Senior registrar training in home treatment

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We offer an account of training experience within an inner city service dedicated to home treatment as an alternative to hospital admission for acute psychiatric illness. The Ladywood service in Birmingham is described and the challenges and opportunities for trainees outlined. A dominantly institutional based training seemed to us deficient, after this exposure. We regarded home treatment very positively and felt that it enriched our professional development in both clinical and conceptual terms.

Recent years have seen major developments in the area of community psychiatry. One of the more radical developments has been with regard to home treatment of acute psychiatric conditions. The recent account by Muijen (1993) concerning the role of the consultant psychiatrist working in expanding community services stressed the urgent need for a thorough revision of current psychiatric training. In this paper we report on our experiences of working as senior registrars (in successive years) in a team which offers home-based treatment. We believe that while very few training schemes at present can offer such experience, opportunities will expand – with obvious implications for trainees both considering placement options during their training and subsequent consultancy applications.

Description of service

The Ladywood Community Mental Health Project was set up in July 1990, led by Dr S.P. Sashidharan, a senior lecturer at the University of Birmingham. The main aim was to provide comprehensive community-based mental health care for residents of Ladywood, an inner city area in the centre of Birmingham. Ladywood is a deprived multi-ethnic catchment area with high psychiatric morbidity. The operational policy emphasised a commitment to provide psychiatric treatment away from institutional settings as far as possible and in particular to avoid hospital admission. All acute psychiatric interventions including assessment and treatment of people with severe mental disorders were dealt with by the home treatment team. Patients on home treatment were visited regularly, at least once or twice per day, and varying amounts of time were spent with patients depending on their needs. A 24 hour, seven days per week, service was maintained. The out of hours cover was provided by the consultant and home treatment nurses only.

During the first two years of the project there were 216 episodes of home treatment. A diagnosis of psychosis (schizophrenia and paranoid conditions), mania or major depressive illness accounted for 70% of the episodes treated. The majority of these clients had a significant previous psychiatric history; 78% had been admitted to a psychiatric hospital at least once and 55% had previous admissions under the Mental Health Act.

Hospital admission with suspension of home treatment occurred in only 33 (15%) of cases. Most patients admitted had a psychotic illness (81%). Admission was arranged most commonly because of failure of clinical improvement and ongoing social or behavioural problems where the team could not establish adequate engagement (e.g. regular contact, access to home or compliance to medication). The team did not retain clinical responsibility for those admitted (while in hospital) but did continue a key-worker-based liaison role. Following the dramatic reduction in hospital bed usage in the Ladywood catchment area and the successful outcome generally of home treatment, the service was expanded (April 1993) so as to constitute the first district-wide home treatment service in the UK.

Training experience

Working without the apparent security of hospital wards initially provoked anxiety as most of the clients were acutely disturbed; in fact the main criterion for commencement of home treatment was that of a perceived need for hospital admission by GP, family or the patients themselves. Our early anxieties were shared by other team members and it was only with time and experience that these anxieties abated. A few patients and relatives were initially dubious about home treatment as they were used to the

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scenario of relapse and admission. It was our experience, however, that most patients and their relatives welcomed this form of treatment and were very satisfied with it. Indeed a number of patients who would probably have needed admission under the Mental Health Act, had this service not been available, were successfully treated without recourse to a section.

The literature on home treatment (Stein & Test, 1990; Muijen *et al*, 1992) reflects concern regarding the safety of these services in respect of suicidal patients. In Ladywood, suicidal ideation in itself did not bring about immediate suspension of home care, but patients who talked about suicide were monitored very closely. No suicides occurred during the two years that we worked with the service.

Staff morale was generally high on the team. The nature of multidisciplinary teamwork seemed quite different from that of our previous experience. The acute nature of the work demanded a blurring of professional roles, rejection of rigid hierarchies, and greater autonomy for individual staff members. We increasingly enjoyed this working practice, without feeling threatened, while retaining a traditional professional concern with accountability and senior decision-making when required. There was little time for debate regarding 'who did what'. The most 'stressful' aspect of the job was that of the frequent revision and disruption of our schedule because of the need for flexibility in the face of developments throughout the day. We needed to respond quickly to the request for urgent new assessments. This work demanded rapid decision-making and prioritisation of our workload.

Training implications

We both found home treatment to be an extremely satisfying working experience. More importantly, we can readily endorse the uniform findings of the literature which indicate that patients and their relatives generally prefer this option to conventional hospital treatment. The treatment alliance with patients had a different quality to that developed in hospital. Family dynamics were observable *in vivo*. A number of patients described in retrospect how when deluded or hallucinated, or both, being able to remain in their familiar environment provided them with some slender hold on reality. In the past they had always found this shattered by the process of admission to hospital, which resulted in a vicious cycle of greater bewilderment, fear and agitation which in turn led to an increase in the medication they received. Working in home treatment made us aware of the extent to which we previously tended to consider admission simply by way of convention and convenience. In every assessment of patients for home treatment one was faced with the question "what will admittance to hospital provide that cannot be provided through intensive home care?" Often the answers to this question revolved around issues of surveillance and control. It became clearer to us that such aspects of psychiatric practice had been derived from the culture and history of the institution rather than as a response to a particular patient's needs. This was repeatedly emphasised as patients were successfully treated at home.

Through our work in home treatment we both became interested in the wide literature of social and community psychiatry. Home treatment has allowed us to view psychiatric care from a new perspective. We experienced a sense of liberation from the ideological constraints which an institutional culture impose. Our training remedied the deficiencies of a dominantly institutional background which Muijen (1993) details. For our part we would be happy to practise home treatment as consultants and recommend the experience to other trainees as a valuable training opportunity.

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