

Patient and Client Council

Your voice in health and social care

Home Treatment Crisis Response Service

People's experience in Northern Ireland

December 2016

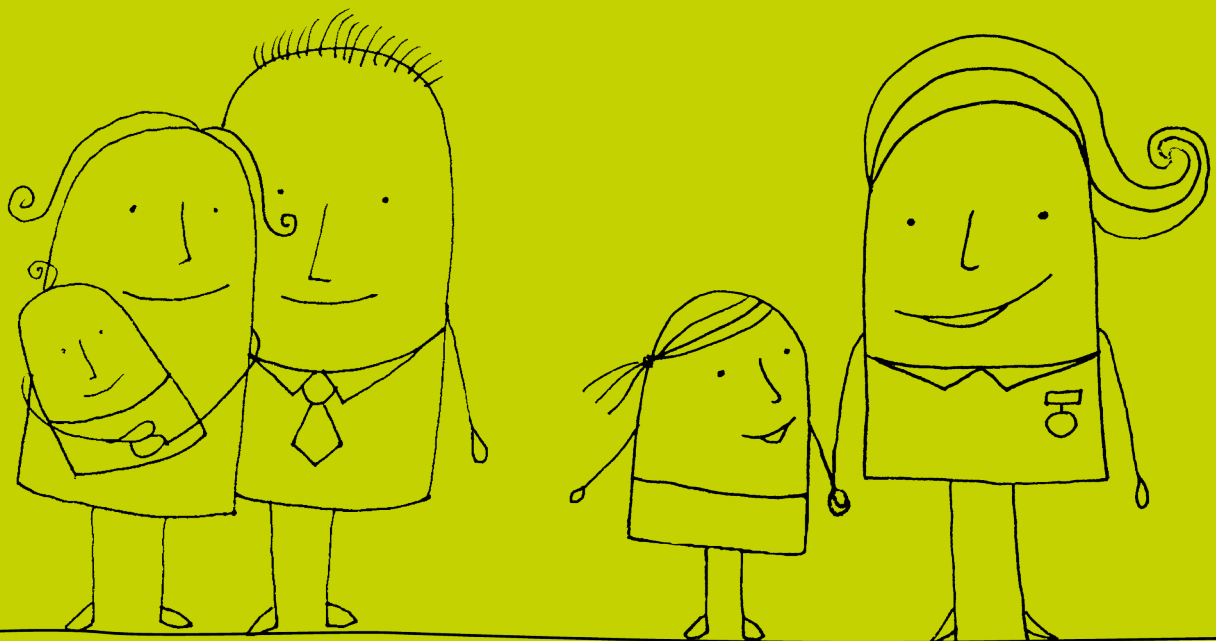


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Executive Summary

Introduction

In the 2015/16 Business Plan of the Patient and Client Council, an objective was included to “seek to understand the experience of service users accessing mental health acute services (Objective 1.9)”. The project evolved from the Bamford Monitoring Group three year action plan which outlined that the experience of mental health acute services needed to be understood and further evidence from the Patient and Client Council Complaints Support Service identifying mental health as a consistent speciality of complaint.

Given that mental health acute services comprise a number of components a decision was taken to refine the project to exploring people’s views on the Home Treatment Crisis Response Service. Home Treatment Crisis Response is a relatively new aspect of mental health acute services in moving treatment and support towards a community model. Home Treatment Crisis Response provides assessment and treatment to people who are experiencing a mental health emergency of a nature or severity that would otherwise require admission to hospital.

What we did

Six discussion groups were held with 37 participants including: service users; family members/friends of service users; and, mental health service providers from the Trusts and the voluntary sector to explore participants experience of Mental Health Home Treatment Crisis Response services. These discussion groups were based on the principles of the dialogue approach recognising that everyone in the meeting is understood to be bringing their own expertise to the conversation so that all can gain from each other.

What we found

Engaging service users, family members/friends of service users, voluntary sector staff and mental health service providers in shared discussion successfully provided opportunities for: sharing experiences; identifying positive aspects and outcomes of Home Treatment Crisis Response; and, suggesting learning to be taken forward.

Learning points that were identified included:

- ▶ **Learning point 1:** There appears to be a level of confusion around how the Home Treatment Crisis Response Service can be accessed and by whom. Participants in this study agreed that there needs to be significant awareness raising of mental health services to promote and improve access for those who are eligible.
- ▶ **Learning point 2:** Service users and carers were able to describe to service providers how a lack of continuity in staff can be a source of tension in a time of crisis and can affect their ability to develop relationships with staff.

- ▶ **Learning point 3:** There was scepticism from service users and carers regarding whether the necessary level of input could be achieved in brief visits from the Home Treatment Crisis Response team. Service users and carers wished for service providers to be upfront with patients about what level of input could be expected.

- ▶ **Learning point 4:** Within discussions there was a consensus that the inpatient setting still plays an important role in mental health services. Participants agreed with the need to avoid a situation where patients are being treated at home inappropriately.

- ▶ **Learning point 5:** Service users and carers felt that service providers needed to ensure that they could identify the significant role played by carers and have processes in place to access additional support mechanisms. There was also a strong feeling from service users and carers that the issue of confidentiality should not be used inappropriately to exclude carers.

- ▶ **Learning point 6:** All groups acknowledged within discussions that Home Treatment Crisis Response was not, neither was it intended to be, a “one stop shop” to deal with people with a mental health condition. In particular, it was highlighted that there needed to be better processes put in place to support service users after their discharge from Home Treatment Crisis Response.

Trust staff who participated in this project acknowledged that the Mental Health Home Treatment Crisis Response service is not fully developed and that further progress was required. However, the findings of this study would suggest that change is needed urgently to ensure an integrated approach to mental health crisis as it would appear that the current service does not meet the needs of individuals. Although we recognise that this was a small study it is an initial step in identifying the changes which service users and carers believe are necessary and a number of recommendations have been made on the basis of the learning points identified which it is hoped can guide future service development.

1.0 Introduction

Acute mental health services have been defined as the treatment and support provided to people who are either experiencing, at risk of, or recovering from a mental health crisis. This could include inpatient care on acute psychiatric wards, care in the community by a Home Treatment Crisis Response Team and care in acute day services or in crisis/recovery houses.¹

A shift in mental health acute services from inpatient care to a community model of service delivery has been influenced by recommendations from the Bamford Review² and reports such as Transforming Your Care.³

In Northern Ireland, the Guidelines and Audit Implementation Network (GAIN) conducted a regional audit⁴ of the experience of users and carers within mental health services in 2013. The audit found that people valued:

- ▶ Being treated with dignity and respect;
- ▶ Being listened to by professionals; and
- ▶ Having continuity of care.

Further to this, an independent commission into psychiatric care for adults in England 'Old problems, new solutions'¹ was published in February 2016. The commission found that there are major problems both in admissions to psychiatric wards and in providing alternative care and treatment in the community.

1.1 Patient and Client Council Objective

In the 2015/16 Business Plan of the Patient and Client Council, an objective was included to "seek to understand the experience of service users accessing mental health acute services (Objective 1.9)".

The project evolved from the Bamford Monitoring Group three year action plan which outlined that the experience of mental health acute services needed to be understood and further evidence from the Patient and Client Council Complaints Support Service identifying mental health as a consistent specialty of complaint.

Given that mental health acute services comprise a number of components including: acute inpatient care; care in the community by a Home Treatment Crisis Response Team; and, care in acute day services or in crisis/recovery houses; a decision was taken to refine the project to exploring people's views on the Home Treatment Crisis Response Service.

The reason for focusing on Home Treatment Crisis Response is that it is a relatively new aspect of mental health acute services in moving treatment and support towards a community model.

Home Treatment Crisis Response provides assessment and treatment to people who are experiencing a mental health emergency of a nature or severity that would otherwise require admission to hospital. The Home Treatment Crisis Response Service is a team of doctors, nurses, social workers and support workers who help families to ensure that their loved ones receive the support they need and can recover at home.

Health and Social Care (HSC) Trusts within Northern Ireland have undertaken their own review of Home Treatment Crisis Response Services with 89%-95% of their participants (n=51) identifying that they had a very positive experience of the service. However, the Patient and Client Council felt that an independent project exploring people's experience of the service could identify important learning which could be used to ensure the service user and carer voice influences the ongoing development of the service.

2.0 What we did

A triologue approach has been used successfully within the area of mental health by the Mental Health Triologue Network Ireland to engage with a range of stakeholders. The purpose of a triologue meeting is to involve at least the three main groups (service users, family members/friends of service users and mental health service providers) in an open conversation. An important aspect of triologue meetings is that everyone in the meeting is understood to be bringing their own expertise to the conversation so that all can gain from each other. The intention is that this combination of knowledge and expertise provides a unique wealth of collective knowledge that individuals or people from different perspectives would not otherwise be exposed to.⁵

Following discussion it was agreed that using a triologue approach seemed appropriate to meet the objectives of this project. The groups organised as part of this project therefore included service users, family members/friends of service users and mental health service providers. However, the small number of participants precluded a true triologue methodology as triologue groups usually have approximately 30 participants.

A topic guide was used by the facilitator of each group. The guide focused on exploring:

- ▶ Participants' views on what the Home Treatment Crisis Response Service includes/covers;
- ▶ Participants' experience of the service;
- ▶ What participants felt worked well and what doesn't work well in Home Treatment Crisis Response;
- ▶ Participants' views on accessing the service;
- ▶ Whether participants felt there is a good relationship between the staff on the Home Treatment Crisis Response Service and the clients they care for; and
- ▶ In an ideal scenario what participants would want provided/included as part of Home Treatment Crisis Response Service and why.

2.1 Participation in the project

A discussion group was set up in each Trust area. In addition, a second group was held in the Southern Trust area with clients, carers and staff of a mental health organisation from the voluntary sector, and a one-to-one telephone interview was conducted with a service user who was unable to attend a group but wanted to share their views. A number of additional service users had expressed interest in attending groups but did not feel well enough to attend on the day.

The structure of the groups is outlined in **Table 1**.

Table 1: Participants of the discussion groups

	Service user	Carer	Trust service provider	Voluntary sector staff
Belfast Health and Social Care Trust	1 Male 2 Females	1 Male	1	2
Northern Health and Social Care Trust	1 Male 3 Females	2 Males	2	1
South Eastern Health and Social Care Trust	2 Males		1	
Southern Health and Social Care Trust (<i>two groups</i>)	5 Females	1 Male	2	4
Western Health and Social Care Trust	4 Females		*	1
Patient interview	1 Female			
Total	19	4	6	8

* Trust representatives from the WHSCT had agreed to participate in this project but were unable to attend the discussion group after it was initially rescheduled due to difficulties recruiting service users.

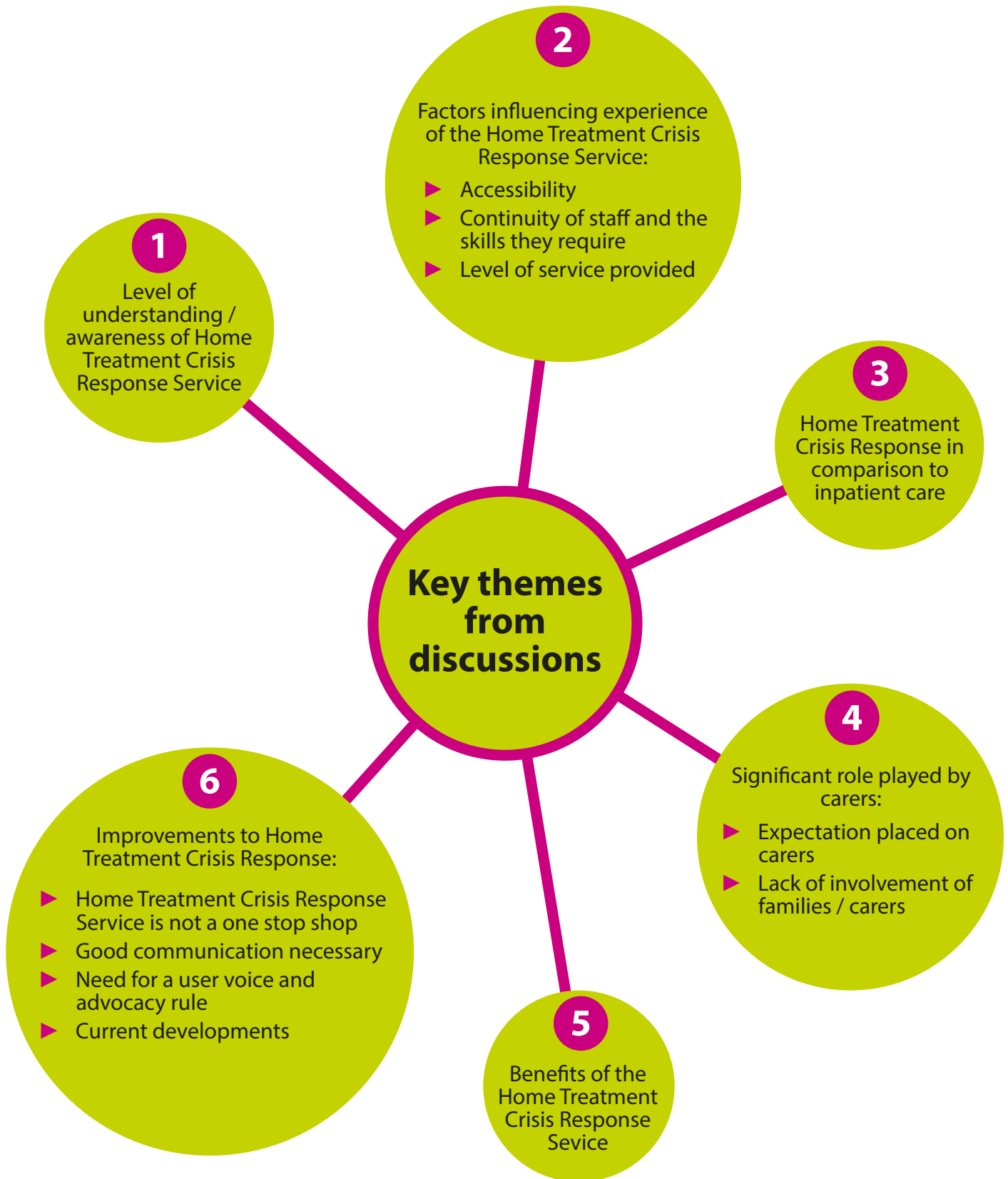
It was anticipated that recruitment of participants to this project would be challenging and therefore an extensive communication plan was devised. The following were the main areas of focus for recruitment:

- ▶ A flyer and poster were developed and shared with relevant organisations in the voluntary sector;
- ▶ Peer advocates were identified within Trusts and contact made to seek their support in recruitment;
- ▶ A targeted social media campaign was conducted;
- ▶ Local press articles were released; and,
- ▶ PPI Officers visited mental health user and carer support groups to make them aware of the project.

Despite this extensive recruitment campaign people who had accessed or were currently accessing the Home Treatment Crisis Response Service and their carers proved a challenging population to engage in the project. In total 37 individuals participated in discussions which was disappointing as greater involvement from service users and carers could have enriched the findings.

The term Home Treatment Crisis Response Service is being used for clarity of reporting in this paper as the names of services are not consistent across Trusts e.g. Crisis Response Home Treatment Team.

3.0 What people told us



1

Level of understanding/awareness of Home Treatment Crisis Response Service

Each group began with a discussion regarding participants' understanding of what the Home Treatment Crisis Response Service entailed. Trust service providers were able to explain at the outset that there was a significant level of variance across Northern Ireland in the service available. Some Trusts were currently offering a 24/7 Home Treatment Crisis Response Service and had plans in place to supplement this service with other acute support such as "recovery teams". In contrast, other Trusts were still developing their Home Treatment Crisis Response Service with the view to becoming 24/7.

Service providers were in agreement that across Trusts the Home Treatment Crisis Response Service formed part of unscheduled care and that for new clients experiencing a mental health crisis, access most commonly came through GPs and emergency departments.

In contrast, service users, carers, and staff from the voluntary sector didn't appear to have the same level of understanding of where the service sat or who was eligible to access Home Treatment Crisis Response. Many service user participants asked questions of service providers regarding the criteria and process for gaining access to Home Treatment Crisis Response and its difference to other community based mental health services/teams.

One Trust had developed a directory of mental health wards and teams including details on what they provided and the service provider felt that the directory may be a useful tool to disseminate to promote greater awareness and understanding of the different mental health services including Home Treatment Crisis Response.

Participants in the group discussions were also asked what they believed the purpose of the Home Treatment Crisis Response Service to be, responses were varied but could be summarised as follows:

- ▶ to facilitate in reach to hospital to expedite admissions/discharge;
- ▶ to avoid hospital admission; to give patients the choice to be treated at home;
- ▶ to provide patients the same rights as a person with a physical health problem to be treated at home with support of family;
- ▶ to provide the opportunity to access the same treatment at home as in the hospital; and,
- ▶ to be a layer of service between Community Mental Health Treatment (CMHT) and acute mental health inpatient facilities.

Service users and carers most commonly identified "avoiding hospital admission" as the purpose of Home Treatment Crisis Response, and the other aspects were highlighted by Trust and voluntary staff.

One service provider explained their belief that Home Treatment Crisis Response sits very much within a "recovery ethos" and that the intention is to:

“... Try to be as tailored and patient centred, as you want to keep people in the heart of their own community and their own family and it is about trying to enhance their own life as opposed to taking things away... it is a very false environment in [inpatient facility], sometimes it is very calm and beneficial and sometimes it is very distressing, depending who the other patients are in with you. And then you feel better in this very nice false environment and then you go home and things fall apart very quickly...”

Service provider

2 Factors influencing service user and carers' experience of the Home Treatment Crisis Response Service

Within this theme three key issues arose:

1. Access to the Home Treatment Crisis Response Service;
2. Continuity of Home Treatment Crisis Response staff and the skills they require; and
3. Level of service provided by the Home Treatment Crisis Response Service.

► Access to the Home Treatment Crisis Response Service

There were conflicting views regarding the ease with which people could access Home Treatment Crisis Response. Service providers explained that in most cases referrals to Home Treatment Crisis Response came from GPs and emergency departments and that there was no option for self-referral/direct access for new clients. One service provider explained the reason for this.

“There are a lot of individuals who turn up to emergency departments who are presenting as acutely unwell in terms of their mental health at the time but it’s a physical cause that’s the issue. That’s why there is often then the physical and medical input that needs to be done in order to access that service. In the community it is a similar situation, the GP has to make that decision and to rule out those issues.”

Service provider

Another service provider explained that while there was no direct access to the Home Treatment Crisis Response Service all referrals made to mental health services receive a full mental health assessment and dependent on the outcome the level of treatment is determined.

Service users and carers on the whole agreed that it would not be feasible for Home Treatment Crisis Response to be direct access but there was a feeling that awareness of the service still needed to be promoted as there are people in crisis who don't know where to turn.

“Direct access even within [service user’s place of residence], they would be bombarded, they would not be able to cope with the demand for the services. There are a lot of people out there who don’t go to services and they are struggling on their own who are sitting in the house and are feeling depressed and don’t know where to go or don’t know what services to access.”

Service user

This point was echoed by a member of staff from the voluntary sector who explained:

“For the people that I work with, because I know the services and how to avail of them, I contact [Trust service provider], or speak to the people that I need to, for those people we can rectify the situation and get them the support that they need. My biggest concern is for those who don’t have those advocates, that support in the community. We need the service to be there for everyone not just for those who know how.”

Voluntary sector staff

A service user participant also explained how patients’ condition can impact their ability to access the service.

“On the occasion about three years ago when I was referred by my psychiatrist, that was only possible because I had sufficient insight not immediately but after about a week, after things deteriorated, I had sufficient insight to contact the psychiatrist, she then referred me to home treatment and they took it from there.”

Service user

There was an acknowledgement from service providers that better links need to be made with other health care providers especially GPs to raise awareness of the Home Treatment Crisis Response Service.

“At the moment with us developing the service I think we need to link better with the GPs to let them know about the developments so once we start increasing our hours of operation and operating over 7 days a week, the GPs will need to know that, because often when someone is in crisis the GP is often the first person involved and if somebody might have to be detained... the GP needs to know that we are available because it could mean not having to detain somebody and also if someone is presenting at the surgery to the GP... if home treatment become involved, they are trying to say well actually we can keep you at home.”

Service provider

People who were known to mental health professionals or who had been seen by the Home Treatment Crisis Response Team previously reported less challenge in being able to contact the service. This was in part because once you were “in the system” many service users received direct contact numbers for the Home Treatment Crisis Response Team. However, there were varying opinions as to how responsive the service was when you made contact.

One service user participant reported that they were “seen immediately on the same day” and was “able to speak to a psychiatrist in a really short period of time”. While a carer reported that their experience was “phoning them [Home Treatment Crisis Response Team] steady to get someone to come out”.

A key issue relating to access was the route of access through emergency departments. Many participants highlighted how emergency departments are not a good environment for anyone experiencing a mental health crisis to have to spend a prolonged period.

“A big part of the problem is when someone is extremely distressed or actively suicidal, having to wait in the waiting room with all of those people, the noise, the lights, the commotion, kids crying, it's too much and they cannot cope. So having to sit for several hours which in most places do, is not appropriate for them.”

Voluntary sector staff

One service provider explained how their service sees large fluctuations in referrals from emergency departments ranging from 30 referrals some weeks to 120 on other which means it is challenging to be responsive at all times. However, they did acknowledge that feedback from service users does highlight that waiting times in emergency departments is a particular issue of concern.

► **Continuity of Home Treatment Crisis Response staff and the skills they require**

There was quite substantial variation in what service users and carers reported with regard to continuity of staff – some saying there was little variation, with the same core team seeing them for the full period they were seen by the Home Treatment Crisis Response Service and others saying there were multiple different staff coming out. The majority of participants had a strong preference that they would be seen by the same staff when receiving treatment and support from the Home Treatment Crisis Response Team. An alternate view was provided by one service user participant who said they valued getting the different perspectives which resulted from being seen by a number of different staff. A high turnover of staff coming into peoples’ homes was viewed by other participants as a potential source of tension for patients at the time of a mental health crisis.

Lack of continuity in staff was a concern for participants who explained that it affected service user and carers’ ability to develop relationships, in particular a sense of trust, with the Home Treatment Crisis Response Team. There was an opinion that building relationships wasn’t straightforward and took time and that people could not open up and discuss issues when they didn’t know or have time to establish a relationship with the staff.

It was important for service user and carer participants’ that they felt staff had all the relevant information which they didn’t believe to be the situation in a number of cases with some participants reporting that they had to repeat their story to staff numerous times. One service user participant explained how they felt the staff of the Home Treatment Crisis Response Team only took into consideration each crisis event in isolation and hadn’t taken time to look holistically into their history; they felt this showed a lack of

preparation by the team. This was echoed by a number of participants who felt that having staff know your background was helpful. Another service user participant explained how the staff member who they had valued the most was the one they had known the longest as they “felt they really understood [service user] a lot better” whereas others only had “superficial understanding” of the individual.

Some service user participants who were known to mental health services described how they had often gotten to know staff while being an inpatient and how those professionals were now working in Home Treatment Crisis Response Teams which gave them a sense that they knew their case.

Having the relevant training such as an insight into a range of mental health conditions was believed to be essential by participants. In one group it was highlighted that service user participants felt there was a particular lack of understanding by staff on how to deal with people with personality disorders.

Overall, it was the approach of staff and their attitude that was indicated as being the most important factor influencing the success of the therapeutic relationship by many participants. A number of service users reported that staff showing a lack of empathy was a barrier to their successful engagement in Home Treatment Crisis Response. Others service users reported that in their experience staff were very sociable, non-judgemental and that they were able to find common ground with staff such as similar interests which helped develop trust between the service user and staff member.

Service providers explained that rota based staffing was necessary to facilitate a 24/7 service and the urgent nature of the workload would always create an element of flux and shift in visiting patterns, however, they explained that it is always the intention of the service to maximise continuity of staff for service users.

► **Level of service provided by the Home Treatment Crisis Response Service**

There was a strong sense from service user, carer and voluntary sector participants that they felt Home Treatment Crisis Response Services across Trusts were under pressure to meet targets and demonstrate success, and that this was impacting on the quality of the service provided. In addition, there was a firm opinion that the volume and nature of paperwork had shaped the service.

Often service users described visits by the Home Treatment Crisis Response Team as brief in nature. Repeatedly participants used the phrase “tick box exercise” to describe their interactions with staff. A number of service user and carer participants questioned what could be achieved in a “five minute” visit and were sceptical about how staff could make a determination on patients’ mental health over a brief period of assessment or intervention, especially when service users were being asked to open up to “complete strangers” in many instances. For one service user they had the view that patients are not being assessed to determine what treatment is needed rather “how far down the road you are”.

For many service users and carers the general consensus was that they did not feel they had received enough support and in many cases they believed this resulted in discharge from the service too early. One service user had reached the situation where they were now refusing to work with the Home Treatment Crisis Response Team due to the brevity of visits but stressed that they did not hold staff responsible as it was their belief that it was not staff as individuals that were the problem rather the service model. A participant from the voluntary sector summarised the issue in the following comment:

"I think that is something we hear time and time again from different people coming in, they [Home Treatment Crisis Response Team] come out for 15 or 20 minutes – 'are you okay at this present moment? Yes. Right well job done, box ticked until we are back tomorrow' or whenever, and that is hard, to put everything in to 15 or 20 minutes is really hard and I know they are working to a schedule and they are under pressure and all of that sort of stuff but it is about finding a balance to make people feel they are being listened to and make a connection and trying to find a way of bringing that all together."

Voluntary sector staff

Some service users reported that they had turned to the voluntary sector for support as they felt they weren't able to access enough support from the Home Treatment Crisis Response Service.

"I thought home treatment would maybe be that help but it wasn't, because they don't listen and they don't go in to your background they don't talk to you about what you want to tell them... but I can come down here to [voluntary organisation] and I think there was one day I came down here I was like a banshee, screaming and shouting and tears flowing but I was able to get that release which I wasn't with home treatment so that is their biggest failing that they don't connect with you, not properly anyway."

Service user

3 Home Treatment Crisis Response in comparison to inpatient care

While there was discussion surrounding the benefit of Home Treatment Crisis Response in comparison to inpatient care for patients experiencing an acute mental health crisis, there were some advantages highlighted in favour of inpatient treatment. Immediate access to treatment and staff was a key factor which made inpatient care the more suitable option for some patients as described by one service provider:

"On a ward someone could be on constant observation and have a staff member at arm's length when they really need them so there is very much a need for beds."

Service provider

One service user participant highlighted their desire for inpatient care in order to receive "proper" treatment, over and above what could be offered by Home Treatment Crisis Response Team.

"I would like to go into hospital to get proper treatment. At the minute I can see Dr [name] as and when, but I feel I need more."

Service user

Another highlighted how they felt the inpatient setting had offered them an escape which helped them to improve.

"I think with me when I did start the [medication] I was really unwell and being in as an inpatient was like a transition it was like an escape and in that sense I think it was quite good."

Service user

Service providers did acknowledge that the inpatient setting "gives a sense of containment and safety for people" especially for those patients who do not have the necessary level of support available at home.

The preference for some service users for inpatient treatment appeared to reinforce their view of the Home Treatment Crisis Response Service as "Gatekeepers" to inpatient beds. There was an opinion from some service users and carers that the Home Treatment Crisis Response Team "try and keep you away from the hospital" and made patients feel as though they were "wasting beds". One carer explained:

"You sort of feel from them, they basically say that they don't have beds and they are weighing up how serious you are before they make any decision to go any further with you and they are sort of taking a gamble with people."

Carer

While one voluntary sector participant agreed with the principle of Home Treatment Crisis Response and seen the benefit of the service they had the perception that in some cases it can turn in to "holding people in their homes".

Service providers explained that there is a challenge in managing inpatient beds as they are limited; hence Home Treatment Crisis Response Teams need to work from criteria for admission to ensure there are beds available when patients need them. The feeling was that at times it comes down to managing the expectations of patients.

"If people already have it in mind, 'no I want to go in to hospital', it's hard to change that, so there is a lot of education to change that because once somebody has that idea that they are getting a bed they hold on to it... but it's the pros and cons and having a full picture and being able to make an informed decision."

Service provider

4 Significant role played by carers

This was perhaps the strongest theme which came from the discussions on Home Treatment Crisis Response. It was the opinion of all participants that carers play a substantial role in supporting people experiencing an acute mental health issue and that expectations made of them in this role can be significant.

► Expectation placed on carers

There was an overwhelming consensus that for people to be treated successfully by the Home Treatment Crisis Response Service, patients and staff are often reliant on the support system carers provide. It was explained that in many cases where this support is not available there would be no other option left than admission to an inpatient facility.

For some participants they believed that role was too much pressure to put on families.

"They put all the pressure on your family because they have to take care of you and how does someone look after somebody 24/7, it doesn't work. It is too much for a family to take that on 24/7."

Service user

It was also highlighted that while a patient may have decided in conjunction with the Home Treatment Crisis Response Team that they will be treated at home the full impact on the family is not always considered nor is the extra support they may require.

"...I do think that from a carers perspective that there is a lot of strain on the family even though they [patient] are being seen by the home treatment team there is a lot of strain on the family because the family is there 24/7, the person may decide that they are getting treated at home but the family are still there and they are not getting a break so you know they need that extra support."

Carer

One service provider explained that when staff don't take into account the support required by carers patients sometimes end up in a situation where they can no longer be treated at home.

“...Sometimes the reason why people have to come into hospital is because their journey, they have gone so far in their journey and their loved ones are exhausted and they are the ones that are actually suffering. And sometimes it is not reasonable for people to be able to stay at home, but they need to actually go away to allow their family to recover so they are better placed to support the recovery. And I think that is the thing that I try to encourage the home treatment team to see is a balance and where it works well it works really well but where it works badly it can be damaging. For not just the one person but the family unit.”

Service provider

The unique situation of patients residing in refuges/sheltered accommodation was discussed at one group and it was highlighted that Home Treatment Crisis Response Teams have to give special consideration to these patients as it can't be assumed that staff in those organisations can provide the suitable level of care.

“There is an expectation that because they are coming in to a refuge with 24 hour care that they will be somewhat looked after, and I think that sometimes in a case like that we [organisation staff] will have to make an assessment as to how suitable with regards to their mental health is to having a refuge at that time.”

Voluntary sector staff

► **Lack of involvement of families/carers**

There was a strong feeling from both service users and carers that carers need to be engaged in the process of Home Treatment Crisis Response but that the issue of “confidentiality” was often cited as a barrier to engagement. Many participants believed that staff hid behind the issue of confidentiality rather than trying to find appropriate ways to engage with carers. It was the belief of participants across each group that professionals could share more general information such as: common presentation of the condition; what to look for to signal a patient is deteriorating; and, skills they could use to support the patient without getting into personal details regarding patients' thoughts and beliefs.

“Confidentiality sometimes I have a feeling that staff hide behind that and give very little information to family and that is not good either but I think if the person is consenting that information can be shared about what goes on at appointments that, that is not going in to the fine detail and experience it's about what are they like when they are well? What are the signs that things are breaking down? What are the really concrete things you can do to help because often the family just want to know how to manage.”

Service provider

There was an agreement from participants that the key was about finding the correct balance. One service user gave an example of how important it is to find an appropriate level of engagement that works for all individuals concerned:

"I was still very young when I had my first diagnosis and illnesses so my [parent] came along with me to all meetings with my psychiatrist... [parent] really wanted to fix me you know... whereas it was probably having the opposite effect because I wasn't telling the doctor quite as much stuff because my [parent] was sitting there so it did have a detrimental effect without a doubt."

Service user

A service provider explained that challenges arise when patients explicitly state that they don't want their family/carer involved, but acknowledged that more could be done to encourage patients to see that benefit of engagement.

"Sometimes the difficulty is the individuals when they are in that circumstance you know are very explicit in saying they don't want their family involved and that is extraordinarily frustrating for families but every individual has to be treated in their own right. We don't do a lot of encouragement to say you really ought to have your family here, that's an issue."

Service provider

Carers and those working within the voluntary sector also highlighted how carers are often able to give more detailed/accurate information at times when patients are experiencing an acute mental health crisis.

"I think it is important that they do speak to the family member as well as the person who is not well because they don't always give all the information – you might be walking the floors with them at night and the home treatment team ring in the morning and they [patient] say they are fine."

Voluntary sector staff

One service user commented that knowing their partner was being involved was helpful in their recovery.

"It was because, the word's not comforting but it was helpful to me to know that they were including my [partner], that would be something that I would criticize, that in my outpatients appointments in years gone by never ever did they bring my [partner] in to them and I didn't have the wit to bring [partner] along with me and feel that was a vast mistake on their part."

Service user

An important consideration was highlighted in one group by staff from the voluntary sector who highlighted that the assumption can't always be made that family members or carers are working in the patients best interest and that the extent to which families/carers are engaged by the Home Treatment Crisis Response Team in a patients care should be carefully assessed on an individual basis.

"In terms of carers and that communication . . . we have had cases where carers have been abusers and that can be very difficult and we have had several cases where the carer has been saying, well [patient] is doing this and doing that and really has got worse and they need to go into hospital and you have a [patient] who is starting to believe they really are worse than they are."

Voluntary sector staff

5 Benefits of the Home Treatment Crisis Response Service

There were numerous benefits that service users and carers associated with the Home Treatment Crisis Response Service. A number of service users described negative experiences of inpatient treatment and were thankful that the Home Treatment Crisis Response Service enabled them to avoid admission to hospital.

"The main thing was I avoided hospital admission which I had in the past, was quite traumatic, that was a major bonus not going in to hospital."

Service user

"...On the whole I saw them in the positive light. I was terrified that I was going to be sent back in to hospital on a number of times and I said that but the team when they arrived they assured me that I was staying in the community and that was good."

Service user

Another service user felt that the Home Treatment Crisis Response Service had developed their confidence to get back into everyday life after having had an inpatient stay.

"In my case they came to me after I had been discharged from hospital, they came to me to help give me that bit of confidence to get back to everyday life."

Service user

Others talked about being able to stay in the home environment with family as a hugely important aspect of the Home Treatment Crisis Response Service.

"It's on your own terms and you can sit around your kitchen table in a safe environment so that's really what it meant to me when I went through it."

Service user

“They came, I was in a bad place and crisis response came out to me every day for a month. And they treated me in the community rather than take me into the hospital and if it wasn’t for them I knew I would have been dead. You know. And they, they just seen me broken and I couldn’t leave the house and they were there, they listened ... Like I have a family and stuff and they tried to work around them... It was my children, so, they were quite young so it was keeping me with my children, you know. And they were very encouraging.”

Service user

Participants also highlighted a positive impact of the Home Treatment Crisis Response Service for families/carers in improving their understanding and helping put their “mind at ease”.

“For me home treatment is helping you so you don’t have to go in to hospital and your family can get involved, it was better for them than it was for me because they could understand it better.”

Service user

While it was discussed above that a number of participants criticised Home Treatment Crisis Response Services for their level of service others highlighted the intensity and continuity of the service as positive aspects in their experience.

“Also what was helpful was the first time I was with them which was my longest time with them... I had a particular key worker who saw me maybe once or twice a week and I was with them about seven weeks that were quite a bit of consistent input there which was very helpful. Also when I was with them last year again I had input from mainly one person over a period of about three/four weeks after I came out of the unit.”

Service user

6 Improvements to Home Treatment Crisis Response

Importantly, within the group discussions participants were able to identify changes that could be made to Home Treatment Crisis Response to continue to improve and develop the service.

► Home Treatment Crisis Response Service is not a one stop shop

Firstly there was an acknowledgement that Home Treatment Crisis Response Services were not a “one stop shop” even in the specific circumstance of an acute mental health crisis. Participants identified the need for Home Treatment Crisis Response Teams to assess what other support services/organisations may be appropriate, such as the need for carers’ assessments.

“We need to look at what other services need to be going in there in terms of maybe support for young carers in terms of maybe their needs, to be helped... in terms of managing things with the children and the dynamics of managing child care and transporting children, all those things, so I think when something like that happens to just go in with home treatment it’s not just enough, particularly in a family unit like that.”

Voluntary sector staff

“Maybe if there was a way of encouraging carers to even get a carers assessment done to arrange extra support that they might need at that time when they are having to deal with that situation and that they could get a bit of respite and get away from the house or whatever.”

Voluntary sector staff

It was also emphasised that there needs to be different layers of service. Participants talked about falling in between services and felt that there was a risk that patients could end up back in the system due to a lack of support after discharge from the Home Treatment Crisis Response Service.

“I know a lot of people at [voluntary organisation] think that the home treatment team and the hospital need something in between maybe for people who are suicidal and maybe need someone in between because there seems to be a difficulty in getting in to hospital sometimes, for families because the family is still under the stress and strain at home so maybe some sort of halfway house.”

Voluntary sector staff

“I have had them twice now in the last 8-10 weeks and maybe if they had come to me a week or two weeks maybe the second crisis wouldn’t have hit.”

Service user

One carer questioned the usefulness of Home Treatment Crisis Response in cases where other sources of mental health treatment/support aren’t already in place and felt these need to be established first.

“Maybe the whole idea of home treatment is back to front. They are giving that to people maybe before they have diagnosed them or helped them where they should get them more access to the help they need even if it is in hospital or seeing a psychiatrist or psychologist or whatever it is on regular basis rather than someone checking them at home to make sure they haven’t hurt themselves.”

Carer

► Good communication necessary

Communication was identified as a key factor influencing people's experience of Home Treatment Crisis Response Services. The need for staff to explain processes and treatments clearly with patients and carers was seen as crucial to ensuring understanding.

Participants explained how poor communication around what level of input could be expected and discharge arrangements resulted in poor experiences.

"I think a lack of communication was probably the main thing. I mean to go from being monitored every half an hour over in the hospital to out to the home treatment team who didn't contact me. And then I was seen twice in the first week and then in the second week I must have said that I felt I needed more support than that, then they said: 'oh we should have explained that it is step-down' so it was very hard."

Service user

Home Treatment Crisis Response Team "asked how I felt. I said 'I feel a bit better' and they said 'right, we will see you tomorrow' and they have not turned up the next day most of the time. I got a discharge letter a few days later in the post and I have a CPN in the community and she phoned down on the Monday and said 'why did you's not turn up' and they said 'we discharged her' but they told me they were coming out on the Sunday which they did not, it happened a few times."

Service user

"They [Home Treatment Crisis Response Team] have discharged me without telling me, and you think 'what have I done wrong? Why are you not helping me? I need your help!"

Service User

Ensuring open communication so that service users and carers have a voice in their treatment was also emphasised.

"I think the frustrating thing is that I don't think there is enough involvement from service users... 9 times out of 10 obviously you say what you need but when it comes to all the professionals sitting there around the table and discussing what is going to happen, what you feel you need never comes in to it. You never get a voice to say well think I need to be in the service for another couple of days or I think I need, acute day care, they don't seem to take on board and obviously at the end of the day you know what you need, and you know where you are it and what is going to help."

Service user

Close relationships between service providers and effective communication pathways were identified by one service provider as a potential way of ensuring patients have a smooth transition through the service.

“We have very close ties between the community mental health team, the inpatient unit that serves that sector, and the home treatment service. That means that we have better communication, we have better interface between services and that people aren’t jumping through hoops in different parts of the system. Hopefully that will help in terms of making that a smooth journey.”

Service provider

Encouragingly, some service providers reported how they were developing their care pathway, part of which was addressing communication through the development of a comprehensive data collection form. The form was for use by teams to promote comprehensive information gathering and to avoid patients and carers having to share the same details with numerous different staff.

“The idea is that when we have that information gathered it will only have to be repeated in terms of updating information . . . the vision is that once you have an assessment that will go on an electronic system that will follow the service user anywhere – all the risk information, all the collateral information from carers, you know all that really important information like phone numbers and then all the clinical presentations, family compositions. It’s something like 18 pages long this assessment so the information that is gathered at that initial contact should in part not have to be repeated much and its then about having systems that will allow us to share that information with others with consent.”

Service provider

One participant from the voluntary sector highlighted that an important consideration in improving communication is ensuring information was accessible for people of all abilities including those with learning difficulties.

“Even something simple as the language and titles, I have worked with people who not only have mental health problems but have learning disability also, in terms of home treatment team and primary care liaison, you know what does that mean, it is alright for us as we have been working and dealing in these systems for years but for someone new to the service it can be quite overwhelming and dumbfound people.”

Voluntary sector staff

► **Need for a user voice and advocacy role**

A number of participants underlined the important role service users and carers can play in understanding and building on successful aspects of the service and how more needed to be made of the user voice in developing services.

"I think often with mental health people move on and maybe come back in to get different things or for psychological health checks, but apart from that they are back living their life which is the right thing to be doing but they have such an amount of information to provide because when someone is at the acute stage they are not able to tell people what help they need, but there is so much learning that can come from people that have come through the service before."

Service provider

However, finding meaningful ways of engaging with service users to discuss mental health services was seen as a challenge.

"I was trying to get people that I knew who had family involved in home treatment to come along as well or get their family, but they were saying no they wouldn't want to because it is such a public thing to come out to and there is still so much stigma and even wider family and even close people in your family still don't know."

Service provider

A number of Trusts conduct service user feedback via questionnaire format but it was acknowledged that alternative means of seeking peoples' opinions on the service need to be devised to maximise potential of a feedback system.

"It's about finding ways through our invitations, through our advocates and meetings and things like that to get as much information back as we can to improve along the way."

Service provider

► **Current developments**

It was clear from the group discussions that Home Treatment Crisis Response and the wider mental health service seem to be in a period of development with most Trusts reporting ongoing service improvements. These were varied and included aspects such as creating additional mental health teams, expanding teams to broaden expertise and recruiting peer workers into teams.

"We've also created a new team called the Recovery Team and again it's going to be a seven day a week service, not 24 hours a day but seven days a week service... We did some analysis and a number of people coming into home treatment because they started experiencing difficulties at the weekend and then had nobody to turn to, so this team which is going to be seven days a week can be directly accessed through the CPN for example they could put a bit more intervention in to try and avoid getting to home treatment, a layer in-between even."

Service provider

"We have peer advocates that work in most of the inpatient wards but they don't have a big role within our community services and that needs looked at and developed more... I think if you actually have somebody on the team that has lived experience and has paid salaried position and is equal within that team, carrying out that role, that will really help people as well. It will help their families because they will really be able to bring in the family and you know be able to say to the family 'look, I actually have a diagnosis but I have a very full and active life now and would see myself in recovery and I know my own signs and I know when things are not good and I have learned how to self-manage!"

Service user

4.0 Conclusion

Engaging service users, family members/friends of service users, voluntary sector staff and mental health service providers in shared discussion successfully provided opportunities for: sharing experiences; identifying positive aspects and outcomes of Home Treatment Crisis Response; and, suggesting learning to be taken forward. This was especially positive as during discussions some service providers reflected on the difficulty they had previously experienced in engaging service users in service improvement. Using the principles of the dialogue approach could be used in future for co-design and co-production of service.

Trust staff who participated in this project acknowledged that the Mental Health Home Treatment Crisis Response service is not fully developed and that further progress was required. However, the findings of this study would suggest that change is needed urgently to ensure an integrated approach to mental health crisis as it would appear that the current service does not meet the needs of individuals. Although we recognise that this was a small study it is an initial step in identifying the changes which service users and carers believe are necessary.

4.1 Learning points and Recommendations

The following learning points were identified through completing this piece of work:

- ▶ **Learning point 1:** There appears to be a level of confusion around how the Home Treatment Crisis Response Service can be accessed and by whom. The discussion between service users, carers and service providers on this topic reflected the complexity of the issue but offered an opportunity for providers to explain certain issues, such as the barriers to self-referral into the service and the need for a triaging system which is currently undertaken by GPs or ED staff. However, service users, carers and voluntary sector staff did not accept that access to the service through ED was acceptable. All groups agreed that there needs to be significant awareness raising of mental health services to promote and improve access for those who are eligible.

Recommendation: There should be consistent accurate information regarding what Home Treatment Crisis Response Services provide, including the eligibility criteria and ways to access the services. This should be made available on HSC online.

Recommendation: There should be alternative methods to improve access to the Home Treatment Crisis Response Services. Service users do not believe it is acceptable that a primary route of access to Home Treatment Crisis Response Services for first time patients is through emergency departments.

- ▶ **Learning point 2:** Service users and carers were able to describe to service providers how a lack of continuity in staff can be a source of tension in a time of crisis and can affect their ability to develop relationships with staff. In particular, the ability to trust staff and to open up and discuss issues was seen as a challenge when being seen by unfamiliar staff members. Service users and carers also felt that a turnover in Home Treatment Crisis Response staff meant staff didn't always have all the relevant information and some also felt that staff didn't always have the necessary understanding of their condition. Service providers acknowledged the issue of continuity in staffing and how this creates inevitable flux and shift but explained that rota based staffing was necessary but that they strive for continuity.

Recommendation: Ensuring staff have the relevant skills, information and understanding, while striving for continuity of staff should be key considerations in Home Treatment Crisis Response team staffing.

- ▶ **Learning point 3:** There was scepticism from service users and carers regarding whether the necessary level of input could be achieved in brief visits from the Home Treatment Crisis Response team which they described as a “tick box exercise”. Voluntary staff also believed there was a need to find a better balance between pressure on service and ensuring clients feel listened too. When reflecting on the level of input from Home Treatment Crisis Response some service users and carers also highlighted that they had experienced issues with regard to the lack of responsiveness of the service. Service users and carers wished for service providers to be upfront with patients about what level of input could be expected.

Recommendation: Home Treatment Crisis Response Services need to obtain a balance between efficiency and a level of input which better meets patients’ expectations.

- ▶ **Learning point 4:** Within discussions there was a consensus that the inpatient setting still plays an important role in mental health services. It was highlighted that inpatient care can offer the advantages of: constant observation and access to staff; more intensive treatment; and, an increased sense of containment and safety for patients. Service users and carers explained how in their opinion Home Treatment Crisis Response staff can gate-keep inappropriately whereas service providers justified their role in managing the expectations of clients regarding getting an inpatient bed. All groups agreed with the need to avoid a situation where patients are being treated at home inappropriately.

Recommendation: Promote better understanding by both professionals and patients of the need to balance the demand on inpatient beds with the support required by patients.

- ▶ **Learning point 5:** The significant expectations made of carers by the Home Treatment Crisis Response Service were discussed by groups. Service users and carers felt that service providers needed to ensure that they could identify when too much responsibility was being placed on carers and have processes in place to access additional support mechanisms, for example, encouraging carers to apply for a carer’s assessment. There was also a strong feeling from service users and carers that the issue of confidentiality should not be used inappropriately to exclude carers. Service providers acknowledged that they needed to find successful ways to engage carers without breaking client confidentiality or negatively impacting their care.

Recommendation: Standards to ensure that carers are engaged, informed and supported in their role of caring for someone who is experiencing an acute mental health crisis should be developed.

- ▶ **Learning point 6:** All groups acknowledged within discussions that Home Treatment Crisis Response was not, neither was it intended to be, a “one stop shop” to deal with people with a mental health condition. In fact it was the belief of some that Home Treatment Crisis Response would never be successful if it was treated as an isolated service for people in a mental health crisis. In particular, it was highlighted that there needed to be better processes put in place to support service users after their discharge from Home Treatment Crisis Response. It was suggested that this support could include aspects such as more intensive follow-up, or admission to a home treatment house. Service

users and carers advised that patients needed to be provided with more information regarding discharge arrangements. Service providers accepted that at times there is confusion in the system or between services which needed to be overcome with better communication pathways.

Recommendation: Patients and carers need to be better informed regarding their discharge arrangements from the Home Treatment Crisis Response Service and what other sources of support are available. If not already available other layers of service need to be developed to ensure that patients receive the necessary level of support and follow-up to prevent future crisis.

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