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UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

PSYCHIATRIC PATIENTS' PERCEPTION OF INVOLVEMENT IN THE
PLAN OF CARE

by

Jaspal Kaur Gill

A dissertation presented to the
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree
DOCTOR OF PHILOSOPHY IN NURSING

May 2019

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UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

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DISSERTATION: Psychiatric Patients' Perception of Involvement in the Plan of Care

DISSERTATION

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Abstract

Background: There is an increased need to actively engage and involve patients in their care planning in healthcare facilities including psychiatric facilities (Wills, Riefer, Schauer, & del Vecchio, 2011). There has been a growing interest in patient-centered care and patients' involvement in their plan of care as it leads to positive healthcare outcomes and increased patient satisfaction. However, there is a lack of research on how psychiatric patients perceive their involvement in the care planning while they are admitted to an inpatient psychiatric facility.

Aim: The aim of this qualitative phenomenological research study was to explore patients' perception of being involved in their plan of care during an inpatient psychiatric hospital stay.

Method: The hermeneutic phenomenological research approach was used to understand and interpret the meaning of psychiatric patients' lived experiences of being admitted to an inpatient psychiatric facility. A sample of 12 participants who had been admitted to an inpatient psychiatric facility within last 12 months was obtained. The participants' ages ranged from 29-76 years. Data were collected using digitally recorded one-on-one semi-structured interviews. Colaizzi's (1978) 7-step data analysis method was used to analyze the meaning of participants' lived experiences.

Findings: Seven major themes were identified: participants' knowledge about the plan of care, involvement, safety, compartmentalization of care, psychiatric inpatient admission as a turning point, inpatient as a holding place, and importance of social support.

Conclusion: This study shows that psychiatric patients desire to be informed and involved in their plan of care. They want to receive care that is individualized and

centered to their specific needs. They desire a safe and therapeutic environment to focus on their mental health. This study also suggests positive inpatient experience when patients' family/friends are actively involved in their care.

Implication: The findings of this study may lead to a cascade of changes at different levels in healthcare to improve the quality of care provided to patients in inpatient psychiatric facilities.

Dedication

This work is dedicated to my family for their continuous support and encouragement that enabled me to successfully complete this study.

Acknowledgement

I would like to express my sincere appreciation to my chair Dr. Jane M. Georges and my dissertation committee members, Dr. Semira Semino-Asaro and Dr. Michael Terry, for their guidance and continuous support throughout this journey, without which this study would have not been possible.

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Finally, I am forever thankful to my husband, Jasinder Singh Gill, for his patience and support throughout my academic journey, to my children for understanding and allowing me the time to focus on this study, and to my in-laws and parents for their continuous support and always being available to assist as needed.

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Chapter 1: Introduction

There is an increased need to actively engage and involve patients in their care planning in healthcare facilities including psychiatric facilities (Wills, Riefer, Schauer, & del Vecchio, 2011). There has been a growing interest in patient-centered care and patients' involvement in their plan of care as it leads to positive health care outcomes and increased patient satisfaction. However, there is a lack of research on how psychiatric patients perceive their involvement in the care planning while they are admitted to an inpatient psychiatric facility.

Background

The importance of involving patients in the plan of their care is demonstrated globally and accepted as a highly recommended practice in the healthcare field (Vahdat, Hamzehgardeshi, Hessam, & Hamzehgardeshi, 2014). There is a substantial amount of evidence showing that the involvement of patients in their plan of care and shared decision-making yields better healthcare outcomes, increases treatment adherence, and improves patient satisfaction (Joosten, de Weert, Sensky, van der Staak, & de Jong, 2008). The current healthcare system highly emphasizes the participatory approach. (Duncan, Best, & Hagen, 2010).

Despite the current emphasis on involving patients in their plan of care, the definition of patient involvement remains vague. When talking about patient involvement, many different terms are used in the literature including patient engagement and patient participation. Current authors also include multiple levels of patient involvement such as micro-level, meso-level and macro-level involvement (Tambuyzer & Audenhove, 2013). This study focused on micro-level involvement, which means the

individual patient participates in his/her own care planning. The key focus of this qualitative study was patients' involvement in their plan of care leading to shared decision-making.

For the purpose of this study, shared decision-making is defined as the process in which there are at least two participants involved in a conversation that is typically between healthcare provider and patient. Both participants get a chance to share information. After the information exchange, both participants build a consensus on the preferred treatment and implement the agreed treatment option (Charles, Gafni, & Whelan, 1997; Elwyn et al. 2010).

The information-sharing phase is the most critical part of this model that helps patients be involved in their plan of care and make a sound decision. In order to offer the best treatment option, the healthcare professional (HCP) needs to listen to the patient's concerns and complaints. After receiving the information from the patient, the HCP should provide detailed information to the patient regarding different treatment options. As the patient receives the information from the HCP and understands the options clearly, the patient will be able to make an appropriate treatment decision. This interaction between the HCP and the patient will prompt the patient to ask questions, get clarification, and become actively involved in treatment-planning and decision-making. Effective HCP-patient interaction also leads to increased patient satisfaction (King & Hoppe, 2013). The study done by Veilleux et al. (2017) showed that the active patient involvement in shared decision-making is directly related to increased patient satisfaction. When patients are involved in their care, they are more informed and have a

better understanding of treatment options. Involvement in plan of care also empowers patients to make sound decisions about their care (Tambuyzer & Audenhove, 2013).

Statement of the Problem

In the inpatient psychiatric unit, healthcare professionals work with a unique patient population. There is a stigma attached to the psychiatric patient population and their ability to be involved in their plan of care. A study done by Hill & Laugharne (2006) showed that psychiatric patients have similar desires to participate in the planning of their care. This study utilized two samples: patients from a community mental health team (111) and patients from the Cornwall Mental Health Forums (49). Each patient completed a survey questionnaire. The results from both samples showed that psychiatric patients want to receive information regarding their psychiatric care and take part in the decision-making process rather than have a clinician decide their care independently. The presence of a psychiatric disorder may influence the patient's desire and ability to be involved in care planning and sound decision-making. For example, patients with acute exacerbation of schizophrenia may not be able to understand the information provided to them regarding their treatment plan and may not be involved in their treatment decision due to their decreased mental capacity. However, providing educational interventions to improve an individual's understanding about the information provided can improve their capacity to make appropriate care decisions (Misra, Rosenstein, Socherman, & Ganzini, 2010).

Due to the variability in levels of functioning among patients with a psychiatric disorder, making the assumption that they would not want to or could not be involved in their care planning is not conducive to providing patient-centered care. Individuals with a

psychiatric disorder can take part in their care planning and decision-making to some extent. Some psychiatric patients may like to be involved more than others, but most patients want to take part in their care decisions (Hill & Laugharne, 2006). Proper assessment of a patient's ability and desire to be involved in care planning needs to be made by clinician to provide patient-specific treatment options and education.

Aim of the study

The aim of this qualitative phenomenological research study was to explore patients' perception of being involved in their plan of care during an inpatient psychiatric hospital stay.

Method

This hermeneutic phenomenological study investigated adults who had a psychiatric diagnosis and had been admitted to an inpatient psychiatric facility within last 12 months. Participants were recruited from an outpatient psychiatric clinic on a voluntary basis. Qualitative data collection was done in the form of individual interviews with the participants and the use of field notes. The analysis of this study was done using Colizzi's (1978) method of data analysis and the results provided insight regarding patients' perception of involvement in their plan of care. Findings from this study will provide a basis for improving psychiatric care and create a foundation for future efforts in the area of psychiatric patients' empowerment and engagement.

Lines of Inquiry

1. What does involvement mean for psychiatric patients?
2. Do psychiatric patients feel they are involved in their care planning and decision making?

3. Do they feel that they get the information that they need to make sound decisions?
4. Do they feel their care plans are personalized by keeping their needs and preferences in mind?
5. Do they feel their opinions are considered?

Psychiatric patients' lived experiences can provide great insights regarding all these unanswered questions.

Importance of the Study

The researcher could not locate any published qualitative research that describes a patient's lived experience in an inpatient psychiatric facility regarding his or her involvement in the plan of care. While hospitals make attempts to involve patients in their plan of care, no documentation exists regarding its effectiveness. Though a plethora of research has been published about benefits of involving patients in the plan of care and patients wanting to be involved in their care, many gaps in the knowledge remain.

Despite much effort, the researcher could not locate any published evidence indicating whether patients at inpatient psychiatric facilities feel they are being involved in their plan of care. In order to fill this gap in knowledge, a qualitative phenomenological study was needed that would explore the patients' perceptions about being involved in their care planning during an inpatient psychiatric hospital stay. The findings of this research study will enable researchers to understand more deeply what involvement in the care planning means to psychiatric patients, including what kind of information they would like to receive while admitted to the inpatient psychiatric facility.

Information obtained from their lived experience will enable healthcare professionals to provide patient centered and individualize care according to patient needs.

Chapter 2: Literature Review

The literature review was done to understand existing knowledge of patients' involvement in their plan of care and its positive impact on patient outcomes. Most current research studies are done in the general patient population. Only a scant amount of published research is present regarding this topic in the psychiatric patient population. Many potentially invalid assumptions are made about psychiatric patients' abilities and desires to be involved in their care planning. This chapter will provide an overview of existing literature pertaining to patient involvement in the plan of care. This chapter will also identify gaps in knowledge, triggering the necessity of conducting a qualitative study to describe the lived experiences of patients in inpatient psychiatric facilities regarding their involvement in care planning and decision-making.

It is very important for patients to understand and receive information regarding their medical and mental health and diseases, what services are available to them, and how to receive the basic care to improve their health. When patients are actively involved in their care and are more informed, they enjoy increased satisfaction, increased accessibility and quality of care, and better healthcare outcomes leading to a better quality of life and better healthcare experience (Hack, Degner, Watson, & Sinha, 2006; Joosten et al., 2008; Mosen et al., 2007; Tambuyzer, Pieters, & Audenhove., 2011). However, this has been a great challenge for many patients who do not have enough knowledge to navigate the healthcare system and access available resources due to multiple factors, particularly a lack of health literacy. Not all of patients receive complete information regarding their illness to make sound decisions. In many cases where information is provided to patients in detail, the patients become overwhelmed with the quantity of

information and are unable to make sound healthcare decisions due to lack of confidence and low health literacy (James, 2013).

In order to improve patients' knowledge regarding their health and understanding these problems in healthcare, the Institute of Medicine (IOM)(2001), renamed National Academy of Medicine, called for reform to create a healthcare system that will focus on "patient-centered" care. This means that a patient's preferences and individual needs should guide treatment decisions. The IOM 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, provided detailed information on gaps in healthcare delivery and required changes to improve the quality of care provided to patients to meet their individual healthcare needs. The aim of that healthcare reform is to provide care that is safe, efficient, timely, equitable and patient-centered.

The healthcare system started to incorporate these changes to cross the quality chasm. Multiple other healthcare models such as the consumer-directed health plans and the Chronic Illness Care Model placed patients at the center of the of care and treatment decisions. Consequently, involving patients and integrating their healthcare beliefs and values to provide individualized care became a very important part of the healthcare delivery system and the arena of patient involvement/engagement emerged. As this field developed, many research studies on different models of patient engagement, different levels of patient engagement, and creative ways of encouraging and motivating patients to take part in their healthcare and treatment decision-making emerged. As a result, a greater understanding of barriers to that engagement developed; barriers such as the lack of health literacy, diverse background, cognitive issues, and cost related issues (James, 2013).

The words patient “involvement” and patient “engagement” are used interchangeably throughout the literature to represent active partnership between the healthcare provider and the patient to create the care plan that meets the patient’s individualized healthcare needs. Carman et al. (2013) described patient engagement at different levels on a continuum, ranging from consultation to partnership with the provider (direct care), to sharing their experience and being part of the healthcare facilities’ care quality improvement committees (organizational design and governance), to being involved in and/or influencing healthcare policies (policy making). The patient engagement continuum ranges from a patient being consulted, to being involved, to being an equal partner in decision-making. At the lower end of the continuum, patients are involved but do not have much power in decision-making. Healthcare providers and organizations put forth their own agenda and ask patients for their input. At this level information is flowing to patient and then flows back to the system. On the higher end of the engagement continuum, patients have shared responsibility and power in decision-making and are actively involved in making agendas. At this level of the continuum, the information flow is bidirectional until the decision is made.

In order to involve patients in their plan of care, healthcare providers need to ensure patients are motivated toward recovery and want to be part of their treatment planning. Patient activation is an important step toward engaging patients in their treatment decisions. Hibbard, Stockard, Mahoney, & Tusler (2004) define patient activation as the patient’s knowledge, skills, willingness, confidence, and the ability to manage his/her health and healthcare independently. Mosen et al. (2007) found that patients who are highly activated consistently have better healthcare experiences. As

patient activation became an important aspect of patient engagement, multiple different tools to assess patient activation and interventions to enhance patient activation emerged and the healthcare systems started incorporating these tools to enhance patient engagement in their treatment decisions.

Patient activation and engagement in treatment planning enables a patient to participate in sound decision-making regarding his/her care. As patients are more informed and more engaged/involved, joint decision-making between healthcare professionals and patients becomes a natural process. This leads to patients receiving care that is centered on their individualized needs. Patient involvement in healthcare delivery also makes care provided in the hospital safer as information exchange between the patient and the provider allows the patient to fill any information gaps regarding his or her care as well as health history and treatment (Bishop & Macdonald, 2017; Légaré, Ratté, Gravel, & Graham, 2008).

A qualitative research study done by Bishop and Macdonald (2017) showed that when patients were not informed or involved in their care plan, they felt that they did not know much about their care and had no control over their situation in the hospital. They communicated feeling overwhelmed by their situation. Patients communicated feeling respected and comfortable sharing their health information with the provider when rapport was built between the patient and the provider. Participants also communicated they were more involved in their care when the provider was not rushed and had time to interact with them. Also, being engaged when the information is provided and asking questions to clearly understand the information provided was a highlight for sharing responsibly for their safety (Bishop & Macdonald, 2017). There has been a plethora of

research showing the evidence of better healthcare outcomes, increased patient satisfaction, and lower medical expenses when patients are actively involved in their care (Wagner et al. 2001).

Healthcare users find it helpful to receive information about their disease process and treatment options. There has been extensive research that shows when patients are actively involved in their plan of care, they achieve better healthcare outcomes (Hamann, Kruse, Schmitz, Kissling, & Pajonk, 2010). When patients are involved in their plan of care, they have the opportunity to discuss their care and needs with their healthcare provider, they can ask questions and add information to the discussion, and thus, they have positive perception of safety (Légaré et al., 2008; O'Connell and Penney, 2001).

Involving patients in shared decision making has been linked to patient empowerment. When involved, patients felt power and control over their care. Empowerment is a psychological state of mind; for example, usage of the term self-empowerment appears attributed to self-determination. It is also attributed to increased knowledge of individual as in the case of usage where knowledge is synonymized to empowerment (Laschinger, Finegan, & Shamian, 2001). Empowerment as a psychological state is characterized as an individual having the perception of autonomy and control. It also signifies the ability to act independently. As a process it is seen as a framework for transferring authority and power to subordinates. Empowered people have the feeling of being in control of their surroundings (Rappaport, 1984). Empowerment is also the sense of having authority to act independently (Montani, Courcy, Giorgi, & Boilard, 2015). When patients are involved in decision-making, they feel a sense of authority and independence about their healthcare decisions (Eliacin, Salyers, Kukla, &

Matthias, 2015; Tambuyzer & Audenhove, 2013). Therefore, shared decision-making leads to patient empowerment.

Despite the potential to improve the quality of the decision-making process and patient outcomes, shared decision-making is not always practiced in clinical settings. Healthcare providers involve patients in shared decision-making practices only when providers were motivated about shared decision-making and perceived that doing so will lead to a positive health outcome for the patient and will have a positive impact on the clinical process. The barriers perceived by providers to implement shared decision-making in clinical practice are not having enough time to include the patient in decision-making, lack of applicability related to the clinical situation, and lack of applicability due to patient characteristics (Légaré et al., 2008).

As the medical field has progressed from the paternalistic model to one of informed choice and has been implemented successfully in several areas, the field of psychiatry remains unexplored regarding the level of involvement of patients in decision-making. The ability and the desire of a psychiatric patient to be informed and involved in their treatment planning needs to be explored rigorously. Most of the existing research on this topic is done in the general patient population. The few studies that are done in the psychiatric patient population do not show that shared decision-making is effectively implemented in psychiatry. Multiple studies have shown that psychiatric patients desire to be fully informed and engaged in shared decision-making with their healthcare provider (Simon, Wills, & Harter, 2009) and majority of them are able to make rational decisions and understand their treatment options (Carpenter et al., 2000; Hamman et al.,

2010; Stroup et al., 2005). The researcher could not locate any research study showing psychiatric patients are regularly provided the opportunity to be involved.

A qualitative research study in the United Kingdom done by Hill and Laugharne in 2006 measured psychiatric patients' preferences for seeking information and decision-making. The researchers used the Autonomy Preference Index (API) that was designed in the United States for measuring medical patients' desire of seeking information and being part of the decision-making process. The researchers modified the index to make it relevant to psychiatric patients. The results of this study revealed that psychiatric patients had a high desire to receive information. Patients also desired some degree of shared decision-making power instead of the provider making independent decision about the patients' care. Patients experiencing more acute episodes of mental illness had less desire to take part in decision-making as compared to other psychiatric patients. These results were very similar to the study done in the general medical patient population by Ende, Kazis, Ash, and Moskowitz in 1989 using the API scale in the United States and by Deber, Kraetschmer, and Irvine in 1996 in Canada. This study advocates the desire of psychiatric patients for autonomy is very similar to the general patient population.

In 2011, Tambuyzer and colleagues published a literature review of the complex nature of patient involvement. In this article, they introduced a holistic model that provided an overview of elements defining patient involvement and the determinant and outcomes of patient involvement in mental health care. The determinants were communication and information provided to the patient, the attitude of the healthcare provider regarding patient involvement, resources and time for patient involvement, education and support provided to the nursing staff about the patient involvement,

accessibility of procedures, and presence of legal framework regarding patient involvement. The key elements that were detected for patient involvement were patients' participation in decision-making, the active role of patient involvement, involvement in a wide range of activities, knowledge by experience, and collaboration with healthcare professionals. In addition, the authors pointed to the negative effect of acute mental illness on patient involvement as it may reduce a patient's capacity for decision-making and reduce the ability to understand treatment options. It can also affect the motivation and the desire to be involved. However, that does not mean that the patient cannot be included or involved at all. Patients may still have the ability to make decisions that are not as complex. The short-term goals of patient involvement are empowerment, recovery, increased satisfaction, increased accessibility and quality of care, and better healthcare outcomes leading to a higher quality of life (Tambuyzer et al., 2011).

The study done by Eliacin and colleagues in 2015 showed that patients communicated a broad range of participation preferences in decision-making regarding their treatment. This qualitative study involved interviewing 54 veterans in the United States who were receiving outpatient psychiatric care at a Veterans Affairs Medical Center. Many participants in this study viewed their full participation in their treatment planning and decision-making as an effective way of communicating with their provider and making sure their care decisions were made based on their needs. Being fully involved in a shared decision-making process gave them a sense of responsibility and empowerment. Some participants left the decision-making to their providers as they felt their providers were experts and have more knowledge in choosing the right treatment. These individuals had a long-term relationship with their providers and trusted their

providers to make the right decision for them. They may have also opted out of the decision-making process for fear of making the wrong decision due to the lack of mental health literacy. Participants also communicated having an unsatisfactory relationship with their providers when there was a disagreement regarding treatment decisions. Some participants were able to overcome this by clearly explaining their concerns to their providers while others changed providers. This study was based on participants' shared decision-making practices with their mental health provider in the community.

A qualitative study done by Tambuyzer & Audenhove (2013) in Belgium utilized surveys of 111 psychiatric patients with serious and persistent mental illness from 36 multidisciplinary care networks to find out the effect of perceived patient involvement on patient satisfaction and empowerment. The study showed a positive relationship between patient involvement and patient reported outcomes. The patients communicated increased satisfaction with their care and a greater sense of empowerment when they perceived they were involved in their care planning and decision-making.

As the studies mentioned above demonstrate, psychiatric patients have a desire to be involved in their treatment planning and information exchange. However, during some phases of the illness, it is hard to keep patients engaged in their treatment. Dixon, Holoshitz and Nossel (2016) suggested the recovery-oriented care model could help increase psychiatric patients' engagement in their ongoing treatment. Treatment disengagement may lead to an exacerbation of psychiatric symptoms and rehospitalization. Some reasons for ongoing treatment disengagement in psychiatric patients are their perception that the treatment is ineffective, their mistrust in the provider, or an unfavorable treatment scheduling/time. The tools and techniques used in

the recovery model may help improve patient engagement in treatment. A therapeutic alliance between the patient and the provider also enhances patient engagement in treatment. Providing person-centered care and addressing their specific needs can help patients become less stressed and more engaged in their treatment. Shared decision-making practices also enhance patient-centered care. If a patient is involved in the plan of care, he/she is more likely to follow the treatment. The use of technology and peer support also enhance patient engagement in treatment (Dixon et al., 2016).

A randomized control study trial was done in Germany by Hamann et al. in 2016 to evaluate the effect and the feasibility of shared decision-making on schizophrenia patients in 12 psychiatric inpatient facilities. A total of 107 patients participated in the study—49 patients were in the intervention group and 58 were in the control group. Patients in the intervention group were provided with the decision aid booklet and were offered planning talks. Patients worked on the decision aid booklets with their healthcare providers. Nurses indicated that most of the patients were able to work through the decision aids, however almost half of the patients struggled making a concrete choice. Psychiatrists noted that most of the patients were interested in and could understand the information discussed. Despite the acuity of their symptoms, more than 50% were able to make a reasonable decision. Patients in intervention group had perceived greater involvement in their medical decision-making as a result of planning talks as compared to the control group at the study entry. Patients in intervention groups were more knowledgeable about their treatment and disease and had a positive attitude toward medication at the time of discharge as compared to control group. Psychiatrists treating patients in the intervention group were more satisfied with the patient outcomes.

A literature review was done by Alguera-Lara, Dowsey, Ride, Kinder, and Castle in 2017 on the shared decision-making practices in psychiatry to evaluate the barriers and facilitators that exist in the implementation of this process. Similar barriers were presented in this literature review as the systematic review done by Légaré and colleagues in 2008 regarding providers' perceptions of shared decision-making in clinical practices. Patient participation in the shared decision-making process was inhibited by multiple barriers involving clinician factors, patient factors, and systematic factors. Time constraints remain the profound systematic factor inhibiting a patient's involvement in shared decision-making. Clinician factors include the psychiatrist's attitude and their perception of the patient's ability to be involved in shared decision-making. The patient factors include the patient's confidence in being part of the decision-making process, level of education, self-stigma, severity of the psychiatric symptoms, lack of trust in the provider, and cultural influences on role of patients and doctors. This systematic review also pointed out some of the behaviors and attitudes that facilitated shared decision-making. These include trust, respect, openness, and patience between patient and psychiatrist, active participation and engagement in the consultation, information exchange, readiness for the session, quick access to required information, and implementing the decision (Hamann et al., 2016).

There have been multiple research studies done on the positive effects of using decision aids to help patients in making decisions about their treatment. The decision aids are the tools that assist patients to become involved in the shared decision-making by clarifying the personal values (asks about experiences, preferences etc.) and pros and cons of the treatment options. The decision aids are used in conjunction with counseling.

Patients can work on decision aids independently or with their provider to reach the decision that is best for them. The use of decision aids improves the quality of decision, improves the shared decision-making process, and leads to better patient and health system outcomes (Légaré et al., 2014; Stacey, Légaré, & Lewis, 2017; Stacey, Légaré, Lewis, Barry et al., 2017).

All of the research studies discussed in this chapter focused on the psychiatric patient receiving treatment on an outpatient basis except one that was conducted in the inpatient setting. The researcher could not locate any published research that investigated patients' experiences of being involved in their treatment planning in inpatient psychiatric facilities. In order to fill this gap in the literature, a qualitative study is needed to explore patients' perception of being involved in their plan of care while admitted to an inpatient psychiatric facility. This study will provide a basis for improving psychiatric care in inpatient psychiatric facilities and create a foundation for future efforts to enhance psychiatric patients' empowerment and engagement and involvement in treatment planning.

Chapter 3 Methodology

This is a qualitative study designed to explore the patient's lived experience of being involved in his/her plan of care during an inpatient psychiatric hospitalization. Qualitative research methods provide a holistic and person-centered perspective of an individual's experience. The phenomenological approach is appropriate to use when a researcher is trying to understand the lived experiences of others as they understand it, as was the focus of this study. People have a unique perception and meaning of their experiences that must be taken into consideration. Healthcare professionals cannot provide the care that best meets a patient's needs if a patient's experience is not understood from that individual patients' perspective. The phenomenological approach helps us understand these subjective patient experiences (Cohen, Kahn, & Steeves, 2000). The hermeneutic phenomenological research approach was used to understand and interpret the meaning of psychiatric patients' lived experiences of being admitted to an inpatient psychiatric facility. Hermeneutic phenomenology is an interpretive method based on the philosophy of Heidegger and Gadamer (Holloway & Galvin, 2017). Heidegger was interested in exclusivity of individual experiences and how different people comprehend similar life events and interpret their own meaning of these events (Rudestam & Newton, 2015). The Oxford English Dictionary describes interpretation as "the action of explaining the meaning of something," and to interpret is to "understand (an action, mood, or way of behaving) as having a particular meaning or significance" (Interpretation, 2019.). The hermeneutic phenomenological method not only involves describing the lived experiences through the language used by those who experienced it,

but also to understand the meaning of the language. The purpose of this method is to paint the picture of what the experiences really were.

Participant Recruitment Strategy

Participants for the study were recruited from a Southern California outpatient psychiatric facility. The clients attending the outpatient programs at this facility have had an inpatient psychiatric admission at various other facilities though they were referred to this outpatient program. The first step of the recruitment strategy at the outpatient facility was to have an agreement with the psychiatric outpatient facility's director, manager, psychiatrists, psychologists, and other staff for the recruitment of participants from their outpatient programs. The researcher was allotted time during the monthly staff meeting to present the study and answered all questions and concerns regarding the study. Management and other staff at the outpatient programs were supportive of the study and willing to assist with the subject recruitment.

The researcher obtained information regarding different psychiatric programs at the outpatient facility including the time and the days when the clients of these programs met as a group. The researcher presented the study to clients at the outpatient programs during their group meetings on different days and times to ensure that large number of clients were informed of the study. The clients were provided with a flyer that included the purpose of the study, what is required of the clients if they choose to be part of the study, inclusion criteria, and the researcher's contact information. Potential participants who met the inclusion criteria of the study and expressed interest in the study provided their contact information to the researcher while still on site. Some of the clients contacted the researcher via the phone number and e-mail address provided on the flyer

and others left their phone number or e-mail address with the program coordinator at the outpatient facility for the researcher to collect. Convenience sampling was used for recruitment of the subjects.

Participant Selection Criteria

In order to participate in the study, outpatient clients had to meet the following criteria:

- Be a community-dwelling adult (age 18 or above)
- Be able to speak and understand English
- Have had an inpatient hospitalization in any psychiatric facility within the last 12 months
- Be capable of discussing and articulating their latest inpatient psychiatric hospitalization experience

The study exclusion criteria were very basic. Anyone who did not meet the inclusion criteria was not included in the study. However, when the information regarding study inclusion criteria was presented, many of the clients who initially wanted to be part of the study were able to recognize by themselves they did not meet the criteria and, hence, did not participate.

The outpatient clients who wanted to participate in the study were contacted by the researcher to set up an interview. After making the initial contact and confirming the patient met the inclusion criteria, an interview date, time, and place was scheduled. To make it convenient for the participants, the researcher scheduled the face-to-face individual interviews on the day the client was to attend their outpatient program.

The researcher met the participants at the designated place and time and conducted one-on-one interviews. Participants signed up to be part of the study on a voluntary basis and were informed of their right to participate in the study or withdraw from the study at any time. Before the start of the interview, each participant received the informed consent with details about the study and his/her role in the study and each participant was informed of the interview process, timeframe, and stipend. This information also was mentioned in the informed consent and was provided on the study flyer.

Sample Size

Fifteen outpatient clients provided their information and were initially interested in being part of the study. Twelve out of the 15 clients participated in the study. Three clients did not answer the researcher's phone calls and did not call back. The sample size of 12 was sufficient for this study as the similar themes started to emerge during the interviews and saturation was achieved. In phenomenological studies, thematic saturation occurs usually around this number if the phenomenon is being accessed in a way congruent with participant understanding (Lincoln & Guba, 1985).

Demographics

The sample consisted of 12 participants: 10 females and 2 males. The participants' ages ranged from 29-76 years. Nine of the participants identified themselves as Caucasian, one identified as African-American, one identified as Romanian, and one identified as Caucasian and Latino. All participants self-reported their reason for psychiatric hospitalization and the date of admission to the inpatient psychiatric facility. The reasons of psychiatric hospitalization included depression, anxiety disorder,

substance abuse disorder, bipolar disorder, post-traumatic stress disorder (PTSD), severe obsessive-compulsive disorder (OCD), paranoia, hallucinations, suicidal ideation, and/or a suicidal attempt. Eight participants reported being hospitalized to an inpatient psychiatric facility only once. One participant was admitted twice, another one admitted three times. One participant had multiple psychiatric hospitalizations but was unable to recall the total number. However, all participants reflected on and shared their experiences about their latest psychiatric hospitalization. All participants were diagnosed with mental illnesses at different ages. Three of the participants were diagnosed between the age of 11 and 14 years, one in his or her early 20s, three in their 30s, two at the age of 41, two in their 60s, and one at the age of 76. The level of education ranged from having a high school diploma to having a graduate degree. (See Table 1.) When asked about their psychosocial support system and who they turn to for support, all participants reported having children, family, or friends. Many of them made their healthcare decisions with the support of an involved family member. All participants had places to live; some rented apartments, others owned a house. Eight of the participants reported having private health insurance, two reported having Medicare, and two reported having Medicaid.

Data collection

The researcher met with the participants on one-on-one basis. The interviews ranged between 11 and 52 minutes. A semi-structured interview was conducted with each participant with the researcher inquiring about the participant's experience regarding involvement in their plan of care while they were admitted to an inpatient psychiatric facility. Eight open-ended questions were asked of participants to obtain information

regarding their inpatient experiences. Interviews were audio-recorded with each participant's permission. Participants had full control regarding sharing information. Interviews took place in a quiet environment without any distractions where each participant's privacy was maintained. The researcher assured each participant they did not need to share any information they did not wish to or feel comfortable sharing.

Verbatim transcriptions of audio-recorded interviews were completed and used to analyze the data. The researcher also took field notes during the interview process to capture the participants' emotions and facial expressions as well as the researchers' emotions or related thoughts that were not captured in audio recordings. Participants were ensured that taking part in this study would not affect his/her care at the outpatient facility or on any future inpatient admissions.

The basic demographic data were collected from study participants before the start of audio-recorded interviews. Institutional Review Board approval from the healthcare institution where the research study took place and from USD were obtained before contacting the study participants. Data was collected over the period of 3 months.

Protection of Human Subjects

During the recruitment phase, the researcher asked participants for only minimum contact information (phone number and/or email address) so she could contact the volunteers to schedule an interview. This information was stored in a secured and locked place. To ensure complete confidentiality, a sequence number was assigned to each participant, which was used throughout the study. Participants were identified by names, phone numbers, and email addresses on the Master Enrollment List only. The Subject

ID# was used on the Demographic Questionnaire, the audio recording of the interview, the transcription of the interview, and the Data Collection Sheet.

During the data collection phase, no personally identifiable information was asked for or recorded. Interview questions were constructed in way so that individually identifiable information was not asked. If a subject inadvertently shared confidential or personal information, it was removed/erased and not transcribed. The interviews were stored on encrypted storage, were used only for transcribing, and were never moved/copied/transferred to any other storage medium. No confidential information was shared with anyone.

The principal investigator (PI) stored all paper-based data in a locked/secured place. Electronic data were password protected and only available to the PI. Anonymous data will be stored for 4 years. Data with subject identifiers is only accessible to the PI. The contact information of the outpatient clients who chose not to participate in the study was discarded securely.

Data analysis

Colaizzi's (1978) seven-step data analysis method was used to analyze the meaning of participants' lived experiences. Data were analyzed by reading and rereading the verbatim transcripts of patient interviews and corresponding field notes. Coding/indexing of the emerging themes was done. Each transcript was read multiple times to gain full understanding of the content. Important phrases and statements from each transcript related to the lived experiences of participants were extracted. The meanings of these significant statements were formulated and organized into themes. Clusters of themes emerged from these categories when organized into the groups of

similar type. The researcher incorporated all emergent themes into an exhaustive description of participants' lived experiences. After combining all the themes that had emerged in the course of the study, the whole structure of the phenomenon of the lived experience of psychiatric patients in inpatient psychiatric facilities was discovered (Edward & Welch, 2011).

Risks /Benefits

The overall degree of risks associated with the participation was minimal. The content discussed in the interviews was de-identified and kept confidential. None of the participants disclosed any information during the interviews relating to child abuse and neglect, elder and dependent adult abuse, or domestic violence that would have required reporting to local law enforcement as mandated by the laws of the State of California. Participants did not appear or report feeling uncomfortable answering questions during the interview. There was not any direct benefit to the study participants; however, many of the participants communicated sharing their experiences as a therapeutic activity and an opportunity to help others dealing with the mental illness.

The information learned from the analysis of the data obtained during this study will provide an insight that can inform healthcare professionals' ability to learn how to engage and involve psychiatric patients in their care planning and meet their individualized healthcare needs. This study will create a basis for future research in the area of psychiatric patient empowerment and engagement. Based on a fuller understanding of this phenomenon, the quality of care provided to patients in psychiatric facilities may be improved.

Ethical Consideration

The IRB of the healthcare facility where the study took place and the IRB of the University of San Diego provided oversight of the study. (See Appendix A.) Participation in the study was voluntary. Each participant received a copy of the consent form and the researcher addressed all questions/concerns regarding the study before starting the interview process. The consent form highlighted that participants may choose not to answer any question that makes them feel uncomfortable and may choose to withdraw from the study at any time. There was no penalty or loss of benefits to which they were otherwise entitled if they chose not to participate or start the study and later choose to stop. Upon completion of the interview, each participant received compensation \$50 in the form of a Visa gift card for his or her time/inconvenience. The PI completed Human Subjects' Protection training before the start of the study and abided by the principles of protection of human subjects in research.

Assumptions

The primary assumption made in this study is the participants were remembering and truthfully sharing their psychiatric inpatient experiences and provided accurate information on demographic form.

Trustworthiness

Demonstrating the quality of a research study is a very important step for a researcher. Different terminology is used in a qualitative study to demonstrate the quality of research than in a study using a quantitative methodology. In a qualitative study, the term trustworthiness is used to address the thoroughness of the study.

Guba (1981) developed a method to demonstrate the trustworthiness of a qualitative study. He identified four important characteristics of trustworthiness that pertain to both qualitative and quantitative studies. These four aspects are consistency, true value, applicability, and neutrality. The term credibility is used by Lincoln and Guba (1985) to address the true value of the qualitative study. This establishes the confidence of the researcher in the truth and accuracy of the results of the qualitative study. To assess the applicability of the study, the term transferability is used, and the term dependability is used to define consistency in qualitative research. The notion of dependability indicates the variability that can be ascribed to known sources. Neutrality refers to the freedom of results of the study from any biases; study results are presented based on the analysis of what was truly presented by the subjects, free from a researcher's biases (Guba, 1981). According to Lincoln and Guba (1985), the credibility (internal validity), dependability (reliability), transferability (generalizability), and confirmability (objectivity) are very important to establish trustworthiness of qualitative research.

The researcher used two strategies to ensure the trustworthiness of the study: an audit trail and the process of peer review. The researcher preserved a record of the data collected as well as clear and concise notes. If an external appraisal of the study is required, the audit trail will permit further review of the data collected. In addition, members of the dissertation committee provided direction and feedback during the research process to ensure the trustworthiness of the study.

Table 1.

Demographics

Subject ID #	1	2	3	4	5	6	7	8	9	10	11	12
What is your age?	39	42	50	29	55	76	45	49	69	51	65	63
What is your gender?	Female	Female	Female	Female	Female	Male	Male	Female	Female	Female	Female	Female
What is your ethnicity?	Caucasian	Caucasian & Latino	Caucasian	Caucasian	Caucasian	Caucasian	Caucasian	Caucasian	Romanian	Black	Caucasian	Caucasian
# of inpatient psychiatric hospitalizations with in last 12 mos?	1	1	1	1	multiple	1	1	1	2	1	3	2
When was your last psychiatric inpatient hospitalization?	1-Dec	1-May	1-Oct	18-Jul	1-Oct	1-Sep	22-Aug	1-Jun	1-Sep	1-Sep	1-Jan	1-Aug
Facility/hospital of most recent inpatient psychiatric hospitalization?	Atlanta, GA	Southern CA (G)	Southern CA (Alva)	Southern CA (G)	Southern CA (G)	Southern CA (G)	Redlands, CA	Southern CA (G)	Southern CA (G)	Southern CA (MV)	Southern CA (MV)	Southern CA (MV)
For which psychiatric condition(s) were you admitted?	MDD	Depression & anxiety	MDD	Depression/Anxiety /SA/PTSD	Hallucinations/Paranoia	Clinical Depression	Severe OCD/ SI	Bipolar	Anxiety/SI	Alcoholism	Alcoholism	Delusions/Opioid withdrawals
Age of diagnosis w/ the condition(s) mentioned in the previous question?	11	Early 20's	14	Dep/anxiety @ 14, PTSD @ 29	36	76	34	41	68	41	63	32
What is your educational level?	Graduate degree	Some college	Graduate degree	Some college	Graduated high school	Graduated high school	Bachelor's degree	Some college	Bachelor's degree	Some college	Some college	Some college
Who do you turn to for support?	Family & Friend	Family & Friends	Family & Friends	Husband/Mother-in-law	Husband & Family	Daughter/Hospital staff	Brother	Family & Friends	Son	Husband/Sister/Church	Husband	Friends
What is your current housing status?	Living w/family/friend	owns home	Renting room in a house	Renting an apartment	Renting an apartment	Mobile home	Renting an apartment	Renting an apartment	Renting an apartment	Renting a house	Owns home	Owns home
Do you have a private insurance?	Yes	Yes	No	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes

Chapter 4 Data Findings and Analysis

The purpose of this Heideggerian phenomenological research study was to explore patients' lived experiences of being involved in their plan of care during an inpatient psychiatric hospitalization. This chapter includes the detailed findings of the research study. The findings include descriptions of the lived experiences of participants and the themes that emerged during analysis of the data to expose the entire structure of the phenomenon under study—the psychiatric patients' perception of being involved in their plan of care while they were admitted to an inpatient psychiatric hospital/facility.

The data were collected through 12, one-on-one, in-person interviews. Interviews lasted between 11 and 52 minutes each. The time of the interview varied depending on how fast the participant talked and how many details of the experience the participant offered.

Interviews were guided by 11 semi-structured questions to obtain rich data from the participants about their experiences. Interviews were audio-recorded with each participant's permission and verbatim transcriptions of audio-recorded interviews were used to analyze data. Interview transcriptions were thoroughly reviewed by the researcher to assure accuracy and completeness.

Discovery of Themes

Each interview started with asking the participant to describe the experience of his/her latest inpatient psychiatric hospitalization. Participants talked about the situations that brought them to the hospital and how long their stay was. This initial step allowed them to think back and remember their experience from their last psychiatric hospitalization. Once the participants shared their general experience from their latest

inpatient psychiatric admission, the researcher used probing questions to get more information about their experience of being involved in their plan of care. Seven major themes emerged from analysis of the data. These themes included their knowledge about the plan of care, involvement, safety, compartmentalization of care, psychiatric inpatient admission as a turning point, inpatient as a holding place, and importance of social support. (See Figure 1.)

Figure 1. Discovery of Themes

Theme 1: The Plan of Care

After receiving general information from the participants about their stay in an inpatient psychiatric facility, the researcher inquired about what the “plan of care” meant to the participant. This was to discover their familiarity with the concept when used in the healthcare setting. All but one of the participants had heard healthcare professionals use the phrase “plan of care.” Some participants had a profound knowledge of the concept, as they worked in the healthcare field. Others described it as a plan for their treatment either in the inpatient psychiatric facility or after discharge from that facility. Participants also recognized the plan of care as a structured plan they could follow to manage their mental illness in the hospital and after discharge. (See Figure 2.)

Figure 2. Plan of Care

Personal meaning of Plan of Care. The following multiple quotes from the participants provide insight regarding the meaning of plan of care.

Participant 1, who worked as a healthcare provider, had a very deep understanding of the concept. She was able to describe the “plan of care” as follows:

“Okay. Um, what it should mean is, you know, essentially doing, um, a physician’s assessment and plan. Meaning that, you know, you have the following issues. You have major depressive disorder with suicidal ideations. Um, and then discussing, you know, a, probably a multi-disciplinary approach to deal with that. Um, you know, such as, um, we prescribe the following medications, and, um, maybe exercise or group therapy, or, um, you know.”

Participant 3 also had some healthcare background. She described the “plan of care” as follows:

“To me, it would be nursing or cycles. When I worked in a nursing home, it would be, we would reach that as an ID team to get together what that child needed, or person needed, along with that person.”

For participant 2, the “plan of care” meant the tools she needs to manage her mental illness.

“To me, it is, uh, like it’s structured. Um, it’s like learning the, the words GRAPES and what that means. I mean, it’s just different tools. Uh, care is just taking care of – plan of care. Just going, okay, uh, this is what I, I need to do to help with what’s going on in my life. I always thought whenever I would see my

doctor, 'cause I suffered from panic attacks. "Oh, I'll take my medicine and I'll be fine." Well, no, that's just part of it. That's – and I learned that this year. Yeah."

The “plan of care” to participant 4 meant knowing and having a structured plan for managing her mental illness after discharge. She describes it as follows:

“Plan of Care – I felt – um, the reason I felt so secure to go home so quickly was we had such an ironed-out plan of what my treatment was going to look like when I left; and that was: you're gonna keep meeting with the same psychiatrist, here's the days and times you're going to be in groups.”

Participant 7 and participant 12 described plan of care similar to participant 4:

“Well when I hear that, the first thing that I think of is a plan for after I leave the hospital.” (Participant 7)

“It means what you are going to do when you get on the outside, outside the hospital.” (Participant 12)

Participants 5 and 7 described “plan of care” as follows:

“It means what they're gonna do for, uh, caring for me.” (Participant 5)

“Plan of care meant to me that there was a plan in motion to take care of me, they had they had a method to their madness.” (Participant 7)

Participant 6, a 76-year-old male who was diagnosed with clinical depression, informed the researcher that he had never heard of the phrase “plan of care.” However, he was still able to describe the “plan of care” as follows:

“Never heard it. plan of care? It’s a schedule of treatment I’m sure.”

According to participant 10, “plan of care” to her was the treatment plan while she was in the hospital and after discharge:

“Umm..., the plan of care to me is, what umm... I was going to be umm... what was going to be arranged for me as I was inpatient umm... what I was going to be, what kind of coping skills I was going to be given umm... while I was there umm... the medications umm... to make sure I don’t have seizures from not drinking.”

Knowing that there is a plan of care. Even though the “plan of care” meant different things to different participants, they all summed it up as a schedule of treatment to help them manage their mental illness while they were in an inpatient psychiatric facility or after discharge. However, not all of the participants knew there was a specific plan of care initiated for them.

Participants 6 and 7 mentioned not knowing that there was a specific plan of care for them. They followed what doctors and nurses told them to do.

“I didn’t feel that there was much planning even though there was, I just never gave it much thought because I belong somewhere between hours of such and

such and what I'm going to be doing during that three hours and just like everyone else do it" (Participant 6)

"I really can't say there was any plan of care umm presented to me or anything like that." (Participant 7)

Making the plan of care. When the researcher asked participants about their participation in creating a plan for care, they had a wide range of responses. Some participants felt they actively participated in creating a plan of care. Healthcare providers involved them in decision-making and their opinions were included in their plan of care. Doctors and nurses discussed the plan with them and modified it in accordance with the input provided. One of the participants communicated that not only she, but also her family, was included in making the plan of care. However, some participants had very negative experiences regarding their contribution in creating their plan of care. They were not included in their plan of care even when they showed interest to be involved and were capable of participating in the decision-making. Some participants felt their opinion was asked but not considered in the plan of care as the provider continued with the plan that was already in place for them.

Joint decision making. The following are some quotes from participants who felt they were treated as part of the team and decisions regarding their plan of care were made with their input. They were always informed of all the changes made to their plan.

"I benefited from them allowing me to let them know what I felt would work for me and what I really didn't think was relevant in my life. It made me feel that even

though I hadn't been responsible in umm... suiting up and showing up in my life, that I once was responsible for myself and that Hey! I can do this on my terms again." (Participant 10)

"I felt part of the team a lot of the times, because I felt like there was communication between the doctor and the nurse and me, I felt like you know the doctor would convey what he wanted to the nurse and the nurse would convey what the doctor wanted to me." (Participant 8)

"It wasn't just me and the medical team, that also my family was involved in the decisions. And they – they got a lot from it." (Participant 4)

"Yes, umm... I was involved umm... the doctor and me we had several umm... different meetings and conversations while I was there umm... I was there 11 days umm... and I saw him umm... each day umm... but he was umm... available if I needed to see him more than once a day umm... I just... the nurses they knew exactly what the game plan was for me umm... to reinforce what the doctor and me had talked about, that was going to be the plan for me to be successful umm... so yeah." (Participant 10)

Healthcare provider made the decision. The following quotes are from the participants who did not contribute in creating their plan of care. Either they were not included in the process or they did not want to be included in the process of initiating the

plan of care. Mostly, the decisions were made by the healthcare providers. Two of the participants allowed healthcare providers to make all the decisions. One felt he was too overwhelmed with his mental illness and he preferred someone else make the decisions for him, as it would have caused him more stress. The other participant felt he could not make the right decisions, which is why he ended up in the psychiatric facility. Therefore, he did not want to make any decision for his care, allowed doctors and nurses to make all the decisions for him, and followed the plan as dictated by the healthcare team.

“I try to suggest sometime, some things and they explain it to me I have this or that and I have to wait and umm... have patience and umm... things like that but umm... usually was the doctor decision, the nurses told the doctor and the doctor made the decision for me.” (Participant 9)

“No, and I will explain why, ‘cause that involved me taking control of myself which didn’t work before and wouldn’t work now until is time. Well if I made the decisions, got me in trouble before and now I have to learn how to make the right decisions, with the help of a group. It wasn’t important what I wanted because what I wanted got me in trouble, what was important was the doctors and nurses wanted and I will be better in recovery by it, by positive reaction to them. It seems I got the needs required in order to handle situations in life, but they were hard to recognize as a plan, it seems more natural (cough) in the outpatient care than being a part of a plan.... whether you wanted or not the doctor still makes the decisions; if the doctor says, take aspirin, take aspirin” (Participant 6)

“Uh my doctor, (pause) knew about my illness, and knew about the withdrawal thing but I was put on Suboxone while I was in there, and I have never even heard of Suboxone, that wasn’t explained very well to me and I didn’t want to get hooked on something else, so that was a big, big ahh.. I didn’t want to do this type of a thing. So, the whole, as far as dwindling off of something, going on to something else, it seemed like it wasn’t explain why I was going on to something else umm... and then, umm... or given a plan of when I was going to get off of this other stuff or how long it might take you know.” (Participant 12)

“I think I may have been more stressed out of having options and asked to make a decision about something, I think I can picture myself being asked such and such, I think I would have been a lot more stressed out about.. during my stay there if I was given options right at that time so, specially at the beginning.” (Participant 7)

“Ideally, everybody would participate, including the patient. I was involved in no such process.” (Participant 3)

Opinion asked but not counted in the making the plan of care. Two participants mentioned they were asked to be part of the planning. Plans made by the healthcare team were discussed with participants and their opinions was asked for but not included in the planning. No changes were made to the plan of care after receiving input from the participant.

“Yes and no. Um, I felt that there was a lot of box checking. You know, they asked my opinion about stuff, but it didn’t contribute to anything. Now, um, and that’s not, unfortunately, limited to inpatient facilities. That happens at a lot of outpatient facilities too. The difference is, of course, that I can go find somebody else. Um, but yeah, no, I, I think that they had a predetermined outcome, and, um, they were going to, their goal was to convince me of it, not to have a conversation with me in which they contribute, consider plusses and minuses, and allow for some compromise, um.” (Participant 1)

“Umm... you kind of did what they told you to do, that was kind of you know, there were meetings umm... you could discuss in the meeting why you didn’t think the meeting was umm... something that you were going to benefit from, I mean they were open to listening to it but they didn’t really change anything that much umm... they would accommodate more, making sure you were in a room, you felt comfortable and safe in.” (Participant 11)

Theme 2: Involvement

After understanding what “plan of care” meant to them and who created the plans of care, the researcher inquired about their thoughts on being involved in their plan of care and why was it important to them to be involved in their plan of care. All participants strongly supported the idea of involving the patient in their plan of care and all of them desired to be involved in their plan of care. (See Figure 3).

Figure 3. Involvement

Types of involvement. As the participants talked about the involvement in their plan of care, three different interpretations of the involvement emerged. One interpretation of involvement was to be an active participant in creating the plan of care. The second interpretation was of being informed/conversed about the plan of care. The third interpretation was to follow the plan of care by actively participating in the meetings, therapeutic groups, and taking medications, etc.

Active participation in making the plan of care. To some, being involved in the plan of care meant as being involved in decision-making about what the plan for the treatment should be. Participants gave their input about what works and what does not work for them. These participants expected their plan of care to be created after considering all available options and with the agreement of both patient and provider. Participants' quotes regarding this type of involvement are as follows:

"I'm happily involved in my healthcare. I like to know every step and why we're doing what we're doing, that's why I really appreciate Dr. X, and he talks to me about how I feel about all the medication changes; whenever we change a dose, or add a new medication, he talks it out with me and asks me how I feel about doing that" (Participant 4)

"It was always umm... consultation with me regarding my umm... plan of care, it was, it was never umm... something that, "Ok, Well we are going to do this with your plan of care and oh ok you have accept it on top of that" it was always umm... asking me will this work for me, saying "hey, I feel this will work for you, umm... how do you feel about that?" you know "do you think you know this is

healthy or help you can help you or?” it was never something, it was never umm... black or white, it was always grey, it was always either you know I can say Yes or I can say No, I was never stuck with anything anyone else had in mind for me to do.” (Participant 10)

“I had to get to know my doctor, my psychiatrist because that was a “whole different enchilada,” he went a different way, I mean it was very short but umm... we finally, we finally met in the middle so, it worked out pretty good that way.” (Participant 12)

Being informed/conversed about the plan of care. The second interpretation of being involved in the plan of care was being informed by the healthcare providers what the plan entails. These participants felt involved as long as nurses, doctors, and social workers kept them informed about the steps that were being taken to support them in dealing with their mental illness. In this type of involvement, participants were not necessarily active in deciding what their treatment should be but were well-versed about their plan of care.

The following are the quotes from the participants who felt their healthcare provider kept them informed of their plan of care.

“When I talked to the doctor and the nurses, they were together, um, and, um, the doctor told me what was gonna happen, how many days I was gonna be here and how he’s helping me.” (Participant 5)

“Every day you met with your doctor and you had time to talk to him about what was going on with you, and he talked to you about what he was thinking on what was going on with you, and it was like you kind of like were team players and that was nice because you felt like you touched base you know, you got to touch base with him, you’re like tagged, like tag team.” (Participant 8)

Following the plan of care. The third interpretation of being involved was to actively follow the plan of care. This type of involvement included attending the therapy groups, taking part in activities, sharing their experiences with their peers, being compliant with medications, etc.

The following quotations are reflecting the third type of interpretation of involvement.

“I was very involved and wrote a lot of notes. And, uh, took all the information I could. I still have them.” (Participant 2)

“Being involved means to follow instructions on writing down what I’ve learned, respond to questions that are presented so that you follow that plan not just hear a plan. Well if I don’t follow a plan of care, I won’t get the tools that I would need to cope with situations that brought me here.” (Participant 6)

Importance of being involved. As mentioned in the previous section, all of the participants supported the idea of involving patients in their plan of care. They provided multiple reasons why they believed a patient should be involved in his/her plan of care.

According to the participants, it moved them toward self-agency and empowerment, kept them informed, and provided an opportunity to address individualized care needs with the healthcare providers. Involving patients in their plan of care also motivated them to follow the plan to accomplish desired outcomes.

Staying informed. According to the participants, allowing patients to be involved in their plan of care kept them informed and up to date with the information regarding their treatment. Patients wanted to know/understand the effect of pharmacological changes on their physical and mental health. Understanding the motives behind a specific treatment option helped them make sound decisions regarding their plan of care and aided in managing their mental illness.

The following quotes from participants describes the importance of involving patients in their plan of care:

“I think that’s 100% good because that way, you know what you’re, uh, planning with the doctor and the nurses.” (Participant 5)

“It’s important to me, uh, that I’m involved with my care so that it can stay on track, and I know exactly what my brain is experiencing, what’s going into my body chemistry. it’s very, very, very important to me that I know exactly what the meds are, why they’re going up, why they’re coming down, everything before we do it....” (Participant 4)

“Because in that you know what your care is, what they’re gonna care for you, um... And you know what’s going on with what’s, you know, what the doctor’s doing in that.” (Participant 5)

“Because it’s, it’s important because it’s involving you as a person you want to be, you want to be involved because it’s your body and it’s happening to you.”
(Participant 8)

Feeling of empowerment and being in control. Being involved in the plan of care made participants feel acknowledged and empowered. Participants also mentioned the feeling of being in control or being in charge of their care when involved in their plan of care.

“I think that’s the only effective way to do it. I firmly believe in patient autonomy. Um, you know, you hear about the, the hierarchy of, of medical ethics. I mean, it’s right after “do not harm,” right?” (Participant 1)

“Well, I think, you know, in a depression you feel kind of helpless, hopeless. So, it’s kind of the first step towards empowerment and self-agency to come back and, you know, to take some control back in your life in a good way. And I think empowerment is important, whether you have depression, anxiety, psycho-... psychotic-type disorders, anything. That’s the ideal best way to be, to be the most motivated to get there. I think from the time they first come in to the time they leave. That’s extremely important.” (Participant 3)

“It made me feel umm..... like I wasn’t just a bystander, because umm..... sometimes if they leave you out of what is going on you just feel like stupid, you feel like you are not even there, like you don’t matter and by having you involved in the plan of care you feel involved in like you matter so that is why I like it”

(Participant 8)

“I benefited from them allowing me to let them know what I felt would work for me and what I really didn’t think was relevant in my life. it made me feel like, I was an adult who was in charge of her life again.” (Participant 10)

“That is my personality in a way, that’s how my mind works I was a litigation paralegal for over 30 years, I’m used to being in charge, I’m used to people saying yes, umm... I’m used to people not arguing with me umm... cause I was the head paralegal on a case you know if we were going to trial, I knew the case the attorneys would look to me and say did this happen? Umm... so yeah I definitely have to, even if I don’t have control, I have to feel I have some control.”

(Participant 11)

Individualized plan of care. One of the Participants mentioned that being involved is important as it provides an opportunity to be part of the planning of care and makes an individualized plan of care that works for you.

“Umm... it’s very important, it’s like that’s the game changer you know what I want, and you know what I feel would be valuable and the things that umm... I

don't think I can use but I learn about anyway umm... my involvement umm... in what was best for me. I felt that if I get overwhelmed with trying to do things that umm... that I knew I wasn't ready to do or interested in doing that you know umm... I would probably would have a less success rate so umm... my input on my recovery was very important... I benefited from them allowing me to let them know what I felt would work for me and what I really didn't think was relevant in my life." (Participant 10)

Experience of Being Involved

All of the participants wanted to be involved in their plan of care. Many of them were ready to be involved from the day of admission, while others needed few days to adjust to the surroundings and for their mood to stabilize. While some of the participants communicated having a very positive experience being involved in their plan of care, others communicated not having a very good experience.

Involved in plan of care. Many participants communicated having positive experience about being involved in their plan of care while they were admitted in an inpatient psychiatric facility. They all communicated that staff was very supportive and encouraged them to participate in their plan of care.

Involved in decision making. Participant 9 describes her experience of being involved in decision making as follows:

"First it wasn't involvement, they take the decision without me, in time after few days after I talk to the doctor the psychiatrist, and the nurses study me and talk to him and explained to him the way I am, you know... yes I try to impose some

things you know, straighten up some things ok, and let them know, the doctor specially because he was with medication and everything and they realize I am all right.” (Participant 9)

Participant 4 was very satisfied with her involvement in her plan of care during her stay in the psychiatric facility. She mentioned that her family was also included in the planning of her care.

“It wasn’t just me and the medical team, also my family was involved in the decisions. And they – they get a lot from it, they come here on Wednesdays for the family group, and that was part of the plan was that they go through therapy too to understand what I’m dealing with. And it’s helped them a lot to understand my depression and my anxiety” (Participant 4)

Participant 10 communicated being included thoroughly in decision making regarding her plan of care.

“I was informed of the medication, umm... I was asked about allergies, I was always, it was always umm... consultation with me regarding my umm... plan of care, it was, it was never umm... something that, “Ok, Well we are going to do this with your plan of care and oh ok you have accept it on top of that” it was always umm... asking me will this work for me... They umm... allowed me to umm... to think for myself umm... to re-learn umm... some things about myself, some strengths, you know the weaknesses umm... and they didn’t push or crawl

you know on me or forced anything on me, so therefore I was able to express umm... any concerns” (Participant 10)

Courteous/knowledgeable Staff. Most of the participants mentioned that staff was very kind and knowledgeable. Staff actively encouraged them to be involved in their plan of care. However, a few of them described negative experience of not being cared for sincerely.

The following quotes are from participants who had a positive experience with staff at inpatient psychiatric facility.

“Everyone was involved, um, whether it was the nurses, uh, the therapists, or, uh, a social worker, um, they were very articulate. Uh, and just were reassuring.”

(Participant 2)

“The staff was very, very comforting. Um, they were very helpful. At first, it was, uh, kind of, uh, hectic because I had to wait so long to be seen in the emergency room. And then once I got back to where I had to go, then, um, they made sure that I was safe and that, um, I was taken care of.” (Participant 5)

“The staff treated me with a lot of dignity and respect umm... they were all very kind and very professional, very knowledgeable and I could tell that they were skillful and they knew exactly what umm... I needed to keep me safe and the environment safe around me.” (Participant 10)

“They kind of noticed that in me, and kind of encouraged it umm... I’m not a person that you can say “this is what you have to do” but if you say to me “this is something that we believe will help you we would like you to investigate it” I am all for it.” (Participant 11)

The following quotes are from participants who felt neglected by staff during their inpatient stay. Staff wasn’t actively involved in their care. Their experience was to approach staff for their needs instead of staff rounding on them to assess their needs and providing the care/intervention needed.

“The night staff, it was, um, I just – they felt very neglectful. They could have given me something for that panic attack that lasted two hours, and they didn’t. Um they could have done – they were told not to – not to directly put the flashlight in my room on three separate occasions, and they continued to do it.” (Participant 9)

“The psychiatrist was not even seeing me. He said, so, I asked to see him to explain this, because according to them, he was seeing me every day. He said, well I saw you. You waved to me. That was his idea of saying he saw me. And he said, I can, I could, I saw you and that was seeing you. And I said no, I don’t count that as a visit. He was actually saying that was an f-ing visit.” (Participant 3)

“There was a nurse who stayed behind the counter a lot he would just come out give the medication and then go back behind the desk and sit there, he never like inquired as to how I felt, he never like really asked how I was doing umm.... I never felt like he totally cared about me.... when he was working, I didn’t feel safe... I felt like I could hurt myself and he wouldn’t even notice. (Participant 8)

Option to choose. Participant 10 and 11 mentioned that they had the option to go to different meetings/groups.

“They encouraged me to go to different meetings and find, if you can find a meeting you are comfortable with and that you want to talk in, and if you don’t that is ok too, whether or not you realize it you are learning from the meeting.” (Participant 11)

“They didn’t force me to open my mind, but they suggested, and I thought on it, so I had some control over it, and then umm... it was very beneficial.” (Participant 10)

Opinion counted in making the plan. Participant 9 mentioned that her plan of care regarding her blood sugar monitoring was changed after she communicated with the staff, as it was not her practice outside of the hospital.

“I have blood sugar up to the border, it took four times a day and I got really upset, I said stop doing that, I don’t eat sugar too much, here anyway and stop puncturing me and things like that, and they go ok we are going to see, we are

going to talk to the doctor and they realize it wasn't normal to do it in four times because it wasn't my situation to be." (Participant 9)

Informed of changes in plan of care. Participant 4 talked about her psychiatrist keeping her informed of medication changes.

"He discusses what medications he's thinking about and why; what he – why he thinks it's gonna work for me; and what he thinks needs to be addressed more so. Like recently, he really helped with my – um, my nightmares from my PTSD where I was having a really hard time with it. He increased my prazosin and now it's less gory, I'm getting more rest, so." (Participant 4)

Not involved in plan of care. Some of the participants shared negative experiences regarding their involvement in the plan of care during their inpatient stay.

Not involved in decision making. Some of the participants felt that they were not given an opportunity to be a part of their plan of care.

"I would've liked to, um, my experience was not being involved, and not, um, feeling like I had to go to them. Not being taken as the expert in my own care. You know, certain counseling theories have the therapist be the expert or the doctors be the expert. Where more the post-modern therapies have the client be the expert in their own experience. And I find those much more humanizing, where maybe other people have information, but you know your own experience, and you know your own culture, you know. Some other person will never be an expert on your

culture, your experience, your family, your limits to certain treatments.”

(Participant 3)

Minimum options. Participant 7 stated that there were not many options for him to be involved in the plan of care.

“Umm was I involved? No, other than when they asked me what I wanted for dinner at times you know that was pretty much it, umm they would give me the option like when there was recreation, like I can either go to recreation or stay behind, umm it was minimal types of choices I got to make. Umm well my gut answered to that would be, if I had to go in again, I think I would like to get some choices, now that I know how the experience is like.” (Participant 7)

Not informed of changes in plan of care. Participant 7 and 12 mentioned that their medications were changed but no information was given for the reason of starting the new medication or for how long they will have to take it.

“Umm well they would just give me the medication, it’s time for you meds and I noticed there was one pill that was different than what I have been taking before. First, I assumed it was just one of the same pills I take but in a different sort of like shape or whatever, umm and I didn’t find out until after I left the hospital that it was Trileptal what it was used for.” (Participant 7)

“Uh my doctor, (pause) knew about my illness, and knew about the withdrawal thing but I was put on Suboxone while I was in there, and I have never even heard

of Suboxone, that wasn't explained very well to me and I didn't want to get hooked on something else, so that was a big, big ahh.. I didn't want to do it type of a thing. So, the whole, as far as dwindling off of something, going on to something else, it seemed like it wasn't explain why I was going on to something else umm... and then, umm... or given a plan of when I was going to get off of this other stuff or how long it might take you know.” (Participant 12)

If involved in plan of care. The participants who did not feel involved in their plan of care shared that their stay would have been meaningful if they were heard by healthcare providers and could be part of their own plan of care. They felt their mental illness would have been better stabilized in the hospital and they would have been more prepared to manage their mental illness outside the hospital. The involvement in the plan of care could have avoided further hospitalizations and reduced the length of stay in the hospital.

Avoid future hospitalization. Participant 1 communicated that her depression worsened after discharge; she became suicidal and attempted to kill herself. She spent many months recovering in the hospital on a medical floor after the attempt. She felt that if she had been involved in her plan of care her future hospitalizations could possibly have been avoided.

“If I had felt safe that I could talk to them about my thoughts and feelings, and if they responded with a give-and-take, um, and actively listened and that sort of thing, then I, I might have devised a plan to avoid future hospitalizations.”
(Participant 1)

Better control on mental illness. Participant 3 communicated that she would have felt better managing her mental illness outside of the hospital if she had been involved in her plan of care.

“I think I would’ve left feeling more confident, and centered, and cared about, versus more harried and like more of like my family-type situation, where nobody cares. It would’ve felt like it was a more, it would’ve felt less depressing, more – less anxious, more, I mean I can only think of it in more like psychodynamic terms. As kind of like, more of like a holding environment, a better healing experience, more holding, holding experience, like where then I feel ready to take on the world afterwards, versus another traumatic experience into out of the pod, into the fire kind of idea.” (Participant 3)

Shorter inpatient stay. Participant 12 felt that if she would have been involved in her care, her inpatient stay could have been shorter.

“I think that maybe I wouldn’t have to stay so long, because that is a lot of money and so and sometimes I think that umm... it’s my opinion, but they are just like keep them coming you know just keep you there, and I’m sure they do the best they can and I’m ok and happy, but I say I did have a medical condition that he knew nothing about so it was just.” (Participant 12)

Factors affecting the involvement. Participants also communicated the factors that affected their involvement in the plan of care. They talked about having a positive

impact on their involvement in care when a connection/trust was established with the healthcare provider. Of note, their perceived mood had a negative effect on their participation in care. The point in time during their hospitalization in which they were asked to participate in planning their care was an important factor. As their mood stabilized, they wanted to be part of the plan and know their options. They were also more involved following the plan when they understood their options and the outcomes.

Making connection with healthcare providers. Establishment of a therapeutic connection or trust with the healthcare provider affected participants' involvement in their plan of care. Participants shared having a positive impact on their inpatient care when they connected with their healthcare provider. Once the therapeutic connection was established, they were able to share their feelings, needs, and concerns. They were able to provide insight regarding their preferred treatment and were willing to try out options offered by the healthcare provider without resistance. Their connection with the provider encouraged patients to successfully follow the plan and achieve desired results. When such a relationship was not established, the patient was resistant to following the treatment plan and did not have positive outcomes.

The following are a few of the quotes from the participants who communicated increased established involvement after a therapeutic relationship was established.

“There was a, a psychologist, there were several psychologists and whatnot there. And I, um, requested one in particular, just because I happened to, to click with her. Um, that made a big difference. And I was very thankful and much more willing to compromise on other stuff.” (Participant 1)

“Um, I used, I used a therapist here. Wonderful man, and he shared his stories. Um, which was very comforting because I – it just made them more of a person, not just somebody instructing, “Do this, do that.” So yeah.” (Participant 2)

“First I didn’t know the doctor, he was a new doctor, before I had another doctor but this was new and I didn’t accept it because I didn’t know him..... I realize he is a good guy, he is a real doctor and a good psychiatrist, I talked to him and I told him what I feel, and I think I suggested some things and I think he understood.” (Participant 9)

“The psychologist that was leading it said just give it a chance, I kind of have a feeling with your personality umm... and the way your mind works this is something you will benefit from because you are going to be able to go into a place where your mind can be quiet umm... and I went all right, I happened to like the guy who was a gay man, who was very sweet and very gentle, so I went all right I’ll try because you think I will benefit from it, I trust you, I’ll try it, and I meditate just about every day now you know.” (Participant 11)

Participant 3 mentioned not having any opportunity to make a connection with the healthcare provider. Even after multiple requests of wanting to see her health care providers, she was not seen, and her plan of care wasn’t discussed.

“I’d speak different times; can I speak to the charge nurse? You know, things I know from being –, okay. But after a while, they’re just like, I don’t have time for

you. You know, I'm a pain in the ass. Well, you need to speak to your social worker about that. Where is my – oh, he doesn't come in until 1:00. You know, they have limited power too. Well, I don't know if the, uh, director nurse, director of nursing will speak to you about that. You know, they're always like referring me to somebody else. They have limited power too. It's a flawed system all over."

(Participant 3)

Mental status. Another factor that affected their desire/ability to be part of their plan of care was their mental status. Many participants were admitted after being severely depressed and anxious. Their ability to participate in their plan of care was affected by their mood. They felt the lack of desire/energy to participate in or following the plan of their care.

The following are the quotes of participants reflecting the impact of their mood on their involvement.

"When I had my anxiety, I was very withdrawn and umm... withdrawn and isolated and umm... I was very to myself, I didn't, I was shaky, and I would... then go hide in my room" (Participant 8)

"Well it was kind of if you wanted to go you could go, umm... it wasn't like a mandatory thing, so I guess that's ok but I did slack on that a bit, you know because I didn't want to be involved in the beginning, I just didn't think I needed it. "I couldn't understand, and they would say, well it's probably from your withdrawal" (Participant 12)

“You realize you can make decisions, you can get better, and you can handle yourself. after a few days I realize I can do that, that was the problem ok, my opinion, they are supposed to take my opinion because it is about me, myself and I know what is happening to me specially and what I feel” (Participant 9)

Timing of Involvement. Some of the participants mentioned that for the first day or two, they had low or no desire to be part of the plan. They did not care much about their plan of care. They followed the plan their healthcare provider had put in place. However, after day two or three, their mood started to improve and their thought process became clear and the ability and desire to participate in the plan of care increased.

The following are the quotes from participants who became interested in their plan of care after few days of hospitalization.

“I – I was definitely pretty disconnected that first day, I was just in a mental fog. And coming down from an attempt is – it takes a lot out of you mentally. And so, I was pretty checked-out, that was like I’m – I’m here to do whatever they tell me to do, and just kind of in a fog following through the motions, and I didn’t care what was gonna happen next. “Do you wanna give me meds? Okay. You wanna do shock therapy? Okay. Whatever happens, happens,” I was just pfft, checked-out, didn’t care about what it was gonna be. And then I – the second or third day I cared a whole lot more.” (Participant 4)

“I was starting to stabilize that second day and I didn’t have thoughts of suicide or anything, I would have liked to know some of the options I may have had for how long I would stay.” (Participant 7)

“After a few days I realize I can do that, that was the problem ok, my opinion, they are supposed to take my opinion because it is about me, myself and I know what is happening to me specially and what I feel.” (Participant 9)

Understanding of treatment. Participants communicated that when they knew the reason behind the treatment that they were asked to comply with, including medications, attending groups, meetings etc., they were more receptive to following the treatment plan and getting involved. When participants were not informed about or they did not understand the purpose, they were resistant or had no desire to get involved.

“You can inflict a treatment plan on me for the next week or two, or – and that’s as long as it’s going to last if I don’t like it – or you can talk to me, acknowledge that I might not think everything you’re doing is the best thing for me, not be hurt by that, but be proactive about finding my objections, and we might come up with a long-term plan.” (Participant 1)

“I like to know every step and why we’re doing what we’re doing.” (Participant 4)

“If I don’t understand what you are telling me to do, not going to happen, it really isn’t going to happen. You know, unless I can ask you questions and you can

explain it to me, if its sounds like something that would help me, I will investigate it, I'll try it, I'll participate but if I tell you this isn't working, I'm telling you This is NOT working, you know we need to do something different or approach it in a different way" (Participant 11)

"I chose to lay around part of the time because I just didn't get it." (Participant 12)

Ideal involvement. All the participants were inquired about what the ideal involvement in their plan of care would look like to them while they were in in psychiatric facility. According to them the ideal involvement will be being offered options, having a say in their treatment planning, longer information exchange sessions with their healthcare provider, and discussion/updates about any changes in the treatment.

Two-way conversation with the healthcare providers. Participants desired to have a mutual conversation about their plan of care.

"It would feel good to have people sitting around, I think just meeting with a team, discussing what are some good options for after the hospital, um, housing options, physical health options, um, even just with my depression. Medication options, where they saw that going." (Participant 3)

"Involvement with you have a psychiatrist and then you have a medical doctor at <name of the facility>, well that medical doctor doesn't see you unless you have a cold or flu or this or that, and that is what he is there for, and your psychiatrist

is for medication, addressing whatever your psych thing is and it's like there is no chit chat about your plan.” (Participant 12)

Voice in decision making. Participants desired the team approach to decision making about their plan of care.

“Just being informed at everything before it happens.... every decision that's made, I'm part of that decision-making process. And that's, for me, ideal: having the power to say yes or no to what's going into my body, or what treatments I'm receiving, what my therapy is. That's – that's ideal to me, it's my voice being seriously considered. I wish I had seen the medical doctor a little bit longer.”
(Participant 4)

“Being able to say what works for me and what doesn't work for me and where do we go from there, umm... having the opportunity to voice my opinion about umm... my care that I'm receiving here umm... having the right to say No! If something is not working for me umm... having the opportunity to say, Hey! I think this will work for me.” (Participant 10)

Having the options. Participants desired to know the options for their treatment.

“Knowing what my treatments are, what my, um... Knowing what my options are.” (Participant 5)

“I think what are some good options for after the hospital, um, housing options, physical health options, um, even just with my depression. Medication options, where they saw that going.” (Participant 3)

Informed of changes. Participants desired that they were informed of any changes to their plan of care.

“Ideally umm... I would have been alerted to any changes they were making, umm I would have, you know if any changes on medication umm I think that I would have appreciated if they told me what they were doing, umm I believe that they should have asked me how the medications I was using prior how they are working for me.” (Participant 7)

While analyzing the transcripts, many other themes emerged that were not directly linked to participants' involvement in plan of care but were important to them and defined their experience of inpatient psychiatric hospitalization. These themes included safety, compartmentalization of care, and positive changes that psychiatric hospitalization brought to their lives.

Theme 3: Safety

One of the common themes conferred by the participants was safety. Most of the participants had admitted themselves into an inpatient psychiatric facility either after an attempted suicide or after having active suicidal ideations. They communicated that being in the facility provided them with a secure and safe environment where they did not have the access to objects they could harm themselves with. They had access to trained staff

whom they could approach, share their feelings with, and get help to deal with negative thoughts. However, some participants shared negative experiences of safety while in the inpatient facility. They mentioned that other patients with multiple different psychiatric illnesses were placed in the same environment. Some of those patients required a higher level of psychiatric care and had behavioral problems. One of the participants mentioned that her anxiety and PTSD was triggered by being in the inpatient facility. Another safety concern was the fear of getting “bugs” from other patients as the patients who were supposed to stay in their rooms on isolation precautions mingled with everyone when not continuously observed by staff. (See Figure 4).

Figure 4. Safety

Safety from self. Participants who were admitted after having suicidal ideations communicated feeling safe being in the inpatient psychiatric facility.

“I felt safe, I felt safer being here than being at home because I didn’t know, feel like I was safe at home, I had bad thoughts and umm... I had bad thoughts you know being in the hospital, but umm... I felt like I was safe being in the hospital so umm... there was people around... I didn’t feel like I had access to anything that would hurt me that I could hurt myself with; like at home I felt like I had access to my meds, which I could overdose on, I felt like I had too many things that I had access to that I could hurt myself.” (Participant 8)

Safety from others. Even though the participants were empathetic and understanding toward their peers in the inpatient psychiatric facility, they communicated feelings of being afraid for their safety from other patients who required a higher level of psychiatric care.

The following are the quotes from participants reflecting their safety concerns.

“Um, so the gentleman came out of his room and he is roaming up and down with no clothes on. It, it kinda startled me. Uh, ‘cause there are no doors, so I’m going, ‘Oh, oh Lord.’” (Participant 2)

“There was someone really bad in there screaming and howling and I don’t know, they did not help her too much, they tried to help her but umm... it was very annoying and one time I got scared because I said to him what if she comes in my room? Because she was very close to me, they keep her in the hall, and in the

hallway one time she was screaming and umm... saying bad things and umm... crying and I feel sorry and sad and I said what if she come to this room, because the door they kept the door open in there” (Participant 9)

“I was pretty overwhelmed with the coed nature of it, just because from my PTSD I have a big issue with men—I’ve been abused in horrible ways and people have gone to jail for the stuff they’ve done to me. And at one point a gentleman was being moved into my room before I had a chance to get my stuff out.... And, um, at night I was having horrific nightmares because with my PTSD it’s people coming into room at night..... it was almost like my issues were being triggered by being inpatient and I wasn’t getting the relief.” (Participant 4)

“There were two or three people that were having trouble and you have to be there to experience it which one on to me was losing absolute control or absolutely losing control, and lashing out, refusing to cooperate, An Asian lady and the whole group who was in inpatient, many felt that it was amusing that she lose control like that, but it was serious situation that she needed help for.”

(Participant 6)

Safety from parasites. Two of the participants talked about other patients having parasites, such as lice, crabs etc., that could spread to others. They were afraid of contracting these parasites while in the facility.

“Umm there were lice in the bedroom (laughs)... Umm I bathed myself really well afterwards so if I did, I got rid of them.” (Participant 7)

“There’s a ton of other people in there that were sick and quarantine and walking around that was kind of weird, I didn’t, cause I had a real phobia against that kind of stuff I still do (laughs). it was addressed but they were still able to mingle amongst others at times when nobody was watching so that was kind of, I didn’t like that.....that I was going to get whatever they had, because it was contagious they were in a quarantine, the nurses when in with all their garb and the stuff outside the door..... but you know they did not always watched you know, and so they get out and that was kind of weird, I did not care for that, that was one thing I did not like.....not just germs, but people had like crabs and stuff like that, it’s not just physically its like blaaah.” (Participant 12)

Safety after discharge. Participants spoke of feeling anxious about managing their medications after discharge. Participant 8 felt safe going home as all of the discharge medications/instructions were explained to her. However, Participant 12 was anxious as she was handed a stack of papers with discharge instructions but no verbal explanation as though the provider assumed the participant would read all the material. However, the participant told the researcher that she did not read the papers as the information was overwhelming.

“And I was really concerned about my medications and what was going to go on with those, because I had new medications that they were giving me and I was,

was very specific about all right when am I supposed to take certain medications and stuff and they went over medications with me, they were really nice and they wrote like take this in the AM, take this in the PM, and they wrote that off to the side for me so I that could stay on the regimen that I was on so that was I thought really thoughtful that they could do because that's really confusing when you go home.” (Participant 8)

“On more Suboxone in the hospital and when I got my prescription they explained that it would be cut in half so I thought so here I go out of the hospital into the mainstream and I'm like going home, and I hope I don't have withdrawals... They give you enough information.... I mean for real, it's like it's like that look was overwhelming at the time. they just said you have a doctor appointment here, this and that. And here is this, here is your discharge summary it was a green folder and it was packed with stuff.” (Participant 12)

Theme 4: Compartmentalization of Care

Many participants talked about generalized care in psychiatric facilities. Many did not feel the care was tailored to their needs; it was more like the “one size fits all” approach. Participants communicated the need for compartmentalization in psychiatric facilities, depending on the patient diagnosis and acuity. They communicated that it was hard for them to concentrate on their mental health when their surroundings were disrupted by patients requiring a higher level of care. However, one of the participants felt there was a degree of compartmentalization at the facility where she was admitted.

“I think, is one of the biggest issues in inpatient is that the – the care is too broad over too much of a – too wide of a spectrum for any one person to move forward with their individual issue....Um... I would... I know it’s almost impossible, but it just seems like too much is blended in one section in inpatient. Like, it would probably be impossible to divvy people up by what they’re going through, or even by gender. But it just feels like this big bucket of psychoses bashing into each other with different genders, and different backgrounds, and different everything. And it’s kind of a hard, uh, situation, hard environment to focus on your health when—for someone like me—you’re overwhelmed by what you’re surrounded by. So, I’m wondering if inpatient could somehow be tailored more, you know, for – for the situations that there are.” (Participant 4)

“Psychiatric hospitals aren’t, are aimed toward I think a certain demographic. And, um, it is, becomes prohibitively difficult, um, for a high-functioning person to be, to receive any real care.... all of the patients were in the same sort of general group, whether they were new patients or, um...” (Participant 1)

“I felt like they kept us apart from the ones that were really strange cause I did have to go to the unit to, that was umm..... the locked unit, I did have to go to the lock unit for a night umm..... and that had some more unsafe type of patients so I felt like they separated me from that pretty quickly so umm..... they kept, I think they kept us apart from the more unsafe patients pretty well.” (Participant 8)

Theme 5: Turning point

Participants perceived their inpatient psychiatric experience as a turning point in their lives. Many of them received the support they needed to manage their mental illness on daily basis. Healthcare providers, group sessions/activities, medications, and referrals to resources outside of the hospital were reported to be very helpful. Participants appreciated the group activities during their inpatient stay as these taught them skills and provided them with tools to deal with their mental illness. Many participants said this taught them to trust themselves again and boosted their self confidence in making their decisions independently. Participants also mentioned that listening to and sharing their problems with peers was helpful. It assured them they were not alone in this experience and they learned how others dealt with similar issues. The psychiatric inpatient stay provided them with the structure and the time to focus on themselves without worrying about outside stressors. They appreciated learning about the resources available to them outside of the hospital to help them stay on track or turn to when future crises hit. One of the resources all these participants received was a referral to an outpatient program as a continuation of their care.

Learned tools to recognizing and dealing with mental illness. The following quotes are from participants who learned the tools to recognize and deal with their mental illness on a daily basis.

“Before, I didn’t realize I was isolating. I didn’t know the term. Um, or just the negative self-talk. Or any, anything. And so, it would just, it would – it was just this spiral. And recognizing it, and this, that’s what I learned. Uh, and I’m

learning. Is recognizing it and pausing and being grounded. Uh, I learned not to be so hard on myself. I learned, um, that there are resources” (Participant 2)

“Well it helped me believe it or not, umm... learning cognitive skill and umm... because umm... they actually explained about umm... the thought process and how you can feel about things and I’ve never slowed down enough to actually think about those kind of things, so that was helpful and actually practicing those you know, and trying to practice them.” (Participant 12)

“They teach you, at least they taught me to self-analyze and think, self-structure.” (Participant 11)

“There were a couple groups that got me a little more involved in my care and made me think a little more about the way my brain works, my mood, um, and how I can try to have more control over.” (Participant 4)

Peer support. Participants shared that being in the groups and taking to their peers and hearing them share their experiences helped them in dealing with their own mental illness.

“Helped me because the people talk about their problems what they feel, exactly what they are doing here. ok, and you learn from people, you feel sorry sure, sometimes you are sad because they suffered and they have some problems and they struggle like you do, but umm... you learn. this was very important for me,

learning, I like people doesn't matter their race, the ethnicity and blah, blah, I like people and I like to hear from people they have experience like me or different than me" (Participant 9)

"Listening to other people that were going through the same thing that I was going through in my life and the encouragement that I can do it, the you know the perception that I can have a normal life again." (Participant 10)

"I befriended a couple of people there, one was severe misconduct and calming down acting friendly quit instigating trouble, anger so I had a good effect on him, which had a good effect on me. Not trying to play his doctor just someone who cares enough to listen to what he has to say so therapeutic for him, therapeutic for me." (Participant 6)

Trusting self again. The following are the quotes from the participants who shared that being in the inpatient facility enabled them to trust themselves again and take control of their lives.

"I trusted me again, I trusted me again I believe umm... I can handle it, everything ok, and umm... like I did before, because I was sick before not everything was the same, was a little bit different but I can handle myself when I get out of the hospital and I did." (Participant 9)

“It was the beginning of my foundation umm... and recovery process. The opportunity to give myself a break, a rest.... I gained a new start on my life, I wasn’t dying anymore you know umm... I’m living I was given a chance to live again... It made me feel that even though I hadn’t been responsible in umm... suiting up and showing up in my life, that I once was responsible for myself and that Hey! I can do this on my terms again and umm... it made me feel like, I was an adult who was in charge of her life again.” (Participant 10)

“It made me feel like safe again I guess it’s a good word because I felt like, ok you know we are doing everything right, it made me feel like we are doing everything right...I got what I needed from my doctor, from the nurses, from myself, I was able to... I was able to focus, I was able to heal, I was able to... I was able to move forward.” (Participant 8)

Continuation of care after discharge. Participants communicated having the referral to an outpatient program as one of the best outcomes from inpatient admission. They shared that the outpatient program helps them, stay on track and provide support to maintain their mental health outside of the hospital.

“We got together, and she gave me all these, um, handouts, information for this group (referring to the outpatient program); she gave me the NAMI information for my family.” (Participant 4)

“It did help me make a transition to outpatient because they tell me to do something I did it and why, which leads to going to outpatient, which leads to learning about why I did what I did and how to control it.” (Participant 6)

“Yes, they asked me [about outpatient], and I said yes, I accepted, and the insurance accepted too.” (Participant 9)

“They were like “Oh well outpatient!” and you know they gave me the information and umm... they made the calls, I didn’t have to do anything except show up, you know for outpatient once I got out of inpatient and I have been saved, I’ve been saved, I come to class, you know I learn new things and its tools that I had before the alcoholism that I had forgot about, that I didn’t really realized that I was using or not using anymore until I got here and these tools are coming up, these life tools are coming up and I’m like “Oh! I used to do that, way back when!” (Participant 10)

“This IOP here was recommended by the staff at <Name of the facility> and umm... I have been in and out of this program, but I’m committed to you know they are saying like three to four more months and I’m committed to really learning everything I can from the, cause now I know there is an end in sight.” (Participant 11)

Safe environment to share feelings. Participants felt that the inpatient facility provided them with a safe environment where they could share their feeling and problems without the fear of being judged by others and helped them break the negative thought process by being around others.

“I needed to get out of my head cause my head, you are in your head and you have racing thoughts of all sorts of things, you are thinking about suicide, you are thinking about hurting yourself, you are thinking about umm..... all these random thoughts of just everything that is going on in your life and you just want to escape that for a little while. Being an inpatient, it takes you, like the meetings that you go to can help you take you out of that for a little while. Other people were talking, and it was like if I wanted to talk, I felt like it was a safe environment to talk, so I could either hold it in and just listen to people and let them you know vent, but if I wanted to vent, I could vent.” (Participant 8)

“Because you know you are safe, you know you can say anything you want umm... it allowed me to be a little more forthcoming about my problems, and realize, yeah, I got problems, but you know I’m a baby in the problem area.” (Participant 11)

“It’s helped me to be able to be with others that are in the same situation and also to be able to voice and talk about my feelings and what not about what I am going through all this you know what I’m going through with umm... not being medicated all the time and what not.” (Participant 12)

Time for self. The following are the quotes from the participants who felt that inpatient stay provides them the time to concentrate on themselves and their mental health.

“It allowed me to, to find myself again, it allowed me the time away from everything, everybody that I had known to focus on myself and my strength.”

(Participant 10)

“I think <Name of facility> sort of refueled self-care, make sure you shower, and your hair is sort of done and you have at least mascara and blush on before you leave the door... I have a good feeling about it, because it allows you to focus on you, I don't have to worry about what the family is going to have for dinner, or laundry is done or blah, blah, blah you know that's all over hear and that's, I don't need, that is not me right now, I don't need to concern myself with that.”

(Participant 11)

Theme 6: Inpatient: A holding place

Some of the participants felt the inpatient hospitalization was not beneficial for them. They felt their mental health needs were not addressed appropriately.

Mental health needs not addressed. The following quotes are from participants who felt that inpatient psychiatric hospitalization was not for them.

“My inpatient stay was abysmal. I saw a psychiatrist and psychologist, but not a whole lot went on, like I said, because I think that I wasn't, my particular issues

weren't appropriate for that hospital. Um, when I went to the other one, the one I was transferred to, um, I, I was treated worse than I would treat my dog.

[Laughs] I was going to say like a dog, but worse than I would treat my dog, actually. Psychiatric hospitals are aimed towards keep them from hurting themselves. That's the goal, you know? I, I voluntarily admitted myself, you know? I wasn't in danger of hurting myself. I, I felt overwhelmed by my depression. Um, and I wanted help for that. And, um, in neither of those two facilities did I receive help." (Participant 1)

"I'd just lost my housing, um, out of the blue, um, and what else was going on? Some really big financial crisis. I didn't know where I was gonna go. I had no support from my family. And, you know, I'm a little less concerned about Medicare regs and more concerned about I needed to talk to someone. The rest of the therapy there was done by MFT trainees, who basically are still in school. That's who's doing their groups? They just came in, made sure everybody signed in, and handed out worksheets. That is not treatment. That is not inpatient treatment. And then the psychiatrist was not even seeing me. It was just a temporary place to stay until I found another place to stay. And then this started helping me get better. It was just better than being on the street that's what I found." (Participant 3)

Just an observation. Participant 6 felt the inpatient stay for him was just an environment where people were observed so they do not hurt themselves or others. He did not gain anything important out of being in the inpatient facility.

“Inpatient is more of an observation than it is actual treatment.....The only thing that the inpatient is you eat, you sleep, you change clothes, you take a shower, you eat, you sleep, there is no really hands on it’s just locked up observation.....About the same thing as sending a child to the bedroom for punishment.....Yes, we are going to put you in this area and we are going to watch you, that was the inpatient. Inpatient was nothing more than a place to put me so that I can think, talk if I want to, don’t talk if I want to, follow orders.”

(Participant 6)

Theme 7: Social support matters

All participants had a family member or a friend who they turned to in case of need. Most participants communicated their family members/friends were very supportive of them and had a positive influence on their healthcare decisions. Participants felt comfortable sharing their mental health issues with their family/friend without the fear of being judged.

After the analysis of the data, I discovered the participants who had a family member or friend living with them or living close by had a better inpatient psychiatric stay and were more satisfied with the care they received in the inpatient facility than those with no support nearby. All but three participants had a family member very involved in their plan of care and helped with decision-making. Participants 1, 3, and 12

communicated that even though they could turn to their family member/friend for support, their family/friends lived in a different state. Thus, the support was not immediately available.

Participant 1 mentioned that her friend helps her in decision-making, but she did not want to bother her friend because the friend was busy with her own family.

“The person that most influences my decisions is my best friend. She’s not, she doesn’t have a medical background, but she knows me. she’s got two kids, and, uh, she lives in, um, well, she lives in Arizona now. I know if I said something, she would’ve flown out. And I, I didn’t want her to, so I didn’t tell her” (Participant 1)

Participant 12 talked about her social support and said,

“I do share with my mother and my father is older, so he doesn’t understand but it’s just umm... and my son he is in Alaska to so, I do share but some of my good friends I haven’t shared everything with I kind try to do research or just find out on my own. it’s kind of scary to be in a situation with no family there and to go through all that and not be able to umm... have somebody else there when you are not in the right frame of mind and physical ability to umm... go through that with you as far as helping explain because you might not get it the first time.”

(Participant 12)

Participant 3 did not have any family member involved. However, she shared limited information with her friends regarding her mental illness.

“My family aren’t involved in that. Friends that like supported me. I think it just felt like I’m on my own and scrambling to take care of myself sometimes.”

(Participant 3)

After an exhaustive analysis of the data obtained from 12 interviews, seven major themes emerged. These themes were participants’ knowledge about the plan of care, involvement, safety, compartmentalization of care, psychiatric inpatient admission as a turning point, inpatient as a holding place, and importance of social support. All the participants had a basic understanding of the plan of care concept. The participants showed a strong desire to be involved in their plan of care and were involved at different levels during their hospital stay. They communicated positive and negative aspects of safety during their stay in the inpatient psychiatric facilities. The participants desired to be placed in an environment where other patients had similar mental health needs and where their specific psychiatric needs could be addressed. Despite some negative experiences during an inpatient psychiatric admission, most of the participants of this study considered their psychiatric inpatient hospitalization a turning point in their life. Only a few participants perceived their psychiatric hospitalization as not being beneficial. The participants who had family members that lived with them or who lived in the same city shared having a better experience with their inpatient psychiatric than those without a support system nearby.

Chapter 5 Discussion

Overview of significant findings

After a thorough analysis of the data obtained from 12 interviews, seven major findings emerged. The first finding of the study was that even though all participants attributed a different personal meaning to the concept “plan of care,” they all had a basic understanding of the concept. They communicated a plan of care as their treatment plan either in the hospital or outside of the hospital that would help them deal with their mental illness. There were three ways in which their plan of care was created. One way was through collaboration between the healthcare provider and the participant. The second way was that the healthcare provider formed the plan independently without the participant’s input, and the third was that the healthcare provider asked for the participant’s input but formed the plan independently without integrating that input.

The second finding had to do with participants’ desire to be involved in their plan of care. All participants talked at length about their involvement in the plan of care. The participants had a strong desire to be involved in their plan of care as doing so provided the opportunity to have a two-way communication with the healthcare provider, made a plan that was individualized to their needs, provided the feeling of being in power or control, and kept them informed. Most, but not all, participants had a positive experience of involvement. Some of the participants felt ignored, dismissed, and not considered experts in their own care. They believed that being involved in their plan of care could have helped them successfully transition into the community with better preparation to manage their mental health. Participants’ involvement in their plan of care was affected negatively by their mood and affected positively by making a therapeutic alliance with

their healthcare provider. The opportunity for two-way communication with their healthcare provider, receiving information about changes in the treatment, having the option to choose, and having voice in their care planning represented ideal involvement.

The third finding was participants' concerns for safety during their stay in the inpatient psychiatric facilities. A positive feeling of safety was shared by participants who were admitted for being a danger to self. Their safety was increased by close observation and limiting their access to material they could use to hurt themselves. However, some participants communicated they felt their safety was jeopardized by being around high-acuity psychiatric patients. Some participants also communicated fear of getting lice and similar parasites from others as the affected patients did not follow isolation precautions and mingled with others in the milieu when staff was not observing.

The fourth finding was participants' desire to be placed in an environment where other patients have similar mental health needs and where their specific psychiatric needs could be addressed. Some of the participants felt that patients were placed in the same unit/area regardless of their psychiatric needs. Patients who were depressed with suicidal ideations were placed with patients who were aggressive with low or no behavior control and had homicidal ideations. Even though both types of patients needed very close observation/monitoring, their mental health needs were different. Patients who were depressed or had previous PTSD were negatively affected by the behaviors of their high psychiatric-acuity peers. The participants who were depressed desired the need for a quieter environment to heal and not a loud, chaotic environment. One of the participants communicated that even though she was initially placed in a high observation area she was quickly moved to less acute area as her suicidal ideation subsided. However, this was

not the case for others. Some of the participants felt their care was not individualized to meet their mental health needs as the meetings/groups conducted on the unit were very general to everyone who was there as a patient. They desired the need of compartmentalization of the units within the psychiatric facility to better meet their individualized psychiatric hospitalization needs.

The fifth finding related to the effectiveness of inpatient psychiatric hospitalization for the participants. Despite some negative experiences during an inpatient psychiatric admission, most of the participants of this study considered their psychiatric inpatient hospitalization a turning point in their life. Peer support was one of the highlights of their inpatient psychiatric hospitalization experience. Participants communicated they learned a lot from their peers who were going through similar mental health issues. They recognized they were not alone in this experience and learned to deal with their mental health problems in a positive way. They also communicated the effectiveness of the group therapies/meetings as those activities provided them with the tools to effectively manage their mental illness and provided a safe and nonjudgmental environment to share their feelings/problems with others. They were also provided with referrals for outpatient treatment/resources that were effective for them in maintaining their mental health outside of the hospital.

The sixth finding was that some participants perceived their psychiatric hospitalization as not being beneficial. Three out of the 12 participants described their inpatient hospitalization as a holding place. They felt they did not gain anything by being in an inpatient psychiatric facility. Their psychiatric needs were not met and adequate inpatient treatment was not provided. They considered their psychiatric inpatient

admission as a holding place where they were observed until their healthcare provider felt it was safe for them to go home or until they found another place to go to. They did not feel there was any treatment planned or offered from which they could benefit.

The seventh finding had to do with the impact of having a family member/friend who lives close by and is very involved in the participants' care. Many of the participants had family members that lived with them or lived in the same city. These participants had a better experience with their inpatient psychiatric hospitalization and were satisfied with the psychiatric care/treatment they received during their inpatient stay than those who did not have a support system nearby. The participants who did not have families or friends living close by or did not share their psychiatric problems frequently/openly, had a negative inpatient psychiatric facility experience, and felt unprepared to manage their mental illness outside of the hospital at the time of discharge.

Consideration of finding in the light of existing research studies

These psychiatric patients were fully aware of the concept plan of care. Even the participant who had not heard the term was able to describe the plan of care. As highlighted in the study by Duncan and colleagues in 2010, there is a high emphasis on the participatory approach in the current healthcare system and there is a plethora of research supporting the shared decision-making approach while planning a patient's care. However, this is not being practiced fully in inpatient psychiatric facilities. The results from this study demonstrate that many healthcare providers are still practicing a paternalistic approach in the treatment planning of psychiatric patients.

Patient engagement/involvement is not an all or nothing phenomenon. Different patients like to be involved in their plan of care at different levels due to many factors

that affect their participation. Sometimes the patients themselves are not ready to participate; other times, the providers do not involve the patients in their plan of care. The factors affecting patient participation will be discussed later in this chapter. As seen in this study, the participants' experience of being involved in their plan of care ranged from no or low involvement to full involvement. This range of involvement aligns with the continuum of patient engagement described by Carman et al. (2013). According to Carman and colleagues (2013), at the lower end of the continuum, patients have very limited control or decision-making authority in their treatment planning. At this end of the continuum, the healthcare providers formulate the plan independently based on their judgement and then present the plan to the patients for their input. At the higher end of the continuum, the patient and the provider share responsibility and power to make treatment decisions after the bidirectional flow of information takes place. This continuum of involvement was clearly seen in this study. Some participants shared experiences that support the lower continuum of engagement where participants were offered the plan of care and asked for their opinion. Others shared the experience of being actively involved in their treatment planning. They practiced shared decision-making and the flow of the information was bidirectional with participants being informed of their treatment options and having their opinions honored.

Some participants shared another aspect of involvement that did not fall on the engagement continuum. In this case, participants' opinions were not asked for and participants were not given any opportunity to be involved in their treatment planning. There were no attempts made by healthcare providers to engage participants in the process of bidirectional information exchange. This type of care planning resonates with

the paternalistic approach that is obsolete and unacceptable in current healthcare practices. On one hand, there is a growing emphasis to move healthcare delivery toward patient-centered care and joint decision-making; on the other hand, healthcare providers are not including patients in their plan of care even when patients want to be part of their care planning as was the case with multiple participants in this study. Perhaps it was assumed, given their psychiatric conditions, these participants were not capable of planning their care. In these cases, participants were never assessed for their mental capacity to participate in their care planning. This paternalistic approach by the healthcare providers may have set these participants up for failure instead of building their confidence and providing them with the tools to strengthen their self-confidence in managing their mental health.

As it has been shown in the study done by Hill & Laugharne (2006), psychiatric patients have similar desires to be involved in their care planning as nonpsychiatric patients. Some psychiatric patients want to be involved more while others want to be involved less but most participants wanted to take part in their care decisions. The findings of this study also align with the study mentioned above. All participants in this study wanted to be involved in their plan of care. They desired to be updated on any changes in their treatment. They wanted to receive information about their pharmacological treatments, their benefits and adverse effects, length of the treatment, and alternative options. Many participants were ready to be fully involved in their plan of care on the day of admission to the psychiatric facility. Others sparked their interest by day two or three. But at some point, during their treatment, they all desired the opportunity to be involved in decision-making and having treatment options.

There has been an overwhelming amount of evidence that involving patients in their plan of care improves quality of care provided to the patients and empowers and encourages them to take charge of their care (Joosten et al., 2008; Mosen et al., 2007; Tambuyzer & Audenhove, 2013). The findings of this study align with the existing literature on patients' active participation or involvement in their care planning. The participants who were involved in their treatment planning and participated in shared decision-making practices had positive inpatient experiences and gained more skills and tools to manage their mental health outside of the hospital than the participants who were not actively involved or were not given the chance to be actively involved in their care planning. According to the study done by Elacin and colleagues (2015), involving patients in their plan of care leads to increased patient satisfaction with the treatment, improves adherence to the treatment, and reduces hospitalizations. When patients have a say in treatment options and they understand the treatment and have enough information about it, they are more likely to stay in compliance with the treatment. This was the belief by the participants in this study. Participants also communicate that if they were involved in their treatment planning and had a say in their care, further hospitalizations could have been avoided. One of the factors that enhanced participants' participation in their plan of care was the therapeutic alliance with their healthcare providers. When trust was built, participants were open to share their opinions and engage in productive two-way conversations with their providers to create a plan that was specific to them. Similar results were found in the study done by Elacin and colleagues in 2015. They also reported that a strong, trusting relationship between the patient and the provider was essential to the shared decision-making process with respect to treatment. The courtesy and

genuineness of the nursing staff also affected patients' participation in care. If participants felt their nurses truly cared about their wellbeing and recovery, they were more receptive to nurses' suggestions about attending therapeutic activities and following their plans of care. These findings align with the study done by Larsson, Sahlesten, Segesten, and Plos in 2011. They showed in their study that the nursing staff's behavior toward patients either inhibited or stimulated the patients' participation in their own care. Patient participation increased when nurses treated patients as valuable coworkers. This also built a genuine connection between the nurse and the patient and resulted in patient-centered care.

For some of the participants, their mood at the time of admission was the biggest inhibiting factor in their desire to be involved. Participants communicated feeling overwhelmed with their mental illness and being involved in their plan of care was not initially their priority. However, that changed by day two or three of the hospitalization as the participants received some pharmacological and therapeutic interventions. Subsequently, participants reported they desired to be involved in their plan of care. As reflected in the systematic review of literature on the effect of depression on patients' decision-making capacity done by Hindmarch, Hotopf, and Owen (2013), depression can negatively impact decision-making capacity by affecting one's ability to appreciate future possibilities and to some extent, inhibit understanding and reasoning abilities. However, it also depends on the severity of the illness. Even though a patient might not be able to participate in his/her plan of care on the day of admission, a patient's capacity to participate should be assessed on a daily basis and an opportunity to be part of their plan of care should be presented.

There has been a great deal of research on safety of staff in psychiatric facilities related to aggressive patients. There has also been extensive research on patient safety during use of restraints, seclusion, or medication errors. However, there has not been enough research on the effect of other aggressing/unpredictable patients on a patient's perceived safety in inpatient psychiatric facilities. The one study done by Frueh et al. (2005) on patients' experiences in the psychiatric setting showed that 54% of the participants reported higher levels of concern for personal safety and distress in psychiatric settings related to being around frightening and violent patients. The participants who met the PTSD criteria reported feeling unsafe, fearful, and more distressed in the psychiatric setting. The findings of the Frueh et al. (2005) study resonates with this study as the participants in this study were also concerned about their safety due to unsafe behaviors of other patients around them. One of the participant's PTSD symptoms were triggered by other patients' behavior in the facility, causing her more anxiety and stress rather than providing a therapeutic environment of healing and allowing her to focus on herself.

The researcher could not locate any study published regarding the prevalence of contracting communicable diseases in a psychiatric facility. Hence, no study was found regarding transmission of lice or pubic lice from patient to patient in psychiatric facilities. However, in this study, participants reported the fear of acquiring these parasites from affected patients when isolation precautions were not effectively maintained. There have been many policies and practices set forth by accreditation organizations for hospitals to address compliance with isolation precautions to reduce the spread of communicable diseases and parasites. Psychiatric facilities must stay in compliance with these

precautions so patients can be free from the fear of contracting diseases at the facility. It might help to educate patients and conduct frequent rounding to address affected patients' needs to reduce patients' chances of coming out of isolation. The isolation practices in psychiatric facilities require in-depth examination.

Involving patients in their plan of care not only empowers patients it also has a positive effect on their rehabilitation. Involved patients acquire skills, knowledge, and self confidence that enable them to manage their care independently. It also provides patients with the sense of responsibility and control (Vahdat et al., 2013). This was also communicated by the participants of this study when they discussed psychiatric hospitalization as a turning point in their life. As participants felt involved and gained the skills to manage their mental illnesses and regained trust in themselves, they felt ready to make decisions independently and take charge of their lives. Participants also communicated that being an inpatient and attending group therapies provided them with structure and an opportunity to disclose their problems in a safe and therapeutic environment. It also allowed them to listen to peers and learn strategies to cope with their own mental illnesses. In addition, these experiences provided universality to the patients and they felt relieved they are not alone in dealing with mental problems as many other people are going through similar situations. These findings align with the study done by Hajek (2007) that discusses the positive role of group therapy in an inpatient environment. According to her study, group therapy contributes to cultivating a therapeutic environment on the unit and help patients become involved in the treatment process by socializing and disclosing to peers. It creates coherence among patients. It also

provides universality and helps reduce the anxiety of being around other mentally ill patients.

The participants who had a negative inpatient experience did not feel involved in their plan of care. They had no feelings of empowerment or having any control over their care. They felt neglected and dehumanized and did not gain any skills to manage their mental illness independently. Hence, they were not able to deal with the reality of living with a mental illness outside of the hospital and felt their inpatient stay was abysmal.

Despite an extensive search of the literature, the author could not locate a publication that looks at the compartmentalization of care based on either a patient's behavior or his or her diagnosis in inpatient psychiatric hospitals. Patients admitted with homicidal ideations, show aggressive behavior, and have no or low impulse control are placed with patients who are depressed and suicidal. Manic patients are in the same milieu as depressed patients, attending the same therapy group sessions on the ward. Many times, they are disruptive in the group and defeat the purpose of group therapy. As participants communicated in this study, sometimes patients are triggered by each other without meaning to disturb the peace of the milieu. There needs to be separation between acutely psychotic patients and patients who are depressed or hospitalized for medication adjustment, anxiety, or PTSD. Having a wide range of psychiatric diagnoses and behaviors in one ward is not therapeutic for any of the patients. They are unable to focus on their problems and gain appropriate therapy when the environment around them is not perceived as peaceful and/or therapeutic. Perhaps the effect of aggressive behaviors of acutely psychotic patients on their peers needs to be studied. Even though there is a plethora of research about providing patient-centered and individualized care in

psychiatric facilitates and it's benefit to the patients, if the environment of the ward is not quiet, therapeutic, and safe for the patients, they will not receive individualized care to meet their needs. Many times, patients voluntarily admit themselves to get away from stressful and/or overwhelming life situations and to have some quiet time to focus on themselves. If the environment in inpatient facilities is not therapeutic, then patients will not get any relief from their symptoms. Consequently, it could make their situation worse, as was reported by some of the participants in this study. Hence, it is important to place patients with similar diagnoses or behaviors with each other to maintain the positive impact of inpatient hospitalization.

In the current healthcare field, family participation in a patient's plan of care is highly supported and recommended as it improves patient and family satisfaction of care. Participants who had family and/or friend highly involved in their care had better inpatient psychiatric hospital experiences. Most of the participants communicated that their family was very supportive and even part of their plan of care during hospitalization and after discharge. Some family members were even offered and accepted attendance at family support groups. This fostered family members' understanding of what the patient was going through and how the family could support the patient in dealing with an unstable psychiatric phase. There have been many scientific publications that support the enhancement of caregiving capacity in family members of a mentally ill person in terms of its clinically significant impact on the patient's mental disorder (Falloon, 2003). In most of the cases in this study, family members were the main source of social support and played important roles in the recovery process of the patient, providing him or her with the feeling of being loved, supported, and cared for. Not having enough social

support or having someone to turn to in case of need can be devastating for a person with mental illness. This can affect a mentally ill person's recovery process negatively.

Limited and inadequate support can delay the process of recovery for a person with mental health problems and can increase the probability of psychiatric readmission due to exacerbation of preexisting psychiatric problems (Resnick, Rosenheck, & Lehman, 2004). The participants with negative experiences did not have family members close by to support them during their psychiatric hospitalization. One of them also communicated feeling frightened because she did not have a support person with her during her psychiatric hospitalization and was not able to understand everything clearly during initial explanations by providers due to her mental status. There is not much research on the impact of family proximity on the mental health of an individual.

Implications of the study

This study explored patients' perception of involvement in their plan of care while they were admitted to an inpatient psychiatric facility. The findings shed some light on many important aspects of care provided in inpatient psychiatric facilities. The findings of this study validated existing research on psychiatric patients' strong desire to be involved in their plan of care. Healthcare providers' perception that psychiatric patients do not want to be involved in their plan of care is, perhaps, a myth. The findings of this study will provide insights for health care professionals to engage and/or involve psychiatric patients in their care planning and to meet their individualized healthcare needs. This will also help providers see psychiatric patients through the same lens as any other patient. This study will also encourage nurses to make a therapeutic connection with their patients and effectively play a role as patient advocates by ensuring a patient's

desire to be involved, informed, and empowered is respected and fulfilled. This study will also spark the interest of nurse researchers to look closely at patient safety and isolation precaution practices in inpatient psychiatric facilities. In addition, this study will also encourage further research on the effect of family proximity on a patient's mental health. This study may suggest changes in the nursing education curriculum to incorporate teaching the importance of involving psychiatric patients in the plan of care. This educational change will enable new nurses to utilize the available tools to encourage and enhance a psychiatric patient's involvement in their plan of care. The study will contribute to improve the quality of care provided to patients in inpatient psychiatric facilities by incorporating the findings of the study about what psychiatric patients really want and are concerned about during their psychiatric inpatient stay.

Recommendation for further research

As this study shows, patients may not always be included in their plan of care. There still seems to be the paternalistic approach being practiced by healthcare providers at psychiatric inpatient facilities. Further research may need to be conducted to explore the possible barriers of involving psychiatric patients in their plan of care when they have the capacity to be involved.

The isolation precautions policies and practices may need to be looked at more closely. It would be beneficial to have further observational and qualitative studies to explore patients' and hospital staff's perception of possible inhibiting factors related to compliance with patients' isolation precautions. This study suggests the need of further research to explore possible interventions to ensure standard isolation practices so other

patients will not experience the added stress of contracting diseases as was communicated by some participants in this study.

There seems to be a lack of research on the effect of aggressive peers or a perceived nontherapeutic environment created by aggressive or acutely psychotic patients on the patients who have a lower acuity of mental illness. This topic needs to be explored further to provide patient-centered and quality care to psychiatric patients without the added stressor and fear of safety in relation to their hospitalized peers.

The effect of family proximity on the mental health of a patient needs further exploration. There does not seem to be enough research on the impact of having a family member living close by and the potential improvement this may foster on a patient's mental health.

Limitations

Participants of this study were all recruited from one psychiatric outpatient program in Southern California. All of them were English-speaking and the majority of them were females. There were only two males out of 12 participants. In the study sample, most of the participants had private insurance, stable financial status, social support, and stable housing. Given these characteristics, the findings might not be applicable to all psychiatric patients. Other psychiatric patients who have English as a second language and are homeless or illiterate might have different inpatient psychiatric experiences regarding their involvement in their plan of care and safety. They might also have different basic psychiatric and social needs from this sample population. This sample lacked socioeconomic, cultural, and ethnic diversity. Therefore, the findings might not support all sociocultural aspects. Being involved in one's plan of care could

have different meanings in different cultures and social backgrounds. Hence, the findings of this study cannot be generalized to inpatient experience of all psychiatric patients.

Conclusion

There has been a plethora of research published about benefits of involving patients in the plan of care in the general patient population. Despite much effort, the researcher was unsuccessful in locating any published evidence indicating psychiatric patients' perception of involvement in their plan of care during their inpatient psychiatric hospitalization. In order to fill this gap in knowledge, a qualitative phenomenological study was designed to explore the patient's lived experience of being involved in his/her plan of care during the psychiatric inpatient hospitalization. The data were collected through 12, one-on-one, in-person interviews and analyzed by reading and rereading the verbatim transcripts of patient interviews and corresponding field notes. After a thorough analysis of the data, seven major themes emerged. These themes included participants' knowledge about the plan of care, involvement, safety, compartmentalization of care, psychiatric inpatient admission as a turning point, inpatient as a holding place, and importance of social support. Some of these themes coincide with the existing literature while others create new opportunities for further research in this field. The findings of this study may lead to a cascade of changes at different levels in healthcare to improve the quality of care provided to patients in inpatient psychiatric facilities. This study may spark interest for multiple other research opportunities in this underexplored field of psychiatry.

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Appendix A

USD IRB

Sep 24, 2018 11:16 AM PDT

Jaspal Gill
Hahn School of Nursing & Health Science

Re: Expedited - Initial - IRB-2019-25, Psychiatric Patients' Perception of Involvement in the Plan of Care

Dear Jaspal Gill:

The Institutional Review Board has rendered the decision below for IRB-2019-25, Psychiatric Patients' Perception of Involvement in the Plan of Care.

Decision: Approved

Selected Category: 6. Collection of data from voice, video, digital, or image recordings made for research purposes.
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Findings: None

Research Notes:

Internal Notes:

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited or exempt review at any time.

Sincerely,

Dr. Thomas R. Herrinton
Administrator, Institutional Review Board

Office of the Vice President and Provost
Hughes Administration Center, Room 214
5998 Alcalá Park, San Diego, CA 92110-2492

PI www.sandiego.edu

Appendix B

Study Flyer

**Outpatient Psychiatric Clinic Patients
Are Invited to Participate in a Research Study****Patient involvement in care planning****Why is the study being done?**

- To find out the patient's perception about his/her involvement in his/her care planning while he/she was admitted in an inpatient psychiatric facility.

What will happen if I decide to be in the study?

You will:

- Fill out a brief demographic form
- Participate in a 60-90 minute interview with principal investigator
- Receive a Visa gift card of \$50 at the end of the interview, as compensation for your time and travel

How long will I be in the study?

- Your participation is expected to last 60-90 minutes total

In order to take part in the study you must:

- Be a community-dwelling adults (age 18 or above)
- Be able to speak and understand English
- Have had an inpatient hospitalization in any psychiatric facility within the last 12 months
- Be capable of discussing and articulating your latest inpatient psychiatric hospitalization experience

For more information, contact:

- Jaspal Gill, Principal Investigator via given phone number or e-mail address

1. What is your age? _____
2. What is your gender? Male Female Other (please specify) _____
3. What is your ethnicity? _____
4. How many inpatient psychiatric hospitalizations have you had with in last 12 months?

5. When was your last psychiatric inpatient hospitalization?

6. In which facility/hospital was your most recent inpatient psychiatric hospitalization?

7. For which psychiatric condition(s) were you admitted?

8. At what age were you diagnosed with the condition(s) mentioned in the previous question? _____

9. What is your educational level?

- a. Some high school
- b. Graduated high school
- c. Some college
- d. Completed a bachelor's degree
- e. Some graduate education
- f. Completed a graduate degree

10. People sometimes turn to others for support. Who do you turn to for support?

11. What is your current housing status?

- a. Owns home.
- b. Renting an apartment.
- c. Living with family/friend(s).
- d. Single room occupancy hotel.
- e. Living in a shelter.
- f. Living in a Vehicle.

12. Do you have a private insurance? Yes_____ No_____

Appendix D

Interview Questions

As I ask these questions, think about your most recent hospitalization.

1. Tell me about your recent psychiatric hospitalization experience?
2. You may have heard doctors, nurses, and social workers talk about your “plan of care.” That can mean different things to different people. What does “plan of care” mean to you?
 - a. If the participant indicates, he/she does not understand what “Plan of care” means, or what researcher is trying to ask in this question, the researcher will define the plan of care as the care that one needs while hospitalized, and how it will be provided.
3. In the healthcare field, as we are moving toward the patient centered care, many hospitals are encouraging patients to get involved in their plan of care. What are your thoughts about being involved in your plan of care?
4. Option 1: Why is being involved in you plan of care important to you?

Option 2: Why is being involved in your plan of care not important to you?
5. Thinking about your latest hospitalization, what was your experience regarding your involvement in your plan of care?
 - a) Give me an example of a situation when you felt involved in your plan of care.

- a. Were there things/situations that made it difficult for you to be involved in your plan of care?
- b. Were there things/situations that made it easy for you to be involved in your plan of care?
- b) Give me an example of a situation when you felt uninvolved in your plan of care.
 - a. What made you feel uninvolved in your plan of care?
 - b. Were there any other factors that contributed to you feeling uninvolved?
- c) Do you have anyone outside of the hospital that influences your decisions around your plan of care? How do they affect your involvement in your plan of care?
- 6. What difference did being involved/uninvolved in your plan of care make on your stay in the hospital?
- 7. What would the ideal involvement in your plan of care look like to you?
- 8. Is there anything else that you would like to share with me regarding your recent psychiatric hospitalization?

Thank you very much for your time. I really appreciate you sharing your experiences with me.