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

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

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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.

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.

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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.intensivehometreatment.com. Twitter @ihtheath

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