Locality Services in Mental Health

Developing Home Treatment & Assertive Outreach

THE NORTHERN BIRMINGHAM EXPERIENCE

Booklet 3

The Sainsbury Centre for Mental Health

Northern Birmingham Mental Health NHS Trust

This is a time of enormous change and great opportunity for mental health care. The message has at last hit home that we need to develop mental health services that offer comprehensive and well integrated care, 24 hours a day, 7 days a week, balancing high quality care for service users with the wider needs of society. The Government's mental health policy emphasises the importance of access, engagement and treatment adherence for people with severe mental health problems. Essential services to achieve these aims are crisis and assertive outreach teams, backed up by a range of support services including 24-hour places of care.

This approach makes intuitive sense and is evidence based. Research has shown that users, carers and staff prefer this style of working, and that safety is not compromised. Nevertheless, only very few services in the UK have introduced this style of care. This means that dissemination of good practice is a priority.

An influential example of good practice is Northern Birmingham, where well-integrated community services have been run now for some 5 years, following the closure of the local asylum. Many lessons have been learnt, both positive and negative. All these have great relevance for others, whether they address how to configure services or how to achieve a competent workforce.

The importance of this publication is that it gives an honest account of how services were set up, run and sustained, as told by the people who did it. This should help managers and clinicians elsewhere to replicate the successes, but avoid the pitfalls.

I very much hope that it will achieve its aim: supporting people anywhere to improve care in a practical and accessible manner. Good luck!

Matt Muijen
Director, The Sainsbury Centre for Mental Health

The Sainsbury Mental Health Initiative

In 1994, the Sainsbury Centre invited mental health services across the UK to bid for a share of £3 million, to establish innovative new services for people with severe and long-term mental health problems. The eight sites, selected from over 300 applications, were awarded a three-year grant as pump priming to get their services up and running. Each of the projects has undergone an evaluation by the Sainsbury Centre.

The range of services developed include assertive outreach, home treatment and intensive community support teams, joint health and social service initiatives, a carers' support team, an advocacy project and a rural out of hours intensive support service.

Many vital service development and evaluation lessons have been learnt from each of the sites. These will be published in a series of journal articles, resource manuals and reports. This is the first in a series of service development manuals providing practical guidance on setting up these services.

The Initiative was funded by the Gatsby Charitable Foundation, the Sainsbury Centre for Mental Health, the Department of Health in England and Wales and overseen by a Steering Group of national experts and leaders in the mental health field.

Acknowledgements

Northern Birmingham Mental Health NHS Trust would like to acknowledge the contributions of all those staff within the Trust who participated in the development of its services. In particular, it would like to make the following special note.

'Without the dedication, determination and co-operation of all the staff within theservices in the Yardley and Hodge Hill Locality, the re-modelling and maintenance of the service could not have happened.

The pioneering work of Dr John Hoult – his passion and energy to make the changes happen was crucial.'

Edited by Helen Wood & Sarah Carr
The Sainsbury Centre for Mental Health

The Home Treatment Team: Making It Happen

Patrick McGlynn
Dr Marcellino Smyth

THIS BOOKLET IS Nº **3**
OF A SERIES OF **5**

3

Defining the Service

The establishment of safe alternatives to hospital is currently attracting much attention. The reorganisation of the Northern Birmingham service was seen as a key opportunity to further develop the model of home-based treatment and support for people with acute mental ill health. This process began in 1995, and was the first stage in developing a different configuration within the Yardley/Hodge Hill locality of the Trust.

Key influences

Research evidence

The establishment of the Psychiatric Emergency Team, latterly known as the Home Treatment Team, as it will be referred to here, was prompted by the success of similar community teams established in Madison, Wisconsin USA, (Stein & Test 1980; 1985) and Sydney, Australia (Reynolds & Hoult, 1984).

The key features drawn from these services were:

- *by providing intensive treatment in the community, the need for hospital admission can be diminished*
- *24 hour 7 day a week access and availability*
- *a need to develop a range of alternatives to hospital admission*
- *crisis services need to be fully integrated into the total service provision*
- *the service should focus on those with severe mental illness*

The following modifications were made:

- the team also needed to act as the gatekeeper to all hospital admissions
- focused and functionalised teams such as home treatment, assertive outreach and primary care needed to be developed
- home treatment teams need to be able to facilitate early discharge from hospital where hospital admission has been necessary.

Local experience

Undoubtedly, it was a great help to have the involvement of Dr. John Hoult who had led pioneering research carried out in Sydney, Australia. The Birmingham area was already the site of similar mental health service developments. Two home treatment teams had been established at Sparkbrook, by Dr. Christine Dean, and at Ladywood, by Dr. Sashidharan, and had been

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operational for some time. This had fostered a culture favouring this kind of working.

Thus, by responding to the:

- *local needs assessment*
- *local experience and knowledge*
- *evidence from international studies*

we were able to develop the rationale for the future service.

Rationale

- It is considered humane to provide care for individuals experiencing acute mental health difficulties in the least restrictive environment, with the minimum disruption to their lives.
- In the majority of cases service users and carers prefer community treatment (Hoult, 1986).
- Research in this country and abroad has consistently shown that clinical and social outcomes achieved by this form of treatment are at least as good as those achieved by hospital treatment and traditional follow-up (Muijen *et al*, 1992; Dean & Gadd, 1990).
- Up to one third of costs incurred in hospitals are for 'hotel services'. This money is therefore not available for clinical services. Community based services will not incur these costs for hotel services.

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Setting up the Team

Having developed the rationale, it was important to examine *what* we wanted to achieve and *how* we were going to achieve it. This involved the development of aims and objectives, as well as principles of care. The team leader was recruited early in the process in order to develop these.

Project leader

The key tasks for the team leader over a period of three months were to:

- *establish the framework for the operational policy*
- *work in liaison with the steering groups to agree development plans and policies*
- *explain to statutory and non-statutory agencies how the service will work*
- *identify and establish links with community resources, such as day centres*
- *recruit, train and induct staff into the team*
- *establish team office space.*

Operational planning

Aims and objectives

- To provide immediate assessment and treatment 24 hours a day, 7 days a week to individuals experiencing mental health crisis. As far as possible this service would be provided in the persons' own environment with minimal disruption to their normal routine.
- To provide an alternative to hospital admission for individuals experiencing acute mental health difficulties.
- To ensure multi-disciplinary assessment and decision making at the point of referral for hospital admission.
- To act as gatekeeper to hospital beds by ensuring that every individual referred for in-patient admission receives a comprehensive multi-disciplinary assessment before a decision is made about treatment location.
- To provide a service which accepts that mental health difficulties cannot be isolated from an individual's social system. Therefore their social system needs to be part of the assessment, treatment and on-going care.
- Having resolved a particular crisis the team should ensure that individuals and carers are, where necessary, linked into on-going care and that they have access to further assistance, on a 24 hour basis, if required.
- If intensive support is available to individuals in the community, discharge from hospital can occur at an earlier stage than had previously been possible.

Principles of care

Experience indicates that the following principles of care are important:

- Providing an intensive service in early stages of intervention, and spending large amounts of time with the client and relatives initially, can help form a therapeutic bond and relieves the burden on the family (Hoult, 1986; Dean *et al*, 1993).

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- Actively involving the client and family in planning and management of care, and providing them with information, support, guidance and counselling can improve outcome.
- Designating a named worker to accept responsibility for each client's care ensures that their needs can be met and effective co-ordination takes place.
- The team needs to be prepared to go out to clients and relatives in an assertive manner, without being unnecessarily intrusive.
- Having a service which is available 24 hours a day, 7 days a week. This service should be easily accessible, able to respond quickly and effective in reducing the number of inappropriate admissions to psychiatric in-patient units (Hoult, 1986; Dean *et al*, 1993).

Referral criteria and target population

We knew from past experience that defining the target group was one of the crucial determinants of how effective this team would be.

If referral criteria are too vague it can lead to the following:

- The service becoming unfocused and beginning to accept individuals who do not require such intensive input.
- The team could become overloaded and as a consequence be unable to offer such intensive support to individuals and families.
- The above can then lead to the team being unable to prevent inappropriate admissions.
- If inappropriate admissions are not prevented the team can lose its ability to be a cost-effective option.
- Ultimately poor focus and excessive workload will lead to staff burnout.

It was therefore important to be realistic about the limited team resources, deciding that it would be inappropriate and impractical to have an open referral system for this service.

In order to maintain a focus on those who most require it, we developed the following entry criteria:

Home treatment target population

- *Individuals between the ages of 16 and 65.*
- *Residents of the Yardley/Hodge Hill locality catchment area.*
- *Those with a psychiatric disorder of such severity that they are at risk of hospital admission.*
- *The service will focus on people with severe mental illness, in particular those suffering from schizophrenia, manic depressive disorder and those with a severe depressive disorder.*

Similarly, we felt it was important to specify the people whom the service did not target, including:

- mild anxiety disorders
- a primary diagnosis of alcohol or other substance misuse
- brain damage or other organic disorders including dementia
- learning difficulties
- a primary diagnosis of personality disorder
- a recent history of overdose, but not suffering from a psychotic illness or severe depressive illness
- relationship issues and situation of domestic violence.

The majority of the above group would receive services from the primary care mental health team. There is not, however, a blanket exclusion on these groups and each case will be considered individually.

Certainly there is an expectation that the crisis assessment function of the home treatment team will provide quick and responsible support to anyone who appears to have a mental health problem; at least until an assessment has been completed and a care plan agreed. Developing

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this criteria for acceptance and non-acceptance has proven to be (after three years managing the team) one of the single most important determinants of how effective the team will be in meeting its aims.

Developing a 24 hour service

During the team planning phase the day to day functions of the team were decided. One of the main challenges was to decide how we would develop a service that is available 24 hours a day, 7 days a week for those experiencing a 'psychiatric emergency'.

24 hour access to the service was required for the following reasons:

- *People being referred for admission to the in-patient unit need access to comprehensive psychiatric assessment from this team. This will determine whether they can be treated at home by the team, or if in-patient care is required.*
- *Contact for individuals and families already being seen by the team, who experience a 'crisis' and need to be able to access the team at any time.*

We therefore developed a shift system to cover any 24 hour period:

- ***Early shift:*** *8.15am to 4.15pm (approx. 6 staff)*
- ***Late shift:*** *1.30pm to 9.30pm (2 staff)*
- ***On–call:*** *9.30pm to 8.15am (2 staff)*

This system is flexible, and staff numbers for each shift are based solely on workload. At times there has been an increase in evening workload, so three people were needed on the late shift.

Staff on call are at home, available for contact by individuals already being seen by the team or for new assessments for admission. The same shifts operate at weekends, although only two people work on an early shift and two people on a late shift.

Team size and skill mix

Obviously, for this service to run effectively a minimum number of staff are required.

The team consists of the following:

- *1 Team Manager (I Grade Nurse or equivalent)*
- *8 Registered Mental Nurses (4 G Grade, 3 F Grade, 1 E Grade)*
- *2 Approved Social Workers*
- *2 B Grade Health Care Assistants*
- *Clinical Psychologist (4 sessions per week)*
- *0.5 Administrative and Clerical Staff*

All of the above staff are managed on a day to day basis by the team manger, and all, apart from the clinical psychologist, participate in the shift system.

When the grade mix of nurses in the team was decided, it was recognised that the range of grades should take into account recruitment, retention, supervision, decision making and provision of high level assessment skills. The E-Grade post is primarily a developmental post.

The choice of grade mix was made because of the level of decision making and responsibility (particularly out of hours) required input from senior team members.

Medical involvement

Configuration

In the start-up phase, one consultant maintained clinical responsibility for all cases taken on by the team. This consultant, with his medical

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TEAM ROLES The main focus of each role is as follows:

Team manager

- day to day management of team
- development of policy/procedure
- development of systems to enable effective communication and facilitate best practice
- supervision – clinical/managerial for the whole team
- clinical leadership
- no designated clinical caseload, but involvement with decision making for all active cases
- dealing with complaints/disputes.

G Grade CPN

- management of team, clinical workload on a day to day basis
- contribution to development of policy/procedure
- clinical caseload – named worker for a selected group of clients
- clinical supervision of junior nursing staff
- ensures effective multi-disciplinary decision making
- acts as first access point for on-call system
- takes lead role in the development of individual plans of care
- responsible for provision of student nurse training
- takes the lead role in assessment
- receives supervision from the team manager.

F Grade CPN

- implementation of agreed team plans of care
- clinical caseload – named worker for selected group of clients
- takes a lead role in assessment and feedback to team meetings
- acts as first access point for on-call system
- supervision of junior staff
- receives supervision from G Grade CPN.

E Grade CPN

- implementation of agreed team plans of care
- clinical caseload – associate works for selected group of clients
- participates in new assessments
- accompanies senior staff for on-call duties
- receives supervision from F Grade CPN.

B Grade Support Worker

- participates in tasks identified by team plan of care
- receives supervision from F Grade CPN
- accompanies senior staff to on-call duties
- clinical caseload – associated worker for a specified group of clients
- involved in new assessments and feeding back to team meetings.

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TEAM ROLES /Continued:

Approved Social Worker

- focuses on assessment of individuals' social needs
- contributes to the development of the team policy and procedure to enhance effective team working
- participates in clinical team meetings on a daily basis
- statutory duties under the Mental Health Act, including co-ordination of mental health act assessments
- acts as the first access point for the on-call system
- supervision of day to day work from team manager
- professional supervision from social services team manager
- participate in training of social work students
- networking, especially with other specialities within social services.

Psychologist

- input to team is psychology orientated including a clinical workload
- takes a lead role in team assessment process
- carries out one-off psychological assessment for active team cases, where requested
- contributes to clinical team meetings
- offers clinical supervision to other team members on areas of expertise.

Administrative and Clerical Staff

- initial contact for the referrer and receives relevant information
- with team manager, develop systems for effective internal and external communication.

team (senior clinical medical officer and junior doctor), accompanied the team on all assessments. The consultant directly provided on-call availability out of hours for the first six months. With these arrangements, the team could become effective from the outset and was quickly established. The consultant had previous experience of home treatment and had a lead role in team support and development.

After the development phase, medical responsibility was reconfigured according to catchment area, with the original consultant and two other consultants (from other locality catchment areas) all working directly with the team. This normalised the function and place of home treatment by mirroring in-patient arrangements (where different medical teams worked with the same ward-based team). It meant that all medical staff were exposed to, and involved with the home treatment model.

There are distinct advantages in the same medical staff preserving continuity with individuals (out-patient and day care), during and after the acute treatment episode and after discharge to the primary care setting. This preserves medical therapeutic relationships with clients and the increased clinical familiarity improves the quality and acceptance of home treatment. It also helps to secure precise discharge planning and consolidation of recovery.

Organisationally, one consultant retains a lead role in supporting the home treatment initiative. The consultant is available to the team manager for discussion of day to day operational matters, supporting adherence to operational policy and smoothing the wider integration of home treatment with other components of overall provision.

Activities

Each consultant has to organise their medical team so as to be flexibly available for urgent joint assessments and able to reprioritise at short notice. Medical staff (usually senior) participate in all assessments and fully contribute to clinical decision making.

When cases are accepted onto home treatment, medical staff clinically supervise treatment planning and monitoring. Formal meetings to review existing cases take place

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between each medical team and the home treatment team, usually twice weekly, in addition to regular daily attendance at team handovers (depending on the number and complexity of cases involved). On average, medical staff accompany the home treatment staff on planned visits in the community setting twice a week.

In general, medical input has focused on assessment, diagnosis, problem formulation and risk assessment, leading to joint clinical decision making. In particular, medical input also involves awareness of organic and physical problems; prescribing; organising appropriate investigations; guidance on any legal issues in the management of cases and communicating with other physicians (especially GPs).

Medical cover out of hours

This is routinely provided by senior doctors, either senior clinical medical officers or associate specialists. They accompany the team on all out of hours assessments. Consultants are also on call for advice and support, but are mainly responsible for all assessments in police custody (some of which have led to further assessment with the home treatment team). Junior doctors on call are responsible for the in-patient unit and casualty assessments (supervised by the consultant).

Role of the team as gatekeeper to in-patient care

Evidence clearly indicated that people experiencing acute mental health difficulties could be treated safely and effectively at home, given the resources. It was therefore essential that we set up a system where all referrals for hospital admission were assessed by the team in order to make an impact on in-patient bed usage. Only by doing this would the service prove to be a cost effective option.

For the team to maintain a gate keeping role, it was important for all parties traditionally involved in hospital admission to be aware how the service would function. The following people were involved in the planning of this team, and were given clear information on the new referral and assessment process:

- GPs
- psychiatrists and their teams
- approved social workers
- staff on relevant in-patient units.

Admission to hospital based on the strength of one person’s assessment was no longer an option. This was seen as a potentially divisive concept, as some would question the need for another team to make an assessment to confirm the practitioner’s view. The counter argument would assert that the home treatment team can best assess if a client can be treated at home, because they have extensive experience of crisis assessment and know the available resources.

Ethical considerations also need to be taken into account. Hospital admission is a major event in an individual’s life and can be very traumatic. Therefore, the decision to admit must be carefully considered and should take into account as broad a range of clinical expertise as possible. The home treatment team, as part of their day to day work, need to be aware of the available alternatives to hospital admission.

The team manager is responsible for the co-ordination and monitoring of the system. There will be occasions when individuals may be admitted without the involvement of home treatment, such as:

- Mental Health Act assessments needing immediate action or
- individuals who clearly do not meet the referral criteria (ie primary alcohol abuse).

However, if individuals are admitted to hospital without the involvement of the home treatment team, the team manager needs to speak to the individuals responsible for the admission to establish the reasons for this. Where appropriate, they can be directed to the operational policy. This process can be monitored on a daily basis by reviewing locality admissions to the in-patient unit.

Risk is a major determinant of hospital admission and plays a significant part in the initial assessment and the gatekeeping of hospital beds. The risk assessment is carried out during initial contact by the relevant practitioners. In a home treatment setting,

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this risk assessment is jointly discussed and completed by all practitioners involved in the assessment.

Every client referred to home treatment receives a risk assessment. There is joint responsibility for completing this, as there is joint responsibility if the wrong decision is made. This is why it is important for decisions to be discussed within the team setting on a daily basis.

It is also important that there is a gatekeeping role *within* home treatment, to ensure that the resources are being appropriately allocated. This allows the team to maintain its focus. The team manager has a major role to play in this, and discusses the outcome of assessments with practitioners. The rationale behind decisions about admission to hospital or home treatment is explored. The team manager also needs to maintain a focus on discharge planning so that home treatment is only provided while the client requires it.

Training and induction

When setting up a new team, with relatively new ways of working, there is a distinct need for training. The majority of the home treatment team had not worked in this way before, many having worked in the 'traditional' mental health services.

A one month training programme was developed, with the emphasis on attitudes to care. Traditionally, community staff had often resorted to hospitalisation if a person became acutely ill, or experienced a mental health crisis. Therefore, staff were encouraged to develop a non-institutional attitude and were encouraged to think imaginatively about preventing hospitalisation, within the available resources.

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The core areas of the training package were:

1 Orientation

- *the local area*
- *social services*
- *user groups*
- *other community resources*

2 Model of care

- *discussion and analysis*
- *dissemination of research*
- *development of operational policy*

3 Skills

- *strategies for working with psychosis in the community*
- *a range of social, psychological and medical home interventions*
- *situational role play*
- *family work and potential effects of home treatment on children in a family setting*
- *team responsibilities*
- *CPA*

4 Role definition

- *community psychiatric nurses*
- *approved social workers*
- *support workers*
- *psychologists*

5 Individual concerns

- *out of hours work*
- *communication*
- *supervision*

6 Team building

- *group exercises*
- *development of common aims*

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Implementation

Launching the service

Immediately prior to becoming operational, there were a number of issues that needed addressing. These are discussed below.

Referral process

Information about referrals to the team and the start date were given to all relevant practitioners, including:

- GPs
- psychiatrists
- medical teams
- approved social workers
- staff from relevant in-patient units.

They needed to be informed about the changing admission process and what to expect following client referral to the home treatment team.

Shifts

Although it was impossible to estimate the work load of the team and the possible daily variations, we were aware that the majority of activity would occur between 9am and 5pm, so shifts were arranged accordingly. The team manager spent time with individual staff members, discussing expectations and on call duties, as well as addressing any last minute questions they might have.

Transport

Because of the nature of the service, staff need to respond quickly 24 hours a day, so when staff were recruited, it was ensured that they had access to a motor vehicle. The Trust runs a lease car scheme, which many staff have opted for, but organising this was a time consuming process.

Practical issues and medication

We needed to ensure that all staff were equipped with the appropriate communication equipment, and knew how to use it. This involved obtaining and distributing mobile phones and pagers. A team base was acquired prior to becoming operational.

Clear policies and systems were needed for the storage, carriage and administration of medication. This required developing links with the local general hospital pharmacy department.

Finally, the team spent much of the last day before becoming operational discussing what would happen when the first referral came through. This discussion was useful for further acquainting staff with the systems that were in place, and made the imminent launch a reality.

Team functions

Referrals

From the outset it was essential that the team was able to maintain its focus on the target group. In order to do this, it was important to have a stringent referral process, designed to protect the team from inappropriate referrals.

The team, therefore, did not accept self-referrals but *would* accept referrals from GPs, existing CMHTs and agencies such as social

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services departments, hospitals, police and non-statutory mental health organisations.

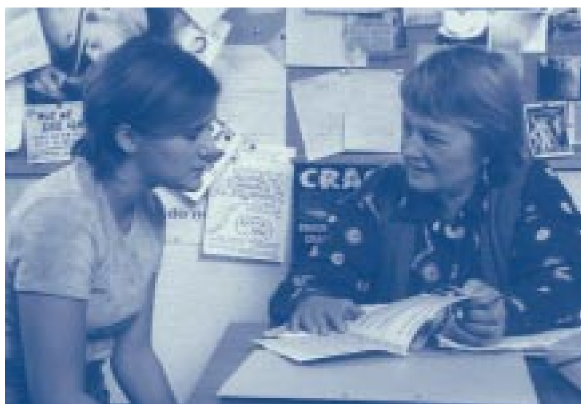
Consistent emphasis was placed on the fact that a person needed to be experiencing a 'psychiatric crisis' of such severity that there was a possibility of hospital admission being required.

- The majority of referrals would be made directly to the team via the telephone and a standardised referral form was developed to record as much relevant information as possible.
- Referrers can expect the client to be seen within one hour if necessary. In practice this one hour response time is not often requested, but is necessary in emergency situations. By being able to respond so rapidly we have been able to de-escalate a crisis before it reaches a point where the only option is hospital admission.
- As far as possible, the team aim to assess people in their own environment, involving relatives or significant others wherever possible. This allows the assessment to account for social and environmental factors as well.

It has become clear that it is far more difficult for service users to accept the idea of home treatment if they are assessed at an out-patient department or in-patient unit. In most cases such settings raise the expectation of admission.

Assessment

The initial assessment is crucial as it determines what is to follow. It is during the initial assessment that the therapeutic alliance is formed, and the process of engaging the client with their treatment plan begins.



The initial assessment will be focused on the following areas:

- *the immediate presenting problem*
- *comprehensive assessment of risk*
- *clinical signs and symptoms (including Mental State Examination)*
- *determining the level of need and therefore the level of input required*
- *unsafe or intolerable behaviour (this is most likely to cause community treatment to breakdown)*
- *interpersonal relationships particularly with close relatives and carers (the status of these will often determine whether the client will be able to remain at home or require alternative accommodation)*
- *social supports and needs, including social systems assessment (Polak,1971)*
- *material supports and needs, such as housing and finance*
- *previous psychiatric history, treatment and intervention outcomes*
- *willingness of the client to engage with the service and ability to negotiate access.*

As previously described, the initial assessment will be carried out by two members of the home treatment team, and a psychiatrist from the relevant team.

Following the assessment, a discussion will take place, initially focusing on the level of need.

Not all referrals will require the input of the home treatment team, and the study conducted by the Sainsbury Centre into this team found that 34.5% were inappropriate for team treatment either because they did not meet the referral criteria or required hospital admission (Minghella *et al*, 1998).

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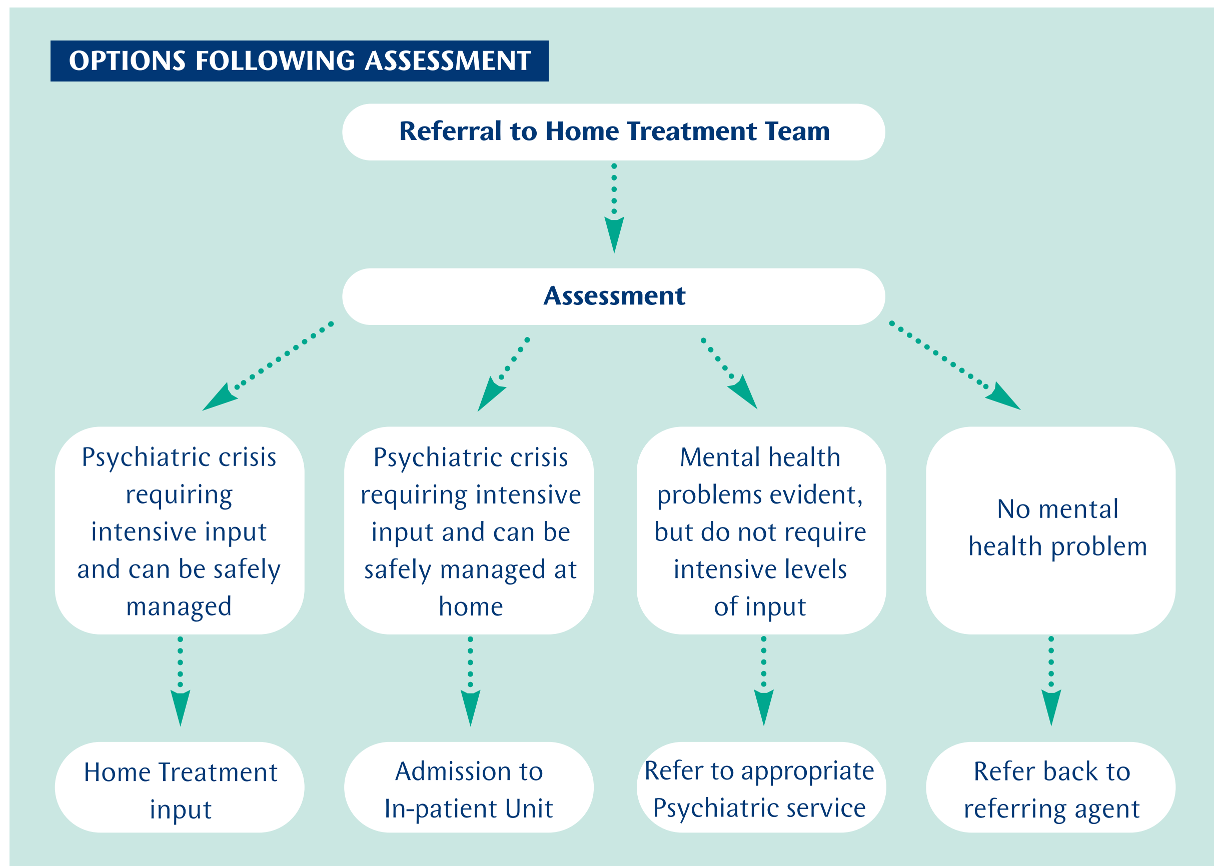

It is essential therefore that there are options available to the team following assessment. The following shows the options available:

Hospital admission may be the outcome of the assessment and this decision will be based on the following admission criteria:

1 Where it is beyond the resources at the disposal of the home treatment team to adequately and safely fulfil the demands indicated by the completed assessment and subsequent care plan.

2 Where the level of continuing observation and care is beyond that which can be provided by the home treatment team, and any agreed support by carers; in order to prevent a serious deterioration in a client's health, or leaves an unacceptable degree of risk of harm by the client to themselves or others.

3 Where the level of observation and support given by the home treatment team and carers, is unlikely to prevent serious psychological trauma to others, (for example, children living in the same residence) or there is a serious risk of attack upon the client by others, because of his or her behaviour.

4 Where the amount of resources necessary to maintain the client at home, even if none of the above criteria are met, are excessive, thus making such an option impractical.

5 Compulsory admission where all necessary Mental Health Act documentation has been completed.

Risk assessment

The decision about whether to admit a client or treat them at home will often depend on the level of risk. It is therefore essential to incorporate an assessment of risk into the home treatment assessment.

Because of the nature of the team, risk assessment and risk management play a major part in day to day team functioning.

Some of the strategies implemented to cope with this are:

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- Assessments are multi-disciplinary and decisions about risk are usually made by at least three practitioners from the team. This will always involve the psychiatrist and a senior team member (i.e. G grade CPN, ASW, psychologist) and one other member of the team.
- The team meets twice daily to discuss all current cases. A major part of this discussion will concern levels of risk.
- Risk levels will determine the levels of team input (the number and nature of the visits). On each visit the level of risk is re-examined, and visits can be altered accordingly.
- By being a 24 hour service the team is accessible to clients and carers if a crisis does occur. This also ensures access to medical support at any time.
- Joint visiting is common place particularly where risk is a major factor. This enables joint decision making.
- The Care Programme Approach documentation includes a structured risk assessment.

If home treatment is the necessary option it is important to take into account that the client's mental health crisis may relate to a number of practical issues, such as:

- behavioural disturbance
- inability to sleep
- not eating
- relationship difficulties.

It is important to deal with these during the initial contact and although this element of de-escalation may be time consuming, it will be time well spent.

In a number of cases, treatment may need to start immediately. It is often unsatisfactory to leave the situation and return at a later time to commence treatment, as the crisis can escalate and may become unmanageable.

Medication will often form part of the treatment plan and therefore needs to be accessible 24 hours a day. The team will take a case of medication to any new assessment so that treatment can start immediately.

Core services of the team

There are 4 stages in the process from referral to discharge.

1 *Assessment*

- *rapid response*
- *home assessment*
- *multi-disciplinary assessment*
- *focus on 'here and now'*
- *involve relevant others, carers and family*
- *problem solving approach*
- *risk assessment.*

2 *Planning*

- *team approach and team decision making*
- *focused crisis plan with short-term goals*
- *based on negotiation with client*
- *decide number of visits and level of input*
- *based on available options*
- *focus on discharge planning at an early stage.*

3 *Intervention*

- *establishing engagement and therapeutic alliance*
- *allocate 'named worker' in team*
- *commence medication*
- *family work*
- *frequent monitoring and continual assessment*
- *explanation as to why crisis has happened*
- *practical interventions e.g. benefits, day care*
- *give contact number of team in case crisis occurs during treatment.*

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4 *Resolution*

- *linkage with on-going care*
- *maintain contact until the above is well in place*
- *learning opportunity – why did the crisis happen?*
- *relapse prevention strategies*
- *coping strategies*
- *joint visits with key worker prior to discharge*
- *develop longer term community care plan*
- *involve family/carer*
- *liaise with relevant others e.g. GP*
- *request feedback from client*

Communication

In a service where there are a number of teams with different functions, effective communication is extremely important. Prior to the team becoming operational we developed clear standards for communication. The maintenance of this is the responsibility of the professionals from all teams involved.

The main interface exists between the home treatment team and the primary care mental health teams (PCMHT). It was essential to ensure that clients could be transferred from the home treatment team to the PCMHT soon after the crisis was resolved, so the short term focus could be maintained and the team remain able to deal with new crisis referrals.

Some of the agreed measures were as follows:

- The keyworker from the PCMHT and the named home treatment team worker are expected to liaise at least once a week to discuss progress. Any major changes to the plan of care should, where possible, be discussed and agreed with the keyworker.
- The home treatment team will meet on a weekly basis with the PCMHT to discuss their current clients, highlighting those who require a keyworker. This will take place within the PCMHT regular team meeting.
- Regular joint visits should take place throughout an episode of home treatment to ensure that keyworker involvement is maintained.
- Home treatment clients were a high priority for allocation within the PCMHT.

There is a danger that teams like home treatment could be viewed as ‘elitist’, which could have a major impact on effective communication and ultimately total service delivery.

A Sainsbury Centre for Mental Health evaluation of the service found that *“there was a decrease in the use of in-patient beds, not only for individual service users, but also at the level of the service as a whole. Over the 3 years (1994–1997) occupied bed days in the locality decreased more than 40%”* (Minghella & Ford, 1998). This outcome must be seen in the context of *total service development*, rather than the result of the introduction of a new team.

This team cannot work in isolation. The relationships between individuals and teams in general need to be strong and workable if it is to be effective.

Relationship with in-patient unit

Some people will still need hospital admission, but an in-patient stay should be as short as possible, with discharge at the earliest possible stage. This can be facilitated by intensive follow-up from the home treatment team.

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In many cases discharge is dependent on individual circumstances and support networks, rather than just on improved symptomology. There may be practical tasks such as securing housing or working with the family which require the intensive input of the team.

For this reason a number of clients will continue to receive input from the home treatment team, whilst in hospital. Such continual input can result in:

- earlier discharge
- therapeutic engagement (where failure to engage with services has been a contributory factor to hospital admission).

Respite services

From the Sydney experience and other research (see: **Home Treatment Team Evidence Base**), we were aware that the provision of respite facilities could further impact on hospital admission.

Within our own locality we found that a number of people who were admitted to hospital were admitted for the following reasons:

- Mental health difficulties can cause unreasonable stress for the family, carers or children. Sometimes a client needs to be removed from the home environment.
- The home environment may contribute to the stresses on the client which can lead to an increase in symptomatology. In this case it may be helpful if the person is taken out of the home environment.
- If the person is isolated and lives alone, acute mental health difficulties can make coping with basic daily activities very difficult.

In each of these cases the type of 24 hour nursing care provided by the in-patient setting may not be necessary.

We have access to a respite house which is run by ex-service users. At the moment the team only have access to this facility during office hours i.e. Monday to Friday, 9am–5pm. The home treatment team will visit individuals in the respite house on a daily basis. Again, the aim is to help them return to their home as soon as possible.

This is a short term facility with a maximum length of stay of 3 weeks.

Day support

Respite can also be provided through day care services which have, since the introduction of the home treatment team, changed their focus to complement this service. Day care can now be accessed quickly and respite care is now seen as a high priority for this service.

By providing respite it is clear that the burden being placed on families and carers has been reduced. It has also provided another option for the home treatment team in its attempts to maintain people within a community setting who would previously have been treated in hospital.

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A Day in the Life

Staff, user and carer perspectives

Patrick McGlynn, Team Leader

What are the skills needed for successful team management?

- It's very important to be part of the team and involved in the shifts, taking part in the clinical work. As well as helping with integration into the team and understanding difficulties staff may have, this also give a clearer understanding of clients.
- A team manager's job can't be understood as a 9 to 5 occupation. You must have flexibility within the shift system and be flexible in the way you work with the team. For example, if team members are on-call or out at night unexpectedly, it's unfair to expect them to do a normal day's work afterwards. You also need to be able to accommodate time-off at short notice.
- If a member of staff becomes stressed you need to be aware of it, and give them time to discuss what is happening, and where necessary, look at measures to reduce stress in their daily work.
- The strength of the team is the team itself. You need to foster close working relationships, formed on a day to day basis. Out of the hospital environment, trust among team members is vital, especially around decision making.
- You have to establish and maintain clear team objectives, so that everyone knows what the team functions are, and this helps them work more appropriately. This also helps to maintain team identity. A manager can engender a strong team character and without this the team will not be optimally effective.
- Try to avoid a sense of elitism with other mental health teams. Give a little, and go to primary care team meetings instead of expecting them to come to you.
- Communication with other teams is crucial, and must be built into the way the team works. The current system works relatively well and there is room for constant negotiation with other mental health teams.

What do you think are the most important skills for staff to have?

Team members need to be 'non-institutionalised' in their way of thinking, and not fall back on the in-patient admission option. They must be creative and have ideas about the alternatives to hospitalisation. Sensitivity about the effects of care at home is needed and staff must be aware of their own role.

A wide range of skills is needed including:

- anxiety management
- dealing with crisis situations, de-escalating approaches
- practical knowledge about how to remove the client from the situation
- ability to work with those who are acutely unwell or experiencing psychosis at home
- understanding of family involvement and how to work well with them.

The team also needs to include staff from a broad range of disciplines to offer a comprehensive assessment of need. This is important for

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formulating more complete care. There will be a blurring of roles, but team members should not lose sight of their unique disciplinary skills and insights.

Staff benefit from managerial and clinical supervision and the twice daily team meetings allow for daily discussions.

The 'team approach' has proved to be a more comfortable way of working for most staff. It allows the whole team to be involved in risk assessment and management, which is better than staff having to make decisions in isolation. This has resulted in a greater awareness of the total system, because the job is not individual task oriented.

The comparatively greater morale and job satisfaction has arisen partly from the feeling that they are doing a useful job with a clear focus. This has also helped to reduce stress.

What are the most rewarding aspects of working in this type of team?

The approach gives greater job satisfaction. When you have supported someone at home through a period of acute mental illness and witnessed the resolution, you feel you have made a difference, and wonder what would have happened if the team had not been there.

Users, carers and other service providers have expressed satisfaction with the service, particularly some of the GPs we deal with.

It's good to work within a system [the team approach] that lets you carry out your job well.

What difficulties have you encountered?

It was difficult to set up the team because we had to adapt a model. There was no blueprint to follow and nothing to compare ourselves to, so we had to deal with problems as they arose, having no one to learn from.

Sometimes it is hard to keep sight of the mental health service as a whole, with different units having the same aims that need to be consistent with each other.

We have been under pressure to change our caseload and have input into cases that do not fit with our referral criteria, such as people with drug and alcohol problems.

How do you think the team benefits service users?

People now have much more say in their care and more control over it. The team are involved in a process of negotiation rather than imposition. Because we can offer alternatives to hospital, service users have a greater choice in their care.

The team offer more one to one care and it is often easier to engage a person and build up a stronger therapeutic relationship in their own home. The service users are especially happy with the 24 hour on-call facility, so they can contact us early on if they experience a mental health crisis. We can come out to them, which is more acceptable than dragging them off to the hospital.

Service users benefit from a more co-ordinated range of services than could be offered in the in-patient setting. The team can be in contact with health and social services, GPs and psychiatrists. We can give them social as well as medical and psychological help.

The model of care offered by the home treatment team is designed to be responsive to user needs and care can be altered immediately, rather than waiting for the ward round.

Service users have sometimes complained about the lack of staff continuity, finding that different staff are coming to see them. This happens because of the shift system, but we are trying to remedy this by having a named worker.

People often want explanations for the crisis, so they can cope better in the future. We ensure that they have the information they need and link them with the appropriate services before withdrawing.

How have carers been helped by the team?

Carers were initially reluctant to accept this form of treatment, because the previous response of removing the person was often not a bad thing for them. This was overcome by reassuring them that the team were genuinely on-call 24 hours a day and could be contacted at any time. It also helps that the team discuss everything that is going on during a crisis with them.

Having the home treatment team available on discharge has been helpful for carers, as they can receive support and education and have the

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opportunity to voice their concerns on a day to day basis. Some carers can now see that a mental health crisis is a problem that they can own and deal with, and have developed coping strategies with the team. It has also helped that the team have limited access to respite services, so the family can have a break if needed.

Has the team offered advantages for locality mental health services?

The service has had a definite impact on in-patient admissions. Since the foundation of the home treatment team and the assertive outreach service, the locality day care services have changed their focus to fit with new priorities and offer more appropriate care.

GPs are happy with the service and are comfortable with the treatment model. They now have quicker access to a mental health service which provides more appropriate care options and a thorough assessment.

Amanda Cooper, E Grade CPN

Amanda has been with the team since October 1997, and has been qualified for 2 years. She previously worked on the acute admissions ward at All Saints Hospital.

What are the most rewarding aspects of working in this type of team?

Firstly, you get to spend time with clients on a one to one basis, which you never have when you work on a ward. It is good to feel that you are empowering clients by visiting them in their own homes, where they feel more in control of the situation.

The team itself offers a really good, supportive atmosphere. There's no hierarchy, but respect for each other. You don't feel afraid to ask questions or share doubts as you know people will listen and talk it over with you. I no longer need to worry about organisational things like getting staff cover and fitting in leave because the team staff rota takes care of that. Unlike working on the ward, there are no phone calls to interrupt you when you are seeing a client, and you feel more empowered to do the job you were trained to do.

Coming to the team is the best thing I've done. I'm much less stressed than I used to be when I was working on the wards, because the team support means that stress is shared.

What difficulties have you encountered?

The only thing I don't really like is getting called out at 2am. As I'm an E-Grade nurse at the moment, I will be second on call and won't have to go out unless it's necessary.

What helped you when you first started the job?

The training helped me to learn how the team worked as I hadn't worked in this type of situation before. As I was totally new to the area it was really helpful that I was driven around, so I could familiarise myself with it. It was also good that I was introduced into the work gradually and was not put on lates until I had been in the team for a while.

What type of skills do you need to work in the team?

- You need to be able to believe in yourself and the team, especially if you are making decisions about risk, for example with suicidal clients. You need to be confident that you can make the right decision about care and the team will support you.
- The ability to admit that you don't know what to do in certain situations is an advantage. If you can communicate with your colleagues about uncertainties, they can help you.
- Social skills are vital as well as clinical ones.
- In our locality it is good to have an understanding of Asian cultures, especially when you are visiting people's home environment.

How do you think you have developed as a professional since joining the team?

I am now far more involved with clients than I ever was on the wards, so my one to one

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skills have improved. My basic skills have also improved and I have learned a lot from the other team members, especially those from different professional backgrounds, like psychology and social work. My confidence in making decisions has got better, particularly as I know I can rely on team support when I feel out of my depth.

How do team members benefit from working in home treatment?

Working with clients in their own homes means that staff have the opportunity to develop new skills in order to deal with the client in their own environment. This means that you might feel disempowered. You also get to see a range of clients, unlike being in a team where you have a fairly stable caseload. The team support is great as you do not have to make decisions alone and there's always someone to talk to.

How do you think the team benefits service users?

Many users are afraid of going into hospital and feel stigmatised, so they are usually glad to be treated in their own homes. Our service is confidential and hopefully non stigmatising, when we call round we usually say we're from the 'health service'. A big advantage for users is having the 24 hour on-call service. They might not use it, but knowing it's there is reassuring. They can also get the individual attention that they could hardly ever get if they were in hospital. On a ward the patients that were loudest got the most attention, but because of the one to one care, every client gets the attention they need.

How have carers been helped by the team?

Most carers are glad not to have their relatives going into hospital. They find the 24 hour on-call availability of the service very supportive, even if they don't use it that often. It's just good for them to know we can come when needed. We've also been able to teach many carers about their relative's illness. Many of them didn't have enough information.

Bob Meese, ASW

Bob has been part of the team since it started in 1995. He trained as a general nurse and then as a social worker with the army. When he left the army his first social work post was with child protection and then he decided to specialise in mental health. His previous post was as the manager of a community mental health team.

What are the most rewarding aspects of working in this type of team?

You get to work far more closely with clients, and you can help them in their own homes. It's good to do multi-disciplinary work instead of having individual caseloads. You are better able to get the full picture when you treat a client at home, and can see that there may be aspects of their background and home life which cause problems. The shift system doesn't really bother me. I have confidence in my colleagues and know that we all understand each other's strengths and weaknesses. Our team leader is very supportive, you can rely on him to back up your decisions.

It's the best move I've made. You can see how the team benefits clients, carers and staff. 90% of feedback is positive and you need that.

What difficulties have you encountered?

It's unfortunate that we have not yet achieved 100% joint working between the health authority and the local authority. If things were more effectively merged, then systems would run more smoothly.

What helped you when you first started the job?

At the beginning we had a four week induction programme. It was a very good way for the team to build and for people to get to know each other. For me the cognitive therapy and medication education was particularly useful, as they're both interventions you need to know more about if you're working in this kind of team.

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What type of skills do you need to work in the team?

You don't need a set of skills as such, but more a mixture of skills and personal attributes. Being calm and relaxed helps! My experience and training in anxiety management techniques has come in very useful for dealing with clients who are experiencing a mental health crisis, because often you are dealing primarily with fear. Cognitive therapy skills can help with short-term work and counselling abilities help you engage the client and keep them involved.

How do you think you have developed as a professional since joining the team?

I think I'm more confident about dealing with crisis situations and thinking on my feet, and feel I can say yes or no to doctors using my own judgement.

How do team members benefit from working in home treatment?

Being with this type of team means that staff can learn more from each other. The environment feels safe to ask questions and to get things wrong sometimes. We're all learning all the time, from each other and from working closely with clients.

How do you think the team benefits service users?

The feedback from service users has been very good on the whole. They have appreciated having more time with the staff, and this compares favourably with the ward. They have more ease and control in their own home because it's their power base. The only complaint we've had is about users seeing lots of different staff at different times, but when the system is explained clearly, they're mostly OK about the arrangement.

How have carers been helped by the team?

Carers have gradually become more positive after being used to hospital admission, but it is hard work for them. The majority say that having home treatment is easier in the long run though, because they don't have to rearrange their lives for hospital visits, which can take four hours out of the day.

We are sensitive to how distressing and difficult it can be, especially during the first few days, so we often stay with the client and can negotiate for extra medication. We do offer lots of practical help as well, to improve the situation while the client is getting better. I've walked a dog, changed plugs, mended a hoover, helped with decorating and shopping, in fact I couldn't say that there's anything a team member wouldn't do to make things better, as long as it's legal!

Has the team offered advantages for locality mental health services?

Within a year of the team being operational there were fewer admissions. Local mental health teams are appreciating home treatment more than they thought they would. I think people were worried that we would be elitist, but communicating with staff from other teams and getting to know people personally has helped. Initially I didn't go to many social work meetings, but I've found that by being more involved, you can deal with niggles before they become complaints.

Mary, Service User

Mary is 52 years old and lives alone. She became ill three months ago with what has been diagnosed as 'psychotic depression' and is troubled by paranoid delusions. At the time of interview she was still ill and receiving treatment from day services as well as the home treatment team. Team members have been visiting her every day since her referral two weeks ago. She had been in hospital three times during the first three months of her illness, but despite the fact that she does not like being alone in her home, she prefers to stay there rather than go into hospital, which she finds traumatic and stigmatising. She wants to go back to her job as a technical clerk as soon as she can.

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- "I saw the doctor and the mental health team before…it's better to have a team that comes to you…"
- "The nurses stay and chat things over with you…but it takes me a long time to get through…"
- "It keeps me in touch with people…"
- "They talk to me about what's happened and what's happening and the way forward…they help me hope that I'll get better…"
- "In some ways it's better, but I still feel trapped in the house…I feel so alone so it's good for them to come, but I could do with someone there more often…"
- "The nurses try to make plans, but I could do with better ones as I'd like to go back to work…"
- "It is sometimes difficult to get hold of the team out of hours…I can't always contact them on the phone…"
- "The whole idea is to keep you in your home, which is better. I don't want to come back into hospital…"

Geoff, Service User

Geoff is 48 and lives with his wife and daughter. He has had mental health difficulties for about fifteen years, and has been admitted to hospital several times. He saw the consultant psychiatrist when he was becoming ill, and was referred to the home treatment team.

- "I'd always gone into hospital on previous occasions, but fortunately this time I was referred to home treatment, which enabled me to stay in my own home to get well…"
- "At first I wasn't keen on the idea of having different people in my home as I felt overpowered…but when I met people from the team, I had a change of heart…They talked to me and told me I was not alone and that they would support me throughout my breakdown…"
- "Rob [one of the CPNs] has a very good way of understanding and explaining my illness and my medication…He calmed me down when times were really bad."
- "They even talked to my daughter, who also suffers with her nerves, and made her feel like a normal person…"
- "I'd really like to say thank you to the home treatment team…"

Mr and Mrs A, Carers

Mr and Mrs A have a 22 year old son, Richard, who recently experienced his first psychotic episode. They were supported by the team through this period and their son was kept from going into hospital.

- "The best thing was to have Richard being kept out of hospital. He ran away when the team first came to see him as he was petrified that he would be sent to hospital. After this, when he was told that he could be treated at home, he was much more accepting of the situation."
- "It was reassuring for all of us to have him looked after in his own surroundings, and we felt that we had more control and say in certain things…"
- "Sometimes it was difficult as different people from the team had different approaches, some of which we weren't so keen on…At times we thought his behaviour was not being challenged enough…"
- "We know that, in the future, if Richard begins to become unwell, there is someone to contact and he will be much more willing to accept help."
- "I felt that I could take a step back, knowing that he was being looked after by professional carers…"
- "I felt able to ask questions…and the team gave us informative leaflets"
- "The team also helped us liaise with the probation service, which relieved the stress on all of us…"
- "It was the one to one contact that really mattered…"

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Case studies

Vebhavi

Vebhavi is 25 years old and lives in Birmingham with her two children, a girl aged 6 and a boy aged 4, and has been separated from her husband for two years, after their arranged marriage broke down. Her parents came originally from India and have lived in Wolverhampton for 30 years, where Vebhavi was born. She also has an elder sister and two younger brothers. However, the family was unable to offer support when Vebhavi started experiencing mental health difficulties and because this was the first time she had become ill, she was not in touch with any agencies. She became low in mood and started experiencing auditory hallucinations, and complained that she could hear voices telling her to harm herself and saying that her children would be taken away from her.

The team began contact with Vebhavi after she was referred by her GP, and found her to be very anxious and frightened and unable to make eye contact. She was very afraid that she would lose her children if she was taken into hospital. Her living conditions were poor and she was having trouble with finances and welfare benefits. The team decided that it was best to try and improve Vebhavi's condition, while she remained with her children in the community.

The team saw her for five weeks, during which time they continually assessed Vebhavi's risk to herself and to her children. Initially staff saw her twice a day to give medication and assess symptoms. Following each visit they obtained agreements that she would contact them if she felt she might harm herself or her children, and was given the 24 hour contact number to phone at any time.

Home treatment team staff were also able to offer practical and psychological support to Vebhavi. Her children remained with her at home, but she was assisted by having access to child care, as well as being put in contact with a social worker and the local CMHT who assisted with finances and furnishings. Vebhavi was also encouraged to explore any areas that were causing her distress, such as separation from her husband and family.

Graham

Graham is 51 years old and lives with his 75 year old mother in Birmingham, who is his immediate carer. He has two sisters and two brothers. Previous to his first episode of illness ten years ago, he worked as a mechanical engineer, initially for a large firm, before becoming self employed. Since he started experiencing mental illness, he has had numerous admissions to psychiatric hospital, and has a history of non-compliance with his anti-psychotic medication, which has regularly contributed to relapse.

When the home treatment team started seeing Graham, he was suffering from paranoid delusional ideas about his neighbours, which pre-occupied him greatly, and was experiencing agitation and sleeplessness. He was not eating and had become thought disordered and unable to concentrate.

Graham's mother had become unable to cope with the situation, and needed support. The team discovered that this relapse was due to Graham's recent refusal to take his medication, and so recommenced his dosage immediately, over-seeing him taking the tablets until he had stabilised. They offered his mother psychological and practical support and discussed his path to relapse with her.

Graham was engaged with the team for five weeks. Staff continuously monitored his medication, symptoms and risk, initially visiting every day to ensure that he was taking the prescribed medication. They decided it would be helpful for Graham and his mother to receive education and information about medication, to help improve compliance.

The team talked to Graham about the levels of personal distress he experienced when not taking his tablets, compared to when he was. Staff also engaged him in discussions about the thoughts and feelings that were troubling him, whilst exploring the reality of these.

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Sustaining the Service

One criticism levelled at such intensive community treatment teams is that they are usually only effective in the short term. It has been claimed that this is due to over-reliance on charismatic leadership and high levels of staff motivation. Critics have suggested that such teams will fail after a period of time, as staff move on and the focus cannot be maintained. The issues around sustaining the service were examined at length before establishing the team. These issues are discussed below.

Recruitment

Team effectiveness will depend on the staff who work within it. We advertised nationally for this team and received a very good response. Staff needed to have an understanding of what we wanted to achieve, and needed to understand the implications of working with this team (such as dedication to being on 24 hour call at times). If staff are not fully informed of what the team requires they can soon become unhappy and disillusioned, which has a detrimental effect on the team as a whole.

Of the fourteen staff who started with the team, in 1995, eight still remain. Of those who have left, the majority have done so for promotion, although two have mentioned the shifts and on-calls as contributory factors in exit interviews.

Training

An essential part of developing this team was the one month training given prior to becoming operational. This training included a two day workshop relating to the Sydney experience. Other elements of the training included:

- area orientation exercises including meeting other teams
- team building exercises
- role playing: how do you deal with the acute situation in the home?
- team discussion of operational issues.

High challenge, high support

The nature of the work is challenging, so there needs to be a high level of support. Support comes in the form of twice daily team reviews, regular team meetings and structured supervision within the team.

Mechanisms for identifying and dealing with stress

Consistently working with individuals experiencing acute mental health crises and working shifts and being on-call can lead to stress and ultimately staff 'burn-out' (Wykes *et al*, 1997; Prosser *et al*, 1996).

Because the team works together very closely, stress can be identified at an early stage and can be dealt with through supervision and informal team support. Flexibility also exists within the shift system where necessary. The results of a recent staff survey on stress factors within the team have been very useful.

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Maintaining focus on target group

The maintenance of target group focus has been a continuing process. There have been suggestions that the target group should be broadened or the referral criteria be relaxed, but losing this focus could have a major impact on the effectiveness of the team.

Support for the model from higher management groups

The implementation of this team has continually received the full backing and support of the Trust board, purchasers and local authority. This has been invaluable for sustaining this service.

Evaluation

Team effectiveness is continually being evaluated, concentrating on the following areas.

1. Number of admissions to hospital.
2. Activity data for home treatment team.
3. Comparison of level of need for clients in Home Treatment and in-patient unit to ensure the team maintains focus using BPRS, GAF and FACE.
4. Service user/carer satisfaction.
5. In-patient bed usage.

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What makes an effective home treatment team?

From the experience of the Home Treatment team in Yardley/Hodge Hill, Birmingham, the following would appear to be important elements when setting up such a team:

- *Home treatment is accepted as a core service and is integrated into the total service provision*
- *Clearly defined target groups*
- *24 hour 7 day a week service*
- *Quick access and quick response*
- *Effective communication within the team*
- *Systems for communication with other teams and agencies*
- *Good linkage with other teams*
- *A range of alternatives to hospital admission*
- *Multi-disciplinary*
- *Constant evaluation of effectiveness*
- *Strategies for sustaining a high level of service*
- *To be effective the team needs to offer crisis resolution as well as crisis assessment.*

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