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Home care services in the community treatment of mentally ill persons

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Summary

Aim. The aim of the current study is to present the characteristics of the mentally ill persons participating in a home care services realised in Warsaw.
Method. 105 long-term patients receiving home care services were included in the study. They were not hospitalised at the time of the interview. The data was collected with the use of GAS and a questionnaire specifically designed for the study's aims.
Conclusions. The chronically mentally ill persons present with numerous difficulties in their social functioning. Good functioning of our respondents in social situations can be accounted for by their participation in the home care services system, and protects them against successive hospitalisation. It is necessary to consider the local home care programmes as an effective mechanism supporting functioning of chronically mentally ill people.

mental illness / home care services / social functioning

INTRODUCTION

Community based forms of treatment as well as supporting the mentally ill persons is becoming more common also in Poland, it concerns specifically services conducted in local communities and not directly related to psychiatry. Their essential aim is to reduce number of psychiatric hospitalisations and to support the maintenance of mentally ill persons in their local community. This can only be achieved if the ill person receives sufficient support that should address two basic goals: counteracting difficulties in everyday life and ensuring access to the support sources. Effectiveness of these actions often depends on both quantity and quality of mentally ill persons' individual social networks [1].

One of the first, classic researches on the role of sources of support in functioning enhancement was doctor Joseph Pratt's study conducted in 1905. In Boston he created a group for patients suffering from tuberculosis. Subjects that were discussed during the meetings included the ways of coping with illness as well as hygiene principles. The findings of the study revealed that gains resulting from the participation in the meetings exceeded simple satisfaction and also included enhancement in both somatic and mental health. One of the most important conclusions was that social support means presence of close friends and people that can be relied upon in difficult or crisis situations. This remarkable relationship emerges among people who are in need of instrumental, informational

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and emotional support. This kind of support can come from both natural and institutional sources. The gains of the person receiving support include reduction in psychological and physiological effects of stress, enhancement in daily functioning and satisfaction of individual and social needs: the need to belong, to feel safe and to feel sense of community [2].

Strengthening existing social support systems or their creation in case of their absence, amounts to extremely important component of the treatment and rehabilitation of mentally ill persons. Over the course of their illness, many chronically mentally ill persons experience reduction of their social networks which results in limited capability to handle difficult situations. This is especially important regarding people living in local communities [3]. The programmes of community support as well as psychiatric day centres, which are the alternative to asylum model, are not only the mean of rehabilitation for patients after the experience of psychosis, but also the substantial support for patients in long- term remission of the symptoms [4, 5]. As a result of extraordinary poorness of their social environment, these patients often loose or even never gain the skills necessary for satisfactory, or at least decent enough, life [6, 7]. For this particular group of patients community treatment becomes the way to exit the vicious circle of both social and personal, negative consequences of mental illness [8, 9]. Help received within local community is mainly related to social support which is provided not only for the patients, but also for their families, who often fail to both function in everyday life and to deal with their relative's illness [10]. They can be assisted with rehabilitation programmes and social support designed for persons who, as a result of their mental illness, experience substantial difficulties in daily functioning as well as in social contacts [11]. Hitherto research results indicate that effectiveness of activities aiming at functioning enhancement is increased if they are conducted basing on local community. It is also recommended by the WHO that the patients maintain their natural social environment [12, 13].

Local social support systems as well as their specific programmes are still underdeveloped in Poland. A major breakthrough in their creation was the Mental Health Act, passed in 1994 [14]. It provided basis for new solutions. The cooperation of many stakeholders such as social welfare agencies, non-governmental organisations and psychiatric care, as well as recognition that local environment should serve as a base of actions, are considered to be of most importance in terms of systematic changes. Thus far, not many local support and rehabilitation systems have been created. Most effective ones include local systems in Warsaw districts: Targówek, Bielany and Białołęka [15].

Currently, occupational therapy workshops, community homes, sheltered accommodation and home care services serve as a base of rehabilitation and social support for mentally ill persons.

CHARACTERISTICS OF HOME CARE SERVICES PROGRAMME

Home care services are offered by social welfare agencies. They are applicable to those persons who require other people's help, would it be because of their age, illness, disability or other reasons, but are deprived of it. Services are provided in patient's home or sometimes in support centres and they may include help in everyday activities, such as shopping, cleaning, cooking, settling a business in the office, medication intake [11].

The aim of home care services is to assist the persons, who are unable to live independent life outside the hospital due to their illness, in everyday activities and social contacts. The services are designed for chronically mentally ill persons who require social support in their community or different psychosocial therapeutic intervention, regardless of pharmacological treatment [16].

Mental Health Act of 1994 mentions home care services, together with community homes, as one of the basic form of social support for mentally ill persons (art. 8 and art.9). Agencies of social welfare as well as other organisations operating on the basis of the Social Welfare Act are obliged to organise support in agreement with psychiatric care services [17]. This programme is being conducted all over Poland. Its specificity lies in conducting the activities directly at homes of the mentally ill persons. They are realised by multidisciplinary team which includes:

psychologists, educators, social workers, psychiatric nurses, occupational therapists. Number of persons benefiting from home care services systematically increases – in 1995 6 500 persons received care and in 2000 there were as many as 11 000 clients (Source: Ministry of Labour and Social Policy). In 2005 only in Mazovian Province the services were provided to 1214 persons and in 2006 – to 1508 (Source: Social Policy Department of Mazovian Province) [18].

Home care services can be considered as remarkable programme. It is designed for persons whose social functioning is significantly impaired due to the illness. Home care services include visiting and supporting the patients in their homes, undertaking crisis interventions and activating the patients which should result in improvement of their quality of life and reduction in number of rehospitalisations.

Home care services offer wide range of assistance for the patients including:

1. Teaching and help in the development of skills indispensable for independent life, especially development of social functioning skills, motivating the patients to being active, undertake treatment and rehabilitation, conducting self-help and social skills trainings.
2. Crisis interventions, psychological support, therapeutic talks, assistance in settling a business in the office, such as obtaining social benefit or pensions as well as assistance in filling in the legal documents.
3. Support and assistance in finding employment.
4. Assistance in money management: teaching how to plan and track fees and expenses, assistance in spending money as well as obtaining reduced fees.
5. Supporting treatment process: setting and monitoring of patients' appointments and diagnostic examinations.
6. Assistance in accommodation related issues: finding an accommodation as well as negotiating and making payments.

Experience from the first years of conducting home care services indicates their effectiveness regarding increase in patients' independence and enhancement of their social functioning [19, 20]. The findings show that this form of community treatment may help to remarkably reduce number and time of hospitalisations, especially in chronically ill persons [21].

In order to be included in the programme, a patient should be referred by a psychiatrist. The referral includes specific data on the patient as well as recommended services and suggested number of weekly hours of the services which may be required. Basing on the referral and after obtaining the patient's consent, social welfare agency decides to grant home care services and determines the duration, kind of activities as well as number of hours and required payment. The decision is the green light for the therapists to start providing the services. This is a standard recruitment process which is obligatory for all service users within three Warsaw districts: Bielany, Targówek, Białołęka. In the current paper this group of service users is described in terms of adjusting the rehabilitation programme to their individual needs.

OBJECTIVES AND METHODS

Although the programme of home care services has been carried out in Poland for over 15 years now, no comprehensive research on the characteristics of its participants or its implementation has been conducted. The aim of this study was to fill this gap. Data on the ways of providing home care services for mentally ill persons, characteristics of the participants as well as their assessment of the programme was collected.

Mentally ill persons who received home care services in three Warsaw districts (Targówek, Bielany, Białołęka) were included in the study. The services are carried out by the association "Pomost", an NGO running local support systems for mentally ill patients. "Pomost" has 10 years of experience in the conduction of home care services and its methods of work became a standard. The subjects were interviewed once, directly at their homes and the interviews were conducted between October 2008 and May 2009. Data was collected by the psychologists and social workers who were experienced both in the work with mentally ill patients and conduction of the interviews. 105 participants were included in the study. Inclusion criteria were the following:

– at least 3 months of home care services use
– diagnosis of F20 to F29
– 18 years of age or older
– mental state at the moment of the interview allowing data collection
– signed consent to participate in the study

Data was collected with the use of the questionnaire designed specifically for this study.

Participation in home care services programme

A total of 105 patients were included in the study.

Table 1. Study participants by district

District	N	%
Targówek	52	49.5
Bielany	42	40.0
Białołęka	11	10.5
Total	105	100.0

Sociodemographic characteristics

Table 2. Gender distribution of the participants

Gender	N	%
Male	46	43.8
Female	59	56.2
Total	105	100.0

As presented in Tab. 2, study population included more females (56%). The mean age of the participants was 52 years (with an age range 24 to 82 years). More detailed data regarding age are reported in Tab. 3.

Table 3. Age ranges of the participants

Age ranges	N	%
30 and Under	10	9.5
31 to 40	14	13.3
41 to 50	24	22.9
51 to 60	21	20.0
61 to 70	21	20.0
71 and Over	15	14.3
Total	105	100.0

Data regarding participants' education are presented in Tab. 4.

Table 4. Education levels of the participants

Education level	N	%
Primary	24	22.8
Basic vocational	26	24.8
Secondary	47	44.8
Higher	8	7.6
Total	105	100.0

As seen in Tab. 4, 7.6% of the participants obtained higher education. Remarkable percentage of this population (44.8%) has secondary education.

Tab. 5 presents data on the civil status of the respondents. As few as 12 persons (11.4% of total) are married and the rest of the respondents are single (88%).

Table 5. Civil status of the participants

Civil status	N	%
Single	62	59.1
Married	12	11.4
Divorced	13	12.4
Widowed	18	17.1
Total	105	100.0

Course of the illness and current mental health status of the respondents

As many as 97.1% (102 persons) of the study population has a diagnosis of paranoid schizophrenia. The rest of the respondents are diagnosed with delusional or depressive disorder. Over 87% of the study participants receive pension or regular benefit and 13% does not have any source of regular income and are dependent on their families.

The mean illness duration in the current sample was 22 years (4 to 56 years) and the mean age of illness onset was 29 years. More detailed data are presented in Tab. 6.

Table 6. Duration of illness

Duration of illness	N	%
5 years and Under	5	4.8
6 to 10	17	16.2
11 to 20	31	29.5
21 years and Over	52	49.5
Total	105	100.0

It is worth noting that the percentage of participants who have been ill for 5 years or less is low.

The mean number of hospitalisation experienced by the participants was 7. The mean number of day hospitalisations was lower (3.1).

Tab. 7 and 8 present data regarding hospitalisations in the last 12 months prior to the interview. Hospital use was relatively low and majority of the admitted patients reported a single hospitalisation only.

Table 7. Inpatient hospitalisations in last 12 months

Number of inpatient hospitalisations in last 12 months	N	%
None	84	80.0
1	19	18.1
2	1	1.0
4	1	1.0
Total	105	100.0

Table 8. Outpatient hospitalisations in last 12 months

Number of outpatient hospitalisations in last 12 months	N	%
None	89	84.8
1	13	12.4
2	3	2.9
Total	105	100.0

Almost all respondents (97.1%) use psychiatric care on regular bases (Tab. 9). The most common form of this care is outpatient mental health care. It is also worth noting that a remarkable percentage of the participants (94.3%) reported regular intake of medicines prescribed by a psychiatrist.

Table 9. Prevalence use of different forms of psychiatric care

Forms of psychiatric care	N	%
Outpatient mental health care	87	82.9
Home care	11	10.5
Psychiatric Day centre	3	2.9
Private psychiatric appointments	1	1.0
No care use	3	2.9
Total	105	100.0

As many as 36 persons (34.3%) used other forms of psychiatric care and support, except for home care services. These were: occupational therapy workshop, community care home, sheltered accommodation or patient's club.

Current mental health of the respondents was assessed with a use of Global Assessment Scale (GAS). The average rating was 60.92 (Min. 28, max. 95), which correspondents with the following description of the mental state and functioning: mild intensity of symptoms (e.g. depressive mood, minor insomnia) or some difficulties in a few areas of activity are reported; the functioning is not completely good; a patient has a few significant relationships with other people and majority of people in his/her surrounding does not consider him/ her to be ill.

More detailed data on GAS results are presented in Tab. 10.

Table 10. Global Assessment Scale (GAS) ratings

	N	%
21–30 unable to function	1	0.9
31–40 major impairment of functioning	9	8.6
41–50 need for treatment	13	12.4
51–60 moderate symptoms	32	30.5
61–70 mild symptoms	25	23.8
71–-80 mild impairment of functioning	19	18.1
81–90 good functioning	5	4.8
91–100 superior functioning	1	0.9
Total	105	100.0

Implementation of home care services programme

The average number of monthly hours provided to the patients was 15.5 (2 to 30 hours). More detailed data are shown in Tab 11.

Table 11. Number of monthly hours of home care services provided to the patients

Range	N	%
10 hours and Under	12	11.4
11 to 15 hours	38	36.2
16 to 20 hours	39	37.1
21 to 25 hours	9	8.6
26 hours and Over	7	6.7
Total	105	100.0

In the study population home care services were provided by interdisciplinary team of the professionals (Tab. 12 – *next page*).

Study participants have been home care services users for 58.9 months on average (4 to 144 months). More detailed data regarding duration of the participation in the programme are included in Tab. 13.

Table 12. Professionals providing home care services

Occupation	N	%
Nurse	31	29.6
Social worker	23	21.9
Psychologist	22	21.0
Occupational therapist	13	12.4
Educator	7	6.7
Psychologist + occupational therapist	5	4.8
Psychologist + educator	1	0.9
Psychologist + nurse	1	0.9
Psychologist + social worker	1	0.9
Social worker + nurse	1	0.9
Total	105	100.0

Table 13. Duration of the participation in the programme

Ranges	N	%
12 months and Under	12	11.4
>12 to 24 months	27	25.7
>24 to 36 months	6	5.7
> 36 to 48 months	10	9.5
> 48 to 60 months	9	8.6
> 60 to 72 months	7	6.7
> 72 to 84 months	5	4.8
> 84 to 96 months	8	7.6
>96 to 108 months	4	3.8
> 108 to 120 months	6	5.7
> 120 to 132 months	8	7.6
> 132 to 144 months	3	2.9
Total	105	100.0

As seen in Tab. 13, services users of 12 to 24 months are the most numerous group. Long-term services users (> 108 months) are also remarkably prevalent and constitute 16.2% of the study population.

Programme quality assessment

One of the objectives of this study was to explore participants' subjective opinions about the programme and professionals providing services. Data regarding patients' gains resulting from home care services use are presented in Tab. 14.

Table 14. What are your gains from home care services use?

	N	%
Help in everyday life	34	33.3
Talks with a therapist	30	29.6
Sense of safety	12	11.8
Better wellbeing	8	7.8
Support in treatment process	4	3.9
Overcoming the loneliness	4	3.9
Support in difficult situations	3	2.9
Support in family contacts	3	2.9
No gains	4	3.9
Total	102	100.0

Help in everyday functioning was the most frequently mentioned gain (33.3% of the participants). The second most common gain was a possibility of interpersonal contact with a therapist (29.6%). Only 4 persons reported no gains from the services use.

Tab. 15 presents data regarding the opinions on specific aspects of the home care services programme. Participants' subjective assessment of the services was generally highly positive. "Readiness for action in emergency situations" as well as "care you receive" obtained the highest scores (34.3% and 32.4% respectively). Table 15 – *next page.*

Participants' opinions of the therapists' qualities are summarised in Tab. 16. Similarly to the evaluation of the programme, the subjective assessments are also very positive. "Manners and kindness" received the highest scores (63.8% of the participants), followed by "discretion and respect" (55.2%). Table 16 – *next page.*

DISCUSSION

The current study is the first attempt of comprehensive assessment of the population of the home care services users in Poland. 105 mentally ill persons participating in the programme were included in the study. Various characteristics of the study population were assessed: sociodemographic variables, course of illness, current mental health status and participants' opinions on the programme. No significant differences were found in regard with gender. The mean age was 52 and the study population may be consid-

Table 15. Assessment of the home care services programme

	Very poor		Poor		Neither poor nor bad		Good		Very good	
	N	%	N	%	N	%	N	%	N	%
Effectiveness in helping to cope with problems	0	0.0	0	0.0	15	14.3	61	58.1	29	27.6
Effectiveness in helping to maintain good wellbeing	1	1.0	0	0.0	26	24.8	50	47.8	28	26.7
Readiness for action in emergency situations	0	0.0	0	0.0	21	20.0	48	45.7	36	34.3
Care you receive	0	0.0	0	0.0	11	10.5	60	57.1	34	32.4
Help in the enhancement of family relationships	0	0.0	2	1.9	40	38.1	50	47.6	12	11.4
Amount of time provided	1	1.0	2	1.9	16	15.2	56	53.3	30	28.6
Effectiveness in helping to enhance self-management	1	1.0	2	1.9	20	19.0	58	55.2	24	22.9

Table 16. Participants' assessments of the therapists' characteristics

	Very poor		Poor		Neither poor nor bad		Good		Very good	
	N	%	N	%	N	%	N	%	N	%
Competences	1	1.0	4	3.8	0	0.0	44	41.9	56	53.3
Ability to listen and understand the problems	0	0.0	0	0.0	0	0.0	40	38.1	54	51.4
Manners and kindness	1	1.0	0	0.0	3	2.9	34	32.4	67	63.8
Discretion and respect	1	1.0	0	0.0	2	1.9	44	41.9	58	55.2
Accuracy and reliability	0	0.0	0	0.0	6	5.7	47	44.8	52	49.5
Ability to cooperate with other professionals within the support system	0	0.0	0	0.0	26	24.8	60	57.1	19	18.1

ered to be relatively young as over 20% of the respondents were 40 years old or younger. Majority of the participants had secondary or higher education. It is worth noting that only 11% of patients were married and the rest of the study population was single.

Majority of the respondents was not employed, 87% received pension or regular benefit. The most prevalent diagnosis in the study group was paranoid schizophrenia. Mean duration of illness was rather long – 22 years. The participants had an average of 7 inpatient hospitalisations. Summarising the above data, it can be concluded that population under study consisted of relatively young, single persons whose illness duration was long, who had number of hospitalisations and who depended on social benefits.

It should be underlined that 97% of the participants are currently under psychiatric care and intakes prescribed medicines on regular bases. This may be related to the participation in home care services programme, whose one of the priority is to support treatment process. It seems to be especially important in terms of lack of insight in the illness and reluctance to comply with maintaining treatment, which is often demonstrated by the patients in the course of chronic mental disorders. The low number of hospitalisations in last 12 months prior to the interview also indicates the effectiveness of activities whose aim is to support treatment process and protect the patients against health crisis resulting in hospitalisation [22, 23].

The above findings are supported by the results of the mental health assessment conducted during the study. Both the average score on the GAS scale and distribution of the scores in ranges indicate a good current mental state which al-

lows proper functioning (The mean score was 60.92); only 20% of the respondents present with considerable symptoms of mental disorders that require treatment or significantly impair functioning. The latter result shows that rehabilitation of this kind can be effective even in case of persons with serious deficits in social functioning. It focuses on individual and personal contact with a patient through whom new skills are being learnt and those so far acquired are strengthened. This rehabilitation also helps to initiate the complex processes of social modelling which, according to the research findings, may contribute to observed, positive changes regarding compliance and care of health in terms of everyday functioning of mentally ill person [24].

The average time of participation in the home care services programme was almost 60 months. Comparing to the experiences of support systems in other countries, this is relatively long period of time [25]. This information indirectly suggests that mentally ill persons are eager to use the services. If they do not accept the continuation of care, the services are terminated. Study population included also long- term services users (20%) who had participated in the programme for over 96 months. It can be concluded that therapists' visits became a constant component of their lives.

As far as data regarding implementation of home care services is concerned, it seems that number of monthly hours of services provided is definitely too low. In this study group it was 15.5 monthly hour on average. Highest percentage of the participants received 15 to 20 hours of care. Less than 10 monthly hours of services were provided for as many as 12 persons (11.4%), which should lead to reflection on the effectiveness of such short time of work of a therapist. However, the therapeutic tasks were realised by the professional and experienced team whose actions were not only effective, but could also accelerate the rehabilitation process. It is also important that thanks to systematic rehabilitation at patient's home, there was no need to undertake additional tasks to adapt skills acquired in artificial conditions created by a hospital stay, to everyday use in natural environment [26].

It seems indispensable that home care services are provided by interdisciplinary teams. It creates a possibility to prepare an individually tailored offer and differentiate the activities accordingly to patients' needs. Three occupations constitute primary personnel: psychiatric nurse (in case of 29% of the participants), psychologist (21%) and social worker (21%). In limited number of cases it was necessary to create teams including different professionals to work with specific patients (e.g. "psychologist and nurse" or"social worker and psychologist"), which correspond with best world standards [27].

Participants also evaluated usefulness of the programme. Subjective assessments of both the services and the therapists were generally highly positive.

According to the respondents, the most important gains from the participation in home care services included help in everyday functioning (31% of the participants) and possibility to talk to a therapist (28%). More than 11% of the study group underlined positive influence of the services use on their sense of safety. These opinions are not surprising, especially in the light of data discussed above. Therapists provide support in overcoming everyday difficulties as even insignificant obstacles may become major issues for persons who generally do not cope well with life due to their chronic illness. As the analyses of support systems reveals, the patients keep regular contact with very limited number of persons. For this reason, a possibility of frequent talk with a therapist is especially valuable and stimulates an increase in sense of safety. In other studies these categories are considered as crucial in terms of participants' support programmes evaluation [28, 29].

The respondents' assessment of specific programme's components was highly positive. This is consistent with earlier findings and constitutes the evidence that the programme is important for its participants and that they gain a lot from the services use. The respondents especially appreciated "care they receive", "help in coping with problems" and "amount of time provided". "Help in the enhancement of family relationships" received worse assessments. Family relationships seem to be difficult for the patients and require intensive therapeutic support.

The opinion of the therapists' work was also highly positive basically in all aspects. It is worth noting that the participants especially appreciated therapists' "manners and kindness" as well as

"discretion and respect". The assessments were made by the patients who had extensive experience in psychiatric care use, both inpatient and outpatient. It can be concluded that the specificity of the home care services programme (work at patient's home) and the specificity of the population under programme (chronic illness combined with significant deficits in functioning) require acceptance and partnership between patients and therapists. This therapeutic attitude helps to meet patients' most important interpersonal needs, such as contact with kind people as well as people who can provide support through the distanced care and who do not threaten the patients with excessive closeness [30]. The findings of the current study show how important for the patients are the therapists providing home care services and also how important they are for the individual support systems. Their work is conducted in specific conditions including close individual contact, significant emotional burden and no support which is usually provided by base facility. It seems obvious that these professionals should be provided with supervision as well as possibility to attend support groups which would help in improving both their qualifications and skills of managing the difficult situations. The team realising services within "Pomost" association is attending supervision sessions on regular bases. The meetings are conducted by experienced psychiatrist, a specialist in community therapy.

Participation in home care services programmes is a real support for the mentally ill persons. In case of lonely patients support provided by therapists is a new quality in their lives. Therapists help to meet economic, social and emotional needs of the participants and at the same time improve patients' quality of life. We assume that long- term changes may concern overall life satisfaction, physical health enhancement as well as health hazards counteracting.

On the basis of the current findings, it can be concluded that:

1. Home care services users constitute a distinguishable group which presents considerable deficits in social functioning, serious difficulties in isolation overcoming as well as exceptionally few and weak social support systems. It can be stated that participants' recruitment in the study is adequately conducted and includes persons in especially difficult situation.

2. The programme of home care services is effective mainly due to the strengthening of the individual support systems. The participants accept the programme and assess it positively.

3. Regarding the specificity of the work, the personnel providing home care services should have access to supervision and support groups.

4. Home care services are an effective tool for supporting the chronically mentally ill persons. The availability of the services should be increased and their qualities should be disseminated among stakeholders engaged in treatment, support and rehabilitation of mentally ill persons.

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