RESPONDING TO CRISIS

HOME TREATMENT AND HOSPITALITY AT 24 HRS CMH CENTERS

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Crisis and the psychiatric circuit

- Oversimplification of the experience, based on a reductionist psychiatry which contain and impoverish the individual’s experience
- Medicalisation in symptoms
- Crisis turned into emergency / acute presentation
  reflected by – shaped by
- A traumatic referral pathway (social emergency – driven by behavioral problems)
- Repression and oppression / restraint
- Hospitalization (coercive care)
CMHC is alternative to something else?

Our hypothesis is that community services must be conceived as alternatives not only to the total institution – the mental hospital, but to a conception of treating illness that is based on a reductionist psychiatry, which contain and impoverish the individual's experience as a patient. Therefore:

Are services tailored on illness management or social behavioral problems, or around the person and his/her experience?

Thus the need for a strategic (effective) but mostly humane and comprehensive viewpoint.
From hospitalisation to hospitality

- Institutional rules (patient, dangerous, unable)
- Institutionalised Time
- Institutionalised (ritualised) relations: among workers and with users
- Time of crisis disconnected from ordinary life
- Stay inside
- A stronger patients' role
- Minimum network's inputs
- Agreed / flexible rules
- Mediated time according to user’s needs
- Relations tend to break rituals
- Continuity of care before/during/after the crisis
- Inside only for shelter /respite
- Maximum co-presence of social network
From hospitalisation to hospitality

Difficult to avoid:
- Locked doors
- Isolation rooms
- Restraint
- Violence

Illness /symptoms /body-brain

- Open Door System

- Crisis / life events / experience / problems
Working with the open door

- Without ‘open door’ professional/relational abilities cannot be expressed.
- Freedom to enter and esp. leave enables person to exercise their own power.
- Operator must get involved both personally/professionally: negotiate as equals, offer alternatives, orient person’s interests and resources, manage conflicts.
- Stay with.....
A value based service, open door, no restraint

The services are value-driven, in that their focus is on:
• Helping the person, not treating an illness.
• Respecting the service user as a citizen with rights
• Maintaining social roles and networks.
• Fostering recovery and social inclusion
• Addressing practical needs that matter to service users
• Change the attitude in the community
CMHC Characteristics

- the **relationship** is the first priority (during the crisis too)
- **recovery** and citizenship
- **Low threshold**

- Responses are **quick** and **flexible** (work organization), **avoiding waiting lists**

- Team work: **multidisciplinarity** and creativity, no strict role (the same team with several functions such as crisis intervention, ACT etc)

- Therapeutic **plans** are based on **individual story**, needs and wishes

- During the crisis **personalised side-by-side assistance** if necessary
Overarching criteria / principles of community practice in the MH Dept.

- Responsibility (accountability) for the mental health of the community = single point of entry and reference, public health perspective
- Active presence and mobility towards the demand = low threshold accessibility, proactive and assertive care
- Therapeutic continuity = no transitions in care
- Responding to crisis in the community = no acute inpatient care in hospital beds
- Comprehensiveness = social and clinical care, integrated resources
- Team work = multidisciplinarity and creativity in a whole team approach – the same team with several functions such as crisis intervention, ACT etc

*Whole life approach = recovery and citizenship, person at the centre*
Access and response to crisis at CMHC

- **8-20**: Direct referrals to the CMHC, non formality, **real time** response (mobile front line)
- **20-8**: Access to the consultation at the **Psychiatric Emergency Unit** (6 beds) through **Casualty Dept**, then overnight accommodation in the emergency unit (**psychiatrist on call**)

But:
- No admissions in the emergency unit as a rule.
- The **day after at 8.00** the CMHC team calls

Usually:
- **Crisis supported at home or hosted in the Centre**
- **Avoiding invol. treatments**
- In case of Invol. Treatments in the CMHC as a first choice.
Crisis management in the Centre

Actions in crisis management

• Personalise the ‘control’ of the problematic or difficult user, including **personalised side-by-side assistance** if necessary

• Contracting the form of acceptance/admission with the user, from the DH to day-night hospitality (Status of ‘hospitality for health’)

• Continuous effort to obtain compliance with treatment/care through a relationship based on trust

• Inclusion of the user in crisis in both structured and non-structured activities

• Escape” / looking for / re-negotiating return: “what was wrong with you in the centre?”

Involving the team

• Information managed collectively (not by select individuals/operators)

• Case notes and the team’s activities: should always be related to individual life-stories, group discussion and the group’s sense of community
Responding to crisis in the community

- Intervention is as far as possible *in vivo*, within service users’ homes or other places they frequent.
- Responses are quick and flexible, avoiding waiting lists and other bureaucratic obstacles to accessing services.

→ CRISIS AT THE HEART OF MH CARE
Make full “use” of the crisis:
- *Crisis is multiplying resources*
- *Crisis is increasing informations and knowledge around the person*
- *Crisis is increasing communication within the service* (“subjectivization”, “illumination” as a social visibility)
Hospitality in 24-hours community mental health center in Trieste: trend 2008 - 2017
Continuity of care

• This is a guiding principle and involves treating service users within the usual care system and maintaining them in their usual social context, thus avoiding de-socialisation and institutionalisation.

• **Follow-up is provided** wherever service users are.

• Interventions take place: in the patient’s actual living environments; within social-health institutions; in legal-penal institutions (Courts of law, prison, forensic hospitals)

• Temporal continuity: this is defined based on the need for care and the threefold criteria of prevention/care and rehabilitation.
Integrated and comprehensive response (social and medical)

• Therapeutic plans are **based on individual history, needs and wishes**. It allows the service to obtain and maintain service users’ consent to and engagement in treatment.

• **Establishing a relationship** is the first priority.

• **Comprehensive/integrated responses** between social and health, therapeutic and welfare assistance. This involves:
  • the use of resources which the Service has available;
  • the activation of health and social services;
  • the use/exploitation of resources which may be present in the micro-social context.
Resources directly provided by the Centre concerning whole life and recovery:

- living situation (restoration, maintenance and cleaning, the search for other housing solutions)
- money, income (cash subsidies, use of the safe in centre, daily money management on a temporary basis, action taken in defense and protection of property)
- personal hygiene (laundry, personal cleanliness, hairdresser, linens)
- work possibilities (assignment to a co-operative society, chores at the centre, work grants)
- free time (workshop in theatre, painting, music, graphics, sewing, ceramics, gymnastic and boating, day trips, holidays, parties, cinema, shows).
Advantages of the 24hr CMHC

• Point of reference open 24 hrs
• The personnel can be utilised flexibly
• Users can receive a wide range of responses
• The crisis comes into immediate contact with a system of resources/options, including for rehabilitation
• The user is always assisted by a single team that has a contractual relationship with him/her
Advantages of the 24hr CMHC

• Both admission (hospitality) and release can be decided and agreed to immediately, without bureaucracy or referrals
• Avoids the immediate loss of contact with normal living contexts and networks
• Avoids the immediate loss of ability, and the role connected to one’s abilities, leaving the user active and free
• Reduces the stigma of hospitalisation
So what helps people in crisis?

- Trustee relationships
- Continuity of care and of experience (no disruption)
- Hope
- Self-determination
- The person’s history or narrative

These are known as main factors for recovery
The person and not the illness at the center of the process of care for recovery and emancipation through users’ active participation in the services

(up close, nobody is normal)