Brief Intensive Treatment Home (TIBD) Team Clinical Plan

1. Context

Since the deinstitutionalization and large-scale deployment of outpatient monitoring of people with mental health disorders, the various Western health systems have been deploying new service models in order to avoid hospitalization, when possible, for people whose clinical needs temporarily exceed the care capacity of the ambulatory teams. Among these innovations, Quebec has notably integrated intensive community monitoring teams (SIM) to meet the needs of people with serious and persistent mental disorders who require long-term follow-up, as well as crisis interventions, which provide temporary accommodation and support for people experiencing a psychiatric, psychosocial or post-traumatic crisis.

In several regions of Quebec, including in the territories served by the CIUSSS Centre-Sud-de-l'Île-de-Montréal (CCSMTL), crisis interventions are the responsibility of crisis centers (Le Transit pour le territory Jeanne-Mance and L'autre Maison for the South-West-Verdun territory). Some crisis centers have mobile teams that can travel within the community to resolve a psychosocial or psychiatric crisis, and are therefore similar to mobile crisis resolution and home treatment teams (ERCTD). However, the crisis follow-up offered by this type of team is generally very brief and aims mainly to prevent dangerousness, to help the person resolve the crisis, to regain their psychological balance and to offer a liaison service (reference for longer term needs, if necessary). In addition, although the crisis centers target all clients in a crisis situation not requiring immediate hospitalization, the vast majority of the clientele served is made up of people with an anxiety-depressive disorder or people in a crisis situation without a diagnosis. mental health. Clientele reporting a serious mental disorder (psychotic or bipolar) represent less than 10% of referrals and psychiatric clientele with medical comorbidity, including geriatric psychiatric clientele, represent less than 1% of referrals to crisis centers[1,2] .

The deployment of ERCTDs represents an innovative alternative solution to hospitalization during acute episodes of mental disorders. The hospitalization model

---

[1] Corriveau, M.-P. (2014). *A new crisis intervention model applied in an accommodation context* [Master's thesis, Laurentian University of Sudbury]. https://zone.biblio.laurentian.ca/dspace/handle/10219/2251

[2] Aimé, A., Leblanc, L., Séguin, M., Brunet, A., Brisebois, C. and Girard N. (2013). The presence and severity of mental health disorders linked to the nature of the crisis, the dangerousness and the crisis services offered? *Mental health in Quebec,* 38(2), 235-256.

home and crisis resolution is established in several countries3, and despite certain differences, common elements considered essential are shared by these different services4 :

- these teams are generally very mobile: they can travel in community or home of people in crisis;
- they are available beyond regular outpatient hours;
- they offer frequent contact for an episode of care lasting relatively short;
- they are dedicated to resolving the psychiatric or psychosocial crisis;
- they contribute to psychiatric treatment directly in the homes of the people or members of their entourage;
- they refer clients to other services for long-term follow-up.

2. Summary review of evidence and guidelines

The effectiveness and efficiency of ERCTDs are documented in the scientific literature, although the level of evidence is considered low for most results. A Cochrane review5 traced six studies that examined the effect of ERCTD teams compared to regular care (hospitalization and regular outpatient follow-up) for people with a serious and persistent disorder (one of the inclusion criteria of this review was that the majority of clients have a diagnosis of schizophrenia). These teams did not all adopt the same model, but shared the common elements presented above.

Among these teams, only one came from England and had adopted the model recommended by the guidelines of the English *Royal College of Psychiatrists6 .* Note also that one of the teams included in the Cochrane review was deployed in Montreal7. In a way

[3] The models differ greatly depending on the health systems: at the start of the millennium, the government of England developed a national policy to force the large-scale implementation of *Crisis Resolution and Home Treatment Teams* (CRHT). These offer an intensity of services that approaches home hospitalization. In continental Europe, rapid crisis intervention teams (such as ERIC in France), often attached to crisis centers, respond to both psychosocial crises (e.g. a situation of domestic violence) and natural crises. psychiatric, mainly of moderate intensity (e.g. major depression with psychosocial issues). In the United States and Canada, several crisis resolution teams have developed according to Gerald Caplan's crisis model and offer non-specialized treatments to all people whose psychosocial functioning is impaired. For a non-exhaustive review, see the informative note: Use of a mobile psychiatric crisis intervention team in the prevention of hospitalizations produced by the University Institute of Mental Health of Quebec.

[4] Johnson, S. et Thornicroft, G. (2004). The development of crisis resolution and home treatment teams. Dans S. Johnson, J. Needle, J. Bindman et G. Thornicroft (dir.), *Crisis resolution and home treatment in mental health.* Cambridge, London.

[5] Murphy, S, Irving, C.B., Adams, C.E. et Driver, R. (2012). Crisis intervention for people with severe mental illnesses. *Cochrane Database Syst Rev.*

[6] Johnson, S., Nolan, F., Pilling, S., Sandor, A., Hoult, J., McKenzie, N., White, I.R., Thompson, M. et Bebbington, P. (2005). Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. *BMJ,* 331(7517), 599-603.

[7] Fenton et al., 1979.

Generally, these studies demonstrated a significant reduction in the use of hospitalization at three months following the use of ERCTD, with a trend indicating the maintenance of this reduction up to one year. They also demonstrated a reduction in the number of post-crisis days in hospital or crisis center. Finally, the studies demonstrated an improvement in the mental state of users, a significant reduction in the number of families reporting a high burden as well as increased satisfaction on the part of users and their families. In return, ERCTDs reported a higher rate of abandonment of the established protocol; user engagement is thus one of the challenges of the model. In another review of the literature, Sjolie (2010)8 demonstrated that, in general, hospitalization rates seem to decrease following the implementation of home treatment teams, while Kalucy et al. (2004)9 demonstrated that the implementation of a “mental health hospital at home” reduces the number of requests to the emergency department.

A recent study examining the effect of ERCTD implementation on the overall reduction in the need for hospitalization in the United Kingdom was inconclusive. Certain sectors noted a marked reduction in the use of hospitalization following the implementation of ERCTDs while no reduction was noted in other sectors during the same period. In this study, the comparison of ERCTD models suggests a link between the reduction in the number of hospital admissions and two factors: (1) the presence of a psychiatrist within the ERCTD team and (2) the role assumed by ERCTD as *gatekeeper.* Gatekeeping is the principle according to which, in some service organizations, the *ERCTD* evaluates all patients before they are admitted to hospitalization units, thus taking an active role in avoiding the need for hospitalization for any patient for whom this is possible.

Randomized controlled studies have not demonstrated significant differences between the “ERCTD” group and the control group for rates of suicide or suicide attempts, but interpretation of these results should be made with caution, given the small sizes of the populations studied and the limited number of these critical events in the general population (Murphy et al., 2015). It is well documented in the literature that the few months following hospital discharge represent a period when patients are particularly at risk of making a suicidal gesture, regardless of the implementation of ERCDs (Chung et al. , 2017;

Hunt and colleagues (2009) studied cases of suicide occurring within 3 months of hospitalization, before the national implementation of ERCDs in England.
This study reveals that 43% of these suicides occurred in the first month following discharge, and that in 47% of cases, the patient committed suicide before going to their first appointment in the community. This study concludes by reiterating the importance of offering a

[8] Sjolie, H. et Karlsson, B. (2010). Crisis resolution and home treatment: structure, process, and outcome; a literature review. *J Psychiatr Ment Health Nurs,* 17(10), 881-92.

[9] Kalucy, R., Thomas, L., Lia, B., Slattery, T. et Norris, D. (2004) Managing increased demand for mental health services in a public hospital emergency department: a trial of ‘Hospital-in-the-Home’ for mental health consumers. *Int J Ment Health Nurs,* 13(4), 275-281.

intensive support in the community during the critical period following hospital discharge in order to provide a safe connection to appropriate services in the community. Some authors suggest that ERCD is not an appropriate treatment for some more vulnerable patients. According to Hunt (2014), 44% of patients who committed suicide while receiving ERCD services lived alone and 49% had recently experienced negative life events. However, these characteristics appear to be important factors in suicide for all patients, regardless of where they are treated. Indeed, 48% of patients who committed suicide in the community (without being followed by an ERCD) and 42% of those who committed suicide in a hospital environment lived alone, while a little more than 40% of patients in the hospital hospital or community had also just experienced recent adversity (Hunt et al., 2014).

Some studies and guidelines have attempted to identify the essential active ingredients that an ERCTD should have to be fully effective: treatment should be short-term (less than six weeks) and intensive (more than two visits per day if necessary; at least 50% of users are seen twice a day during the first three days of follow-up, and seven times during the first week) and links with other community services must be made as soon as the crisis is resolved. During circumstances

exceptional circumstances (e.g. temporary absence of the caregiver, introduction of medication), it should be possible to provide constant presence for up to four hours. When necessary, the ERCTD must have access to other crisis services, mainly crisis accommodation centers and day hospitals.

A systematic review published in 201510 broadened the inclusion criteria to examine the effect of ERCTDs. The authors thus analyzed 69 studies:

- 5 comparing two ERCTD models;
- 16 comparing ERCTDs to hospital admissions;
- 4 national surveys;
- 24 surveys and qualitative interviews with ERCTD stakeholders;
- 20 practice guides (expert or government).

Even if the description of the characteristics of the 20 CRT teams studied was sometimes incomplete:

- 16 offered a medical service with a psychiatrist on the team;
- 14 controlled access to hospital admissions;
- 13 offered 24-hour service;
- 13 were multidisciplinary;
- 9 discharged the patient quickly.

[10] Wheeler, C., Lloyd-Evans, B., Churchard, A., Fitzgerald, C., Fullarton, K., Mosse, L., Paterson, B., Galli Zugaro, C. et Johnson, S. (2015). Implementation of the crisis resolution team model in adult mental health settings: a systematic review. *BMC Psychiatry, 15,* 74.

Two scales used to measure the fidelity of ERCTD implementation can serve as guidelines to specify the contours of the service: the *CORE Crisis Resolution Team Fidelity Scale11* and the *Home Treatment Accreditation Scheme* (HTAS)12. The CORE is a scale developed by Dr. Sonia Johnson of *University College London.* Its objective is to optimize the development and operation of home crisis resolution teams. HTAS is an accreditation given by the *Royal College of Psychiatrists* to teams in England meeting certain implementation standards. The HTAS aims to help teams assess themselves to promote best practices, ensure high quality of care and uncover opportunities for improvement.

3. The mandate

The mission of the home hospitalization team is to offer any person in the CSSS Jeanne-Mance territory experiencing a psychiatric crisis rapid access to assessment and treatment services at home. By assessing people before emergency services, it can help avoid recourse to them. By offering treatment at home, it helps avoid hospitalizations. The mandate of the hospitalization team is complementary to that of the crisis centers, rapid intervention modules and brief intervention units, which also make it possible to prevent recourse to emergency services and/ or long-term hospitalization.

4. The objectives

- Avoid resorting to emergencies by assessing people in advance;
- Propose a safe alternative to hospitalization by assessing people in the emergency room and offering hospitalization at home for anyone whose situation allows it *(gatekeeping) ;*

- If hospitalization is required, shorten its duration;
- Combat stigma by providing a normalizing care experience;
- Promote the retention in the living environment of people in crisis situations;
- Promote the maintenance of usual functioning;
- Identify and resolve the social, environmental and relational problems that contribute to the crisis;
- Involve the support network;
- Teach crisis management and relapse prevention strategies *in situ*
- Once the mental state is stabilized and the crisis resolved, connect the person to the service adapted to their situation (mental health network, crisis center, community organization, etc.).

---

[11] *The CORE Study.* University College of London. http://www.ucl.ac.uk/core-study

[12] Royal College of Psychiatrists. (2017). *Home Treatment Accreditation Scheme (HTAS) ; Standards for Home Treatment Teams – Third Edition* (publication no CCQI262). www.rcpsych.ac.uk/HTAS

5. Description of the clientele and eligibility criteria

5.1 Eligibility Criteria

- Be aged 18 or over;
- Have a home in the territory of the CSSS Jeanne-Mance;
- Present a deterioration in mental state of such intensity that recourse to emergency or hospitalization services is required immediately or in the following days;
- If hospitalization was necessary, it began ÿ 7 days;
- The person and their loved ones accept the follow-up proposed by the team.

5.2 Contraindications

- Too high risk of self- or hetero-aggression;
- Unsafe environment;
- Presence of cognitive disorders hindering the potential for collaboration;
- Presence of an intellectual disability or an autism spectrum disorder;
- Personality disorder or substance abuse at the forefront.

6. Description of services

6.1 Origin and prioritization of references

- UPS-J (priority 1);
- Notre-Dame Hospital emergency (priority 2);
- Outpatient psychiatry clinic at Notre-Dame Hospital, responding psychiatrists and IPSSM from CLSC Des Faubourgs (priority 3);
- Brief hospitalization unit at Notre-Dame Hospital (priority 4);
- Regular hospitalization units at Notre-Dame Hospital (priority 5).

6.2 SEO Process

- Call by the referent to the liaison worker;
- Sending the reference form by email;
- Immediate support or discussion in liaison meeting (once per week).

6.3 Initial assessment

- For priority 1 references, evaluation on the same day of the reference;
- For priority 2 references, evaluation within 24 hours of the reference ;
- For priority 3 references, evaluation on the same day of the reference or in the 7 days following this;
- For priority 4 and 5 references, evaluation within 7 days of this.

The assessment is done in person to assess the client's needs, explain the services of the home hospitalization team and ensure that the person and their loved ones accept the follow-up.

The assessment takes into consideration: (1) on the one hand the different risk factors of the person such as suicidality, the risk of committing hetero-aggressive acts, self-harming behaviors and addictions and (2) on the other hand, protective factors, all with a view to positive risk management.

Following the assessment, if the person is eligible, the team begins treatment at home. Otherwise, recommendations are made to the referent to redirect the request towards the most appropriate resource.

6.4 Home treatment

Interventions in the environment

- During the first days, visits twice a day to the person's home (or in the community); at least 50% of users are seen twice/day during the first 3 days of follow-up;

- As the mental state progresses, the frequency of contact is gradually reduced, up to approximately 2 times/week at the end of follow-up;
- The meetings are of variable duration, depending on the mental state and needs of the person. person ;
- The objectives of the meetings are;
    - o To assess the mental state;
    - o Evaluate the effectiveness and tolerance of pharmacological treatment;
    - o Identify the psychosocial and relational factors that contribute to crisis;
    - o Develop solutions to identified psychosocial problems;
    - o To implement these solutions (e.g. support to collect food baskets, to meet with a owner, employer, etc.);
- Members of the entourage can be involved in meetings at any time moment ;
- Members of the entourage can also benefit from individual meetings which aim to support them and guide them in accompanying their loved one.

Telephone interventions

- The person and members of their entourage can call at any time between 8:00 a.m. and 11:00 p.m.;
- A member of the team is designated to answer the phone each day;

- Telephone intervention aims to reduce the level of distress by actively listening, providing advice and suggesting medication if necessary;

- For members of the entourage, the telephone intervention also aims to provide support and psychoeducation regarding the state of health of their loved one.

Medical follow-up

- The person is met at least once a week by the psychiatrist treating;
- The psychiatrist visits the person's home as often as possible, at least once during follow-up;

- Follow-up includes assessment of mental state, diagnosis and implementation of a treatment.

Duration of follow-up

Follow-up is approximately 6 to 9 weeks.

6.5 End of tracking

At the end of follow-up, a relapse prevention plan is developed in collaboration with the person, their network and partners. This plan equips the person and those around them to prevent future crises or, if they occur, to manage them as a community.

The team ensures that follow-up is relayed to the most appropriate service for their situation (e.g. follow-up in an outpatient psychiatric clinic, return to the family doctor, follow-up of varying intensity, community follow-up, etc.) .

6.6 Information for patients and their entourage

From the start of monitoring, users and those around them receive clear information concerning :

- The team's mandate;
- Inclusion criteria;
- Reference modalities;
- The treatments and interventions proposed;
- The monitoring modalities;
- Opening hours;
- The telephone number;
- The point of contact in the event of an emergency outside of opening hours.

7. Human resources

7.1 Team composition

The team is made up of 12 to 14 professionals as well as a department manager.
In addition, two psychiatrists will be involved, for a full-time equivalent. In the context of a labor shortage, the composition of the team may vary depending on availability during recruitment.

Projected team composition:

Job title	ETC	Salary estimate
IPS nurse	1	129 155 $
ASI Clinician Day-evening	2	226 951 $
Nurse day-evening	2	190 454 $
Clinical nurse Day-evening	4	421 680 $
Social worker	2	165 910 $
Occupational therapist or psychoeducator	1	85 786 $
Administrative Agent(s).	1	50 856 $
Service chef	1	108 970$
Total	14	1 379 761$

In order to ensure twice-daily visits, all stakeholders will be called upon to intervene with the person. However, a nurse will be designated as a “pivot” to coordinate the care plan.

The caseload should be 1 to 3 people per worker.

Partnerships and service corridors will be developed so that users can benefit from consultation with other professionals if necessary:

- Drug addiction worker
- Peer helper
- Family peer helper
- Pharmacist in a hospital environment

7.2 Roles and responsibilities of stakeholders

Psychiatrists

- Decide on admission requests submitted with the ASI and the intervenor of liaison ;
- Evaluate the client within 24 hours of admission;
- Determine the diagnosis;
- Implement medication if required;
- Guide the treatment plan;
- Set up post-stay follow-up if required and liaise with psychiatrists external teams who will follow up with customers.

Nurse practitioner specialized in mental health (IPSSM)

Clinical nurses

- Are the main stakeholders who make home visits;
- Assess mental state;
- Report relevant information to the IPSSM and the psychiatrist;
- Communicate important information regarding the condition medical care of people to other members of the team;
- Review medical records;
- Take care of medication management;
- Manage links with the community pharmacy;
- Provide basic medical care (including taking vital signs);
- Consult regularly with the social worker in the case;
- Initiates/follows up on current referrals (e.g. psychologist, SIV, etc.);
- Liaise with external medical teams;
- Participate in daily meetings;
- Participate in medical appointments;
- Ensure consistency of the treatment plan overall.

Pivot nurse • Ensures that the medical file is duly reviewed and complete (including recent consultations, laboratory results, medication and non-medication prescriptions, up-to-date pharmacological profile, medication monitoring protocols, etc.);

- Ensures that the work plan is up to date;
- Ensures that interventions are consistent with the treatment plan;
- Ensures that post-stay follow-up is planned and liaises.

Social workers

- Participate in home visits, sometimes alone, sometimes with nurses;
- Carry out an assessment of the person's social functioning;

- Identify psychosocial stressors contributing to the crisis;
- Support people in various procedures (e.g. regularization of their financial situation, socio-professional reintegration activities, etc.);
- Communicate important information regarding the situation psychosocial aspects of people to other members of the team;
- Initiates/follows up on current referrals (e.g. psychologist, SIV, etc.);
- Ensure liaison with external psychosocial teams (both at the start of follow-up only to ensure relay at the end of monitoring);
- Participate in daily meetings;
- Attend medical appointments.

Psychoeducator

Occupational therapist • Participates in home visits, sometimes alone or with another member of the team; • Carry out a functional assessment of the person in their living environment;

- Supports early rehabilitation, the reactivation process, the resumption of positive life routines and engagement in different occupational spheres; • Supports social and professional integration; • Identifies personal and environmental factors impacting autonomy and occupational commitment;
- Supports the development of independent living skills and abilities to to promote the maintenance of the person in their living environment; • Through activities, helps the person to invest in their interests, recognize their strengths, actualize their power to act and make occupational choices; • Supports the person in their life plans and their recovery process; • Participates in daily meetings;
- Participates in medical appointments.

Liaison speaker

- Receives all references;
- Consults the file of the person referred and, if necessary, speaks with the referent to obtain details;
- Travels to assess the patient, ideally in the company of the psychiatrist and a nurse (who will become the pivotal nurse);
- In collaboration with the psychiatrist, decides whether or not the person ;
- If follow-up is not indicated, makes recommendations to the referent;
- Maintains statistics regarding requests received.

Assistant Head Nurse • Coordinates the

team in place to ensure efficiency and coverage of visits
at home for each client;

- Projects the visit table for the coming week;
- Ensures the proper distribution of professional tasks;
- Leads team meetings;
- Participates in joint visits with staff to get to know the people followed by the team, train stakeholders, help resolve complex situations, etc. ;

- Carry out regular staff evaluations;
- Determines training needs;
- Acts as a consultant for the team in difficult situations;
- In the absence of the psychiatrist, makes connections with him;

Service chef

- Ensures the planning of professional schedules;
- Leads the weekly huddle;

Administrative Agent(s).

8. How the team works

8.1 Working hours

- A nursing shift from 8:00 a.m. to 4:00 p.m.
- A nursing shift from 3:00 p.m. to 11:00 p.m.
- A shift from 8:00 a.m. to 4:00 p.m. for other professionals (social workers, occupational therapists, etc.)
- Staff rotation to ensure coverage 7/7 days.

8.2 Meetings

- A meeting in the morning during which the notes from the previous evening's visits are reviewed, and during which the plan for the day is established;
- A meeting between 3:00 p.m. and 4:00 p.m. during which both shifts are present and during which treatment plans are revised; • One meeting per week

to discuss pending cases, attended by the head of department, the psychiatrist, the IPSSM, the ASI and the liaison worker.

9. Training of stakeholders

- Suicidal risk assessment
- Community Omega
- P-38

- Mental status assessment
- How to intervene with people suffering from psychosis?

10. Evaluation methods

10.1 Presentation

The evaluation mandate concerns *the evaluation of the implementation of the home hospitalization and crisis resolution service.* Implementation evaluation, also known as process evaluation, is particularly useful to decision-makers by showing them what is happening inside a service, notably facilitating reporting to donors. This type of evaluation is also an important step before evaluating the effects of a program insofar as it ensures that the effects obtained are linked to the intervention or to specific elements of the intervention.

The proposed implementation evaluation will focus on the analysis of the contextual determinants of the degree of implementation of the intervention. Indeed, there is already literature on the form that a home hospitalization and crisis resolution service should take.
Based on this literature, we propose to evaluate variations in the degree of service implementation. In this way, it will be possible to determine to what extent the service will have been implemented as planned. It will then be possible for decision-makers to make the adjustments deemed necessary.

In addition, certain measures examining the effect will begin to be monitored during the implementation phase, such as for example the use of hospitalization and the duration of hospitalization, taken from medico-administrative data and some clinical measures of the the user and those around him.

10.2 Evaluation methods

The evaluation of the implementation of the HDRC will mainly draw on two sources: the “CORE Crisis Resolution Team FIDELITY SCALE ”13 and the “Home treatment accreditation scheme (HTAS) – Standards for home treatment teams – Third Edition ”14.
The implementation evaluation will pursue specific objectives which will be determined by committee. Here are some examples of goals that could be followed:

- Describe the users of the service
    - o Socio-demographic data: age, origins, place of residence
    - o Medical-administrative data: diagnosis, hospitalization history, o Data on accommodation
- Describe the degree of implementation of the guiding principles
    - o composition of the caseload, average duration of follow-up, number and average duration of visits, staff training, composition of teams, staffing

[13] http://www.ucl.ac.uk/core-study
[14] www.rcpsych.ac.uk/HTAS

- Describe the context leading to a reference to the service
    - o Reference and intervention deadline, description of the end of monitoring process and reference/feedback to the treating team
- Describe the intervention model of the service's clinicians
    - o nature of interventions, documentation of adherence to treatment, documentation of suicide/homicidal risk, etc., support coverage for those around them, presence of a PII and relapse prevention
- Describe the service's relationship with its partners
    - o Comparison between the service offering and that of crisis centers, teams ambulatory

After an implementation period (6 months?), a measurement of the effects will be undertaken. This measure will include data that will be able to measure the effect of hospitalization at home for: - The use of hospital resources

- o The number of emergency room visits and the duration of hospitalizations will be monitored both individually and at the program level using medico-administrative data provided by the InfoCentre.

- The evolution of the clinical severity of the mental state
    - o For example like the handover of the HoNOS tool.
- The evolution of the mental condition and the burden of those around us
    - o To see if we take a tool like the Psychological Distress Index of the Quebec Health Survey (IDPESQ-14) if we do interviews.

Indicators	Measure
1. Total number of clients admitted to home hospitalization	Nbr
2. Average duration of care episodes (days)	Nbr
3. Number of patients who visited the emergency room or admitted 6 months later HAD	Nbr
4. Number of customers who decided not to complete their stay (abandonment rate)	Nbr
5. Origin of references to home hospitalization	Place
6. Post-hospitalization referral location at home	Place
7. Number of clients who required hospitalization during the home hospitalization episode	Nbr

Satisfaction questionnaire

	En tant que famille ou proche recevant des services de l'équipe du traitement intensif bref à domicile **Quel est votre degré de satisfaction à l'égard….**	**pas du tout satisfait**	**peu satisfait**	**moyennement satisfait**	**assez satisfait**	**très satisfait**
1	des services reçus à domicile (rencontre, information,…).	**1**	**2**	**3**	**4**	**5**
2	de la facilité à rejoindre le personnel clinique (infirmières, travailleur social, psychiatre).	**1**	**2**	**3**	**4**	**5**
3	de la fréquence des rencontres avec le personnel clinique.	**1**	**2**	**3**	**4**	**5**
4	de la rapidité d'intervention en cas d'urgence.	**1**	**2**	**3**	**4**	**5**
5	de la qualité de l'ensemble des services que vous avez reçus.	**1**	**2**	**3**	**4**	**5**
6	de la compréhension du personnel clinique face à ce que **vous** vivez.	**1**	**2**	**3**	**4**	**5**
7	de la façon dont le personnel clinique respecte vos besoins et vos limites à titre de proche ou de famille.	**1**	**2**	**3**	**4**	**5**
8	de la façon dont le personnel clinique vous aide à développer vos habiletés à faire face aux problèmes rencontrés par la personne suivie par l'équipe de TIBD.	**1**	**2**	**3**	**4**	**5**
9	de la façon dont vous êtes impliqué dans les interventions proposées pour la personne suivie par l'équipe de TIBD.	**1**	**2**	**3**	**4**	**5**
10	de l'information que vous recevez sur l'état de santé de la personne suivie.	**1**	**2**	**3**	**4**	**5**
11	de la façon dont le personnel clinique vous a préparé à la fin du suivi de la personne traiter par l'équipe.	**1**	**2**	**3**	**4**	**5**