Therapeutic Relationships: From Hospital to Community

June 2002

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Decision Maker Partners:

Funding provided by:
Canadian Health Services Research Foundation
St. Joseph's Healthcare, Hamilton, Centre for Mountain Health Services
St. Joseph’s Healthcare, London/St. Thomas, Regional Mental Health Care
Whitby Mental Health Centre
Lawson Health Research Institute
The Donner Foundation
The Trillium Foundation
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Therapeutic Relationships: From Hospital to Community

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Acknowledgments:

Co-Sponsors:

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Key Implications for Decision Makers

- This new way of helping people with mental illness make the difficult transition from hospital to community saved more than $12 million through shorter hospital stays while improving how patients function. The savings were achieved through the early discharges of patients on 13 wards, in four cities, over the period of one year.

- This model saves the most money and is most beneficial when targeted at individuals who say they are lonely.

- Patients under the new model of treatment who were characterized as “lonely” — describing their quality of social relationships as neutral or unsatisfactory at enrolment — used an average of $20,300 less per person in hospital and emergency room services during the year after discharge, and reported improved costs, quality of life and level of functioning. Those receiving usual care consumed just over $1 million more in hospital and emergency room services than the “lonely” people who received the new model of care.

- Partnerships between mental healthcare consumer organizations and professional mental health services were crucial in yielding cost savings. Consumer organizations will need ongoing funding of peer support programs to continue offering these services. Treating just one “lonely” person per year would pay for a part-time volunteer co-ordinator through reduced hospital and emergency room costs.

- Those receiving the new model of treatment used an average of $4,400 less per person in hospital and emergency room services during the year after discharge (three-quarters of whom didn’t describe themselves as lonely.) This number was not statistically significant.

- Because patients under the new model had a support network ready for them, hospital staff could discharge them about four months earlier than patients who did not have the same type of support. A more flexible role for hospital staff that has them act as a transitional caregiver in the hospital and in the community leads to the shorter lengths of stay, since discharge is less dependant on how available community resources are and because clients can access supports immediately.

- Patients getting help from community peer support groups reported improved social skills and feelings of well-being. They also appeared to be further along in the therapeutic recovery process than those getting the usual care.

- As this study progressed, wards with usual care started to implement the new model of care based on a strong belief in its value.

- As a clinical trial using a randomized cluster design, the study was highly rigorous in looking at the experiences of 390 patients in 26 wards in London, St. Thomas, Whitby and Hamilton.
Executive Summary

This study tested a new approach to supporting people with chronic mental illness as they make the transition from the hospital to the community. It involved 390 discharged patients from the Regional Mental Health Care London/St. Thomas (formerly London/St. Thomas Psychiatric Hospital), the Centre for Mountain Health Services (formerly Hamilton Psychiatric Hospital), and the Whitby Mental Health Centre.

The transitional model focuses on interpersonal relationships. It includes two important elements: the first is peer support for one year from former clients of the mental healthcare system who promote friendship, provide understanding, teach community living skills, and encourage current clients in making a transition from psychiatric hospital to community. The second element is an overlap of in-patient and community staff in which the in-patient staff continued to treat clients until the clients have a working relationship with a community care provider, which can take up to one year.

The model was developed and tested in a pilot project developed at Hamilton Psychiatric Hospital. The pilot demonstrated significantly improved quality of life for nine participants who were given transitional support, while resulting in savings of $496,862.55, during a one-year trial. A diagram which depicts the model is included in the full report as figure 1.

The research had two components: a randomized cluster design and a qualitative critical ethnographic component. Outcome measures included quality of life and costs. It was hypothesized that, in the year following discharge from a psychiatric hospital, individuals participating in the transitional discharge model would have improved quality of life and incur fewer health and social services costs compared to individuals receiving standard care.

There were 26 psychiatric tertiary care psychiatric wards included in the study. They were matched into 13 pairs of similar wards (treatment focus, staffing level, average length of stay). Of each pair, one ward was randomly selected to implement the new intervention while the other was to continue offering treatment and discharge as usual. To implement the intervention, extensive staff training of 12 hours per staff member was offered to all members of the multi-disciplinary team. The intervention wards were connected with consumer groups who had agreed to offer the peer support component. There were 17 mental health consumer groups involved throughout the study. They recruited volunteers, offered a standardized 10-session peer training program, matched volunteers to patients about to be discharged and provided ongoing support to volunteers. They were greatly assisted by a three-year grant from the Trillium Foundation.

An advisory committee of members of the research team, the pilot ward, the participating hospitals, the consumer groups and community agencies greatly assisted in the implementation.

Intervention participants were able to be discharged at an average of 116 days sooner than control ward participants. One nurse in London, eager to finish her training so she could help with her client’s transition into the community had commented “With this model, my patient can leave after six weeks, instead of six months.” The client was one
that was difficult to refer to an appropriate community services in a timely manner, but discharge was not delayed by the need to find appropriate community-based services.

The data showed this change in practice was significant and widespread. At a rate of $632.30 per day — the cost of a bed in a psychiatric hospital — the people in the intervention group consumed $12,212,242 less in hospital costs than the group receiving regular, standard care, prior to discharge from the pre-enrolment admission. In the first year after discharge, the intervention group consumed $4,400 less hospital and emergency room services per person than the group receiving regular, standard care. This trend was not statistically significant. Despite the significantly shorter length of the intervention group’s hospital stay, they did not need more services after discharge, and actually had a trend for fewer hospital services after discharge.

The intervention group showed a trend toward improved quality of life on global quality of life, but this was not statistically significant. However, quality of life related to social relations, the specific area target by the intervention, did improve significantly for intervention participants.

The intervention group had higher general levels of functioning one year after discharge as measured by the global functioning subscale of the Colorado Client Assessment Record.

Twenty-six percent of the participants identified themselves as feeling negative or neutral about their social support at the beginning of the study. This was identified by three questions on the Lehman scale about how they felt about the things they do with other people, the amount of time they spend with other people and the people they see socially. This group was termed “the lonely group.” The lonely subgroup in the intervention group used $20,300 less in one year per person in hospital and emergency room services than the group receiving usual discharge care. The people receiving usual care consumed a total of $1,078,900 more hospital and emergency room services than the “lonely” people receiving support. All outcomes (costs, quality of life and level of functioning) improved using the new model of care on the lonely subgroup. Only the level of functioning was still significant when examining the differences between the people under the new model of care and the people under the usual care who were already satisfied with their social relations. Therefore, although all may gain through improved functioning, the lonely group makes far greater gains generally.

Both contamination (when the regular standard-care wards began to implement the intervention) and under-implementation (by two wards in the intervention group) were issues. As the project progressed, regular standard-care wards identified that the intervention groups were getting better results with discharge and readmission. They then began to gradually attempt to implement parts of the intervention. Although they did not implement as fully as 11 of the 13 intervention wards, this weakened the results that would otherwise have been available. Similarly, the two wards that did not fully implement reduced the size of the differences between intervention and control wards.
Recommendations

Partnerships between consumer organizations and professional mental health services can yield cost savings and improved care. Consumer groups will need ongoing funding of volunteer co-ordinators to continue offering this service. Treating just one lonely person per year would pay for a part-time volunteer co-ordinator through reduced hospital and emergency room costs.

A more flexible role for hospital staff that has them act as a transitional caregiver in the hospital and in the community results in shorter lengths of stay, since discharge is less dependant on how available community resources are and because clients can access supports immediately.

Hospital staff needs access to client records and systems for documenting care following discharge. Budgeting needs to include time and transportation costs for staff to provide this service.

The intervention has the most benefit when targeted at individuals who perceive themselves to be lonely.

Consumer groups should be considered part of the treatment team. Regular weekly time should be provided for consumer organizations to meet with hospitalized patients. Community outings from hospital should regularly include consumer groups.

Further study is needed to better understand why some wards more readily adopted the intervention than others.