

Mad in America

SCIENCE, PSYCHIATRY AND SOCIAL JUSTICE

EDITORIAL

DRUGS

EDUCATION

VETERANS

FAMILY

MIA GLOBAL

GET INVOLVED

ABOUT



Intensive Home Treatment for Acute Mental Disorders: An Alternative to Hospitalization

By **David Heath** - February 4, 2021

2001
 89

In 1978, I became the medical director of a general hospital psychiatric unit serving the twin cities of Kitchener/Waterloo in southwestern Ontario, Canada. Over the next four years, population growth accelerated, and more psychiatrists joined the department, both of which resulted in increasing pressure on beds. We reached a point where patients had to wait a dangerously long time to be admitted.

The provincial Ministry of Health policy was clear: no more funding for hospital beds—only funding for community programs. I couldn't see a way forward. An acute day hospital did not seem feasible; most of our patients were too ill to reliably attend, and public transportation is poor. There were no workable models for a crisis residence at that time.

The solution arrived fully formed in August 1982, when, casually flipping through a psychiatric journal, I spotted a review of the book *Home and Hospital Psychiatric Treatment* by psychiatrist Fred Fenton and his home treatment team at the Montreal General Hospital: "The results are clear and consistent. Home treatment emerges as a safe, acceptable, effective, economic alternative to hospital care for all three diagnostic groups" (schizophrenia, affective psychosis, and depressive neurosis, all ICD 8 terms).

In 1979, Fenton's group had conducted a randomized controlled trial of home treatment versus hospital treatment published in the *Archives of General Psychiatry*—a respected journal. Depending on diagnosis, 35-58% of patients avoided hospital completely. In 1982, it was an epiphany to suddenly look around the ward at all the patients and realize that we didn't need to admit all these people; we could actually treat many of them in their own homes!

The book contained sufficient practical information on how to set up and operate a home treatment service. Modelled on the Montreal service, our intensive home treatment service (IHT), named the Hazelglen program after its location in a strip mall on Hazelglen Drive in Kitchener, opened in 1989.

Our results have been consistent with the research findings in Fenton's and other studies. We have been able to treat many patients at home who would otherwise have needed hospital, and almost all patients and their families have preferred it to hospital.

Research which formed the basis of the current model of IHT started with Leonard Stein's service in Madison, Wisconsin in 1978. This service has the potentially confusing distinction of being cited as supporting evidence for two prominent service models: IHT and Assertive Community Treatment (ACT).

Subjects were any patients in a crisis needing admission to the Mendota Mental Health Institute. After patients improved, they were not discharged from the program as currently is the practice in IHT today, but continued to receive intensive treatment with the long-term goals of improving their stability and social functioning. Stein's study was replicated by Hoult in Sydney Australia in 1984.

In discussions between Stein and Hoult, it was decided that it was unrealistic to expect one team to provide both crisis care for a broad range of service users and intensive community care for the particularly disabled group requiring it. This resulted in the subsequent development of ACT teams serving a narrow group of patients long-term and IHT teams serving any patient destined for admission for a short term—up to six weeks. ACT and IHT are two branches of the same root.

There have been 18 comparative studies on IHT in five countries and four continents. All have shown that IHT enables a significant proportion of patients to avoid hospital admission altogether and for others to be discharged early. IHT patients' improvement in their symptoms and their functioning was equal to hospital-treated patients; risk of harm to self or others was also the same.

How Does Home Treatment Work?

The easiest way to conceptualize how IHT fits into a mental health system is to think of it as simply an alternative to admission. It targets any patient who is destined for admission. Whatever is the clinical pathway to hospital admission in the community, just substitute IHT for the hospital. In actual practice, because IHT is mobile, because it is not bricks and mortar, more alternative routes into the service are allowed, such as from family doctors and crisis teams.

It is important to make the distinction between *preventing* admission and providing an *alternative* to it. Crisis services—usually acting for a brief time, can *prevent* admissions. IHT provides an *alternative* disposition for patients whose crisis has already been evaluated and who subsequently are deemed in need of inpatient level of care.

IHT is different from mobile crisis intervention services. Such services, often working with police services, provide rapid assessment of emotionally disturbed persons in the community. They help de-escalate crises, provide support and advice, and make referrals to community agencies—all within a very short period of time lasting up to a few days, usually. Such services may make referrals to an IHT team if the person would otherwise require hospital admission.

Care takes place in the patient's home—which can include any temporary arrangement, such as a crisis house. A multidisciplinary team, including a psychiatrist, is available 24 hours a day, seven days a week. They make frequent home visits—often daily, sometimes two or three times a day. Treatment lasts up to about six weeks, and patients are then transferred to less intensive care such as an outpatient clinic.

It is not unusual for IHT patients to require hospital admission during their course of treatment. This is not failure. Indeed, if the service is targeting the appropriate level of acuity, it is to be expected that some patients' problems may become more severe due to unpredictable stressors suddenly appearing or just the natural fluctuation of their illness. Ideally, there are close working relationships with a nearby inpatient ward where team input can be provided and can contribute to the discharge decision.

A key concept in home treatment is acuity. Acuity is a combination of five factors: risk, symptom severity, functional impairment, degree of cooperation, and degree of social support. IHT is aimed at patients in the lower 40-45% of the range of acuity of those destined for admission. It is important to hit this "sweet spot," the "Goldilocks" range; less than that and one risks wasting resources on patients who could be treated as an outpatient; above that creates unacceptable risks.

IHT can reduce hospitalization in two ways: avoiding it completely in up to 65% in some of the studies and by enabling early discharge of patients to an IHT service.

That many patients can be treated at home instead of the hospital should come as no surprise when we consider the fact that hospital psychiatric treatment boils down to just three things: we talk to patients and their families, we give them medication, and a few get ECT. These can all be done in the community.

Psychiatry is probably unique in this regard among medical specialties, in which hospitalization usually involves interventions that cannot be safely provided in the community such as electronic monitoring and complex, potentially risky procedures.

While hospitalization is a vital part of mental health systems, there are numerous negative aspects, such that it should be avoided wherever possible. It disrupts patients' lives and can damage their social networks and social functioning. Hospital admission carries a lot of stigma and can be a strange frightening experience for patients; some groups may be particularly ill-suited to it. These can include refugees and other immigrants—many of whom may speak little English—developmentally disabled people, elderly people, homeless people, first-episode psychosis patients, and those with post-partum disorders.

Many crises that lead to admission (called the "referral crisis") are triggered by life events and changes in the various social networks, of which the patient is a part. One of the negative aspects of hospital admission is that these social system factors are not recognized and dealt with sufficiently; the ascendancy of biological psychiatry has not helped. It is estimated that an acute admission addresses only one-third (largely related to the individual) of the pertinent issues creating the need for hospitalization. Two-thirds (largely related to social circumstances) remain, to cause future difficulties after discharge.

Hoult lamented the "perseveration" of the mental health system, whereby patients may undergo repeated admissions without the underlying social system problems ever being identified.

Managing the crisis at home is an opportunity for patients to learn skills and insights that they can apply in the future. Families have said to me that it was their first time they had fully understood the patient's problems and what is the best way they can help

The relationships established between patients and professionals are more equal and based on negotiation and partnership than when they are admitted. You're on their home ground; they can ask you leave if they don't like the way things are going; they are in control.

For IHT to work, patients need to have, or develop the right attitude: an awareness at some level that they need help; a perception of the team as benign experts who can be trusted and are potentially helpful; and an understanding that to recover they have to do certain things such as let the worker into their house, telephone them, engage in counselling, and take medicine if required.

IHT is consistent with the principles of recovery, particularly that of least intrusive interventions. For some patients, the fear of restraint is like the elephant in the room, a continuous threat that shadows the recovery process. Patients appreciate the, non-medical ethos of home treatment. They are more willing to tell clinicians about signs of impending relapse when they know it won't lead to automatic admission—there is now an alternative. Involuntary hospitalization can be particularly dehumanizing, and two research studies have shown that IHT can reduce the need for it.

Megan: An Example

To give you an idea of how IHT works, its versatility and its holistic approach, consider Megan, a 19-year-old teacher's aide. She was taking an enforced break from university studies, which had to be terminated the year before due to an episode of severe depression. She lived at home with her parents and two brothers in a large house; her father is a chiropractor and mother a homemaker.

I first met Megan at the hospital crisis clinic, where she had been taken in the early morning a family friend with whom she had been staying overnight, after she exhibited manic behavior. Megan had a history of cyclical mood swings, including what her mother and family friend considered risky and self-destructive behavior.

The hospital wasn't feasible for Megan; she was adamant about not being admitted and wanted to keep working. After being admitted to the psychiatric ward, she had simply walked out, refusing to take the medication prescribed—and since she was not a danger to herself or others, she was not restrained.

After my conversation with Megan, she accepted referral to the IHT service, which she considered much less intrusive than being admitted to the hospital.

As part of the IHT service, Pauline, a mental health nurse visited her at home, as did I. It was clear that the home environment was a source of trauma and conflict for Megan. We learned that Megan had endured childhood sexual abuse from her uncle and physical abuse from one of her brothers. Her father had a drinking problem, and her parents had severe marital difficulties.

After Pauline and I had worked with Megan for a while, she agreed to start medication and gradually became more settled. Her mother began to talk to Pauline about her own problems, particularly her husband's drinking, and started attending AA meetings.

As Megan improved, Pauline met with her and a counselor to help her get started on therapy for the childhood abuse issues regarding the uncle. After three months Megan was able to be discharged from IHT to outpatient follow up in my office. Eventually she was able to resume her university studies in her home town.

Like many patients with severe mental health problems, hospital was not a good fit for Megan, but with IHT she had an alternative. Twice, her family tried to get her admitted but she refused. IHT's nimble versatility enables it to turn on a dime to respond to the complex ups and downs that are not unusual in the course of serious mental health problems.

Although the whole team were at some time involved in Megan's care, a key principle of IHT—a designated named worker—is well illustrated here. Pauline was able to engage her in a trusting relationship, negotiating with her about every step of treatment and teaching her family how they can best help.

Home treatment deals with not only the patient's immediate family group, but with the wider social context such as work; the aim is to deal with any problems relating to the illness in these various outside groups, with an emphasis on preserving the patient's role functioning. Pauline worked with Megan, her family, and even her employer to help ensure Megan could return to work.

Hospital treatment in a case like this would typically have had a much narrower focus, mainly on symptoms and medication. Megan would have been discharged home with likely little or no attention to the family issues, or helping her negotiate re-entry into her job at the school. Longer-term treatment.

How "Psychiatric" is IHT?

Home treatment services vary in the degree to which they hew to a non-psychiatric philosophy, and the most enthusiastic in this regard must surely be the Ladywood IHT service in North Birmingham, England—which I visited in 2002 for my book.

"We don't use diagnoses," said the founder of Ladywood, psychiatrist [Sashi Sashidharan](#). "Diagnoses do not lead to action, they are not reliable, [and they] can cause stigma. There is a danger of diagnosis trumping everything else, including the leaking roof. We make a problem list with the patient whose problems may be no money, no food; voices may not be a problem." The service is specifically targeted at young Black men.

The initiative for the creation of this service was a revolt against the local traditional mental hospital, which served the ethnic population poorly, especially Afro-Caribbean people. Central to Ladywood's philosophy was giving patients more power. Sashidharan was influenced by the innovations in Trieste Italy, where all the psychiatric hospitals had been closed.

At Ladywood, much effort is expended to accommodate patients' needs, even to the extent of paying for faith healers, mediums, and acupuncture. Staff work regularly with priests and Mullahs, and local churches, temples, and gurdwaras are a great resource. Patients are given an opportunity to select which drug they will take from a list. Practical help is emphasized and staff go to great lengths sometimes.

For instance, during my visit to Ladywood, a worker brought in a cat in a cage and proceeded to order kitty litter and cat food, in preparation for taking it to a patient's home while she was in hospital.

The Ladywood team was a major influence in the development of the UK [national plan](#) to disemPOWER IHT.

The Success of IHT

England's influential National Institute for Health and Care Excellence (NICE) clinical guidelines now list IHT as the first line choice of treatment for patients with acute psychosis and for patients with severe acute depression who are at significant risk.

The Royal College of Psychiatrists has created Home Treatment Accreditation Standards (HTAS) in 2013 and a fidelity scale called CORE was created in 2016 at [University College London](#).

The mental health systems of eight countries now feature IHT services: UK, Ireland, [Australia](#), [New Zealand](#), Netherlands, Germany, [Norway](#), and Belgium.

In Canada, my IHT team was created in 1989 in Kitchener/Waterloo; a second team was established in nearby Cambridge in 1998, but was disbanded in 2007 due to lack of financial support; Hazelglen is still the only IHT service in Ontario.

Health care planning is the responsibility of each province, and British Columbia is the only one that features IHT in its mental health system; there are now five teams. [Vancouver General Hospital](#), the second largest hospital in Canada, replaced a complete mental health ward with an IHT team called "adult acute home treatment" in 2009. An IHT team had been created in Edmonton, Alberta, modelled on Hoult's Sydney service, in 1993. [A team serving only psychotic patients was established in Quebec City in 2016.](#)

Buttonholing as many psychiatrists as I could at US conferences was one rewarding, I could only find one IHT type service in the country—Baltimore Crisis Response—which I visited it in 2002 and included it in my book *Home Treatment for Acute Mental Disorders: An Alternative to Hospitalization*.

Some people who have been involved in the creation of an IHT service find it so rewarding, so different from working in a hospital, and they have such different relationships with patients and families, that they want to go out and "spread the gospel" of IHT. This was why I wrote my book and created my [website](#), which is a repository of documents that can be downloaded.

In spite of the success of IHT in countries around the world, it feels like my efforts to disseminate the IHT model of treatment have met a wall of complete indifference. I have always thought of IHT as being a win-win proposition: for clinicians, it has many advantages for their patients, is evidence-based, and is mainstream in eight countries; for governments, it's cheaper and as effective as hospital admission; for hospitals, it save beds and reduces pressure on ER's; and most patients and families prefer it.

Barriers to uptake of IHT may be, in part, due to its inherent polarity: it provides conventional psychiatric treatment—*same as the hospital*—but it takes place in the patient's home, the family are recruited to help, and social systems intervention is a major feature—*different from the hospital*.

With no actual experience of how IHT works, some stakeholders can focus on one or the other polarity. I've seen first-hand how non-medical clinicians and psychiatric survivors quickly dismiss IHT as "too medical." In Canada, these two groups dominate committees that make decisions about adopting and funding services like IHT. As a consequence of this, for example, patients in Toronto continue to have no choice but hospital admission when in a severe crisis.

On the other hand, psychiatrists and other physicians, when contemplating what to do with a patient in a crisis, may dismiss IHT as *not hospital enough*. Everywhere I went, visiting teams for my book in the UK and in Canada, *staff complained* of how psychiatrists regularly bypass the service, admitting patients who could be treated in IHT, or if their patient ends up in the service, admitting them once a bed became available, even if the patient is by then settled in and doing well.

Neil Brimblecombe, Director of Mental Health Nursing at the Department of Health, England, concluded, "Essentially, for many clinicians, direct exposure to the benefits of home treatment services may be needed before they see it as a real alternative."

When our home treatment was first launched, it was a rare physician who referred to us. Over the years, trust gradually grew, and doctors, non-medical clinicians, patients, and families began to accept us as a vital element in the local mental health system. We had developed a positive brand image—recognized as a team that could be trusted and relied upon to help patients. To thrive, the IHT model needs this positive brand image, which it now has throughout much of Europe and the Antipodes.

What Would A Comprehensive Alternative to Hospitalization Look Like?

The other two alternatives to hospitalization are acute day hospitals and crisis residences. Together with IHT, they form a *triad of hospital alternatives*. Each can work in tandem with another, in parallel or sequentially. They can also reduce the duration of hospital stay for some patients for whom admission could not be avoided.

Each of the three types of service is quite different in its method of care and has complementary strengths. Day hospitals provide structured activities, interpersonal contact, and prolonged contact with staff. Crisis residences offer a level of respite and asylum close to that of a hospital, but in an informal home-like setting

These two approaches are still significantly disruptive to the lives of patients and their families and not every patient needs them. In certain areas, they may be used extensively, such as in very socially deprived inner cities. For the most part, their place should be as a judiciously used addition to IHT, which, because of its nimble versatility and preservation of the patient's usual family life, should be the *default disposition* for psychiatric emergencies wherever possible.

Mad in America hosts blogs by a diverse group of writers. These posts are designed to serve as a public forum for a discussion—broadly speaking—of psychiatry and its treatments. The opinions expressed are the writers' own.

Previous article

4 Specific Nutrient Levels To Test If Your Child Has ADHD Symptoms

Next article

Historical Redlining Practices Shape Racial Health Inequalities Today, Study Finds

David Heath

David Heath trained in medicine in Liverpool England, and in psychiatry at Queens University Ontario and the Tavistock Clinic in London. He founded Canada's first intensive Home Treatment service in 1989 in Kitchener-Waterloo Ontario, and his book *Home Treatment for Acute Mental Disorders: An Alternative to Hospitalization* was published by Routledge in 2005. His website is www.intensivohometreatment.com. Twitter @ilhtheath

89 Comments

[Click to Show Comments](#)

Help MIA Survive - Click to Donate Now

© 2022 Mad in America Foundation

Site Map