**14.3.3 from the full Interim Report: Community-based alternatives**

Many people living with mental illness and their families and carers prefer to be treated in their home or in a community residential facility because it is less disruptive, more familiar and less stigmatising. For many people, a hospital-based setting can be intimidating and upsetting. In the past, crisis assessment and treatment teams and mobile treatment and support teams provided more community outreach and comprehensive home treatment to people needing acute mental health care. The evidence suggests the quality of care provided was good and that people living with mental illness often preferred this approach. Many organisations have called for more community-based acute treatment options and cited the benefits of the model:

'Assertive outreach to my mind has been the best model of practice so far that I've seen that supports the most vulnerable people in community. There should be 'hospital in the home' mental health support programs for acute conditions that provide 24/7 nursing on call, daily doctor visits, delivered meals and cleaning. This intervention would support people to stay at home and involve their family and natural supports while they recover. At scale it would be cheaper than hospital.'

Underfunding has meant that most of these services have been dismantled and merged with case management, and acute treatment has retreated into the hospitals. Reviews of acute home-based treatment show that, compared with inpatient units, it has comparable, and often better, recovery outcomes for people living with mental illness and has high satisfaction rates. It has also been found to be more cost-effective than conventional inpatient care. The general health portfolio has an established Hospital in the Home program that provides acute care to general health patients in their own homes. A 2009 review of the service found it to be effective and highly valued by staff and patients.63 In 2019 Tasmania expanded this service to include mental health treatment, in recognition of people's preference for being treated in the community.

Some of the funding for additional beds should be directed to establishing multidisciplinary teams that provide comprehensive acute clinical and therapeutic treatment and care to people living with mental illness in their own home or place of residence. The service should have five important characteristics:

- It is a genuine alternative to an inpatient stay, yet the person is still regarded as a hospital inpatient and remains under the care of the hospital.
- The person is assessed as requiring the equivalent to an inpatient admission.
- Active clinical and therapeutic treatment, care and support are provided along with high-intensity engagement with the person with mental illness and their family and carers.
- Clinical support is available 24 hours a day seven days a week.
- Governance, admission and discharge policies are in keeping with hospital admissions policies, and key performance indicators (including length of stay, percentage of people admitted from the emergency department within eight hours and Health of the Nation Outcome Scale changes) are the same as those for inpatient units.

The home-based acute beds should be counted as part of the area mental health service's overall bed ratio per 100,000 population. A service could choose to establish the home-based model as an interim measure while new physical hospital-based acute beds are being built, or it might opt to substitute some of its total acute bed base for at-home beds in the longer term. Regardless of the approach taken, introduction of the new beds needs to intersect with and complement future long-term service planning.