MENTAL HEALTH HOSPITAL IN THE HOME

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SETTING THE SCENE
- THE RATIONALE AND EVIDENCE BASE FOR HOSPITAL AVOIDANCE AND HOME BASED TREATMENT IN MENTAL HEALTH

Key principles

- Consumer rights
- least restrictive environment – MHA 2013
- Trauma informed care and practice
- Recovery model
- Family and carer involvement

Key functions of CRT – national survey UK

- Treatment optimisation including medication management
- Practical help with basics of daily living
- Supporting families
- Interventions aimed at increasing resilience
- Relapse prevention work
- Crisis planning risk mitigation

- Radical pioneers of home treatment such as Bracken and his Bradford group argue that it presents an opportunity to implement an entirely revised 'post-psychiatric' understanding of mental illness, in which the 'expert' view of the doctor is no longer privileged (Bracken 2001).
- Others still, such as Smyth & Hoult (2000), present a more pragmatic view in which the interventions used to treat mental illness in the community are not substantially different from those used in hospital.
- Notwithstanding these substantial divergences, there are some principles on which leaders in the development of this model seem to agree (Johnson 2008b). These may be summarised as follows.
- • Hospital admission has harmful as well as therapeutic effects, is unacceptable to many patients and carries a heavy stigma (Rose 2001). It should therefore be avoided whenever possible.
- • Crises have important social and environmental triggers (Polak 1970). Treatment in the home allows these to be better assessed and addressed.
- • Coping skills are most effectively applied in the context in which they have been learnt (Stein 1980). Thus, after home treatment, patients are more likely to be able to apply skills learnt to pre-empt or reduce the severity of future crises.
- • Relationships between patients and professionals are different and less dominated by inequalities of power when crises are managed in the patients' own homes (Mezzina 1995).
- Although ideas and values such as these have shaped home treatment services, the role of economic and political pressures in the development and dissemination of this model should not be overlooked: deinstitutionalisation has throughout its history been driven by both idealism and a wish to be parsimonious in expenditure on costly hospital services, and this also applies to CRT implementation.

Evidence base - positives

- When the model is implemented with relatively high fidelity, including 24-hour cover and gatekeeping, congruent evidence from national bed-use data (Glover 2006), naturalistic investigations of the effects of implementing the model within catchment areas (Johnson 2005a; Jethwa 2007; Keown 2007; Barker 2011) and a randomised controlled trial (Johnson 2005b) shows that reductions in numbers of admissions occur, with accompanying falls in costs (McCrone 2009a,b).

- Greater satisfaction among service users has also been reported in some CRT studies (Johnson 2005a,b; Winness 2010; Barker 2011

- . Where they have been examined, other outcomes, such as symptoms and social functioning, appear similar after an episode of acute care with or without a home treatment team involved. The workforce implications of this reorganisation of the acute care system are also important: a survey of London CRT staff was reassuring, suggesting fairly good satisfaction and low burnout (Nelson 2009), subsequently confirmed in a national investigation of staff morale (Johnson 2012).

Evidence base – Negatives

- Reports that contacts are fleeting and superficial and that too many staff are involved in each episode of care (Hopkins 2007), and to the range of interventions offered, with complaints that teams focus too much on prescribing and dispensing medication and too little on emotional and practical support (Lyons 2009).

- A common feature of the cited UK national reports is an emphasis on the need to develop integrated acute care pathways within catchment areas, with good continuity between components in the system.

- In Norway, where CRT introduction has been national policy for several years, implementation studies suggest both substantial divergence from the English model, with a greater focus on less severe disorders, and considerable variation between Norwegian teams (Hasselberg 2011).

IMPLEMENTATION IN HOBART

Aims of service

- To provide of care treatment and support to people who would otherwise be admitted to the RHH MHIU
- To improve experience for people with mental illness and their carers
- To assist with patient flow and assist with reduction in DEM waiting times for those with acute mental health presentations

Profile of service

- Staffing
  - Nurse unit manager
  - Psychiatrist
  - Career medical officer/ registrar
  - Registered nurses – 11 FTE
  - Allied health – 2 FTE
  - Consumer and per workers
  - Admin support officer
  - Pharmacist
- Hours of operation
  - Extended hours across two shifts seven days per week
- Work venue
  - Office base City centre
  - assessments DEM MHIU consumer home
- Referral sources
  - Referrals internal from other parts of SMHS
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Admission criteria

- Aged over 18 years
- Reside within 40 km of city centre
- Reside in an environment that supports safe and effective home based care
- Acute phase of mental illness
- Achievable objectives for an expected length of stay of around 14 days
- Willing to be actively involved in decision making
- Have family carer support
- Additionally recently
    - Acute course ECT
    - initiation of clozapine

Patient journey

- Referral
  - Internal referral only
- Assessment
  - Connecting With People
- Admission
  - Ad hoc correspondence to GP
  - Metabolic review including Hep C screening
  - Physical health review
- Progress
  - Care planning – care level and level of medication supervision
  - Peer and per carer support
  - safety planning
- Discharge planning
  - Links with longer term care providers
  - Discharge summary

Core interventions MHHITHU

- Comprehensive initial assessment, including risk, symptoms, social circumstances and relationships, substance use and physical health
- • Engagement – intensive attempts to establish a therapeutic relationship and negotiate a treatment plan which is acceptable to patients
- • Symptom management, including starting or adjusting medication
- • Medication administered to patients in the community and their adherence encouraged and supervised, twice daily if needed
- • Practical help – support with resolving pressing financial, housing or childcare problems, getting home into a habitable state, obtaining food
- • Opportunities to talk through current problems with staff, brief interventions aimed at increasing problem-solving abilities and daily living skills
- • Education about mental health problems for patients and their social network
- • Identification and discussion of potential triggers to the crisis, including difficulties in family and other important relationships
- • Relapse prevention work and planning for management of future crises
- • Discharge planning beginning at an early stage, so that continuing care services are available as soon as the crisis has resolved

- No diagnosis or type of risk is necessarily an exclusion criterion for successful home management, but lack of engagement despite considerable persistence by CRT staff, very chaotic behaviour that does not resolve quickly when treatment is started, and severe and persistent substance misuse problems often result in hospital admission; people with a history of compulsory admission are also more likely to be admitted despite the availability of a CRT (Cotton 2007).

STRENGTHS AND LIMITATIONS,

Lessons learned

Strengths

- Welcomed alternative to hospital for many individuals
- Opportunity to full understand a persons lived experience
- Privilege to be allowed into peoples homes and for staff to develop strong therapeutic alliances
- Engagement with carers
- Staff satisfaction – true MDT style of working
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Limitations

- Intrusion into a persons safe space
- Multiple staff
- Maintaining a consistent approach
- Clear communication
- Liaison with referrers and links post discharge
- Paucity of services
- Substance use
- Risk management

REVIEW OF OUTCOMES

- Bed occupancy
  - High since inception
- Health outcome activities
  - Good adherence to Key performance indicators
- Management of bed flow
  - Ongoing high demand and long waits in DEM
  - Likely hospital avoidance for numbers of patients
- Consumer/ carer feedback

FUTURE DEVELOPMENTS

- To work as part of the new “Acute Care Stream” being developed as part of the Mental health Reforms for southern Tasmania.
- To maintain the positive culture and lead by example.
- To further develop model of collaborative care and recovery focus
- To strengthen links with other service providers/ sectors
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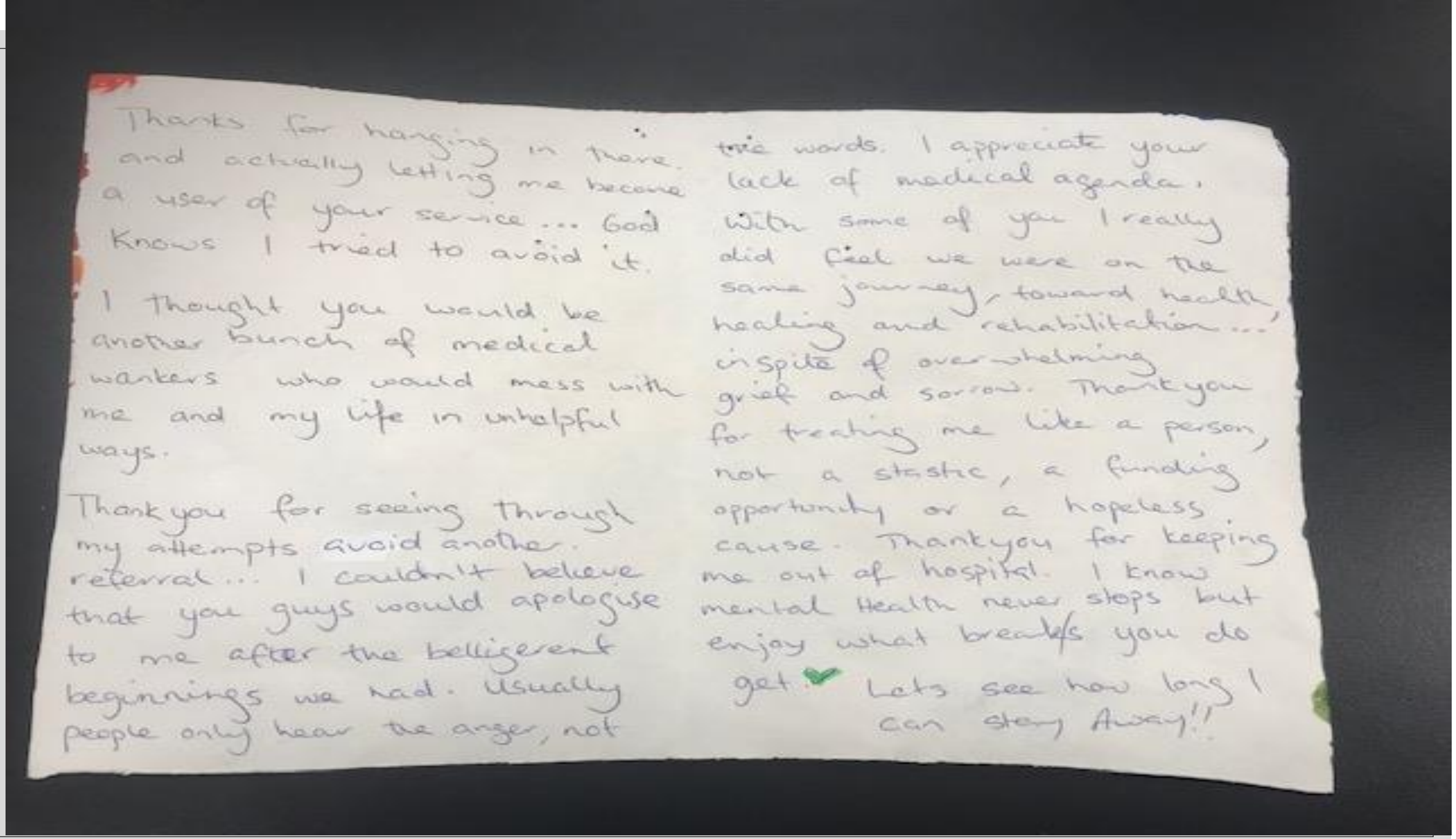

Thanks for hanging in there and actually letting me become a user of your service ... God knows I tried to avoid it.

I thought you would be another bunch of medical wankers who would mess with me and my life in unhelpful ways.

Thank you for seeing through my attempts avoid another referral ... I couldn't believe that you guys would apologise to me after the belligerent beginnings we had. Usually people only hear the anger, not the words. I appreciate your lack of medical agenda. With some of you I really did feel we were on the same journey, toward health, healing and rehabilitation ... in spite of overwhelming grief and sorrow. Thank you for treating me like a person, not a statistic, a funding opportunity or a hopeless cause. Thankyou for keeping me out of hospital. I know mental Health never stops but enjoy what breaks you do get ✔ Lets see how long I can stay Away!!