

Intensive, not intrusive

Our visits and telephone interviews with individuals and carers who have had contact with Intensive Home Treatment Services and the service providers.

Our visits and telephone interviews with individuals and carers who have had contact with Intensive Home Treatment Services and the service providers: October 2011– February 2012.

Who we are

We put individuals with mental illness, learning disability and related conditions at the heart of all we do: promoting their welfare and safeguarding their rights.

There are times when people will have restrictions placed on them to provide care and treatment. When this happens, we make sure it is legal and ethical.

We draw on our knowledge and experience as health and social care staff, service users and carers.

Our Values

Individuals with mental illness, learning disability and related conditions have the same equality and human rights as all other citizens. They have the right to

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health and learning disability care. Sometimes we investigate where something has gone seriously wrong with a person's care.
- We identify and promote good practice in mental health and learning disability services.
- We provide information, advice and guidance to service users, carers and service providers
- We have a strong and influential voice in service and policy development
- We promote best practice in mental health and incapacity law.

OUR VISITS

One of the ways in which the Commission monitors individual care and treatment is through our visits programme. We visit people in a range of settings throughout Scotland: at home, in hospital or in any other setting where care and treatment is being delivered. As part of this programme we carry out a number of national themed visits each year. The aim of national themed visits is to enable us to assess and compare care and treatment for particular groups of people across Scotland. Our aim is to help services learn from good practice and to respond to any issues that we identify.

The following report focuses on the specific theme of Intensive Home Treatment Services. The information provided was gathered from visits and telephone interviews carried out between October 2011 and February 2012. We visited services to meet staff and managers. We visited individuals who used the services and their carers. We interviewed some individuals and carers by telephone.

WHY WE VISITED

For several years now, there has been a move away from hospital-based care and treatment for people with mental illness, learning disability and related conditions. Many more people now receive care and treatment in the community. The Commission need to remain accessible and continue to have optimum contact with individuals and their families and carers. We are working to increase our contacts with people receiving community based services.

Intensive home treatment is an alternative to hospital admission. Studies have shown that many individuals find it preferable to hospital care¹². MIND published a helpful report and raised issues about responding to mental health crises³ such as commissioning services to meet people's needs rather than to meet service needs and giving people choice and control in their crisis supports. In our annual monitoring reports⁴, we highlighted the fall in the use of emergency detention in Scotland and thought it may be due in part to better crisis services, including the availability of intensive home treatment.

In November 2006 the Scottish Executive published *Delivering for Health: Delivering for Mental Health National Standards for Crisis Services*⁵. They then went on in

¹ Gilburd et al (2010). Service users' experiences of residential alternatives to standard acute wards: qualitative study of similarities and differences. *British Journal of Psychiatry* 197: 25-31

² <http://summaries.cochrane.org/CD001087/crisis-intervention-for-people-with-severe-mental-illnesses>

³ Mind (2011). Listening to experience. An independent enquiry into acute and crisis mental health care.

⁴ http://reports.mwscot.org.uk/web/FILES/Publications/Our_Annual_Monitoring_Report_2009-10.pdf

⁵ <http://www.scotland.gov.uk/Publications/2006/11/22094720/0>

Delivering for Mental Health (2006)⁶ the mental health delivery plan for Scotland to make a commitment to more effectively manage and care for people in the community avoiding repeated inappropriate admissions to hospital by achieving the crisis standards.

Each year, we ask stakeholder groups for their views on priorities for our visiting programme. They asked us to consider visiting intensive home treatment services across the country. People were specifically interested to explore the views of people who had received intensive home treatment, as well as their carers. They wanted to know whether or not it appeared to be a good alternative to hospital admission in times of crisis.

The main purpose of our visits was to hear the views of individuals who had received intensive home treatment and their carers. We also tried to look at the different models of service. There are major differences in service provision across Scotland. It is not possible from these visits to compare and contrast different models.

HOW WE CARRIED OUT THE VISITS

From October 2011 to the end of February 2012 we visited or held telephone interviews with service providers, individuals who had used IHT services between 1st June and 31st August 2011 and, where possible, their carers. We visited adult services and child and adolescent mental health services (CAMHS). In total we spoke to 106 individuals, 25 carers and 23 service managers. For the purposes of this document carers are defined as family members living with individuals using services.

We wrote to all NHS Boards in Scotland informing them of our intended visits and asking for information on the service provision in their areas. We then wrote to services asking them to contact individuals and their carers who had contact with them during the specified period to invite them to share their experiences with us. Services provided us with contact details of people who were willing to do this. We are aware that this might not have produced a completely representative sample.

At this time we gave the option of either a visit to carry out the interview face to face or telephone interviews. We offered the telephone option as we were acutely aware of the number of professionals that can be involved in the provision of crisis care, and how intrusive this might have been for the individual.

WHAT WE EXAMINED

We conducted semi-structured interviews with individuals, carers and service providers. In our contact with individuals we focussed on the following areas:

- Perception of contact with a crisis service

⁶ <http://www.scotland.gov.uk/Publications/2006/11/30164829/0>

- Support from the crisis service
- What would make the service contact a better experience

With carers we looked at the following:

- Their perception of contact with services
- Their perception of support received
- Their views on what would make the service contact a better experience

When interviewing service managers we looked at the following:

- Service configuration
- Days and hours of service operation
- Referrals, assessments and treatment delivery
- Impact and evaluation
- Operational difficulties and scope for improvements

In addition, we wanted to find out about continuity of care. We looked into sharing of information within the intensive home treatment teams and procedures for follow-on care after the IHTT withdraws.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

OVERALL FINDINGS

In general, we formed an overwhelmingly positive view of intensive home treatment. Individuals who had received this service praised its benefit and felt the level of support was about right. Most of the carers we met were also generally positive about the service. Also, we were impressed with the energy and enthusiasm of service managers and staff.

There is no overall consistent model of intensive home treatment across Scotland. There are differences in geography, population distribution and other models of mental health service provision. While it is unrealistic to expect a “one size fits all” model for intensive home treatment, NHS Boards should ensure that they have services to assess and support people at home during times of mental health crises.

The clearest message from this report is that intensive home treatment is highly valued by the vast majority of people who we interviewed. We have developed a

number of key messages and recommendations to help to develop further this model of service.

Most services had collected data which demonstrated a reduction in the use of in-patient beds. Many reported that there had been fewer admissions. The availability of intensive home treatment also resulted in shorter spells in hospital where admission had been necessary.

Summary of key messages and recommendations:

Key messages

- 1. It is important to monitor the uptake and impact of intensive home treatment. From the information we collected about service provision, we are not satisfied that intensive home treatment is equally available to all. Not all NHS Boards appear to offer this service. Men and people over 65 may have less access to intensive home treatment.**
- 2. The vast majority of people and their carers interviewed told us they valued the service they received and were especially pleased regarding the accessibility and speed of the intervention provided.**
- 3. People told us they were generally satisfied with the level of support offered to themselves and their carers. There was a general view that contact with IHTTs helped avoid or shorten hospital admission. Some individuals raised the feeling that their views were not being heard.**
- 4. Individuals appreciate consistency of IHT staff and sometimes found it difficult when different staff visited. Good information on who would visit and when they would visit was viewed as helpful.**
- 5. An important part of offering intensive home care is the inclusion of carers in the process. Carers told us they generally felt involved and part of care and forward planning. A minority felt they had insufficient opportunity to discuss their concerns.**
- 6. Information was generally passed on well within teams, but there is a need to make sure that individuals and carers know what happens to their personal information**
- 7. We were pleased to see that discharges from the team are generally handled well. However, not all individuals had plans in place in the event of possible future crises.**

Recommendations

- NHS Boards should monitor the uptake of intensive home treatment to ensure equality of access across all groups.**
- NHS Boards should continue to evaluate these services, paying particular attention to the views of those who receive services and their carers.**

- The Scottish Government should review standards for crisis services to provide the maximum level of consistency and equality of access.
- Service providers should ensure that individuals and their carers are given the opportunity to voice their concerns and feel listened to in a meaningful way during contact with IHT services.
- IHT services should address the issue of hospital admission when giving information to individuals and carers. This should provide assurance that admission is still available if necessary and should be regarded as an important step towards recovery and not “failure.”
- IHT services should ensure that individuals and carers know who will visit and provide explanations as to why it will not always be the same staff who visit.
- Service providers should not underestimate the importance of including the views of carers when engaged in service delivery. They should endeavour to include carers in the delivery and future planning of service provision, taking on board their needs as well as those of the individual being cared for whilst observing appropriate use of confidentiality as per our “Carers and Confidentiality” guidance.
- IHT services should have policies and procedures to make sure that all team members visiting individuals have all relevant information and do not have to ask individuals to repeatedly give the same information to different practitioners.
- It is good practice to give written information about the IHT service at first contact. IHT services should, as part of this, tell individuals and carers that information will be shared within the team. They should offer opportunities to discuss any concerns about this.
- Service providers should have clear policy and processes for discharge planning. All staff must be aware of these. Discharge plans and supports should be clearly explained to individuals and their carers.
- Services should have procedures for developing or reviewing crisis plans after an episode of intensive home treatment. This is a good time to encourage individuals to make advance statements.

FULL FINDINGS AND RECOMMENDATIONS

A. GENERAL DESCRIPTION OF INTENSIVE HOME TREATMENT SERVICES

Key message 1. It is important to monitor the uptake and impact of intensive home treatment. From the information we collected about service provision, we are not satisfied that intensive home treatment is equally available to all. Not all NHS Boards appear to offer this service. Men and people over 65 may have less access to intensive home treatment.

What we looked at

We asked NHS Boards to describe their intensive home treatment services.

All but one mainland NHS Board gave us information about intensive home treatment teams. We also received information from Western Isles. We identified team managers and asked them to describe their services. Some managers had responsibility for multiple teams. We received no information on IHT from NHS Grampian, Orkney or Shetland.

What we expected to find

We were aware that models of intensive home treatment varied across Scotland. While geography and differences in general service provision will result in different models, we expected services to give attention to equality issues when providing intensive home treatment. We looked at the range of people who could have access to the service and examined equality information from the sample of people we interviewed.

What we found

Intensive home treatment services differed in some aspects of their operation. All offered the same general model of intervention: support during periods of crisis and acute illness, person-centred problem solving approaches and, where needed, monitoring of medication.

Overall, we received information from 23 IHT service managers. Some managers were responsible for more than one team.

Table: Number of IHTT services and teams identified

NHS Board	Adult IHTT Services	CAMHS IHTT services
Ayrshire & Arran*	1 (3 teams)	
Borders	1	1
Dumfries & Galloway	2	
Fife	2	1***
Forth Valley	1	
Greater Glasgow & Clyde**	6 (7 teams)	
Highland	1	
Lanarkshire*	1 (9 teams)	
Lothian	1	1
Tayside	2	1
Western Isles	1	1
Total	19 (32 teams)	4

*one service manager for all teams

**six service managers over seven teams

*** unable to take part in questionnaires, but provided service information

(Grampian does not designate services as IHTT/CRHT Services, but offers home and crisis treatment between GPs and CMHTs, procedures for urgent access to Consultants and others by GPs, a Liaison Service in the Acute Hospitals and developed community services based around CMHTs and which are equipped to maintain people at home wherever possible.)

The range of staff within these services includes consultant and other psychiatrists, psychologists, consultant nurses, nurses, and health care assistants. A few services have occupational therapists and social workers on the teams. One area reported having a pharmacist. Some services reported having access to these disciplines as required. Nursing staff make up the majority of staffing across all services.

Practitioner numbers in adult services varied from 2.5 whole time equivalents (WTE) (3 staff) in a rural service to 26WTE (28 staff) in an urban setting. The largest urban setting had a range of 12WTE (13 staff) to 14 WTE (17 staff) which totalled 104.3 WTE (103 staff) over 7 teams across the Board area.

For CAMHS the staff numbers varied from 2WTE (2 staff) in a rural setting to 7.4WTE (10 staff) in an urban setting.

Days and Hours of Service provision (Adult):

The days and hours of the provision of service varied across the country. We were pleased to see that of the 19 adult services who participated in the exercise:

- 15 services operated seven days per week, of which;
- 11 services offered extended hours during the week, nine of these working to 8 or 9pm in the weekday evenings;
- Four services operated 24 hours per day all year.
- In addition, one service told us they had initially offered to operate at weekends. Referrers and service users told managers that this was unnecessary. The service was reduced to weekdays only. The general community mental health team remains on call at weekends.

In rural areas with smaller teams, it may not be practicable to provide extended hours of service. We were pleased to see that NHS Boards assessed local need and consulted with stakeholders when deciding on hours of service provision.

Days and Hours of Service provision (CAMHS):

All four participating services told us they operate 9-5 Monday to Friday flexibly. One service reported operating on-call outwith office hours seven days per week

Age Range

Information from the Scottish Crisis Resolution/Home Treatment Network (November 2010)⁷ states that adult services range from age 16 or 18 up to age 65 with all ages seen out of hours in NHS Lothian Greater Glasgow and Clyde and Forth Valley.

In general we found that the IHTT services take referrals of individuals aged between 18 and 65. Six services receive referrals of younger clients from age 16 years and in practice services operate flexibly as appropriate for individuals aged over 65.

(See further comment under **Gender** on page 11.)

Referral Numbers

Staff reported annual referral numbers to us ranging from 2160 referrals per year in a large board covering a mixed rural and urban setting, through to 600 per year in a mainly rural setting, to a low 25 per annum referral rate in a smaller Board area of mixed rural and urban setting. In NHS Greater Glasgow and Clyde, where there are seven crisis teams in operation, the average referral rate per team per year was 317.

Source of referrals

Managers told us that teams commonly received referrals from mental health in-patient wards, GPs, A&E departments, community mental health teams, psychiatrists, psychologists, social work, self referral, carers/relatives, voluntary agencies, drug & alcohol services and the police. There was local variation, often because of the way other services operated. For example, in NHS Lothian, the majority of the service does not accept direct referrals from A&E as there is a specific A&E mental health liaison service.

We were surprised to note that four teams do not receive referrals from mental health in-patient wards. These were exceptions, operating in more remote locations. We were also informed that seven of the 19 services do not accept direct referrals from self or relatives/carers, nine do not accept voluntary agency referrals and seven teams do not take referrals from drug and alcohol services.

We were pleased to note that, in nine board areas, we were also told of referrals being received from a range of other sources (general hospital wards, NHS 24, mental health liaison services, specialist mental health teams and schools).

Most services told us that they all visited patients on in-patient wards. This was mostly at discharge planning meetings prior to the person engaging with the IHTT.

⁷ Unpublished paper from the Scottish Crisis Resolution/Home Treatment Network (November 2010).

All but three areas said they would do joint visits with ward or CMHT staff already engaged with the person

Assessments

In all areas, the core professional involved in carrying out assessments was a nurse. In eight services there was consultant psychiatrist input to the assessment process and in three areas staff grade and training grade psychiatrists were involved. In four services, occupational therapists participated in initial assessments. We were informed that some of the services would ask other professionals, such as dieticians or colleagues from the local community mental health team, to jointly assess where appropriate.

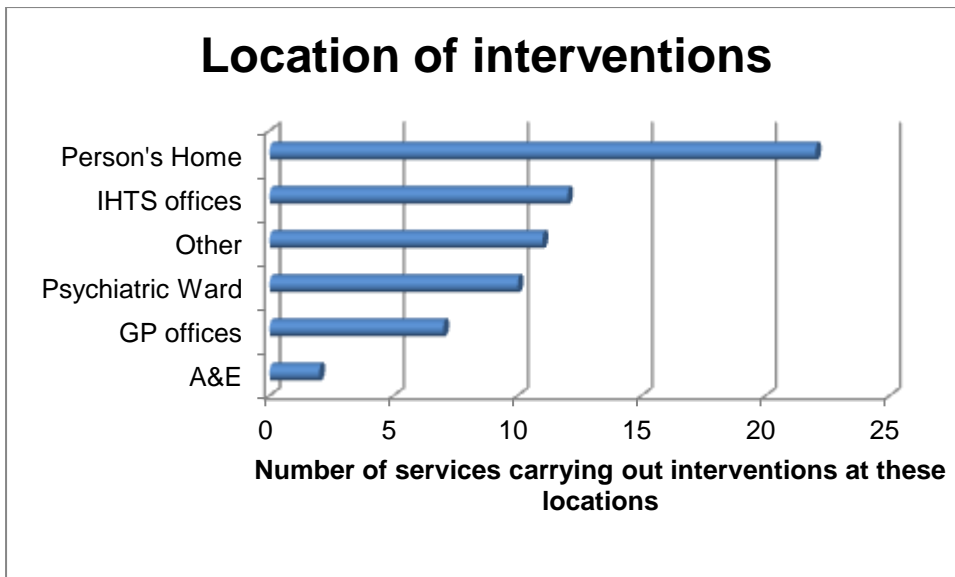
Assessments were carried out in a variety of settings but in almost all services they were carried out in the individual's home (22 of 23); the one exception carried out all of their initial assessments in the hospital setting. Other settings for assessment included psychiatric in-patient wards, A&E, IHTT offices and GP surgeries, community settings and police cells.

Interventions

Following assessment and accepted for service support, all services reported that they offered individualised interventions based on need following assessment. This included frequency and duration of contact, the location for contact, and the nature of the contact.

We found that nurses carried out planned interventions in all board areas. In a few areas they were joined by psychiatrists (6), psychologists (4) healthcare assistants (3), and social workers (2). In one area a dietician was involved as required.

Where interventions are carried out:



All but one service carried out treatments in the individual's own home. This one service saw everyone in their office base. Interventions were only conducted at IHTS offices for just over half (12) the services. Use of GP offices tended to be reported in more rural locations. Two teams in two different services only carried out treatments in A&E. At least half the services used other locations including other health or professional locations e.g. CAMHS and CMHT offices, health centres, sick children's hospital, school. One service manager commented;

'If the situation is high risk, we see people at the team base or GP surgery. We sometimes do this also to meet the individual's preference not to be seen at home.'

Local community settings and venues were also used (e.g. cafe, sports centre) or other arrangements made to suit and support the individual for example:

"We sometimes meet individuals in cafes or community settings. We have access to a social fund to support this."

"Sometimes we see people in local community based facilities, e.g. person may be seen at a leisure centre if plan is to encourage them to access this facility".

"May take service user out on trips sometimes."

Length of contact:

In the *National Standards for Crisis Services*, overall contact time with crisis services in an episode of crisis was set out as;

*Overall contact (receiving crisis intervention or support from a specialist service or a CMHT or other linked service) should be **no longer than 21 calendar days** unless exceptional circumstances apply.*

From service responses we noted that there was a great deal of variation in the duration of service contact. Only five services were working directly to this recommendation. We were pleased to see that flexibility is widely practiced, focusing on the needs of the person requiring service intervention. In our view, services are right to operate more flexibly. The Scottish Government may wish to re-examine this statement when reviewing crisis standards

Evaluation of services

We were also mindful that in *Delivering for Mental Health (2006)*, the then Scottish Executive set a target to reduce the number of readmissions; one of the commitments made towards achieving this aim was to:

“Ensure that people are managed and cared for more effectively in the community and avoid inappropriate admissions by ensuring that the crisis standards are achieved...”

It was therefore also important to ask about evaluation of service provision in order to understand more clearly if the services in focus were achieving what they set out to do. We were encouraged to see that all but one of the services were involved in ongoing evaluation. This one service was about to embark on an evaluation process.

Of the 22 services that told us about their evaluation processes, 16 had used service user feedback and nine of these had also sought carer feedback. Fourteen services mentioned data collection in a broad sense; three services had utilised GP surveys and four services stated they were externally audited. There was however, no standardised data gathering.

We asked service managers whether they thought there had been an impact on hospital admissions since the crisis service in their areas began. The general response was yes, with 15 of the 23 services reporting that data gathered clearly indicated this to be the case. Additionally, nine responses said lengths of stay were shortened when admission had occurred. Four of the interviewed managers found that the option of home or hospital care at time of crisis had enabled people to choose to stay at home.

Services acknowledged the need for improvements including: clarity for referrers on referral criteria, improving links with referrers and wider services, increasing times that service operates, improving partnership working with patients and carers and improving recording of interventions. However, the most common reply we had (11 of 23) was a wish for an increase in staffing levels with seven services highlighting the need for more multidisciplinary staffing.

General description of the sample we interviewed

This was a relatively small self-selecting sample of all the people who were referred for intensive home treatment. We have been cautious about drawing too many conclusions from this sample, but there were interesting findings, especially on age and gender.

i) Age

The age range of the 106 individuals we interviewed was:

- Two were under 15
- Three were aged 16 or 17
- Four were aged 18-24
- 88 were between 25 and 64
- Nine were age 65 and over

Despite some service information indicating an age cut off at 65 years, we found that older people are receiving intensive home treatment. We would expect to see policies in place to ensure that service provision is based on need and available to people of all ages.

ii) Gender:

Just over two thirds of the individuals we interviewed were female (69%, 73) and just under a third were male (31%, 33). We asked services to provide us with information on gender of people referred to the service. Across all the areas that were able to give us this information, we found that 57% of referrals were for females and 43% for males. In comparison, we know that the number of all admissions to mental health care⁸ and admissions under mental health legislation⁹ are divided approximately equally between men and women.

Some IHTTs provide a “gatekeeping” service to inpatient care. We received data from one NHS Board that showed that 51 of 263 male referrals were admitted, compared with 35 of 301 female referrals. This was quite significant ($p=0.011$).

There is therefore some evidence that more women than men are referred to IHTT services. There is also limited evidence of a significant relationship between gender and in-patient admission from IHTT referrals. Our data suggests that a greater proportion of male referrals than female referrals are admitted.

This finding deserves further research. It may be that there are differences in the way that men and women present in a crisis situation. It would be important to

⁸ <http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2011-12-20/2011-12-20-MentalHealth-Report.pdf>

⁹ http://reports.mwscot.org.uk/annual_monitoring/overview2010-2011/Newordersgrantedin2010-11/NewOrdersGranted2010_11.aspx

ensure that there is no inherent discrimination against men when intensive home treatment is contemplated as an alternative to admission.

iii) Ethnicity

We asked about the ethnicity of 101 of the 106 people we met.

- 78 were white Scottish
- 15 were from other white ethnic groups, including other British, American and European
- Three were south Asian (Indian or Pakistani)
- Five declined to state their ethnicity

We can draw no conclusions about the availability of IHT across all ethnic groups on the basis of this sample. We were pleased to see people from minority groups receiving this service. We would encourage managers to collect equality information on a routine basis.

iv) Home circumstances

Of the 106 individuals,

- 64 lived with relatives or friends
- 40 lived alone
- One lived in supported accommodation
- At the time of interview one was in hospital and had been for some time before referral and was being intensively supported to move into his own tenancy.

v) Legal status

Only two people were subject to compulsory treatment at the point of referral. In both cases, IHT was used to shorten the period of hospital treatment in line with the principle of least restriction of freedom.

vi) Previous mental health service contact

Of those we interviewed, 74 told us of previous contact with mental health services. The other 32 people had not received any specialist mental health care and treatment.

Recommendations

- NHS Boards should monitor the uptake of intensive home treatment to ensure equality of access across all groups.
- NHS Boards should continue to evaluate these services, paying particular attention to the views of those who receive services and their carers.

- The Scottish Government should review standards for crisis services to provide the maximum level of consistency and equality of access.

B. Individuals' views on the experience of intensive home treatment

i) General views

Key message 2

The vast majority of people and their carers interviewed told us they valued the service they received and were especially pleased regarding the accessibility and speed of the intervention provided.

What we looked at

One of the main objectives of this themed visit was to hear from the people who use IHTT services across Scotland and to get a clear picture of these services from their perspective. Individual interviews therefore began by asking people to tell us about their experience of using these services.

What we expect to find

From the available literature on IHTT service interventions, we had expected to hear that most people were happy with services offered from IHT teams. A recent review¹⁰ found that ease of access and quick response were particularly valued.

What we found

We thank Jo McFarlane for her permission to publish this poem. We think it sums up everything that is good about intensive home treatment.

Intensive TLC

It's the little things that make a difference
when your head's a ticking bomb.
To de-activate the switch
they gave me time to ditch my load,
tended me with kindness, patience, warmth

Acceptance without judgement
when I told them of my shame
A history of violence,
they listened without blame

It's being there to take a phone call
when you're troubled through the night,
not to rush or push you

¹⁰ Winness et al (2010). Service users' experiences with help and support from crisis resolution teams. *Journal of mental health* 19(1) 75-87

when you're teetering on the edge,
but offer consolation
that will lead you from the ledge

Nobody can mend a heart or heal a wound
by empathy alone,
it's those tried and tested strategies
that keep you safe at home:

Medication, dedication to a treatment plan
that works, challenging the voices,
being prepared to ask for help

And getting all the help you need
to see you through the clock, trusting
they'll be there until the fear gives way to hope

They offered me a rope to stop me drowning,
now I'm safe upon the shore
If I should need their help again,
I'll welcome them with thanks into my door

**To all the staff of South Edinburgh IHTT
With deepest thanks from Jo McFarlane**

Jo was not alone in her praise of intensive home treatment. We were very encouraged to receive mainly positive responses; 88 of the 106 people interviewed had found the service a helpful experience. Some of the general comments were:

"They worked with me in my own world with my own routine...normalised my life...transformed my life"

"Very accessible, got me back on track"

Good to have someone to talk to...they sorted out stuff and saved me a lot of worry"

People told us about the prompt responses to referrals to services;

"I saw them within 24 hours"

"On a Saturday they arrived within 2 hours"

Some individuals highlighted the benefit of the IHTT staff working alongside their usual support;

"Very helpful when I was really unwell, visited every day until I was better. Worked with my CPN and support worker so it all came together for me"

We see this intervention as particularly good practice, ensuring the whole support system is involved in the care provision.

Nine individuals declined to answer or gave a neutral response regarding their experiences. Another nine people across different services told us they did not feel helped by contact with the service and expressed this strongly:

“Their way or no way, didn’t value my opinion”

“Do what they have to then just dump me back to my CPN”

“Don’t feel adequately supported or listened to”

Although we are pleased that individuals and carers value the service interventions overall we note that there is an underlying theme from the more negative comments. This is one of not being listened to and feeling that their input to intervention planning was of little importance. This is consistent with the MIND survey in England and an important message for service providers.

Recommendation

Service providers should ensure that individuals and their carers are given the opportunity to voice their concerns and feel listened to in a meaningful way during contact with IHT services.

ii) Support from the service

Key message 3

People told us they were generally satisfied with the level of support offered to themselves and their carers. There was a general view that contact with IHTTs helped avoid or shorten hospital admission. Some individuals raised the feeling that their views were not being heard.

Key message 4.

Individuals appreciate consistency of IHT staff and sometimes found it difficult when different staff visited. Good information on who would visit and when they would visit was viewed as helpful.

What we looked at

We asked if individuals and carers felt adequately supported by the services during contact and if they thought contact had helped them stay out of hospital. We comment on the views of carers later in the report.

What we expect to find

From our visits to services we had noted the reduction in acute admission beds across Scotland. We expected to find that this was in part due to the investment in IHTT services and the resultant difference in dealing with crisis that may have led to hospital admission in the past. We expected to hear from individuals and carers that they were happier to have the option to remain at home during a time of crisis rather than to be admitted to hospital. We also expected that the interventions would offer “good enough” support without being unnecessarily intrusive.

What we found

When we asked people what they thought of the support they received at home from IHTT services the majority (80%) responded positively, stating they felt they had enough support. Many with strong statements, such as:

“Absolutely right, they took time to support me as an individual and to help me believe in myself.”

“It was very helpful, also input and discussion with my relative made them more supportive, gave them a better understanding of my difficulties”.

“Help me build confidence, take me out when I don't want to go, monitor me, make sure I am ok. Have taken me to hospital when I needed to go. It's like a friend to talk to.”

“At first I needed three times a day visits but as I felt safer this was reduced till I could manage with my "normal" CPN support. I felt I had a say in how much help I got.”

“Service offered was very much centred on me and my needs so couldn't have been better.”

Others, although positive, spoke of specific issues they felt less positive about. A particular issue was changes in staff input during treatment.

“Really good as support can be twenty-four hour support. Negative - different people offered support. Would have been more helpful if smaller number visited”

“Thought it was very good, except didn't always know who was coming, was told but didn't always remember”.

There were 12 people who told us they were unhappy with the intervention they received at home. Reasons given included disagreeing with the staff assessment of their problems and feeling their opinion was not heard:

“Awful! They just didn't listen to me”.

“Team tried to do what I wanted at first but that soon changed and they got me admitted to hospital. Not what I wanted at all.”

Individuals also told us about contact details from services for extra support if needed. Most people (89%, 94) said they had contact details of someone for extra support if required. These were mainly with the IHTT service directly. Only four people told us they had no emergency contact details. The position was unclear for a further eight people.

We asked specifically about individuals' views of intensive home treatment as an alternative to hospital admission. Of the 76 people who told us they did not need a hospital admission, 61 felt their contact with the IHTT services helped them to stay at home.

“Definitely kept me at home. They were there every day so I didn’t need to go into hospital”

“Because the team were there so much and offered intensive therapy at home, hospital just wasn't a consideration.”

Of the 30 people who told us they had to have a hospital stay during their contact with IHT services, 24 said they thought contact with the service had contributed towards a shorter hospital stay.

“Because they were able to see me as often I got out of hospital when I did.”

Very few people had specifically wanted hospital admission. Five people appreciated the efforts made by IHTT staff to keep them at home but felt unhappy that the choice of hospital admission was not available to them until after home support had been tried.

“They tried very hard to help me and keep me at home but I'd have been better in hospital. I didn't feel safe at home. I did feel safe in hospital.”

“Wanted to go to hospital, team said try the home service. I was self harming, didn't refer me in - not supportive.”

We asked everyone interviewed what they felt could make the experience of engagement with IHT services better. Just under half of the individuals interviewed (48%, 51) did not want to see anything done differently by the IHTT service. However a considerable number (41%, 43) said they would like some changes to IHTT services if they were to use them again. These people told us of the need for consistency of staff visiting.

We understand it is not always possible to have the same staff visiting. In these circumstances we would encourage relevant information sharing to avoid individuals having to repeat their situation and issues to every visitor. We deal with the issue of sharing information in greater detail later in this report. Individuals highlighted the difference this made for them;

“...Good to talk to someone who understood. Good that it was always the same nurses that came.”

“...Visited at home...also had phone contact and was told when a specific worker would call later in the day...always kept their commitment.”

Individuals and carers who were not so happy with the service they received brought up the issue of not being listened to in answer to several questions.

“Staff need to listen and not judge people before they even know them.”

Recommendations

- IHT services should address the issue of hospital admission when giving information to individuals and carers. This should provide assurance that admission is still available if necessary and should be regarded as an important step towards recovery and not “failure.”
- IHT services should ensure that individuals and carers know who will visit and provide explanations as to why it will not always be the same staff who visit.

C. INVOLVEMENT OF CARERS

Key message 5

An important part of offering intensive home care is the inclusion of carers in the process. Carers told us they generally felt involved and part of care and forward planning. A minority felt they had insufficient opportunity to discuss their concerns.

What we looked at

We encouraged carers to share their views and experiences of the IHTT service, where there was identified involvement. From the 106 individuals we spoke with, we were able to identify and interview 25 carers who shared their views and experiences with us. Because this was such a small sample, we also looked at the views of individuals and service managers on the involvement and support available to carers.

What we expect to find

We view the involvement of carers as often crucial to a person’s treatment. However, we recognise the need to ensure people are given the opportunity to consent to how much information about them is shared in this context. We highlighted this in our guidance *Carers and confidentiality (June 2006)*¹¹, in which we state:

¹¹ http://www.mwcscot.org.uk/web/FILES/Publications/Carers_Confidential.pdf

“Practitioners should have ongoing discussions with service users about the value of involving their carers...”

We expect practitioners to work with carers towards providing the best care and support for individuals in receipt of intensive home treatment. We therefore expected to find service support and inclusion of carers as an integral part of service delivery.

What we found

We were pleased to note that 21 of the 23 services involved carers in their contact with service users. Only nine services told us they sought consent from service users to involve their carers prior to doing so. It is generally good practice to seek consent, but it is very important if information is to be shared with carers.

We asked individuals about whether they thought their carers received enough support. We found that 42% of the individuals who had identified carers did not know whether their carers received enough support. Of those who did know, two thirds felt that the amount of support received was about right. They told us that staff took time to explain their intervention and what carers could do to help the person being supported and themselves,

“They supported my elderly mum as she didn’t know what was wrong with me”

Seventeen felt that their carers could have benefitted from more support. Comments were often about support for children and included:

“No support offered to them (children) about my illness, but one of them has had to use service too. Yes it might have helped if they had spoken to them.”

“My 17 year old could have been given more help. Must all have been very distressing for him. Don't think staff approached him as a carer, though he was and it might have been good for him.”

Of the 25 carers we had contact with, 24 were very positive about their views being sought in relation to providing treatment at home. All 24 felt that they had an opportunity to input into the development of the care plan.

“Really happy with teams’ plans and they always asked what I thought.”

“Took time to discuss what they could do and to include what we needed and wanted.”

“Worker involved family, who live with her - had joint discussions, helped her family understand more about her problems, which she had always found it hard to talk to the family about”

In discussing direct support for carers, around 75% (18) felt that they were offered support and advice in their own right. Some carers had individual one-to-one discussions.

“I got lots of sensitive support in one to one and joint meetings. Never felt intrusive despite the nurse having to go through every room with the person. Having the crisis phone number was so important and made things so much less frightening. Wouldn't have coped and my relative would have been in hospital without them”.

“Offered support to talk about pressure I was under”.

In relation to concerns carers may have wanted to raise, about 75% (17) felt that issues they were worried about were taken on board and discussed. The remaining 25% (7) did not feel that there was an adequate opportunity to discuss concerns or felt that the service did not take account of their views.

“Never offered any advice or help by IHTT. Feel that's important, I'm the one looking after him

“It didn't work, she didn't have anything wrong with her but they took her into hospital”.

Recommendation

- Service providers should not underestimate the importance of including the views of carers when engaged in service delivery. They should endeavour to include carers in the delivery and future planning of service provision, taking on board their needs as well as those of the individual being cared for whilst observing appropriate use of confidentiality as per our “Carers and Confidentiality” guidance.

D. INFORMATION SHARING

Key message 6

Information was generally passed on well within teams, but there is a need to make sure that individuals and carers know what happens to their personal information

What we looked at

We were interested to find out if individuals were aware of information sharing between professionals involved in their care and how this was done.

What we expect to find

It is standard practice to share information among health care practitioners working within mental health teams. Practitioners should tell individuals and carers that their confidential information will ordinarily be shared with other professionals, stating why this is necessary and desirable. We would not expect individuals to have to repeat information to several different practitioners.

What we found

Many (59%, 63) of the interviewees felt information about them was shared well between professionals. However, a quarter (26%, 27) said they did not know whether any information was passed on and an additional 15 people felt that information was not shared adequately.

People happy with the information sharing that took place commented;

“All lines of communication were open and well handled and this was down to the crisis service and how they operate”.

“GP and CPN were involved in big meeting as well as pharmacy to get my medication sorted and that was a real turning point.”

Those who reported not knowing what information was shared expressed their thoughts on this from having ‘no idea’ to ‘feeling clueless’ about what happened to personal contact information;

“Haven’t a clue what they do with information”.

“No idea what people have been told”

Others expressed a frustration that information shared which they had expected to be confidential was shared:

“After a second call to the service when she said she was feeling low, she said the nurse in the Crisis Team she spoke to shared all the information with an OT who subsequently came out to see her. She was not happy that all her information she gave the nurse was passed on to the OT - she thought what she said should have been confidential.”

We think it was appropriate that the information was passed on. The problem here was that the individual and/or carers had not been told this would happen and had not received an explanation as to why this was necessary.

Some people told us they felt their expectations of information sharing between professionals were not met. For example visiting staff did not appear to know any background information about the person’s situation when they arrived to provide support. This was rare, but caused significant distress.

“I saw several different people and was asked the same questions, and had to repeat story. This was not helpful - it got me more agitated.”

“Think it might have been good if everyone knew what they were coming for.”

Recommendation

- IHT services should have policies and procedures to make sure that all team members visiting individuals have all relevant information and do not have to ask individuals to repeatedly give the same information to different practitioners.
- It is good practice to give written information about the IHT service at first contact. IHT services should, as part of this, tell individuals and carers that information will be shared within the team. They should offer opportunities to discuss any concerns about this.

E. Discharge planning

Key message 7

- **We were pleased to see that discharges from the team are generally handled well. However, not all individuals had plans in place in the event of possible future crises.**

What we looked at

We are aware of the importance of services working together to provide as seamless a support as possible for the individual and their carers. We therefore asked individuals to tell us about the plans put in place for their support following discharge from IHT services and asked services about their liaison with other parts of the mental health network of service provision.

What we expect to find

We expected to find close working relationships between services to help the individual's continued recovery. There should be clear plans for ongoing support after crisis intervention and some evidence of thought about future crisis planning

What we found

We collected information on ongoing support arranged when their support from the IHTT services came to an end. Most (82%, 89), told us they went on to be supported from the local community psychiatric team. See table below:

Referral to	Number	%
Day Services	1	1
GP	4	4
Local Community Psychiatric Team	89	82
Hospital	1	1
Don't Know**	5	5

Other*	6	6
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*in this category 1 person went onto CAMHS, 2 to voluntary organisations, 1 to psychology and 2 had no additional information.

**no additional information was supplied in this category.

Although services told us that they all visited patients on the ward this was mostly at discharge planning meetings prior to the person engaging with IHTT. All but 3 areas said they would do joint visits with ward or CMHT staff already engaged with the person but acknowledged there is room for improved liaison with referrers around discharge planning at the end of IHTT intervention.

We were surprised to hear that less than half (46%, 49) people had changes made to their crisis/relapse plan. With 39% (41) people having told us there was either no change made or none was put in place and a further 15%(16) did not know.

From those who were positive we heard comments such as;

“First illness. Didn’t have plan before this happened.”

“CPN now has a clear plan in place for me. I see him every week and things are getting better.”

“Relapse plan clear and shared with all services and I knew exactly what to do should I relapse in the future. I am better prepared now.”

The people who felt nothing had changed or that there had been nothing put in place commented;

“Just discharged me back to CPN, not really good enough.”

“No-one put a relapse plan in place so I continue to have contact with services from time to time. I would have found a plan helpful.”

“No changes as CPN is main contact and she is my link if I feel unwell...”

Of the 25 carers interviewed, 24 felt that they had an opportunity to have input into the ongoing care plan:

“Really happy with teams’ plans and they always asked what I thought.”

Recommendation

- Service providers should have clear policy and processes for discharge planning. All staff must be aware of these. Discharge plans and supports should be clearly explained to individuals and their carers.

- Services should have procedures for developing or reviewing crisis plans after an episode of intensive home treatment. This is a good time to encourage individuals to make advance statements.

CONCLUSIONS AND FURTHER ACTION

CONCLUSIONS

Intensive home treatment is now available in most NHS Boards. In general, the people we interviewed were very positive about the service. Local service managers report that the availability of IHT has reduced the need for hospital admission. The Boards that have not adopted this service must give urgent consideration to developing intensive home treatment.

It was particularly reassuring to find that, in most cases, there was good transfer of care and joint working with other parts of the service. Because overall service models differ across NHS Boards, there is no single consistent model for an IHT service. There is a network of IHT teams across Scotland that meets regularly. We would encourage the network to consider the issues arising from this report.

We also draw our findings to the attention of Scottish Ministers. They should be reassured that intensive home treatment is generally viewed positively. In our view, it should remain a key strand of mental health strategy and should be developed further. We draw particular attention to equality issues and the lack of provision of intensive home treatment in some NHS Boards.

We are aware that the Scottish Government will be discussing the balance between home treatment and in-patient treatment with NHS Boards. When doing so, we recommend that they consider:

- A statement on the Government's expectations for the availability of crisis assessment and intensive home treatment;
- A core data set on service provision and uptake;
- Integration of intensive home treatment with local authority and third sector support, as well as other NHS services.

FURTHER ACTION

It will be interesting to compare the experiences of people receiving intensive home treatment with those in acute adult mental health in-patient care. At the time of writing, we are about to embark on a major programme of visits to the latter group.