special articles

Psychiatric Bulletin (2001), **25**, 310–313

JUDY HARRISON, NOOREEN ALAM AND JOHN MARSHALL

Home or away: which patients are suitable for a psychiatric home treatment service?

AIMS AND METHOD

Home treatment offers an alternative to in-patient care, but little has been written about the practicalities of running such a service. Using routine information sources, details of referral and outcome are presented for patients assessed by a home treatment service over 6 months.

RESULTS

Forty-eight per cent of referrals were not accepted, mainly because of lack of cooperation, risk to self or others or the illness not being acute enough. Referrals from junior doctors and accident & emergency were least likely to be accepted. Seventy-two per cent of patients accepted suffered from schizophrenia, bipolar affective disorder or depression with psychosis, similar to the diagnoses for in-patients. Twenty per cent of patients accepted had to be transferred to in-patient care later.

CLINICAL IMPLICATIONS

Staffing levels need to take account of time spent assessing patients. Junior doctors need training in how to use home treatment services appropriately and a wider range of options are needed to manage patients in crisis out of hours. It is possible to target patients with severe mental illness in a home treatment setting, but a significant number will need transfer to in-patient care.

The National Service Framework for Mental Health (Department of Health, 1999) recommends the development of acute home treatment services as part of a spectrum of care to reduce reliance on hospital admission. The key components of this model are short-term acute treatment, mostly in patients' own homes, provided by an intensively staffed team available 24 hours a day. Several services of this kind have now been described in the UK (Bracken & Cohen, 1999; Brimblecombe & O'Sullivan, 1999; Harrison *et al*, 1999) with one controlled trial demonstrating reduced bed occupancy and costs, and improved integration with community teams (Minghella *et al*, 1998). Despite recommendations for home treatment to be more widely adopted, the existing literature provides little information about the type of patient suitable for this approach and the practicalities of the referral process.

Background

The Home Options Service in Central Manchester was established in March 1997 as a direct development from the psychiatric day hospital. The day hospital was already managing acutely ill patients as an alternative to in-patient care (Creed *et al*, 1990, 1997), but was limited by 9 a.m. to 5 p.m. opening hours and a focus on treatment occurring at the team base. Additional funding allowed an increase in staffing to provide 24 hour cover on a shift basis and a choice of treatment at the team base or in patients' own homes. The resulting service model is something of a hybrid between day hospital and home treatment, with a roughly equal number of contacts occurring at home and at the base.

Psychiatrists and community staff can refer patients to the service at any time if they are experiencing an acute mental health crisis that would otherwise require in-patient care. The Home Options staff must feel the level of risk to self or others is manageable and the patient must be able to offer a degree of cooperation. Short-term intensive treatment is offered in patient's homes and at the team base, with patients and carers able to contact the service at any time. There are 30 available places with no waiting-list in operation and a median length of admission of 35 days. Further details of service delivery have been described elsewhere (Harrison *et al*, 1999).

Method

During a 6-month period from January to June 1998 all referrals to the service were tracked using a combination of case notes and local information system. Details of date, time and source of referral were collected plus immediate outcome of the referral and the reasons given by staff if the patient was not accepted. Clinical information included age, gender, ICD–10 diagnosis (World

https://doi.org/10.1192/pb.25.8.310 Published online by Cambridge University Press

special articles

Health Organization, 1992) and previous contact with the service. Information was also collected for all in-patient admissions during the same time period and also for patients accepted by Home Options who subsequently needed to be transferred to in-patient care.

Results

Of the 195 patients referred to the service, 101 were accepted and 94 (48%) were refused. The most common reasons for non-acceptance were that the patient was unwilling to cooperate (22, 23%), was not considered sufficiently acutely ill (22, 23%) or was considered too ill (20, 21%), usually because of the degree of risk to self or others. Of the patients considered too ill, all but three were subsequently admitted to in-patient care, whereas only four of the patients not considered acute enough were admitted. In each case clear reasons could be identified why Home Options was not suitable, for example, the patient may have had a previous admission to Home Options that was not productive.

Female patients were more likely to be accepted by Home Options (58% of women accepted compared to 43% of men, $P<0.05$) and the mean age of patients accepted was greater (36 compared to 32 years, $P<0.05$). Patients were more likely to be accepted if they were referred by a senior doctor (72% of referrals accepted) rather than a junior doctor (32% accepted, $P<0.0001$); if they were referred from the community or out-patients (73% accepted) rather than accident and emergency (28% accepted, $P<0.0001$); if they were referred in normal working hours (58% accepted) rather than out of hours (36% accepted, $P=0.01$); and if they were already known to the service (58% accepted compared to 43% of those not already known, $P<0.05$) (Table 1).

Diagnosis was aggregated into four groups: schizophrenia and related disorders; severe mood disorders (including bipolar affective disorder and psychotic depression); less severe depression/anxiety disorders; and personality disorder/substance misuse. Patients were more likely to be accepted by the service if they suffered from schizophrenia and related disorders (62% accepted) or severe mood disorders (77% accepted) and less likely to be accepted if they suffered from milder mood disorders or anxiety (38% accepted) and personality disorder or substance misuse (18% accepted) ($P<0.001$). Most of the patients with schizophrenia and related disorders and with severe mood disorders who were not accepted by Home Options were admitted to in-patient care instead, whereas for the less severe mood disorders and personality disorder/substance misuse, the most likely outcome was for other follow-up arrangements to be made (Table 2).

Using logistic regression analysis with forward stepwise regression, the strongest predictors of acceptance by Home Options were diagnostic group ($P=0.0005$), location of referral ($P=0.0007$) and the identity of the referrer ($P=0.0048$).

Twenty (20%) of the patients accepted by Home Options later had to be transferred to in-patient care. This included eight out of 23 (35%) patients with severe mood disorder, nine out of 47 patients with schizophrenia (19%) and three out of 27 patients with other diagnoses (11%) (χ^2 $P=0.05$). The other variables that predicted original acceptance by the service (time and source of referral, previously known to the service age and gender) did not appear to influence whether patients later required in-patient care.

Two hundred and three patients were admitted to in-patient care during the same 6-month period, of whom 43 (21%) had been assessed and refused by Home Options immediately prior to admission. Forty-six per cent of patients admitted to in-patient care were detained under the Mental Health Act. Using the same diagnostic groupings, patients admitted to in-patient care had very similar diagnoses to those admitted to Home Options (Table 3).

Discussion

Home treatment is being advocated as an important component of comprehensive mental health services (Department of Health, 1999) but little has been written about the practicalities of running a home treatment service. In keeping with other reports (Brimblecome &

Table 1. Outcome of Home Option referral

	Accepted *n* (%)	Refused *n* (%)	*P* value
Female patients	64 (58)	46 (42)	<0.05
Male patients	37 (43)	48 (57)	
Mean age (years)[1]	36	32	<0.05
Referred by senior doctor	56 (72)	22 (28)	<0.0001
Referred by junior doctor	32 (32)	67 (68)	
Referred from community or out-patients	66 (73)	24 (27)	<0.0001
Referred from accident & emergency	20 (28)	51 (72)	
Referred between hours of 9 a.m. to 5 p.m.	81 (58)	59 (42)	<0.01
Referred out of hours	16 (36)	29 (64)	
Previously known to service	68 (58)	50 (42)	<0.05
Not previously known	33 (43)	44 (57)	

1. Independent Student *t*-tests. All other statistics using χ^2.

https://doi.org/10.1192/pb.25.8.310 Published online by Cambridge University Press

special articles

Table 2. Outcome of referral to Home Options by diagnosis

	Accepted *n*=97	Refused but admitted to hospital *n*=39	Refused and not admitted to hospital *n*=46
Schizophrenia and related disorders (*n*=76)	47 (62%)	16 (21%)	13 (17%)
Severe mood disorders[1] (*n*=30)	23 (77%)	6 (20%)	1 (3%)
Less severe mood disorders/anxiety (*n*=65)	25 (38%)	15 (23%)	25 (38%)
Personality disorder/substance misuse (*n*=11)	2 (18%)	2 (18%)	7 (64%)

1. Includes bipolar affective disorder and psychotic depression.

$P<0.0001$ using χ^2 test.

O'Sullivan, 1999), our data suggest that a high proportion of patients referred will not be accepted and account needs to be taken of the amount of staff time spent assessing patients who are not considered suitable. As yet there has been little national debate about whether general practitioners should be able to refer new patients directly to a service of this kind, but we would require significant extra staffing to deal with the increased referrals such a change would generate.

As decisions about acceptance to a service of this kind shift away from doctors, non-medical staff involved in assessing patients need training in risk assessment and carefully considered policies and procedures for decision-making. The outcomes demonstrated for patients considered either too ill or not ill enough for our service suggest staff are making correct decisions about referrals and that many of the referrals received were not appropriate. This was particularly likely to be the case for patients referred from casualty by junior doctors. Emergency psychiatric services in the UK remain highly dependent on both casualty and junior doctors (Johnson & Thornicroft, 1991) and it is therefore not surprising that in the absence of other back-up services and with in-patient beds hard to find, junior doctors appear to have a lower threshold for referral.

Diagnosis appears to exert a strong influence on outcome for patients referred to home treatment. In general, patients with severe disorders were more likely to be accepted by Home Options and also more likely to require in-patient care, either because the referral was refused or the patient was accepted and later required transfer to in-patient care. This suggests appropriate targeting, with over 70% of the patients accepted by Home Options suffering from schizophrenia and related disorders or severe mood disorders, an almost identical figure to the in-patient unit. Home treatment studies in Bradford (Bracken & Cohen, 1999) and Birmingham (Minghella *et al*, 1998) have reported similar figures, though the service in more rural Hertfordshire treated a much lower proportion of patients from these categories (Brimblecombe & O'Sullivan, 1999).

Patients with severe mood disorders may present particular difficulties in home treatment. Although this group of patients was most likely to be accepted, it was also the most likely to later require transfer to in-patient care. Other studies have also reported difficulty treating patients with bipolar affective disorder, particularly those who have mania, in home treatment (Bracken & Cohen, 1999; Brimblecome & O'Sullivan, 1999) or a day hospital setting (Creed *et al*, 1990), suggesting particular attention should be paid to the initial assessment and treatment plan for such patients.

Patients with personality disorder or who misused substances were the least likely to be accepted by Home Options and the least likely to require in-patient care either at the time of the original referral or as a transfer from Home Options. Similarly, patients with personality disorder were least likely to be accepted by the home treatment service in Hertfordshire (Brimbecome & O'Sullivan, 1999). Patients with personality disorder can be difficult to manage in a home treatment service as the 24 hour accessibility of staff may lead to an abandonment of adult coping mechanisms and an increase in maladaptive behaviours. With time we have successfully managed some patients with personality disorders presenting in crisis by adopting firm boundaries at the start of the admission, for example a fixed duration of treatment and degree of contact.

Table 3. Diagnosis for patients admitted to Home Options and in-patient care

	Successfully treated by Home Options[1] *n*=78 (%)	Admitted to in-patient care *n*=184 (%)
Schizophrenia and related disorders	38 (49)	101 (55)
Severe mood disorders	15 (19)	33 (18)
Less severe mood disorders/anxiety	23 (29)	39 (21)
Personality disorder/substance misuse	2 (3)	11 (6)

1. Excludes patients admitted to Home Options and then transferred to in-patient care.

Differences not statistically significant (χ^2).

https://doi.org/10.1192/pb.25.8.310 Published online by Cambridge University Press

special articles

In the light of these findings we intend to provide more information and training for junior doctors about the role of Home Options, to emphasise that all potential referrals should be discussed first with a senior doctor and to bid for additional funding to increase the range of services available for patients presenting in crisis out of hours, who would not usually warrant in-patient care or admission to Home Options.

Acknowledgements

With thanks to all the staff of Home Options and particularly Sharon Kenny for her invaluable work as administrator.

References

BRACKEN, P. & COHEN, B. (1999) Home treatment in Bradford. *Psychiatric Bulletin*, **23**, 349–362.

BRIMBLECOMBE, N. & O'SULLIVAN, G. H. (1999) Diagnosis assessments and admissions from a community treatment team. *Psychiatric Bulletin*, **23**, 72–74.

CREED, F., BLACK, D., ANTHONY, P., *et al* (1990) Randomised controlled trial of day patient versus inpatient psychiatric treatment. *BMJ*, **300**, 1033–1037.

—, MBAYA, P., LANCASHIRE, S., *et al* (1997) Cost effectiveness of day and in-patient psychiatric treatment. *BMJ*, **314**, 1381–1385.

DEPARTMENT OF HEALTH (1999) *The National Service Framework for Mental Health*. London: HMSO.

HARRISON, J., POYNTON, A., MARSHALL, J., *et al* (1999) Open all hours: extending the role of the psychiatric day hospital. *Psychiatric Bulletin*, **23**, 400–404.

JOHNSON, S. & THORNICROFT, G. (1991) Emergency psychiatric services in England and Wales. *Social Psychiatry and Epidemiology*, **28**, 45–47.

MINGHELLA, E., FORD, R., FREEMAN, T., *et al* (1998) *Open All Hours: 24 Hour Response for People with Mental Health Emergencies*. London: Sainsbury Centre for Mental Health.

WORLD HEALTH ORGANIZATION (1992) *The ICD–10 Classification of Mental and Behavioural Disorders*. Geneva: WHO.

***Judy Harrison** Consultant Psychiatrist, **Nooreen Alam** Medical Student, **John Marshall** Home Options Manager, Department of Psychiatry, Central Manchester Healthcare NHS Trust, Oxford Road, Manchester MI3 9WL

Psychiatric Bulletin (2001), **25**, 313–315

GEOFFREY G. LLOYD

Origins of a Section: liaison psychiatry in the College

Why has liaison psychiatry been slow to develop in the UK? The asylum mentality and the current flight into the community have focused psychiatric resources on chronic psychotic illnesses, neglecting the psychological problems of general hospital patients. Nevertheless, there is abundant evidence that medical and surgical patients have a high prevalence of psychiatric disorder that can be effectively treated with psychological or pharmacological methods.

Until the 1970s specific liaison psychiatry services were virtually unknown in Britain. The separation of psychiatric services from university and district general hospitals made it difficult to provide an effective service. Patients referred from other medical specialities were seen as ward consultations by general psychiatrists, or allocated to general psychiatry out-patient clinics. A small number of specialised consultant posts were established but there was no officially recognised body to represent liaison psychiatry.

Inception and early development

Informal discussions between interested clinicians took place in the early 1980s and a consensus emerged that liaison psychiatry would be served best by establishing a group within the College. A letter to the *Bulletin* drew a response that indicated there was considerable enthusiasm for establishing a national group to provide a forum for clinical, research and teaching interests in the field of consultation and liaison psychiatry (Mayou *et al*, 1982). A preliminary meeting was held during the College quarterly meeting in Oxford in 1983, followed by a further meeting during the Annual General Meeting in Edinburgh in 1984. The College was then persuaded to recognise liaison psychiatry as a special interest group, although there was opposition from some senior Fellows who did not regard liaison psychiatry as a distinct clinical activity. A survey of members of the group (Mayou & Lloyd, 1985) indicated that there was substantial clinical and academic activity but respondents complained there was insufficient time to carry out all aspects of the work satisfactorily. Services appeared to have developed haphazardly and few districts had given priority to developing liaison psychiatry. Most of the services were provided by general psychiatrists, some of whom had a special interest in liaison psychiatry. Only nine full-time liaison posts were identified in adult psychiatry and one in child psychiatry. Little had changed by the time a second survey was undertaken 5 years later (Mayou *et al*, 1990).

Richard Mayou, who had been the prime mover in establishing the group, was elected chairman and served in this capacity until 1989. Subsequently the chair has been taken by Francis Creed (1989–1993), Christopher Bass (1993–1997), Allan House (1997–2000) and Geoffrey Lloyd (2000–). Rachel Rosser, Geoffrey Lloyd, Charlotte Feinmann, Trevor Friedman, Allan House, Robert Peveler and Elspeth Guthrie have held the post of secretary. The first residential meeting was held in Oxford in September 1987. Its success was vital to the development of the group and the annual residential meeting has now become an established event in the College's calendar.

The increased recognition and status of liaison psychiatry have led to the creation of a growing number

https://doi.org/10.1192/pb.25.8.310 Published online by Cambridge University Press