Chapter 12
Creating Hospital and Community-Based Therapeutic Environments

Deinstitutionalization

- Began in the post–World War II period
- Large public mental hospitals were:
  - Overcrowded and had fallen into disrepair.
  - Widely criticized for “warehousing” residents.
  - Phased-down.

Deinstitutionalization - continued

- Community mental health movement
  - Reached its apex in the 1960s.
  - CMH Centers were constructed to provide acute care and ambulatory services
Disturbing Trends

- Hospital care remained the main treatment for severely mentally ill clients
  - Repeated readmissions
  - Inadequate and inaccessible community resources

Disturbing Trends - continued

- New mentally ill populations
  - Homeless, crack cocaine addicts, mentally ill criminal offenders
  - Unable or unwilling to use services

Types of Treatment Programs

- Hospital-based (inpatient)
  - For clients with life threatening diagnoses
- Community-based (outpatient)
  - Community Mental Health Centers (CMHC)
  - Mobile Outreach Units
  - Assertive Community Treatment (ACT)
  - Psychiatric Home Care
Hospital-Based Treatment

- Severely impaired functioning
  - GAF score 10 to 50 to qualify for admission
- Admission of clients with:
  - Active suicidal ideation
  - Extreme psychotic and delusional behavior
  - Acute withdrawal symptoms
- Requires intensive skilled nursing care and case management

Services Provided by CMHCs

- Emergency services
- Medication management clinics
- Psychoeducation groups
- Vocational rehabilitation

Services Provided by CMHCs - continued

- Consultation to hospitals, nursing homes, etc.
- Specialty programs for:
  - Homeless mentally ill clients
  - Chemically dependent clients
  - Elder clients
Treatment Goals of Mobile Outreach Units

- Provide greater access to mental health care.
- Increase medication adherence.
- Prevent relapse and re-hospitalization.
- Identify and assess community needs.

Treatment Goals of Mobile Outreach Units - continued

- Facilitate entry into mental health system.
- Emergency intervention or crisis prevention
- Satisfy requirements of court-ordered treatment.

Assertive Community Treatment (ACT)

- ACT programs are believed to:
  - Prevent relapse and re-hospitalization.
  - Be more cost-effective than hospitalization.
  - Reduce arrests, emergency room visits, and homelessness of SPMI clients.
  - Reduce stress and burnout of case managers.
**Assertive Community Treatment (ACT) - continued**

- Deliver service in client’s own environment
  - Team of 7-12 interdisciplinary professionals in mobile outreach capacity

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**Psychiatric Home Care**

- Growing demand due to managed care
- Cost-effective alternative to hospitalization
- Provision of direct psychiatric care to clients through home care agencies

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**Psychiatric Home Care - continued**

- Medicare reimbursement requirements:
  - Care is provided by qualified and experienced psychiatric nurse.
  - Client must be homebound and have a diagnosed psychiatric disorder.
Case Manager Challenges

- Assessment phase
  - Trust and clear communication among team members
  - Need for clarification of case manager role

- Planning phase
  - Information regarding benefits, limitations, resources, expectations

Case Manager Challenges - continued

- Implementation phase
  - Objective consultant who takes holistic view
  - Conflict resolution and arbitration
  - Provide additional data or client education

- Evaluation phase
  - Continuous monitoring of client response and progress

Managed Mental Health Care

- Method for capping rate of increase in cost while ensuring access to services

- Impact of Managed Care on:
  - Inpatient Settings
  - Primary Care Settings
  - Employer-Based (onsite) Clinics
MCOs as a Practice Environment

- Boundaries (burnout prevention)
- Legal Issues
  - "Flexing" of benefits
  - Authorization of out-of-plan services
- Treatment & Medication Adherence

MCOs as a Practice Environment - continued

- Unrealistic Member Expectations
  - Entitlement versus covered services
- Continuity of Care
  - Possible seamless movement from one level of care to the next

Box 12.2: Mental Health Services Often Excluded from Typical Managed Care Plans

Following are some examples of mental health services that are not included in typical MCO plans:

- Psychiatric or substance abuse therapy in any setting, except for treatment of a psychotic disorder.
- Psychiatric or substance abuse treatment for any condition that may be a result of personal injury or illness, including anxiety disorders and depression.

Box 12.2 Mental Health Services Often Excluded in Managed Care Plans
Ethics in Managed Mental Health Care

- 4 guiding principles for ethical dilemmas:
  - Act as a steward of society’s scarce mental health care resources.
  - Recommend least costly treatment if ethically and medically sound.
  - Advocate for justice.
  - Discuss reimbursable parameters of care openly with clients.

Case Management

- Help clients and caregivers make informed decisions.
- Consider client needs, abilities, resources, and personal preferences.
- Respect client’s need for autonomy in making decisions regarding treatment.

Central Element

- Coordination of one episode of care across multiple care settings
- Integrate, coordinate, and advocate for services.
Gatekeeper & Facilitator

- Initial contact for care and referrals
- Physical assessment or illness-detection skills
- Prevent unnecessary hospitalization.
- Treatment in least-restrictive settings
- Prevent duplication and fragmentation of services

Client Advocate

- Negotiating complex mental health care systems
  - Active involvement in treatment planning
  - Resolve conflicting needs of several parties.
    - Requires creativity and flexibility
  - Defend clients’ rights and responsibilities.

Therapeutic Environment in Hospital-Based Care

- Purposeful use of people, resources, events and environment to:
  - Ensure safety.
  - Promote optimal functioning in ADLs.
  - Develop or improve social skills.
  - Enhance capacity to live independently in the community.
Therapeutic Environment

- Unique role for nurses
  - Provision of 24-hour care 365 days a year
  - Influence on environment and client behavior
- External factors
  - Privacy
  - Autonomy
  - Safety
  - Group well-being

Applying Therapeutic Environment Principles

- Restrictiveness
- Orienting client and family
- Safety and the structural environment
- Program structure
- Supportive social climate
- Spirituality
- Client and family education

Restrictiveness

- Physical restrictions
  - Least restrictive alternative for treatment
  - Locked doors, communal living arrangements, limited access to community resources
- Psychological restrictions
  - Client and staff behaviors, attitudes, beliefs, values
- Social restrictions
  - Program rules and regulations
  - Treatment standards for managing client behavior
Orienting Client and Family

- Inform clients about all aspects of the therapeutic environment.
- Encourage them to relate their concerns and questions about what to expect.

Orienting Client and Family - continued

- Review clinical problems, treatments, and behavioral outcomes.
- Encourage client and family to:
  - Identify personal goals.
  - Participate in evaluating the course of treatment.

Safety and the Structural Environment

- Evaluate safety and structural environment for:
  - Sufficiency, advantages, necessity, and possible detrimental impact.
- Consider alternative security interventions that do not have a detrimental impact
  - Implement alternative steps to seclusion and restraint whenever possible.
Safety and the Structural Environment - continued

- Reevaluate structural controls for relevance or possible discontinuation.
  - Use reality-oriented resources to contribute to a sense of normality.

Program Structure

- Inform clients of rules and regulations ASAP.
- Community Meetings function to:
  - Welcome new members and discuss expectations.
  - Discuss aspects affecting quality of life such as:
    - Cleanliness, privacy, radio and television use.
    - Other interpersonal problems and conflicts.
  - Plan activities.

Program Structure - continued

- Client Government provides opportunities for:
  - Participation, corrective learning experiences, and development of new behavior patterns.
  - Feedback essential to increase insight and promote learning.
**Supportive Social Climate**

- Influences on individual and group behavior:
  - External sources such as professional practice standards, regulatory agencies, and laws
  - Client’s attitudes, beliefs, and behaviors, styles of interaction between people
  - Nursing routines

**Spirituality**

- Use spiritual beliefs of clients to enhance wellness and coping.
- Strive to provide spiritual resources that are both culturally congruent and culturally competent.
- Nurses must also recognize and explore their own beliefs in order to minimize the impact of bias in their client interactions.

**Encouraging Partnership with Clients and Families**

- Establish a daily schedule.
- Use positive communication skills, be empathic.
  - Give instructions or directions at client’s level of ability.
    - Verbal prompting alone or with physical assistance
    - Praising independent performance.
  - Avoid criticism, argument, and negative reinforcement.
Encouraging Partnership with Clients and Families

- Identify and participate in support groups.
  - Identify signs of stress and community supports.
- Recognize illness relapse or exacerbation.
  - Develop plan for managing symptoms and emergency behaviors.

Treatment Settings and Programs for SPMI

- SPMI: Severe, persistent mental illness
  - Clinically diverse population, with
    - Different diagnoses
    - Varied patterns of illness
  - Psychiatric Disability
    - Psychiatric impairment that alters functional performance or behavior over time

Community Support Programs 1

- Case management
- Support for basic needs
- Residential services
- Medication management
- Outpatient treatment
Community Support Programs 2

- Crisis stabilization
  - Emergency
  - Acute inpatient care
- General health care
- Vocational programs
  - Americans with Disabilities Act

Community Support Programs 2

- Day treatment, partial hospitalization programs
- Family and support network
- Advocacy – NAMI resources

Rehabilitation Approaches

- Philosophy
  - Prevention or reduction of impairment or handicap
- Clubhouse Model
  - Group activities, successful supported employment, and housing assistance
Rehabilitation Approaches

- Vocational Rehabilitation
  - Set goals and choose a job focus
- Social skills training
  - Individual, group, family treatment

High-Risk SPMI Clients

- Concurrent substance related disorders
- Homeless and mentally ill
- Frequent readmissions and relapse
- Frequent criminal justice system involvement

Resources

- [www.bazelon.org/decrim.html](http://www.bazelon.org/decrim.html)
  The Bazelon Center for Mental Health Law is committed to reducing the criminalization of people with mental illnesses by reducing the likelihood of arrest or re-arrest, by exploring legal advocacy approaches such as jail diversion or discharge planning.
- [www.eeoc.gov](http://www.eeoc.gov)
  The EEOC enforces federal laws prohibiting job discrimination.
Resources - continued

- [http://www.nechmi.samhsa.gov](http://www.nechmi.samhsa.gov)
The Homelessness Resource Center brings together providers, consumers, policymakers, researchers, and public agencies to improve the lives of people affected by homelessness who have mental health conditions, substance use issues, and histories of trauma.

- [www.nami.org/about/pactstd.html](http://www.nami.org/about/pactstd.html)
This NAMI site provides information on Assertive Community Treatment.