CHATHAM KENT HEALTH ALLIANCE
INPATIENT MENTAL HEALTH

“RECOVERY SUPPORT”
INPATIENT REHABILITATION
PROGRAM

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PRESENTATION OUTLINE

- Why did we change?
- What were the needs?
- Our goal
- Why a recovery approach?
- The program objectives
- What the program looks like
- Preliminary findings
- Next steps & Lessons learned
WHY CHANGE?

- Although the importance of general hospital psychiatric units has been recognized as an integral component of service delivery to the mentally ill, there is growing awareness of the need to rethink key functions and mechanisms, or reconsider models to better link facility and community based care (Standing Senate Committee on Social Affairs, Science and Technology, 2004; Glick, Sharfstein & Schwartz, 2011)
WHY CHANGE?

- The shift to a recovery framework as recommended by the first Canadian Strategy on Mental Health, *Changing Directions, Changing Lives* (2012) requires an expansion of services to include recovery based plans and a focus on community inclusion.
A2 NEEDS

- Lack of co-ordination and no consistency with offering inpatient programs
- Patient satisfaction is low. Complaints of boredom
- No formal means of family support or education
- Length of stay is long for complex cases
NEEDS ASSESSMENT SURVEY

- Inpatient Staff and Community Providers Identified the following barriers for patients:
  - Lack of knowledge about community services
  - The transition from hospital to community
  - Patients not retaining information from hospital
  - Lack of communication and respect between community providers and hospital staff
NEEDS ASSESSMENT SURVEY

- **Barriers**
  - Housing
  - Poverty
  - Lack of community and family support/acceptance
  - Lack of patients belief in their own ability to recover
  - Skill deficits
  - Discharge process is problematic
COMMUNITY TRANSITION-RESEARCH

- Community providers and inpatient staff both indicate the discharge and transition period to be problematic
- Period following discharge is stressful
  - Characterized by loneliness, fear of relapse and lack of support (Nolan, Bradley & Brimblecomb, 2011; Durbin, Line, Layne & Teed, 2007).
  - 30 day period immediately after discharge is period of high risk (Durbin et al., 2007).
COMMUNITY TRANSITION- THE RESEARCH 2

- **Risk of Suicide**
  - 43% of suicides occur within 3 months of discharge, with a heightened risk period in the first 5 days following discharge (Harkavy-Friedman *et al.* 1999).
  - The risk of suicide peaks immediately after discharge and is particularly high with those having a short admission (Qin & Nordentoft, 2005).
“I went from a controlled environment and then it felt like I was thrown to the wolves. There is just not enough follow up.”

Former patient
OUR GOAL

- Implement a rehabilitation program based on the principles of recovery that facilitates improved transitions for patients and promotes community integration.

And

- Provide the tools to foster patient self management
WHY A RECOVERY APPROACH?

- Opportunity to introduce patients to recovery at time of crisis
- Not discipline specific
- Consistent with patient-centred care
- Empowering to our patients
- Holistic approach to care
- Evidence based practice
- Transitions well to community approach
- Promotes community inclusion
THE BENEFITS OF INPATIENT REHABILITATION

- Offering inpatient rehabilitation services in conjunction with treatment
  - a more holistic approach
  - increases the supports that patients receive at a critical time
  - maximizing their opportunities for recovery.
- Rehabilitation programs focused on community re-entry have demonstrated positive results including improvement in symptoms, social recovery and follow through with after care (Kopelowicz, Wallace & Zarate, 1998; Mann, et al., 1993; Kopelowicz & Liberman, 2002)
PROGRAM OBJECTIVES

- Providing holistic individualized assessment and comprehensive inpatient groups that are recovery focused and facilitate community re-entry.

- Partnering with service providers to achieve continuity of care through post discharge goal planning, conferencing, and transitional discharge services that provide enhanced supports at discharge.
Providing patients with tools such as recovery binders, and wellness kits to assist in the patient’s ability to self manage their illness.

To connect rather than simply refer patients to community resources during their stay in hospital to increase the likelihood of follow though after discharge.

To provide a climate of hope and recovery for inpatients to foster their belief in their own abilities.
To provide support to families by providing educational manuals and support with social work

To provide community follow up 3 months after discharge to encourage patient accountability of discharge goals and to provide an evaluation of program needs
THE INPATIENT REHAB PROGRAM
Psycho-educational Groups

- Recovery and Hope
- Self Management
  - Relapse Prevention & Crisis Planning
  - Coping, Relaxation
  - Problem Solving
  - Wellness education
  - Mind & Mood connection
  - Medication and its role in recovery
  - Substance use
Psycho educational groups

- Leisure planning
- Social Skills
- Spirituality, Self Esteem, Self Identity
Psycho-educational Groups

- **Health & Self Care**
  - Smoking cessation (+ individual coaching)
  - Diet & Nutrition
  - Exercise
  - Sleep Hygiene

- **Lifeskills**
  - Budgeting
  - Cooking
  - Decision making
INPATIENT REHAB PROGRAM

ADDITIONAL INTERVENTIONS

- Family Support & Education
- Individualized Strengths based assessments
- Transitional Support Program
- Connections to Community Resources
- 3 month follow up
INPATIENT REHAB PROGRAM

OTHER INTERVENTIONS CONT’D

- Individual skills teaching and counselling
- Referrals to & Discharge conferences with community service providers
- Recovery binders and Wellness tools
- Peer recovery Stories
PRELIMINARY FINDINGS

- Improvement in Recovery Star Assessment by patient at 3 month follow up

Completed both N=24

12.5% mean increase

mean # domains improved = 6.25
“For me this was very good to see it on paper- it connects with my brain. All the things seem abstract but Recovery Star makes it more tangible and visual and easier to measure”

“This showed my progress. Without doing this I would not have sat down and thought about this.”
PRELIMINARY FINDINGS

PATIENT DISCHARGE GOALS

- 83% Achieved discharge goal
- 100% Partially achieved
TRANSITIONAL SUPPORT

- Started in May 2012
  - 20 patients referred in 2012.
  - All followed thru with service & attended outpatient appts
  - No readmits during transition period
OTHER FINDINGS

NRC PICKER
- Improvement in patient satisfaction
  - Mean 95% = 6% increase
- Were You Given Reassurance and Support About Your Ability to Recover? 16% increase

SMOKING CESSATION
- 5 referrals to smoker’s helpline referral program
- 2 followed through and 1 quit smoking
- 1 referral at 3 month follow up
- Informal feedback from FHT’s
“The “classes” (as I like to call them) taught me more during my stay than I have received in the past 20 years.”

“..Also, the Recovery Binder was a very welcome tool. I appreciated being able to constructively organize all the handouts for future reference when I was home. It helped greatly to organize my thoughts. I had never done anything like this before.”
NEXT STEPS

- Nursing staff training in Recovery
- Formation of a Recovery leadership committee to guide Recovery process on the unit
- Increased peer role - volunteer, recovery story
- Explore ways to further meet needs of concurrent patients & other hard to serve
- Research - quantitative pre-post with 3 recovery measures
Lessons Learned

- Biomedical model can be moved to a recovery model - it is work
- Acute care is the perfect place to start an introduction to recovery
- Need a physician to champion it as well
- Staff attitude can be affected by seeing the positive results of the program.
ANY QUESTIONS?

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References


