the theme of socio-demographic influences were level of education, socioeconomic status, mental health diagnoses, coping skills, insight, and co-occurring disorders.

Participants stated the following after being asked about the traits of patients who stabilize with one inpatient hospitalization versus those who are frequently hospitalized:

<p>“Again I think socioeconomic position can play a part. In my experience I think a lot of it has to do with chemical dependency issues too.”</p>
<p>“I think, cognitive ability is one of them. The ability to reason, the insight I guess is what I am talking about, and reasoning. The acceptance of the mental illness and doing their part for it, to be stable.”</p>
<p>“I think diagnosis is a big thing. Follow through. The type of support they have outside of the hospital, their kind of family structure. I think too, just their level of economic status.”</p>
<p>“Falling back in to old patterns, old negative patterns that they had previously learned, and inability to use the tools that they may have learned from their first hospitalization.”</p>

When asked to describe commonalities in patients that are frequently hospitalized participants stated:

<p>“Homelessness, chemical dependency, lack of support, lack of coping skills, diagnosis, thought disorders, mood disorders, personality disorders.”</p>
<p>“Axis II traits.”</p>
<p>“Like I say they are the more vulnerable, probably more hopeless. Chronic. Multiple admissions before. Poor support systems, poor coping skills.”</p>

The following is a participant statement in regards to soci-demographic influences of those that are frequently hospitalized:

They get in to drugs again, is one commonality. You get your personality disorders in to this too, and some personalities are tougher than others, and it goes back to that gaining the insight, and able to self-exam, and take care of their problems.

Findings from this study indicate commonalities in patients that are frequently hospitalized.

Findings indicate that level of education, socioeconomic status, mental health diagnoses, coping skills, insight, and co-occurring disorders are socio-demographic influences affecting frequent mental health hospitalizations.

Inpatient Factors

The theme of inpatient factors include assigned staff, staff frustration, admission criteria, services in the hospital, and pressure to discharge patients from the hospital.

Mental health stability at discharge and compassion are identified as factors missing for patients that are frequently hospitalized:

And even their own mental health stability when they leave, sometimes they leave when they are just not ready. And sometimes it's just impossible to keep them in the hospital long enough to really get them the stability that they are going to need to be successful and with some mental illnesses it just takes so long.

I think a lot of times they are coming back to the same institution, seeing the same doctors, seeing the same staff, sitting through the same groups, again and again and again, I think sometimes a fresh perspective for the patient would be good. I think that compassion is missing for them, either from staff or from their family, or friends. And I think, when they get out maybe they don't have the supports that they need. We are a crisis stabilization unit, so we don't provide the long term care, supposedly. But it just seems like maybe their discharge plan wasn't thought out well enough, the resources weren't in place for them.

Resourceful triaging and improved communication were identified as factors to reduce frequent hospitalizations:

I think sometimes we admit people that the criteria isn't there. They are intoxicated and they say they are suicidal so we admit them. The ER doctor puts them on a hold, and when they are sober they want to leave, and they can cause a lot of problems and they are not suicidal, they just want to get out of there. Sometimes it jeopardizes their jobs even, but I will say we look at the record, and if this happens frequently and if there's been suicide attempts then of course they need to be there. But a lot of times that's not the case, I was hoping the ED suite downstairs would sober them up safely and give them resources and send them on their way.

I think better triaging in the Emergency Department. And also the ability to point people to resources in a meaningful way down there, that would be really good. Another one I would add would be an improved communication system between outpatient providers and inpatient providers. So that if people do doctor hop there is a way to be aware of that, or stop it, or if their outpatient person has them on certain meds that we do a much better job of communicating is that, or those the correct meds? Or do we need to change it all up. Too many patient's go from doctor to doctor, their diagnoses can change, their meds can change, from month to month, and then they end back up in the hospital because too many things have changed, out of their control. One thing we didn't talk about in some of these previous questions too, is the chronic pain population, and the mentally ill, and that's another factor I think that brings people in to the hospital quite a bit.

The following question was asked during one participant's interview: "Do you see structure and routine as something that might be bringing people back in frequently? The participant stated the following:

Yes, yes. I've seen them come back early from their pass for their baked potato or to play bingo. [Laughter]. Yes, we make it real comfortable for them. I have talked to my director, and we need a psychologist on board. People are there way too long, the commitment process is way too long, they get better, and then they get depressed cause they are there so long. I think they need some one on one in depth therapy that we are not providing these people when they are here, a quarter of a year. And, they get really bored. But I think the cognitive behavioral, one on one would be a wonderful, wonderful thing. I've been told it's a money thing and a budget thing. But that would be fabulous, just fabulous. Our groups are good, but they're mostly time fillers, they're pretty general. Everybody goes to the group, so if you have a disruptive person, or ya know, they are not in depth at all, they're pretty superficial.

Assigned staff was identified as an inpatient factor of frequent mental health hospitalizations:

I have noticed a pattern over the years that if a patient receives certain staff members, those patients will be much more successful compared to others. I believe this is because those staff members take time to educate their patients and advocate on a higher level than others.

Here is an example of assigned staff familiarity and frequent hospitalizations:

I do think it's tragic for the patient. It can be demoralizing to staff. You can think you have the best plan in the world in place, and then two weeks later here comes, ya know, Joe Patient again, and you're like wholly crap, I thought we had this. It's not easy being a patient, or being a staff member. And I do think that familiarity that we can get with frequent flyers can also be a disservice. There are times when I will ask one of the other chaplains to go up and see somebody that I know pretty well to see if a fresh perspective would be helpful. Ya know, because they know all my shtick, they know all my spiel, and

I know there's. So maybe fresh eyes and fresh ears will see or hear something that I'm not picking up.

Staff frustration was identified as an inpatient factor of frequent mental health hospitalizations:

I think there's plenty of cases where just on a personal basis it can be frustrating to see the name again, like wow. And I get so judgmental about that, maybe I feel like I didn't do my job good enough or something, I don't know. There's a lot of factors involved.

Pressure to discharge patients was identified as an inpatient factor of frequent mental health hospitalizations:

I see a lot of it in the job I'm doing now, I think with the present economy, we are under tremendous pressure in the hospital to get people in and out as fast as we can, and it's way too fast time. And the insurance companies pressure us to get people moved along. And everybody knows that being hospitalized is expensive, but repeated hospitalizations are also very expensive, it'd be nice to give people the time they need, to get brain chemistry turned around a little bit better before they were pushed out the door, so they go out the door more stable, and can maintain themselves out in the community. We've seen a lot of people return because they get pushed out too soon and they're back again, they just weren't ready to go in the first place. And that's frustrating, very frustrating. And I think because we are going as fast as we are we don't do as good as we can. In our own hospital environment, I really don't like the way we are organized in that, we as nurses are never included in the team meetings on patients. And the team meetings have turned in to just discharge meetings where the focus is get them in and get them out. And I am an old nurse, and I really hang on to my old values of what nursing should be, and what good care for patients should be and I think that we need to focus the team on providing good care and that would expedite the discharge of a patient.

Findings from this study indicate the following inpatient factors affect frequent mental health hospitalizations: assigned staff, staff frustration, admission criteria, services in the hospital, pressure to discharge patients from the hospital, mental health stability at discharge, resourceful triaging, improved communication, structure and routine in the hospital, and compassion.

Utilizing Psychiatric Hospitalization

Participants were asked what strengths they see in patients that are frequently hospitalized and what is positive about utilizing psychiatric hospitalization.

Participants shared strengths of those that are frequently hospitalized and identified that patients return to the hospital to find community:

Persistent. Resourceful. Able to ask for help when they need it. One thing, I'm not going to claim that this is my own answer, it's coming from a psychiatrist, but one of the psychiatrist's on the unit we kinda talked about how some of these kids who keep re-presenting are really just trying to get their own needs met. And their life is so dysfunctional out of the hospital, and they know it! And they know that they can have some stability here in the hospital, so that's their way of getting some needs met. And the adult patients, and I'm sure that the other ones too you are talking about, it's just this can be a community for a lot of these people that keep coming back. And heck, who doesn't need a community!

The ability to ask for help when it is needed is viewed as a strength:

When I see somebody on the unit I go, you knew it was time to come here again, you know when to ask for help, you always know that this is where you can come. She was here two days, but it's somebody that's been here 75 times. But to me it's a strength in her, cause she knows when she's starting to spiral out of control. But yet can catch it before it gets so far out of control. She knew, she called her case manager and said I need to go to the hospital. And everybody knows her well enough that when she says it, she doesn't take advantage. Or use the hospital inappropriately.

Securing resources was identified as a positive factor of utilizing psychiatric hospitalization:

It gets people resources. I think there is, such a lack of mental health resources, and community resources. It gets people off the streets, it gets people on meds. But again we are just a crisis unit so we get them that stuff and then send them back out in the same situation and think it's going to be different results. For those who do get better with one hospitalization, however it's amazing, it's wonderful, it's great. I'm glad that there are psych meds, because I do think that there are people that just need a little boost, and maybe people just need to come in for a tune up, every now and again, make sure the meds are working.

A safe environment was identified as a positive factor of utilizing psychiatric hospitalization:

It provides a safe environment, and that is our number one goal and priority. That's why we're here, cause this is acute care. Safe environment. The milieu can be very therapeutic for patients, and when that happens it's something wonderful. They'll get together and talk and vent and they help each other, it's more powerful I think than people realize. And just that somebody cares and will listen to them, again very therapeutic. And there is structure and routine, and safeness, and they feel that.

Medication management and respite were identified as positive factors of utilizing psychiatric hospitalization:

There is a lot of opportunity between the therapy, and the assessments the doctors do. Get back on medications. Resources. For some people, it saves their lives. I mean if they are serious enough at risk we can catch them before they've completed a suicide, or hurt someone else. And it just interrupts that cycle of despair. Sometimes I think it's positive because it gives families a break too. Caregivers is a right way to put it. Everybody. Whether it's group home staff, or family members or whatever. And sometimes the patient. Sometimes they do just need a break from each other to regroup and to form a new plan of action or something... Another good positive is it speeds things up for people, significantly with those waits for psychiatrists, if need to be in the hospital, they don't just have to hang on, they get it all done. Sometimes they get priority for other services. I think the other thing is for people who come in you hope that maybe each time they will learn more about their own symptoms. So it's education. And their visits get shorter. Symptom management. Education for the family. It's one of the only ways to really monitor medications, if they are new, or maybe adjusting their meds.

Findings indicate that there are viewable strengths and positive attributes to utilizing psychiatric hospitalization. Psychiatric hospitalization provides a safe environment for those who are experiencing a mental health crisis. Findings indicate that those utilizing hospitalization can be viewed as resourceful and persistent.

Discussion

The purpose of this study was to gather provider opinions on frequent mental health hospitalizations. This study aimed to gather qualitative data to add to previous research on mental health recidivism. A discussion of this study's findings is presented in this section.

Both the literature review and findings of this study support the notion that defining frequent hospitalization yields varying results and finds no clear consensus. Participants from this study answered with a variety of definitions when asked to define a revolving door patient. Information from the literature review and findings from this study suggest that a revolving door patient is one that requires frequent mental health hospitalizations. What constitutes frequent however is still unclear. Participant answers from this study would suggest that a revolving door patient is one that has been hospitalized multiple times a year. Information from the literature review yields varying data and presents multiple phrases for those frequently hospitalized.

All participants in this study indicated that medication management was a precipitating factor to psychiatric hospitalization. Medication management is influenced by many factors. Findings from this study indicate the following: inability to afford prescribed medications, inability to consistently take prescribed medications, inability to find medications that work properly and do not have counterproductive side effects, and the hope that medication is not needed after a period of stability. Researchers Langdon and colleagues (2001) and Oyffe and colleagues (2009) also indicated medication management as a variable in their research on frequent mental health hospitalizations. These researchers studied the type of medication prescribed and medication non-compliance.

Findings from this study indicate that level of education, socioeconomic status, mental health diagnoses, coping skills, insight, and co-occurring disorders (chemical dependency) are similarities in patients that require frequent mental health hospitalizations. From this list, the most frequently named influence was coping skills. Previous researchers have studied similar socio-demographic influences in regards to precipitating factors of those frequently hospitalized. From the above listed influences, Langdon and colleagues (2001) and Hodgson and colleagues (2001) indicate that a psychotic disorder and co-occurring chemical dependency were found to be strong predictors of admission.

Findings from this study indicate that support at discharge is present for those who stabilize with one inpatient psychiatric hospitalization versus those who require frequent hospitalizations. Participants indicated that this support can be utilized from family, friends, outpatient services, and community resources. Participants specified that a patient's living situation can greatly affect their ability to stay stable and remain in the community.

The findings from this study parallel those of the literature review, suggesting that support at discharge is a variable of significance for those frequently hospitalized. Langdon and colleagues (2001) found that living status proved to be a variable of significance, stating that revolving door patients were more likely to be living alone. Hodgson and colleagues (2001) found that marital status was a variable of significance, stating that those who were not married were at higher risk for admission. Miller and Willer (1976) suggest social factors are significant rehospitalization determinants; and Morin and Seidman (1986) indicate that key social network characteristics can be modified and anticipate that hospitalizations will decrease.

Findings from this study indicate that community resources are missing for patients who are frequently hospitalized. Participants identified that funding and availability are significant variables to the access of community resources. Findings indicate that adequate community resources could reduce frequent mental health hospitalizations.

Findings of this study reference success at discharge to community variables. While Oyffe and colleagues (2009) and Langdon and colleagues (2001) studied place of discharge, accommodation at discharge, and type of outpatient treatment, these variables were not found to be of statistical significance in these studies.

Hillman (2000) indicates that case management has been the most commonly researched systemic intervention and the method most frequently used to reduce recidivism. While case management is an effective intervention, greater access to community mental health resources would serve many more than case management is able to.

Participants indicated that there is a lack of appropriate resources for patients that are frequently hospitalized. While the deinstitutionalization movement aimed at community reintegration, many unintended consequences have developed. Participants from this study site benefits to ethical long term care of those with severe and persistent mental illness.

Findings from this study indicate that decreasing the stigma of mental illness would be beneficiary to those that are frequently hospitalized and could possibly decrease frequent mental health hospitalizations. Participants identified education as an intervention for patients and their families; participants stated that education to meet each patient's specific mental health needs is of significant value. This study found that persistent stigma is of concern for those utilizing mental health services. Similarly, Corrigan (2007) examined clinical diagnosis and the potential

exacerbation of the stigma of mental illness. While a diagnosis assists in the understanding of symptoms and possible treatment, each person's lived experience operates on a continuum that requires versatility. Findings from this study indicate that education in the hospital setting could increase the knowledge base and coping skills of those frequently hospitalized.

Findings from this study indicate that assigned staff, staff frustration, admission criteria, services in the hospital, and pressure to discharge patients from the hospital affects frequent mental health hospitalizations. Participants from one hospital indicated that they see positive results when staff take time to educate and advocate for their patients. Participants from this same hospital indicated that seeing the same staff and attending the same groups may be detrimental for those frequently hospitalized. Differing in this notion were participants from a second hospital who indicated that working with patients who have been admitted before can provide them with knowledge that assists in treatment and discharge planning. However, participants from both hospitals indicated that some frustration is present when a revolving door patient returns once again. Participants indicated that they believe the patients feel this disappointment as well. Montgomery and Kirkpatrick (2002) discuss patient and staff differences of the controllability of rehospitalization stating that staff view non-compliance as a variable, while patients view hospitalization as out of their control. The findings in this study appear to be similar to the research presented on controllability of rehospitalization.

Participants of this study indicated that admission criteria and psychiatric emergency room services could decrease frequent mental health hospitalizations. Participants indicated resourceful triaging as an intervention as some patients are admitted due to substance misuse. Ledoux and Minner (2006) found that variables of significance for frequent presentation to the psychiatric emergency room are grief and cravings (related to substance use). The findings of

this study indicate similarities to this research on frequent presentations to psychiatric emergency rooms.

Findings from this study indicate that some patients are discharged from the hospital before they are stable. Participants indicated that pressure from the hospital and insurance companies are contributing factors. On the opposite side of this spectrum are those who are hospitalized in the acute setting for too long of a time. Some patients are awaiting placement via the commitment process and can be hospitalized for months before availability at an appropriate facility is obtainable. Participants stated that these patients and others could benefit from individual therapy, specifically suggesting cognitive behavioral and dialectical behavioral therapy.

Findings from this study indicate strengths and positive attributes of psychiatric hospitalization. Participants indicated that appropriate rehospitalization does not have to carry a negative connotation. Participants stated that some patients will need to have mental health hospitalizations throughout their lifetime but see this as maintenance and as the ability to get help before all control is gone. Of similarity, Montgomery and Kirkpatrick (2002) suggest that factors concerning the patient's quality of life are more relevant indicators of success than readmission rates.

Strengths and Limitations

Strengths of this study include qualitative data that was gained from mental health providers on the subject of those who are frequently hospitalized. There is a lack of qualitative data in the literature on mental health recidivism; this study added personal narrative where a voice is currently lacking. Limitations of this study may include the lack of generalization of the

findings. This study gained a small number of interviews by providers who shared their own opinions; the data does not speak for all providers who work in mental health.

Implications for Social Work Practice

Education, advocacy, and community support are ways in which social work practice can facilitate change in the area of frequent mental health hospitalizations. Findings of this study indicate interventions that social workers could assist with in order to support patients who receive mental health services. Findings also suggested that for some patients rehospitalization for mental health may be a necessary part of treatment. Advocating for best practice and educating patients and their families will help ensure that patients receive the individualized treatment they need.

Implications for Policy

Findings of this study indicate that community resources are greatly instrumental in the care of those with mental health needs. Further findings suggested that community resources are scarce. Without changing the environment patients return to, frequent mental health hospitalizations will continue to be burdensome. Community mental health resources provide opportunities for patrons to remain stable in their living environments. There are many factors that affect frequent mental health hospitalizations, awareness can be shared through education and advocacy. Findings from this study indicate that restructuring services within acute inpatient facilities may modify the need for frequent mental health hospitalizations.

Implications for Research

To add to the research that has been conducted on frequent mental health hospitalizations it would be beneficial to gather data from patients who have experienced such hospitalizations. Findings from this study indicate that support is a key factor in success after discharge. Whether qualitative or quantitative, further research focused on gathering data from these patrons will be valuable.

References

- Ashcraft, L., & Anthony, W.A. (2010). Are we revolving or evolving? *Behavioral Healthcare, 30*(2), 22-23. Retrieved from <http://www.behavioral.net/article/are-we-revolving-or-evolving>
- Berg, B.L. (2009). *Qualitative research methods for the social sciences* (7th ed.). Boston: Allyn & Bacon.
- Bradshaw, W., Peterson-Armour, M., & Roseborough, D., (2007). Finding a place in the world: The experience of recovery from severe mental illness. *Qualitative Social Work, 6*(1),27-47. doi:10.1177/1473325007074164
- Brunero, S., Fairbrother, G., Lee, S., & Davis, M. (2007). Clinical characteristics of people with mental health problems who frequently attend an Australian emergency department. *Australian Health Review, 31*(3), 462-470. doi:10.1071/ah070462
- Carpenter, J. (2002). Mental health recovery paradigm: Implications for social work. *Health & Social Work, 27*(2), 86-94. doi:10.1093/hsw/27.2.86
- Corrigan, P.W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work, 52*(1), 31-39. doi:10.1093/sw/52.1.31
- Encyclopedia of Mental Disorders. (2012). *Crisis intervention*. Retrieved from <http://www.minddisorders.com/Br-Del/Crisis-intervention.html>
- Fleury, M., Greiner, G., Barnvita, J., & Caron, J. (2010). Professional service utilisation among

patients with severe mental disorders. *BMC Health Services Research*, 10, 141.

doi:10.1186/1472-6963-10-141

Greenblatt, M., & Norman, M. (1983). Deinstitutionalization: Health consequences for the mentally ill. *Annu. Rev. Public Health*, 4,131-154.

doi:10.1146/annurev.pu.04.050183.001023

Hayne, Y.M. (2003). Experiencing psychiatric diagnosis: Client perspectives on being named mentally ill. *Journal of Psychiatric and Mental Health Nursing*, 10(6), 722-729.

doi: 10.1046/j.1365-2850.2003.00666.x

Hillman, S.L. (2000). *Predictors of rapid psychiatric admission* (Doctoral dissertation).

Available from ProQuest Dissertations and Theses database. (UMI No. 9989826)

Hodgson, R.E., Lewis, M., & Boardman, A.P. (2001). Prediction of readmission to acute psychiatric units. *Social Psychiatry Psychiatric Epidemiology*, 36(6), 304-309.

doi: 10.1007/s001270170049

Holmes-Eber, P., & Riger, S. (1990). Hospitalization and the composition of mental patients' social networks. *Schizophrenia Bulletin*, 16(1), 157-164. doi: 10.1093/schbul/16.1.157

Langdon, P.E., Yaguez, L., Brown, J., & Hope, A. (2001) Who walks through the 'revolving-door' of a British psychiatric hospital? *Journal of Mental Health*, 10(5), 525-533.

doi:10.1080/09638230126725

Ledoux, Y., & Minner, P. (2006). Occasional and frequent repeaters in a psychiatric emergency

room. *Social Psychiatry Psychiatric Epidemiology*, *41*, 115-121. doi:10.1007/s00127-

005-0010-6

Lichtenberg, P., Levisons, D., Sharshevsky, Y., Feldman, D., & Lachman, M. (2008). Clinical

case management of revolving door patients- a semi-randomized study. *Acta Psychiatrica*

Scandinavica, *117*, 449-454. doi:10.1111/j.1600-0447.2008.01170.x

Miller, G.H., & Willer, B. (1976). Predictors of return to a psychiatric hospital. *Journal of*

Consulting and Clinical Psychology, *44*(6), 898-900. doi:10.1037/0022-006X.44.6.898

Montgomery, P., & Johnson, B. (1998). Chronically mentally ill individuals re-entering the

community after hospitalization. *Journal of Psychiatric and Mental Health Nursing*, *5*(6),

497-503. doi: 10.1046/j.1365-2850.1998.560497.x

Montgomery, P., & Kirkpatrick, H. (2002). Understanding those who seek frequent psychiatric

hospitalizations. *Archives of Psychiatric Nursing*, *16*(1), 16-24.

doi:10.1053/apnu.2002.30494

Morin, R.C., & Seidman, E. (1986). A social network approach and the revolving door patient.

Schizophrenia Bulletin, *12*(2), 262-273. doi: 10.1093/schbul/12.2.262

National Alliance on Mental Illness. (2012). *Mental illness: Facts and numbers*. Retrieved from

http://www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/Conte

[Management/ContentDisplay.cfm&ContentID=53155](http://www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/Conte)

National Association of Social Workers. NASW Code of Ethics (Guide to the Everyday Professional Conduct of Social Workers). Washington, DC: NASW, 2008. Print.

Novak-Grubic, V., Zalar, B., & Saje, M. (2009). The revolving door patients-are they different? *European Neuropsychopharmacology*, 19(3), 481-482. doi:10.1016/S0924-977X(09)70758-8

Oyffe, I., Kurs, R., Gelkopf, M., Melamed, Y., & Bleich, A. (2009). Revolving-door patients in a public psychiatric hospital in Israel: Cross sectional study. *Croatian Medical Journal*, 50(6), 575-582. doi:10.3325/cmj.2009.50.575

Public Broadcasting Service. (2005, May). *Deinstitutionalization: A psychiatric 'titanic.'*

Retrieved from

<http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html>

Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions.

Social Work, 41(3), 296-305. doi: 10.1093/sw/41.3.296

Strack, K.M., Deal, W.P., and Schulenberg, S.E., (2007). Coercion and empowerment in the treatment of individuals with serious mental illness: A preliminary investigation.

Psychological Services, 4(2), 96-106. doi:10.1037/1541-1559.4.2.96

World Health Organization. (2001, October 4). *Mental disorders affect one in four people.*

Retrieved from http://www.who.int/whr/2001/media_centre/press_release/en/index.html#

Appendix A
Interview Questions

Interview Prelude: Researchers differ on defining frequent hospitalizations and what constitutes frequent. Revolving door patients and frequent repeaters are terms that have been used to describe those needing multiple psychiatric hospitalizations. Research on this subject yields varying results and finds no clear consensus.

1. What is your job title and if applicable your licensure?
2. In your opinion, what is a definition of a revolving door patient?
3. In your experience, please describe precipitating factors that lead to hospitalization.
4. What are the strengths that you see in patients that are frequently hospitalized?
5. Regarding patients who are frequently hospitalized, what difficulties do you see them going through?
6. What do you think is missing for patients who are frequently hospitalized?
7. In your opinion, what are the traits of patients who are frequently hospitalized versus those who stabilize with one inpatient hospitalization?
8. Please describe any commonalities you see in patients that are frequently hospitalized.
9. Please describe what you would change in order to reduce frequent hospitalizations.
10. In your opinion, what is positive about utilizing psychiatric hospitalization?
11. Is there anything else you would like to add regarding frequent psychiatric hospitalizations?