

Building Blocks:

Evaluation of a Home Based Service
for Patients with Acute Mental Illness
in North Kildare



Dr. Pat Gibbons, MD, MRCPsych.
Angela Cocoman, RPN, FFNRCSI, MsC.

2006



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Evaluation of a pilot project for home-delivered care for patients with acute mental illness in North Kildare

**Dr. Pat Gibbons, MD, MRCPsych.
Angela Cocoman, RPN, FFNRCSI, MsC.**

August 2006

This report has been prepared for the HSE to evaluate a pilot project for the provision of home-based care for patients with acute mental illness in North Kildare, in order to guide the decision whether to extend the project beyond the pilot year, and whether to extend the model to other parts of the service. Dr. Pat Gibbons is a consultant psychiatrist with the Kildare / West Wicklow Psychiatric Service. Angela Cocoman was Research and Development Advisor with the Psychiatric Nurses Association at the time of participating in this evaluation, and is now lecturing at the School of Nursing, Dublin City University.

August 2006

CONTENTS

1

1. BACKGROUND TO THE DEVELOPMENT OF HOME CARE IN NORTH KILDARE	
1.1: Introduction	1
1.2: Difficulties with the current model of care	1
1.3: Home-based care for the mentally ill: New services in the UK and Australia	2
1.4: Home-based care in Ireland	3
1.5: Summary of the potential benefits of home-based care	4
1.6: Potential pitfalls in providing home care	5

2

2: DEVELOPMENT AND DESIGN OF THE NORTH KILDARE HOME CARE PROJECT	
2.1: Initiation of the project.	6
2.2: Outcome of the planning phase	7
2.3: Systematic assessment of patient care needs.	7
2.4: Development of protocols, procedures and operational guidelines for Home Care Project.	8
2.5: The Training Programme	9

3

3: EVALUATION OF THE PILOT PROJECT YEAR OF THE NORTH KILDARE HOME CARE TEAM:	
3.1: Descriptive statistics on referrals for home care	10
3.2: The range of clinical problems in patients accepted for home care	10
3.3: Audit of completion and documentation of standardised assessments.	11
3.4: Liaison with General Practitioners	12

4

4: IMPACT OF THE INTRODUCTION OF THE HOME CARE PROJECT	
4.1: Introduction.	13
4.2: Impact on admission rates to the Lakeview Inpatient Unit.	13
4.3: The effectiveness of home care in reducing symptom levels.	14

5

5: THE SUBJECTIVE EXPERIENCE OF HOME CARE IN PATIENTS AND THEIR RELATIVES & CARERS	
5.1: Methodology	15
5.2: Administration of the questionnaires	16
5.3: Survey results	16
5.3.1: Patient satisfaction with home care - quantitative data	16
5.3.2: Satisfaction of relatives/carers with home care - quantitative data.	16
5.3.3: Level of Family Burden	17
5.3.4: Satisfaction of patients and carers - qualitative data	17
5.3.5: Discussion	19
5.4: The impact of the introduction of Home Care on nursing staff.	19
5.5: Experience of other Mental Health Team members	21

6

6: CONCLUSIONS AND RECOMMENDATIONS	23
REFERENCES	25
APPENDICES	27

1 BACKGROUND TO THE DEVELOPMENT OF HOME CARE IN NORTH KILDARE

1.1 Introduction:

The provision of specialist mental health care has gone through a period of radical change over the almost twenty years since the publication of 'Planning for the Future' in 1984. During the intervening years, the shift in the locus for the delivery of acute care from the Victorian Asylums to small units based in general hospitals has been largely completed, associated with a great decrease in the total provision of in-patient beds and a gradual increase in the availability of day-care facilities and community residences with varying degrees of support from sector-based staff. The shift from long-term asylum care to the current model of acute in-patient and community-based care has been largely welcomed by staff, patients and families, but has also presented considerable difficulties which have had a significant negative impact on the quality of care delivered to patients and their carers. Many of these difficulties have been particularly acute in the Kildare area generally, which in some ways has served as a 'pilot project' for the development of the psychiatric services during the 1990s.

1.2 Difficulties with the current model of care:

The major difficulties presented by the current combined in-patient/community care model can be summarised as follows. Firstly, there has been an increasingly acute shortage of in-patient beds to cope with the demand for acute care. This problem has been particularly acute in the Kildare area, which has the lowest provision nationally for in-patient care at approximately 0.2 beds per 1,000 population, compared to a national average of 2.0 per 1,000 and recommended figures of 0.35 per 1,000 (Green Paper on Mental Health) and 0.5 per 1,000 (Planning for the Future). Admission data to units throughout the Eastern Regional Health Authority area were analysed in depth in a lengthy report published by the Health Research Board (Keogh et al 1999). From these data, it is no surprise to learn that the Lakeview Unit had at that time a 'bed-requirement occupancy' of up to 145% of existing capacity (combining beds occupied at the time of the census, patients on leave and patients waiting for admission), the highest figure among the inpatient units included in the survey. Similarly, the Lakeview Unit was found to have the shortest mean length of stay (16 days). The maximum recommended bed occupancy rate is generally felt to be in the range 85-90%.

The principal cause of excessive bed occupancy identified in the report is the lack of appropriate support facilities in the community. The under-provision of acute in-patient facilities in Kildare is combined with a relative scarcity of long-term community residence facilities for patients with enduring mental illness. The Kildare services were reported to have the lowest provision of community residence places (4 places per 1,000 population over 15 years of age) compared to 12 per 1,000 population over 15 years in the catchment areas served by St. Vincent's Hospital, Fairview, St. Brendan's Hospital and Newcastle Hospital. Again, Day Care places were found to be fewest in the Kildare area (4 places per 1,000 population over 15 years).

While there has been some improvement in the provision of community facilities in the intervening years, deficiencies remain in several important areas. The in-patient unit thus remains under constant pressure due to over-occupancy. This reality presents difficulties in a number of important areas. Firstly, it is a cause of considerable extra stress for nursing and medical staff, both in the in-patient unit and at the community level. This may arise when acutely ill patients have to be nursed in the community while awaiting a vacancy on the in-patient unit, when acutely disturbed patients have to be nursed in the somewhat over-stimulating environment that the Lakeview Unit sometimes presents, and when there is pressure to discharge a less severely ill or perhaps less acutely dangerous patient to make way for a patient perceived to be at more immediate risk of harm to self or others. All of these factors increase the risk that the services simply react to crises rather than being in a position to proactively plan and implement a comprehensive and integrated treatment plan for individual patients. This form of crisis management carries obvious medicolegal implications for staff, and in the long-run, increases the risk of staff burn-out and attrition of staff numbers at a time of increasing difficulty in recruiting health professionals at all levels. Furthermore, some patients in crisis may be inappropriately admitted due to the lack of alternative acute care services, for example in the case of alcohol or drug abuse. At present, there are no plans to expand the availability of inpatient care in the Kildare/West Wicklow Psychiatric Service. Therefore, given the increasing number of patients presenting in need of acute care, alternative means of providing safe and effective care must be examined. The existing academic literature

in relation to the provision of acute care in a non-inpatient setting can provide guidance as to the alternative modes of care available in other health services.

Home-based treatment for the mentally ill: New services in the UK and Australia:

The possibility of providing care for even severely ill patients in a community setting has been investigated over the last 20 years or so in the U.S.A., the U.K. and Australia, as well as more recently in Ireland. A shift from in-patient to home-based care has been signalled in the U.K. in a recently published White Paper ("Modernising Mental Health Services", 1998). Much of the early research focussed on the provision of home care to the chronically ill and disabled, in an attempt to decrease the 'revolving door' type admissions which can characterise this group of patients. Stein & Test (1980) described a 'Training in Community Living' programme for such patients, and found that the clinical outcome was equal to that achieved by hospital care. Similarly, the 'Daily Living Programme', described by Muijens et al (1992) and Marks et al (1994) suggest that at 2-year follow-up, patients showed fewer symptoms, improved social function and greater subjective satisfaction with the care provided and with their quality of life than with standard hospital based treatment. The cost of community provided care to the chronically ill has not been consistently reported as differing from traditional models of care.

More recent studies have focussed on the provision of care in the home to the more acutely ill patient, most of which are based on a crisis intervention model, with an acute home-care team providing care for a time-limited period, after which ongoing care is arranged with the general community mental health team. A number of such services have been described in the U.K., Australia and Ireland. It is instructive to review these existing services in order to examine the way in which these services are structured and operate in practice.

Home-care in Manchester:

In Manchester, Harrison et al (1999, 2001) have described a service with both home based and day hospital components in the provision of acute care. The service covers two traditional sectors and is available on a 24 hour-a-day and 7 day-a-week basis, with staff on-site at the community base between the hours of 9am and 11 pm, and with 2 staff available on an on-call basis outside of these hours. The staff complement consists of 17 psychiatric nursing, occupational therapy and other support staff, complemented by 13 sessions of psychiatrist support at consultant and NCHD level. The team provides care for up to 30 patients at a time, and is orientated towards patients who would otherwise have been admitted to the inpatient unit.

Care is provided on a designated 'key-worker' system, and contact is at least daily in most cases, with day hospital care being available between 9am and 10 pm. Service activity over a 6-month period consisted of approximately 350 assessments. Of these, 200 patients (60%) were found to be suitable for acute care. The most frequent diagnosis was of schizophrenia (40%), depression (30%), bipolar affective disorder (15%) and other (neurotic and personality) disorders (15%). The mean length of time in treatment was 20 days. Of note is that 20% of home-treated patients were subsequently admitted to the in-patient unit, half of these as involuntary patients.

Home-care in Bradford:

In Bradford, a city with a high index of socio-economic deprivation and with a low provision of in-patient psychiatric beds (0.22 per 1,000 population), a 24-hour home-based crisis intervention service has also been developed in recent years, and is available on a 24 hour-a-day basis (Bracken et al 1999). The service covers two sectors in the city, with referrals being made by the sector consultant or on-call consultant (for out-of-hours referrals), and admission to the programme being dependent on the agreement of the patient, carers and team members.

The development of the service led to a 25% decrease in admissions from the relevant sectors, though this effect was less when locum consultants were in-situ, due to their unfamiliarity with the service. Compared to in-patients, home treated patients (two thirds) were more likely to suffer from severe mental illness (schizophrenia or bipolar disorder) and less likely to suffer from a personality disorder (10% compared to 33% of inpatients). The median length of time in home treatment was for 35 days (compared to 17 days for inpatient care). Of note is that 11% of home treated patients were subsequently admitted to inpatient care.

Home-care in Hertfordshire:

In a recently described service developed in Hertfordshire (Brimblecombe et al 1999), the team consists of 9 staff nurses, 1 staff grade psychiatrist, 3 sessions of consultant psychiatrist time and with on-call support

available from service S.H.O.s. The number of assessments over a one-year period was 318, of whom 60% were admitted to the home-care programme. Again, patients with a diagnosis of depression or schizophrenia were more likely to be eligible for home based care, while patients with acute hypomania were more likely to be admitted due to associated behavioural disturbance as were patients with a personality disorder, due to threats of self-harm. Approximately 15% of the home treated patients were subsequently admitted to inpatient care, mostly due to the perceived risk of self-harm.

Home-based care in Australia:

In Australia, a Crisis Assessment and Treatment service has been described by Carroll et al (2001) in response to government support for the development of home-based care and assertive community treatment for the enduring mentally ill. The service serves a population of 225,000 and includes an inpatient unit with 25 beds. The team consists of 12 staff nurses, a psychologist, a social worker, a manager and secretary, a psychiatric registrar and half-time consultant psychiatrist. Three staff are assigned to a day-shift, 4 staff to the evening shift and 1 staff is on-call overnight, though home assessments are not done during night hours. One staff member is assigned to A/E during day-time hours.

The crisis assessment and treatment team is available on a 24 hour-a-day basis, accepts referrals from a broad range of sources, including self-referrals and aims to assess all urgent referrals within 2 hours, with assessment usually carried out by 2 team members. The assessment consists of a standard psychiatric history and mental state examination, a rigorous risk assessment and an assessment of suitability for home-based treatment. All patients referred for inpatient admission are seen initially by the crisis assessment team, which thus acts as a gate-keeper to the inpatient unit, and also assesses inpatients with a view to facilitating early discharge. Continuing care plans are developed from the early stages of patient contact, to allow early referral to other ongoing support agencies. Within-team communication is facilitated by handovers between each shift, overseen by a consultant psychiatrist from Monday to Friday, and by weekly staff meetings. Over a one-year period, 1,400 patients were assessed. Of these, approximately 400 were accepted for home treatment, of whom 45% had a diagnosis of a neurotic disorder. The median duration of contact was 11 days.

1.4

Home-based care in Ireland:

The Cavan-Monaghan experience:

A number of home treatment services have been developed in Ireland over the last decade or so, most notably in Clondalkin and more recently in the Cavan-Monaghan areas. The experience of these services provides useful 'home-grown' examples of how this model of service can be adapted to the specific conditions of the Irish health services. The Cavan-Monaghan experience has been comprehensively detailed in a monograph (North Eastern Health Board 2001), from which the following data are drawn. The factors which gave impetus to the establishment of the home care initiative included the low G.P. referral rates (3.4 per 1,000 population per year), the disproportionate amount of in-patient resources were being dedicated to 'revolving door' patients, the high involuntary admission rate (60 per 100,000 population), and the high proportion of patients which were being lost to out-patient follow-up, resulting in over half of referrals to OPD withdrawing from treatment in an unplanned fashion.

These difficulties, by no means unique to the Cavan-Monaghan service, lead to a reassessment of the model of service delivery to acutely ill patients or patients in crisis, resulting in the development of a home-based treatment service which operates in conjunction with the community mental health team. The Home-Based Team for County Monaghan (population 52,590 in 2002) consists of 6 staff nurses and 1 unqualified community support worker, with support from 1 ACNO, 2 CPNs and a medical team of 1 consultant psychiatrist, 1 SR and 3 SHOs. The team operates in close cooperation with the community mental health team and the Addiction Resource Centre. The service is provided on a 9am to 9pm basis, 7 days per week. Referrals for HBT are jointly assessed by a doctor and other HBT team member, with a stated aim of assessing urgent referrals within 2 hours. Cases are managed on a 'key-worker' system, with a second key-worker designated to treat patients when the primary worker is unavailable. Team members have a small case load of 5-7 patients or so at any one time. Ongoing supervision and team communication is provided through two meetings per week between the HBT Team and medical staff.

In a 2-year period (1998-2000), the total number of referrals to the HBT service was 275, of whom 160 were first-time attenders and 120 or so were re-referrals. The diagnoses of these patients included depression (40%), schizophrenia (20%), mania (20%), personality disorder (10%), alcohol dependence syndrome (5%) and neurotic

illness (3%). The median length of stay in Home-Based care was 43 days. Of note is that during the 2-year period following the introduction of the new service, the overall admission rate decreased to less than 200 per 100,000 population per year (against a national average of 900 per year) and the overall rate of involuntary admission decreased from 60 to 30 per 100,000 population per year (which is less than half of the national average). At the same time, the overall referral rate to the service increased from 3 to 5 patients per 1,000 population per year.

The Clondalkin experience:

The Home-Care team in Clondalkin has been in operation since 1991 and serves a population of approximately 70,000 in a deprived area of Dublin. The team consists of 1 ACNO and 6 staff nurses, with support provided by 1 consultant, an SR and 3 SHOs, one of whom is assigned full-time to the Home-Care team. The referrals are made by the psychiatrist following discussion with the team at one of the two weekly team meetings, or can be made by direct liaison with the ACNO at other times. Following a routine psychiatric assessment and referral to the HBT, a standardized risk assessment (based on an instrument designed 'in-house') and standardized nursing assessment are carried out. Again, patients are nursed on a primary and secondary 'key-worker' system. Ongoing medical assessment is carried out at OPD, though patients can also be seen at the Day Hospital or on Domiciliary visits if appropriate. The team carries a small number of acute patients (usually approximately 10) as well as 30 'continuing care' patients, who are felt to require somewhat more intensive input on an ongoing basis than the CPN is usually in a position to provide. In an audit of the service carried out in 1996, it was found that the range of primary diagnoses nursed by the HBT included schizophrenia (approx. 33%), depression (25%), bipolar affective disorder (20%), neurosis (10%) and personality disorders (7%). The in-patient bed requirement for the catchment area has been consistently low, at approximately 4 beds at any one time.

1.5

Summary of the potential benefits of home-based care:

From the above review of services, a number of distinct advantages can be discerned. Firstly, the admission rate decreases by at least 25% in the least effective service in Bradford (Bracken et al 1999) up to a mean of 60% in services reviewed by Smyth & Hoult (2000), who also reported a large decrease of 80% in the average length of stay for those patients who did require admission. The decreased use of in-patient care for acutely ill patients is associated with less trauma and removal from usual social supports for the patient and a decreased exposure to social stigma. Decreased pressure on in-patient bed use also decreases the risk of premature and unsafe discharge of acutely ill patients to a low-support community service, with obvious medico-legal benefit.

Perhaps the most striking and persistent finding, however, is that home-care is greatly preferred by patients, who report that hospital care limits their liberty of movement and autonomy, emphasises behavioural conformity and often provides a poor physical and social environment for recovery and which distances them from their family (Smyth & Hoult 2000). Family members and carers also report a preference for home care, due to the increased opportunity for interaction with staff and increased opportunities for learning about the illness and involvement of carers in its management. There is also some evidence that access to home care reduces family burden among carers (Joy et al 2004). The strongly expressed preference of patients and their carers for home-based treatment carries the important clinical benefit of improved compliance with care and increased retention of patients in care until discharge is planned and agreed. The reduced need for coercive methods of care delivery have already been described.

A large majority of acutely ill patients can be successfully treated at home, as is clear from the large decrease in admission rates in sectors where home-based care is available. Where this issue has been specifically studied, 80% of patients who would otherwise be eligible for admission were found to be suitable for home-care (Smyth & Hoult 2000). From the data quoted above, it can be seen that home-care has been successfully targeted at patients with severe mental illness, especially schizophrenia and severe affective disorders. Clinical outcome has been found to be at least as good as standard care for every outcome measure which has been studied, and has proved superior in measures of the extent of the social network, quality of life and patient satisfaction (Kent & Burns 1996). Meta-analytic studies have showed no increased risk of suicide or DSH compared with hospital care (Joy et al 2004).

Factors that affect the success of Home-care:

A number of the factors which influence the success of home-care delivery have been described by Kent & Burns (1996), in relation to the establishment of an Assertive Community Outreach service for the provision of continuing care, though the principles described can be equally well applied to home-care for more acutely ill

patients. Kent & Burns emphasise the importance of developing a comprehensive operational policy, which addresses the following areas:

- the philosophy and aims of the service
- operational details in relation to staffing, training, deployment, size of case-load, case supervision and team accountability
- pathways in and out of the service
- definition of the role of the key worker
- definition of the role of the team leader/psychiatrist
- hours of cover provided

1.6

Potential pitfalls in providing home-care:

In a recent critique of home-care based on their experience of a pilot study carried out in Glasgow, Pelosi & Jackson (2000) have suggested that this form of care proved to be more expensive than hospital care, that the home-care team became immersed in dealing primarily with those presenting with social and emotional problems rather than the severely mentally ill and that home-care broke the continuity of care provided to the chronically ill by CPNs, as well as ignoring the role of GPs. These findings are at variance with all of the studies described previously, and suggest that the difficulties were due to a local rather than general failure of the model.

Staff burn-out and an increased burden of care on family members have also been proposed as potential pitfalls, as well as decreased access to in-patient care and traditional 'asylum' (Harrison et al 1999). However, as noted previously, the evidence available to date suggests that carers report a reduction in subjective burden while staff have responded positively to the increased clinical autonomy and improved opportunities for training and multidisciplinary work, and home care services commonly report a low turnover of staff (Harrison et al 1999). Another potential problem is that the increased emphasis on acute care in the community may lead to an attrition of experienced staff to work in the new services, leaving the residue of the most severely ill in-patients to be nursed by the least experienced staff. Anecdotal reports from staff in the Lakeview Unit suggest that this latter difficulty does apply to some extent, though the ongoing rotation of staff between the inpatient unit and the community services should ameliorate this problem.

Other potential pitfalls have been described by Kent & Burns (1996), including the potential for inefficient use of time, due to the need for regular 'hand-over' and team meetings. Because of the increased clinical independence, some staff may feel professionally isolated. There may be some confusion over the limits of clinical responsibility, e.g. between medical and nursing staff or between home-care and CPN staff. These operational difficulties are best addressed by the home-care management team with the development of clear operational guidelines on policies and procedures as described above.

Initiation of the project:

The North Kildare Home Care Project began as a joint initiative between the Multidisciplinary Teams (MDTs) in the North East and North West Sectors of the KWW Psychiatric Service. The North East Sector covers the general areas of Celbridge, Leixlip and Straffan, and serves a population of 35,000 people (Census 2002). The sector MDT consisted of a consultant psychiatrist, 2 NCHDs, 4 community nurses, 1 psychologist, 1 occupational therapist and 1 secretary. The North West sector serves a wider geographical area, extending from Maynooth to Enfield, with a population of 24,000 people. The North West sector MDT consisted of a consultant psychiatrist, 3 NCHDs, 3 community psychiatric nurses, 1 psychologist (part-time), 1 social worker and a secretary. In addition to the above, the sectors share a day hospital (providing care for up to 10 patients daily), located with the North East sector HQ in Celbridge, and a day centre located with the North West sector HQ in Kilcock.

Given the difficulties in obtaining additional funding for new initiatives from the traditional funding stream (i.e. via the annual Service Plans submitted to the funding authority and the subsequent 'Letter of Determination' process), an alternative source of seed funding for an innovative project in providing acute care to mentally ill patients was identified in the Partnership Fund. This initiative of the Irish Government aims to promote the inclusion of staff and their representative unions in the development of public services using a collaborative model of management, and was originally developed as part of the most recent Government Programme for Development and Progress.

Dr. Pat Gibbons, Consultant Psychiatrist for the North East Kildare sector, developed a proposal for the development of a Home Care project in conjunction with Karl Duffy, of the S.W.A.H.B. Partnership Committee, to be submitted in application to the National Partnership Fund. This application was successful, being awarded a sum of Euro 100,000 for the implementation of the proposal on a one-year pilot project basis. Once the funding was secured, a Partnership Steering Group was instituted, with representatives from the senior service management group (medical, nursing and administrative), staff unions (P.N.A., I.M.O., I.H.C.A. etc.) as well as from each of the professional groups making up the multidisciplinary teams (Nursing, Medical, O.T., Social Work, Psychology and secretarial).

The initial objectives of the Steering Group were:

- To develop a specific proposal for the restructuring of the available human resource to staff a home care team for the North East and North West Kildare sectors (with full-time nursing and medical staff, and access to support from other disciplines on an 'as-required' basis)
- To anticipate how this restructuring would impact on meeting the non-acute care needs of patients (especially the long-term mentally ill) and to plan for meeting these needs within the new structures
- To address the integration of the proposed Home Care service with existing acute care facilities (in-patient and Day Hospital) as well as with continuing care and out-patient services
- To address the likely impact of Home Care on the triage of G.P. referrals, the management of urgent referrals, and on communication with G.P.s both before and after psychiatric assessment. This issue was expected to be important in diverting acute referrals away from the A/E Department in Naas General Hospital, and in decreasing admission rates to the Lakeview Unit
- To identify appropriate standardised methodologies for the systematic assessment of patient care needs, both in terms of psychopathology, and in relation to psychosocial deficits that might be amenable to psychiatric intervention
- To identify appropriate training for staff in relation to the assessment of patient care needs, and in the development of clinical skills in responding to these needs
- To outline the procedures and operational guidelines by which the Home Care Project would operate in terms of the triage of referrals, the comprehensive assessment of patient care needs, the planning and provision of care, and the discharge of patients to a less intensive level of care
- To identify an appropriate methodology for the evaluation of the quality, clinical efficacy and efficiency of the clinical care provided to acutely ill patients and the acceptability of such care to patients and to their families

In order to progress these objectives in the most inclusive way possible, and in order to benefit from the experience and creative thinking of the whole staff, many of the practical tasks involved were devolved to a working group consisting of the entire teams from both the North East and North West sectors. While meetings of this large group were expensive in terms of staff time, they were very useful in involving the entire staff in taking ownership of the process of the development of the project. Most of the practical work in progressing specific aspects of the project was in turn devolved to working subgroups, consisting of 4-5 members of staff representing the different sectors and disciplines.

2.2

Outcome of the Planning Phase:

The total staff complement available to the two sectors consisted of the following:

- Two Consultant Psychiatrists (one in each sector)
- Four Psychiatric Registrars (two in each sector)
- One Senior Psychiatric Registrar (North West Sector)
- Seven Community Mental Health Nurses
- Two Nursing posts in the Celbridge Day Hospital (serving both sectors)
- Two Nursing posts in the Kilcock Day Centre (serving both sectors)
- One Social Worker (North West Sector)
- One Occupational Therapist (North East sector)
- One Psychologist (Part Time, North West sector))
- 2 secretarial staff (one in each sector)

The Partnership funding available allowed for the recruitment of two additional staff nurse posts. On discussion, the planning group agreed that the nursing and medical staff complement would be redeployed in the following way:

Of the 9 staff available to work in the community in both sectors, 5 were to be allocated to the Home Care Team, and the remaining four allocated to continuing care duties (2 in each sector). The Day Hospital and Day Centre staff was to remain as previously allocated.

The complement of 4 registrars was redeployed as follows:

1 registrar was allocated to the Home Care Team on a full-time basis (i.e. serving both sectors). 1 registrar was allocated to care for the inpatients from both sectors.

The remaining 2 registrars were allocated to general duties in the community (1 in each sector). The remaining staff were largely unaffected (in structural terms) by the introduction of the Home Care Project.

2.3

Systematic Assessment of patient care needs:

The working group addressing patient assessment identified a comprehensive battery of assessment tools that would be used in identifying patient care needs to complement the routine psychiatric assessment of patients presenting to the service. These included:

- **Funcional Assesement of the Care Environment (FACE):** this is an established instrument that assesses the psychosocial functioning of the patient, and identifies deficits
- **The Montgomery Asberg Depression Rating Scale (MADRS, Montgomery & Asberg 1979):** this instrument is sensitive to change in depressive symptoms over time, and was considered suitable to assessing response to treatment in depressed patients
- **The Hamilton Rating Scale for Anxiety (HAM-A, Hamilton 1959):** this scale measures anxiety symptoms in patients presenting with an anxiety disorder
- **The Positive and Negative Symptoms Scale for Schizophrenia (PANSS, Kay et al, 1987):** This is perhaps the most widely used measure of psychotic symptoms
- **The Clinician Administered Rating Scale for Mania (CARS-M, Altman et al 1994):** This is a measure of manic symptoms in bipolar patients
- **The TWEAK test (Russell 1991):** this is a screening tool for alcohol abuse

In addition, a Brief Risk Assessment checklist was developed in-house (in the absence of satisfactory screening tools from other sources) to identify patients with a significant risk of harm to themselves or others. In cases

where such risk was identified, a Comprehensive Risk Assessment procedure was developed to guide the proactive management of risk.

Furthermore, in order to facilitate the recording of the various assessments, it was agreed that the structure of the case file needed to be refined, and a working group was formed for this purpose. The new case file format has been implemented in the latter part of the pilot phase project.

2.4

Development of protocols, procedures and operational guidelines for the Home Care Project:

The Home Care Team developed a manual describing practice protocols and operational guidelines. In summary, these included the following:

Principles guiding the provision of care:

The working group felt it was of great importance to outline the essential principles which would guide the staff in providing care to acutely ill patients in their homes. These included the belief that care must be patient-centred, and emphasise support for the patient's autonomy and active involvement and responsibility for decisions around meeting their needs for care. Support for families and carers was also emphasised, where this was appropriate.

Triage for referrals:

A standardised referral form was developed for all referrals (i.e. both urgent and non-urgent) to both sectors. This referral form provided an option to indicate the perceived urgency of the need for assessment, and advised that for high-risk referrals, that the form be faxed to the Celbridge Mental Health Centre Office. In addition, the GP was invited to alert the Home Care Team to urgent referrals using an 'on-call' mobile phone to be carried by one of the Home Care Team during office hours, to ensure that the referral was attended to. Once all the appropriate referral information had been gathered, the case would be discussed with the appropriate consultant psychiatrist and a response planned and implemented.

Documentation of patient contacts:

It was agreed that the medical and nursing case records would be amalgamated into a single file. The allied disciplines continued to maintain separate records, for confidentiality reasons and also to prevent files becoming unwieldy.

The staff was to record relevant details of every patient contact, and to record any standardised assessments carried out, each record being signed and dated. It was agreed that assessments were most usefully completed as close as possible at the point of intake into home care, and repeated on discharge from home care, to provide an objective measure of change following treatment.

Clinical leadership and support:

While staff members were expected to operate at a greater level of clinical autonomy than in the standard care model, it was agreed that the 2 sector consultants (Dr. Sheila McGauran and Dr. Pat Gibbons) would continue to carry ultimate responsibility for clinical leadership and the quality of care provided to patients attending the service. For this reason, regular review meetings were felt to be of great importance, to allow the consultant to be actively involved in the management of each case and to support staff in providing day-to-day care for acutely ill patients and their families. It was decided that in addition to informal contact on a

day-by-day basis, there would be 2 formal team meetings between the Home Care Team and each sector consultant each week.

Liaison with Sector Mental Health Teams:

Given that there would be a constant interface between the provision of acute care in the home and care in other settings (e.g. combined with day hospital care or follow up care in the community), the importance of providing a seamless transfer of care was recognised. It was agreed that the best opportunity for liaison with the Mental Health Teams from each sector was at the weekly Team Meeting in each case, though in recognition of the fact that the Home Care Team needed to attend meetings for both sectors, they were to be excused from the Team Meeting once the home care patients had been discussed.

Liaison with Primary Care Providers:

Primary care providers, especially General Practitioners, have a vital role to play in providing and coordinating care to mentally ill patients in the community, both prior to and following discharge from a specialist secondary care service. It was agreed that close liaison with G.P.s would be important, both in providing ready access to a specialist assessment, and in providing feed-back to G.P.s as regards the outcome of the assessment and details regarding treatment needs and care provided. It was agreed that all patients should have a summary report forwarded to the relevant G.P. immediately following initial assessment, with a follow-up report on discharge from home care.

The Training Programme:

Having identified new assessment and treatment strategies to be implemented in the context of the Home Care project, the need for training and up-skilling of staff was identified in a number of areas. A comprehensive training programme was developed and implemented in April/June 2004, as outlined:

Theory and application of the MADRS (3 hours: Dr. Pat Gibbons)

Theory and application HAM-A, CARS-M (3 hours: Dr. Pat Gibbons)

Theory and application of the PANSS (2 x 3 hours: Dr. Pat Gibbons, Dr. Peter Whitty)

Introduction to CBT techniques in community care (5 x 2 hours: Dr. Rita Keville and Dr. Aileen Moran)

Solution-Focussed Brief Therapy (2 x full-day sessions)

Risk Management (3 hours: Dr. Pat Gibbons)

Medication Management and Concordance (1 full day session: Mr. Liam McGowan, Dublin City University)

Once the training was largely complete, May 4th was agreed as the start date for the commencement of the new service. The evaluation of the project was implemented in the final 3 months of the project (February to April 2005), the results of which are contained in this report. The evaluation was designed to assess the quality of the service from both a qualitative and quantitative point of view, and aimed to include the opinions of service users, their families and carers, and of service providers. The evaluation was carried out by Angela Cocoman (Research and Development Advisor, PNA) and coordinated by Dr. Pat Gibbons, Consultant Psychiatrist. A comparative component was included in the consumer satisfaction component of this evaluation, using patients and families attending the Mid-East Kildare sector (based on the town of Naas) as a comparison group, as acute care for these patients is largely hospital based, due to the lack of community facilities in the Mid-East sector.

3 EVALUATION OF THE PILOT PROJECT YEAR OF THE NORTH KILDARE HOME CARE TEAM

3.1

Descriptive statistics on referrals for Home Care:

The Home Care service was launched as a pilot project from May 1st 2004. The months following the 'go-live' date saw relatively low numbers of referrals for home care, perhaps reflecting a settling-in period, in which the service providers became familiar and comfortable with the new method of working. The number of referrals has increased on a continual basis since then, and reached a total of 112 for the full year (Table 1), and it is to be expected that the total number of referrals for the following year will be significantly greater (for comparison purposes, the Home Care Team in Monaghan receives approximately 136 referrals per year).

TABLE 1. DESCRIPTION OF THE SUMMARY STATISTICS:

SUMMARY STATISTICS:	
Total Number of Referrals 01/05/04 to 30/04/05	112
North East Sector	72 (64%)
North West Sector	40 (36%)
Number of patients who did not engage with HCT	11
Mean length of time in home care:	31 days
Average number of patients attended per nurse per month:	13

Of the 11 patients who did not engage with the home care service, the majority did so having decided to withdraw entirely from psychiatric care, rather than having any objection to home care per se. A further 2 patients were found to require hospital admission following emergency assessment by the Home Care Team, but were referred for ongoing care with the Home Care Team following discharge from the inpatient unit. Two patients (2%) were admitted to the Lakeview Unit after being on home care for a period of time. Six patients (5%) were referred for home care having been directly admitted to the Lakeview Unit for the initial period of acute care. The mean length of stay in home care was 31 days, which is in the mid-range of figures previously quoted for other services, which range from 11 days in the Crisis Intervention Service in Australia described by Carroll et al to 43 days in the Cavan/Monaghan service.

3.2

The range of clinical problems in patients accepted for Home Care:

The range and prevalence of diagnoses presenting for acute assessment and care in the community was found to broadly parallel the diagnoses of patients admitted to psychiatric units around Ireland (Table 2). This finding is consistent with the previously reported finding that acutely ill patients treated via home care closely match patients in inpatient care, and indicates that these patients would very likely warrant admission to the inpatient unit in the absence of an adequate community alternative.

TABLE 2. DIAGNOSES OF PATIENTS ACCEPTED FOR HOME CARE:

PRIMARY (Axis I) DIAGNOSIS: (n=81)	
Depression	39 (48%)
Mixed Anxiety/Depression	10 (12%)
Schizophreniform Psychosis	17 (21%)
Bipolar Depression	4 (5%)
Bipolar Mania	6 (7%)
Adjustment Disorder/DSH	2 (2%)
Alcohol Abuse	3 (4%)
AXIS II DISORDERS	11 (14%)

The small numbers of patients on home care who presented with adjustment disorders, substance abuse or Axis II disorders is reassuring, given the concern expressed by Pelosi & Jackson (2000) that a home-care service is likely to be primarily used by patients presenting with social or emotional problems, rather than major psychiatric disorders. The diagnostic pattern represented closely reflects the overall patient mix attending the psychiatric service generally, and corresponds quite closely to the diagnostic categories reported for the Cavan Monaghan home care service, where the principal diagnostic groups attending the service are depression (40%), schizophrenia (40%) and bipolar disorder (20%).

3.3

Audit of completion and documentation of standardised assessments:

As outlined in the assessment protocol identified by the Working Group, all patients were to have a battery of standardised assessments to measure specific symptom areas as well as psychosocial function, to complement the routine psychiatric assessment. The following data (Table 3) represents the results an audit of the documentation of these assessments throughout the pilot year of the project.

TABLE 3. COMPLETION AND DOCUMENTATION OF STANDARDISED ASSESSMENTS:

Standardised Instrument	Completed/ Documented	Incomplete/ Undocumented
FACE (n=76)	68 (89%)	8 (11%)
Treatment Care Plan (n=75)	43 (56%)	33 (44%)
Brief Risk Assessment (n=75)	43 (56%)	33 (44%)
MADRS (uni/bipolar depressive disorder: n=54)		
Intake assessment:	30 (56%)	24 (44%)
Discharge reassessment:	21 (39%)	33 (61%)
HAM-A (anxiety disorder: n=26)		
Intake assessment:	8 (80%)	12 (20%)
Discharge reassessment:	8 (80%)	12 (20%)
PANSS (schizophreniform disorder: n=17)		
Initial assessment:	5 (29%)	12 (71%)
Discharge reassessment:	3 (18%)	14 (82%)
CARS-M (manic patients):		
Intake assessment:	1 (14%)	5 (86%)
Discharge reassessment:	0 (0%)	6 (100%)

Note: the total number of FACE assessments is less than the total number of Home Care assessments as some patients were referred more than once, and others withdrew from contact before the assessments could be completed).

As can be seen, the completion and/or documentation of standardised assessments has been rather patchy, with the psychosocial assessment being the most comprehensively administered and documented tool, while the instruments for monitoring change in clinical symptoms have been less systematically used. This can partly be understood as an inevitable aspect of the process of adaptation to a new model of service delivery, with change being adopted on an incremental basis. As staff become more familiar and comfortable with the new model, it can be expected that the adherence to the agreed patient assessment and monitoring protocols will improve significantly. Furthermore, several patients were referred to home care from the inpatient unit and day hospital, where the new assessment protocols are not established as yet. It will be important to consider extending the use of the new assessment and monitoring protocols to the other acute care services in the future.

3.4

Liaison with G.P.s

Prior to the launch of the Home Care Project, all G.P.s in the North Kildare area were invited to an informal presentation and 'Question and Answer' session with Dr. P. Gibbons, Consultant Psychiatrist, Ned Cusack (A.D.O.N. North East Sector) and Eugene Kearney (C.N.M. II with the Home Care Team). A small number of G.P.s attended this session. Eugene Kearney and Dr. Gibbons liaised further with local G.P.s informally by phone and letter to inform them of the new service. The only specific suggestion to arise from G.P.s in relation to the new service was that mobile phone or other direct access should be provided to a Home Care Team member to facilitate urgent referrals.

A standardised referral form was developed by the working group to improve the quality of the information provided by G.P.s for all referrals to the psychiatric service in North Kildare. This referral form provided an option to identify whether an assessment was urgently required, in which case the G.P. was asked to fax the referral to the Celbridge Mental Health Centre, and to follow this up with a phone call to a designated mobile phone number which was manned by a member of the Home Care Team during office hours. After initial resistance, G.P.s are now widely using the referral form, leading to an improved quality of information provided. While a significant minority of patients have been referred as urgent cases, and the referral forms forwarded to the Home Care Team via fax, the G.P.s have followed this up with a phone call to the Home Care Team in only a small minority of cases (average of 2 phone calls per month in the period September '04 to April '05). This may be because Team members have in any case been following up all urgent referrals with a phone call to the G.P. to clarify the nature of the perceived risk/urgency in each case, and to agree a response with the G.P. as appropriate for each patient.

In relation to feeding back information following assessment, the agreed protocol was that an initial report would be sent to the G.P. following assessment and that a further summary of progress in treatment be sent to the G.P. on completion of the acute phase of care (whether in the Day Hospital, inpatient unit or Home Care). An audit of correspondence with G.P.s following discharge from home care showed that assessment or discharge letters were sent to G.P.s in 35 (46%) of cases where such correspondence would have been appropriate, suggesting that there is room for improvement in this area of practice as medical staff become more familiar with the new model of service.

4

IMPACT OF THE INTRODUCTION OF THE HOME CARE PROJECT

4.1

Introduction:

The effectiveness of the Home Care Project was assessed from a number of different perspectives, which will be explored in this evaluation. Firstly, we examined the impact of home care on other components of the acute care service in the wider Kildare/West Wicklow Psychiatric Service, specifically on the admission rates to the Lakeview Unit in Naas, given that a reduction in the use of the inpatient resource was one of the expected benefits of the service. Secondly, we investigated the impact of home care on patients (and their relatives/carers), both in terms of their subjective experience of the quality of the care provided, and also objectively in terms of clinical improvement and reduction in psychiatric symptomatology. Thirdly, we examined the impact on staff, in terms of their conditions of employment, job satisfaction and so on. By its nature, the latter data are subjective in nature, and best captured using qualitative methodology (specifically the focus group), as described below.

4.2

Impact on Admission Rates to the Lakeview Inpatient Unit:

As can be seen from Table 4, there is a significant difference in the admission rates across the Kildare/West Wicklow sectors. The two North Kildare sectors have the lowest admission rates, being lower than equivalent rates for the Cavan Monaghan service in the case of the North East sector. There is no consistent pattern in involuntary admission rates on the other hand, suggesting that involuntary admission rates are more influenced by factors other than the availability of home care. For example, 27 of the total 68 admissions from the North East sector are accounted for by 9 patients, who had multiple 'revolving door' admissions, either due to recurring life crises occurring especially at weekends (when Home Care assessment is not available) or due to recurring non-compliance with treatment. Similarly, 8 of the 19 involuntary admissions from this sector are accounted for by only 3 patients, each suffering from schizophrenia, who chronically default from any contact with the psychiatric service on discharge and rapidly relapse. Home Care has not been more successful than traditional care for these patients, as their lack of insight into their illness and need for treatment jeopardises their ability to accept any form of care, and suggests that the introduction of a community treatment order might be the only mechanism to avoid recurrent admission. Another potential explanation for the relatively high involuntary admission rate in the North East sector is that threshold for admission (in terms of the level of patient pathology) is relatively higher when home care is available, so that only the most ill patients are likely to be admitted. Despite this, the length of stay is not correspondingly higher for these patients, suggesting that while this cohort may be relatively more ill, their discharge is not delayed on this account, a possibility again accounted for by the availability of acute home care on discharge.

TABLE 4. IMPACT OF HOME CARE ON ADMISSION RATES TO THE LAKEVIEW UNIT:

	North East	North West	Mid East	Mid West	South	West Wicklow	Cavan / Mon.
Total admissions	63	64	144	142	92	55	
Involuntary admissions	19 (30%)	7 (11%)	14 (10%)	29 (20%)	5 (5%)	10 (18%)	
Admission rate/1000 pop.	1.85	2.56	3.0	2.96	3.17	4.23	2.0
Invol. admission rate/1000 pop.	0.6	0.3	0.3	0.6	0.2	0.8	0.3
Average length of stay	9.2	8.9	8.7				

The effectiveness of home care in reducing symptom levels:

The success of service delivery in terms of clinical outcome can effectively be measured by a comparison of symptom levels at intake and at discharge from acute care. The monitoring of clinical effectiveness has been built in to routine assessment and discharge protocols for the Home Care service in North Kildare, as previously described. The intake and discharge symptom scores for the pilot year are presented below (repeat scores were not available for all patients assessed, due primarily to patient withdrawal from care or unavailability).

TABLE 5. INTAKE AND DISCHARGE SYMPTOM SCORES:

	Intake score	Discharge score	Mean difference	t-test	95% C.I. of difference
MADRS (n=21)	24.5	6.3	18.1	t=5.8, p<0.001	11.9-24.4
HAM-A (n=8)	20.4	6.4	14.3	t=4.0, p=0.001	6.6-21.9
PANSS pos.* (n=3)	12.7	8.3			
PANSS neg.	7.0	7.0			
PANSS gen.	24.7	16.7			

PANSS scores refer to the positive, negative and general psychopathology subscales. The scores were available for 3 patients only, and do not allow for statistical analysis.

The data presented in Table 5 indicate a definite and statistically significant decrease in depression and anxiety scores in the course of treatment, and supports the clinical effectiveness of the interventions offered by the Home Care Team. The PANSS measures of psychotic symptoms are available for 3 patients only, which does not permit detailed analysis. For the three patients included here, it is interesting to note that there was a decrease in positive and general psychopathology symptom scores, with no change noted in the negative symptom scores. Negative symptoms are known to be the most resistant to treatment, and would not be expected to improve significantly in the acute phase of treatment.

Methodology:

Satisfaction among service users with the North Kildare psychiatric home care services and the Lakeview service was assessed using the Verona Service Satisfaction Scale (adapted VSSS-EU, Ruggeri & Dall'Agnola, 1993), a self-administered instrument which comprises 34 questions (see Appendix 1) covering the following seven domains:

- overall satisfaction
- professionals' skill and behavior
- information
- access
- efficacy
- types of intervention
- relatives involvement and support

The Verona questionnaire is scored on a Likert Scale, from a score of 1 indicating 'very unsatisfied' to 5 indicating 'very satisfied' (some questions were reverse scored, to minimise response bias). The questionnaires were posted to all patients who had been accepted into the home care treatment programme in the initial 9 months of the pilot project period. As a comparison group, questionnaires were also circulated to patients who had been treated as inpatients in the Lakeview Unit from the Mid-East Sector over the same period. This sector was chosen as it does not have access to acute care facilities in the community, and relies on the in-patient unit to provide care for acutely ill patients. While not controlling for other factors which can affect patient satisfaction with care, such as the quality of individual therapeutic relationships or relative severity of symptoms, the availability of this comparison group allows some estimation of the relative preferences of patients for inpatient as against home based care when acutely ill.

A shortened version of the Verona Questionnaire comprising 18 questions (see Appendix 2) was administered to the carers of patients attending the Home Care service and also of those admitted to the Lakeview Unit from the Mid-East sector as a comparison group.

The Verona Satisfaction Questionnaire also allows subjects to express their qualitative comments on what it was that they liked or disliked about the home care service and also their view on how the service could be improved. A qualitative research method was used to analyse all these statements that were returned in the survey questionnaires. A "mixed methods" approach to this evaluation was adopted and the results of both analyses (quantitative and qualitative) were then triangulated to enrich the interpretation of each data set. Triangulation of methods is defined as the use of two or more research methods in one study and may occur at the level of data collection or design (Begley, 1995), and leads to a more complete understanding of the data collected as well as reducing the potential for bias. Sequential triangulation was used in this study, which involves using one method (quantitative, using closed questions) prior to the other (qualitative, using open questions) with the first step being necessary to lead on to the second method.

Qualitative data from the comments made by service users and carers were analysed using Colaizzi's framework for descriptive data analysis (Colaizzi 1978). Colaizzi's framework includes the following:

- read the text in order to understand it
- extract significant statements about the phenomenon being studied
- formulate meanings for each significant statement
- arrange the formulated statements into clusters of themes
- integrate all the ideas into an exhaustive description of the phenomenon
- reduce the exhaustive description to an unequivocal/ unambiguous statement of the fundamental structure of the phenomenon

Level of carer burden:

The subjective level of burden experienced by the relatives/carers was measured using the Burden Interview (Zarit & Zarit 1990). This instrument consists of 22 questions which address the impact of the patient's disabilities on the caregiver's life, and is scored on a Likert Scale, from 0 (indicating that the carer has never

had the experience in question) to 4 (indicating the experience is nearly always present) The questions can be administered as an structured interview, though for the current study, it was administered as a pen-and paper test. The instrument is reported to have a high degree of acceptability to subjects, is sensitive to change over time and has been validated against other indicators of burden, such as depression, hostility and self-efficacy expectations (Handbook of Psychiatric Measures, APA 2000, pp 411-413).

Analysis of the quantitative questionnaire data was carried out using SPSS (Statistical Package for Social Sciences version 10.0). For ease of interpretation, reverse-coded items were inverted prior to analysis.

5.2 Administration of the questionnaires:

The questionnaires for service users and relatives/carers were all distributed by mail from March to June 2005. The questionnaires were accompanied by an explanatory letter describing the purpose of the evaluation exercise, and inviting their participation. It was emphasised that participation was voluntary and questionnaires were made anonymous in not identifying the patient by name. After 2 weeks, a follow-up letter was circulated to patients who had not responded, to provide a further opportunity for participation. 76 Verona questionnaires were distributed to Home care service users and 33 completed questionnaires were returned, giving a response rate was 43.4%. Seventy-five Verona questionnaires were distributed to Lakeview service users and 24 completed questionnaires were returned, giving a response rate was 45.3%.

Sixty-three Verona and Family Burden questionnaires were distributed to Home care relatives/carers and 30 questionnaires were returned, giving a response rate was 48%. Seventy Verona and Family Burden questionnaires were distributed to Lakeview relatives/carers and 26 questionnaires were returned, giving a response rate of 46.4%.

5.3 Survey results

5.3.1 Patient satisfaction with home care – Quantitative data:

The results of the patient satisfaction survey are presented in Appendix 1. Of note is that the satisfaction scores for home care are higher for 28 of the 34 questions, and this difference reaches statistical significance ($p < 0.05$) for four questions, and approaches significance ($p < 0.1$) for two further questions, addressing such issues as the overall effectiveness of the service in helping to deal with the patient's problems, and arrangements for support out of hours and at weekends. In general, both groups indicated quite a high degree of satisfaction across all domains. The highest ratings in both groups were for satisfaction with the personal manner and competence of medical, nursing and reception staff. Rather surprisingly, given the emphasis on family intervention and support intrinsic to the North Kildare home care model, the lowest ratings in both home care and inpatient groups were for items dealing with the provision of information to family members and the effectiveness of the service in helping families deal with the patients' problems. It is unclear whether this finding indicates an opinion that the home care team provide insufficient contact for families, or alternatively, whether the frequently high level of contact provided is perceived by the patient as intrusive or controlling. This issue did not emerge as a unitary theme in the subsequent patient focus groups.

5.3.2 Satisfaction of relatives/carers with home care - Quantitative data

In assessing the satisfaction of carers with the Home Care service, the Verona Questionnaire was modified to exclude questions which specifically addressed the concerns of patients only, leaving 18 questions. The questionnaire was mailed to the principal carers or identified next of kin for all patients admitted to home care in the initial 9 months of the pilot project year. Again, carers of patients admitted to the Lakeview Unit from the Mid-East Kildare Sector were surveyed to provide a comparison group. The data are presented in Appendix 3. Again, the carers in the Home Care group indicate a higher degree of satisfaction on all 18 of the items, this difference reaching significance at the $p < 0.05$ level for 4 items and at the $p < 0.10$ level for a further 5 items. These items mostly addressed the overall effectiveness of the Home Care Team in addressing the patient's problems, in preventing relapse, and arrangements made for the out-of-hours support, suggesting that carers and family perceive the home care intervention as being more effective than the standard care model. Again, the lowest overall satisfaction ratings for both groups were for items which addressed the impact of the psychiatric intervention in improving the relationship between the patient and carers, suggesting that this area continues to pose a challenge in providing psychiatric care, despite the increased contact provided by the Home Care model.

5.3.3

5.3.3 Level of Family Burden:

Results from the application of the Burden Interview indicate a clear and consistent lowering of subjective burden in the Home Care group, which have lower burden scores in 20 of the 22 questions in the questionnaire (Appendix 3). This difference reached statistical significance ($p < 0.05$) for 5 of the items, including the summative item (Total Family Burden Score), and was close to significance ($p < 0.10$) for a further 3 items. Of note is that the two items in which the home care relatives reported a greater sense of burden address whether the respondent feels that they 'should be doing more for your relative' and 'could do a better job in caring for your relative'. It may be the case that as relatives are more actively involved in acute care in conjunction with the home care team, that they feel more responsible for any ongoing symptoms or difficulties in treatment. While this sense of involvement can be usefully harnessed to aid the patient's recovery, one must be mindful of the risk that a sense of responsibility can also lead to inappropriate guilt and over-involvement, and in turn to negative expressed emotion, with a detrimental effect on the patient's recovery.

5.3.4

5.3.4 Satisfaction of patients and carers – Qualitative data:

The analysis identified clusters of themes relating to the things clients and carers liked about their experience of the Home Care. These included: the availability of the service, the one to one relationship with staff and having someone to talk to and who listened and understood.

Theme 1. The availability of the service

The home care service was valued by the clients and their carers who accessed it, as the following comments would indicate:

"I think it's super; it worked for my husband and family. Its convenience and available, its local and it's a free service" (carer)

"The availability to see them daily when I was at my worst and knowing I could contact someone when I needed them" (client)

"They always come when they say they will visit and they let me know when they are coming again" (client)

"They were available and relatively quick to intervene in problem situations" (carer)

"The professionalism, confidentiality, availability and kindness of all members of staff" (client)

"I suppose everyone is looking for customisation to meet their particular needs, but overall service is second to none. Well done to all concerned your help, advice and warmth is appreciated" (carer)

Theme 2. "One to One" relationship with staff

The one to one patient relationship is the foundation for caring practice and is dependent on an effective therapeutic relationship between the nurse/doctor and the client. Clients valued the establishment of this relationship with the home care team as the following statements give evidence of this:

"I enjoy and value the one to one relationship with the Doctors and Nurses" (client)

"The individual care from staff, I found the home visits very helpful I felt the nurses gave me encouragement and called regularly to my home" (client)

"They said they would call and they did this. They helped me a lot also because I felt that someone else cared and it helped me cope a lot better. They were not running off somewhere else 5 mins later. They had plenty of time" (carer)

"The provision of one to one care outside the hospital environment enabling me to deal with difficulties as they arise also the personal ongoing support from a specialist who knows me" (client)

"The Nurse was also excellent in every way and gave me all the support I needed" (client)

Theme 3. Having someone "to talk to" who listens and understands.

Being able to communicate effectively is a necessary and vital part of the service offered by home care staff. Effective communication improves the clients understanding of their illness, medication, treatment options, and improves social outcomes and client satisfaction. Having a health professional to "talk to" was valued by the clients and the carers, as the following statements demonstrate:

"I liked having someone to talk to, I valued these friendly visits" (client)

"The understanding and practical help received from the nurses without a feeling of intrusion. They were absolutely brilliant without their help and support I don't know what I would have done" (client)

"I'm happy that Doctors, Nurses and Social workers have time and commitment for my daughter" (carer)

"The nurse was excellent in her understanding of my illness. She could see how I was coping in my home environment. She was patient kind and a good listener" (client)

"I found the nursing staff made every effort to listen and try to understand the difficulties I was having" (client)

The analysis of clustered themes of the things clients and carers disliked about their experiences of the Home Care and identified the problem: Choices over treatment, frequent change of staff and not having enough time.

Theme 4. Personal choice of treatment

Advances in the delivery of health services delivery have led to a holistic approach to treatment and care, where people with a mental illness having choice in treatment. Advocates believe they should be offered information about a range of treatments and their efficacy, to enable them to participate fully when decisions are made about their treatment. Clients and carers expressed their frustration in the delivery of certain aspects of the home care service and their lack of personal choice and information on treatments.

Respondents made the statements:

"I would welcome the provision of family therapy or counselling for relatives of patient with psychiatric illnesses, as the impact on their lives is immense" (carer)

"Too many hours wasted in the day hospital doing nothing. I felt there should have been some self-help books that could have been recommended. Overall not enough information given also any coping skills given" (client)

"I disliked the lack of continuity, comments made about my illness that were not accurate. Also inaccurate information regarding contacting my husband regarding my illness" (client)

"The day hospital felt like a complete waste of time as there was nothing to do there" (client)

"It would help us as a family if we were given more information on what to expect on low days with the patient and a lot more information on his condition in the long term"(carer)

"I know the service is meant to be of benefit, I feel it is an invasion of my personal privacy and much prefer meeting my care worker outside of the home" (client)

Theme 5. Changes of staff

Continuity refers to whether a client sees the same clinician from one visit to the next. Longitudinality refers to whether the patient has an established, long-term relationship with a clinician. Continuity of staff ensures and encourages communication between the health professional and client throughout the course of a long-term relationship. As health care providers gain familiarity with a client's history, they may more effectively manage chronic conditions or monitor long-term development, all of which is appreciated by the client.

Clients and carers alike disliked the staff change that take place on a regular basis, as their remarks indicate:

"Why must we endure psychiatric doctors who change every 6 months? Is this some form of punishment for having a mental disease?" (client)

"More continuity of staff especially medical staff" (carer)

"I felt that the new psychiatrist had very little knowledge of my illness and therefore was unable to understand me and my situation. I feel that this resulted in a deterioration of my mental health" (client)

As the medical input in home care in North Kildare is provided by the respective consultant psychiatrists (Dr.s Gibbons and McGauran) and by a designated N.C.H.D. assigned to home care on a full-time basis, the references to a lack of continuity of medical staff by patients and carers may well relate to routine OPD care, where N.C.H.D.s rotate on a six-monthly basis, rather than to home care per se. Interestingly, neither patients nor carers reported a concern in relation to the continuity of nursing care (i.e. between the Community Psychiatric nurses providing long-term support and the Home Care Team), as suggested by Pelosi & Jackson (2000).

Theme 6. Not having "enough time".

Sufficient time is vital in order to practice in a truly client-centred way, with clients as equal partners in making decisions about their care. Developing meaningful relationships with clients requires time. Regrettably, insufficient time is often cited by health professionals and suggests a need to redesign care to better meet the needs of clients. Clients disliked not having enough time to engage and gain the benefits of an effective therapeutic relationship. Carers also value spending time with the home care health professionals to keep themselves informed on their treatment options and progress. Comments from respondents include:

"I felt the nurse coming to my home did not spend enough time, they never advised on mental health groups around the area which could be helpful" (client)

"Their (the home care teams) understandable need to support and retain the confidence of the patient leaves no time for the immediate relatives, who feel isolated and helpless in conflict situations. Also, while the service addressed the psychiatric illness of bi-polar disorder, they did not successfully address the patient's alcohol abuse at any stage" (carer)

"I had difficulty getting through on the phone. I felt the home care service was very quick to scale down visits" (client)
"I would value more time for the involvement and education of those family members close to the client" (carer)

5.3.5

5.3.5 Discussion:

We assessed the impact of Home Care on patients and their carers from a variety of perspectives, including subjective and objective measures, and using both quantitative and qualitative methodologies. Data across all of these domains are consistent in showing that Home Care is an effective means of providing acute assessment and care to patients, in reducing clinical symptoms across the main symptom domain areas (Table 5). This success in relieving symptoms is associated with an acute admission rate little more than half that for sectors which do not have access to Home Care (Table 4).

In terms of patient satisfaction, while the data indicate an encouraging degree of satisfaction from users of both Home Care and inpatient care, the results indicate a greater degree of satisfaction with Home Care in most of the Verona Questionnaire items. Interestingly, for both Home Care and Inpatient care groups, the items addressing the involvement of and support provided to carers were among those indicating the least satisfaction for patients. It is unclear why this might be the case, especially for the Home Care group, as the provision of home support provides ample opportunities for staff to liaise with carers, and this is one of the explicit aims of the project and is identified as a priority for staff.

The qualitative data also indicate a dissatisfaction among some patients and relatives with the lack of continuity of care, especially with the changeover of medical staff, though this is an issue not specific to homecare, and is a structural difficulty in the current operational structure throughout the health services that may be somewhat improved as the service moves towards a consultant-delivered service, as promised by government policy. There was no consistent report by relatives that the home care option was considered to be more emotionally burdensome on families than inpatient care, as might have been expected from the previous report by Harrison et al (1999). On the contrary, the data from the survey of relatives using the Burden Interview indicate that the availability of support from Home Care staff compensates for any stress related to an increased exposure to the patient's symptoms, with a net decrease in the carers' sense of burden.

Some patients indicated that they appreciated the provision of more choice in their options for acute care, and the involvement of patients in the decision around the mode of delivery of acute care contributed to their sense of involvement and commitment to treatment and their sense of autonomy. Furthermore, some patients felt that the emphasis on providing care in their own homes gave the care team a greater understanding of the context of the patient's difficulties and therefore a greater ability to assist the patient in finding solutions to these difficulties.

5.4

The impact of the introduction of Home Care on nursing staff:

Focus groups took place nearing the end of the pilot year with all the Nurses working in the North Kildare service. A focus group is a 'research technique that collects data, through group interaction on a topic determined by the researcher (Kreuger 1994, p10). The focus group interviews were used in the end stages of the pilot project as a tool to assess whether the home care service had worked and under what circumstances it had worked from the nursing staff perspective, using the 'realistic evaluation' methodology (Dawson & Tilley's 1997). This method also notes what has been learned by participants, ensuring that the process is as important as the outcome. A list of questions were formulated that were to be asked during the course of the interviews. Three focus groups were held with different nursing staff groups who provide care in the North Kildare psychiatric services. The same format was followed in each of the three focus groups to aid continuity. The questions were designed to logically progress from the general to the specific whilst leaving room for more probing questions to be asked should the need arise. The focus group interviews were audio recorded with the permission of the participants. Field notes were also taken by the researcher to complement the audiotapes. Participants were assured of the confidential nature of the data and anonymity of participants ensured.

Analysis of the focus group interviews consisted of analysing the transcripts for key themes, using the Collaizi framework previously described in relation to the responses from relatives and carers in relation to home care. Data was collected and coded by theme and category before the final analysis. Categorization of themes

was done manually, as the amount of data for analysis was relatively small. The first stage consisted of identifying the categories that emerged and the responses were then inter-linked as appropriate. Changes were made to the categories as the understanding of emergent themes grew. The themes were then sorted into related categories and the process was then repeated to ensure completeness.

The Home Care Nursing response:

All the home care nurses embraced the new home care model, as shown in their willingness to participate in the pilot project. The home care nurses felt the project was effective as part of the menu of services offered by the North Kildare mental health services. It afforded strong links to be made with individual General Practitioners and other primary care providers in the North Kildare area. All of the home care nurses found the work enjoyable and satisfying, they liked the opportunity to organize and be responsible for their work. They found it offered an opportunity to work autonomously which clearly contributed to this sense of satisfaction. All the home care nurses supported the team philosophy of: "Supporting the person exhibiting symptoms of illness, to stay within their family whenever possible, as this enhances bonds within the family by sharing information, reducing stigma, decreasing helplessness and promoting independence".

Theme 1. Encouraging outcomes

All home care nurses agreed that the initial client assessment was crucial as it contributed to the process of engagement with the client and determined what their treatment plan would be. Home Care nurses explained that:

"You've got a small caseload which allows you to offer "time" (in 1-2 hour slots) where you can provide a systematic assessment which takes time but allows you to identify factors in the social, psychological and physical environment which may have contributed to the client's illness"

Several nurses mentioned the more equal relationship between nurse client and family member. This occurred in two ways:

"The voluntary nature of contact; for example a client was meeting with a home care nurse because they wanted to and there was the opportunity for clients to be more involved in decision making about their care"

All the home care nurses mentioned the quality of nurse-client relationship and the opportunity that this afforded for providing good quality care.

The specific home care interventions which nurses felt to account for the effectiveness of the care provided included the following:

"We intervene in crisis situations; engage in various psycho-social interventions such as anxiety and stress management, health education, individual psychotherapy, family therapy, bereavement counseling, solution focused therapies and as appropriate work with other community agencies as necessary and ensure a coordinated team treatment plan"

and:

"We make recommendations for crisis and or continuing care; suggest alternative treatment plans; teach caretakers/ family methods of dealing with emergencies, and provide advice"

Theme 2. Stumbling blocks

A difficulty reported by several home care nurses was the experience of "continual change and/or uncertainty, as the new services adapted to meeting changing needs".

Some clients were referred to the Day hospital for further assessment and this became known as a "combined care" programme. The smooth transition of combined care to day hospital or to continuing care was not always apparent. Some negativity existed and this was possibly due to lack of communication or simply adjusting to new ways of working and a challenge to the status quo that previously existed.

A number of nurses found the weekend cover difficult, due to a perception of pressure to visit a large number of clients over the two days, and it was felt that this area needed improvement. One nurse suggested that nursing staff in the home care team may be unclear about their roles and went on to say:

"I am very clear about my role but others are not. There is lack of time (due to pilot and rotation) to develop the role and that affects it"

This difficulty may in part relate to the rotation system for nurses, where one person had been employed to work in another (non-home care) setting since the time of their appointment, and having adjusted to that role, they were then told that they would be required to participate in a newly formed home care team. This no

doubt causes stress on staff, as they have to quickly adapt to a change in role. All the home care nurses agreed that changing work patterns has been difficult. Being part of a multidisciplinary team with changing work practices often challenges existing hierarchical structures and it was felt that this required more time, resources and patience on everyone's behalf.

The impact on other aspects of the service:

As a considerable interface exists between the home care team, community mental health teams, outpatient clinics, day hospital and day centres, making effective communication extremely important. Since the introduction of the home care service, the staff members in the day hospital in Celbridge have had to change their focus to complement this service. The day hospital meets the need of seriously ill clients as an alternative to in-patient or home care. An increase in numbers attending the day hospital has been noted over the past year. The volume of work has also increased due to the severity of illness of clients attending the day hospital.

The combined care of clients posed further pressure on day hospital staff as this type of practice was not previously operated and this required additional time to be made available for communication of client's assessment and care planning. Throughout the pilot year, there was some evidence of blurred boundaries for those working in day hospital and the home care element of the service. Traditionally the day hospital nurses had provided locum relief to all the community nursing staff, this results in temporary nurses being employed to staff the day hospital. This situation often resulted in lack of continuity and quality of client care.

As noted in the introduction, the seven community nurses providing care across the two sectors of North Kildare were reduced to two nurses per sector on the commencement of the home care project. All the Community Mental Health Nurse's (CMHNs) objected to being referred to as a "Continuing Care Nurses", preferring to retain the title given to specialist community nurses (i.e. that of "Community Mental Health Nurses"). CMHNs spoke of their frustration that many clients were now not receiving good-quality care due to pressure of work and that the wealth of the CMHN's knowledge was being under-utilized.

The following are some of the issues that have implications for the quality of patient care. Large caseloads were identified by the CMHNs as inhibiting care provision. The caseloads ranged from 60 to 120. Some nurses said that clients remained on caseloads for longer than was necessary, due to difficulties in maintaining contact that is more regular. A concern for CMHNs was that they needed to see six to eight clients a day because of their high caseload. Adhering strictly to appointment times was essential if all patients were to be seen. Consequently, CMHNs sometimes find it difficult to concentrate during a session with a client, because they were preoccupied with the time.

Finally there was discussion among nurses that there could be a danger that teams dedicated to home care could be viewed as "elitist", and there was a consensus that the role of the CMHN was slowly being eroded. CMHNs spoke of the need to "categorize clients into different lists depending on dependency levels". CMHNs supported the introduction of mixed case loads which enable CMHNs to utilize their skills in aiding clients through relapse, recovery and ongoing care.

Discussion:

The concept of quality of care provided to the patient was perceived as pivotal by all the nursing staff. The findings attributed the quality of home care to a number of factors, including the small caseload which allows nurses to offer more time to the patient, the patient's and family's active participation in care planning and the patient's ability to remain in their home environment. The stumbling blocks encountered related to the challenge for staff in adapting to changing nursing roles and establishing role clarity between the different areas of the service provision. A number of unresolved questions were posed by the nursing groups, including the nursing implications of the Home Care model in caring for acutely ill clients, the potential for mainstreaming this Home Care model across the entire Kildare/West Wicklow Mental Health services, and the extended role of Nurses in responding to the needs of acutely ill patients in the home situation.

5.5

Experience of other Mental Health Team members:

A focus group for all non-nursing team members (medical, allied professions and secretarial) was held to address their experience of home care and its impact on their work lives. As with the nursing staff, there was a consensus across the group that home care provided a qualitative improvement in care to many patients attending the service, in offering more choice around the way in which care is provided. Furthermore,

a significantly enhanced service was being provided to acutely ill patients who might not have met the very demanding criteria for admission to the Lakeview Unit, but who nevertheless are acutely distressed. Support for families has also been enhanced, with greater opportunities for psychoeducation and problem-solving interventions. Similarly, severely ill patients who did not wish acute admission and whose families likewise did not wish to instigate involuntary admission were able to receive acute care at home as an alternative.

In general, junior medical staff reported that the quality of clinical support from consultant colleagues was very good and easy to access at short notice when required. The staff training was felt to have had an important role in preparing staff for the increased clinical responsibility and autonomy involved in delivering home care, and was felt to have been relevant and appropriate. However, the junior medical staff had joined their respective teams after the start of the project, and had not had the chance to participate in the initial training or receive a copy of the staff manual on joining the sector teams. In relation to the workload for the SHO assigned to cover Home Care, it was felt that the workload was considerable, and that it was difficult to provide adequate cover while also assigned to other duties, such as attendance at OPD and providing rostered on-call cover at the Lakeview Unit. Finally, some referrals for acute/emergency assessment by GPs were felt to be inappropriate, and possibly motivated by a wish to bypass any possible delay in obtaining access to assessment through the routine outpatient route. This suggests a need to pursue ongoing outreach to GPs to inform them about the purpose and function of Home Care, and on appropriate criteria for urgent referral. Meantime, team members are continuing to follow up urgent referrals by phone with GPs to clarify the appropriateness of early response in each case. In general, the new referral forms were felt to provide an improved quality of referral information than the previous GP letters.

It was observed that the referral criteria for Home Care appear to have been broadened during the pilot phase on an ad hoc basis e.g. to include the psychosocial assessment of routine as well as emergency referrals. Furthermore, the issues of attachment and the risk of dependency was raised, especially for patients with longer term or Axis II disorders. It was agreed that the Home Care Team need to be mindful of these issues, and that regular (i.e. weekly) review of ongoing care and discharge planning is important to manage the transition to routine OPD care and minimise the risk of dependency.

It was also observed that there were occasions where care was shared between Home Care and other branches of the Psychiatric Team, such as Day Hospital, with the risk of confusion of roles and responsibilities between staff. It was felt that this could be best addressed by having a clearly identified 'key worker', who would take responsibility for ensuring the implementation of agreed interventions for the patient.

Structure of Home Care in North Kildare:

The Home Care programme in North Kildare was developed from the experience in existing prototype services both in Ireland and overseas, especially the U.K. It differs from some existing models in that it operates relatively restricted hours, and in covering two sector areas. The operating hours (9am to 5am on a seven day per week basis) appear to provide sufficient contact with patients and families to lead to a significant decrease in the demand for inpatient care in the two sector areas in which the service operates, compared to the neighbouring sectors within the Kildare/West Wicklow service, and even with existing home care services such as that in Cavan/Monaghan (Table 4). The importance of this achievement can be gauged from the ongoing chronic overcrowding of the Lakeview inpatient unit, despite the diversion of a significant number of acutely ill patients to the Home Care service in North Kildare. If we assume that 70-80% of these patients are likely to have required inpatient care, based on published data from existing services elsewhere, it is difficult to envisage how these 80 or so patients could have been accommodated within the existing inpatient unit in any circumstances, as it constitutes a 20% increase in demand for beds in a unit already operating at over 100% capacity. Of those patients who were admitted to the Lakeview unit from the North Kildare sectors during the pilot year, the average length of stay was similar to that of patients from the other sector for which data was available (Table 4), though this in turn is much lower than the average length of stay in other inpatient units nationwide (reported by the Inspectorate of Mental Health Services to be around 21 days). Given that these North Kildare patients were more likely to be severely ill in order to qualify for admission, the data on length of stay do suggest that the existence of acute care services in the community does facilitate discharge earlier and more safely than would otherwise be possible, providing further relief for the inpatient unit.

Quality of care to patients:

The quality of the care provided appears to be at least as effective as that provided by inpatient care. This is evident from the significant decrease in depression and anxiety scores reported, and by the successful treatment of acute psychotic episodes without resort to inpatient care. In all, of the patients accepted for home care, only 3 (4%) were subsequently admitted to the inpatient unit. This figure is lower than that reported for other services described earlier in this report, which range from 11-20%. There were no suicides reported during the pilot year, and no 'near-miss' incidents. Patients and relatives did not identify the lack of a 24-hour home care service as being a significant drawback in their care, and appeared satisfied to use the on-call service at Naas Hospital as their 'out-of-hours' support for crisis management, and few patients attended the A/E department for emergency assessment while in the care of the Home Care Team during the pilot year. There appears to be little justification at this stage for extending the hours during which the service operates, as the marginal benefit to patients is unlikely to justify the significant increase in staffing that would be required.

Quality of support for families and carers:

Although home care provides many opportunities for staff to extend their supportive role to carers and family members, this does not appear to meet the expectations of either patients or staff, as is shown in the satisfaction ratings described previously. The lack of any relative benefit as against standard care is rather surprising and disappointing, as in addition to home care, there is an active psychoeducation programme in North Kildare, at least for the carers and relatives of schizophrenia spectrum patients. The expansion of the psychoeducation programme to address the needs of other illness groups, especially affective disorders, might go some way to support families in a practical and efficient way.

Use of standardised assessment tools:

As a project which aims to set objective standards for the quality of service delivery to patients, the use of objective and validated measures of patient symptomatology and psychosocial functioning plays an important role in the Home Care service. The routine use of instruments as MADRS and PANSS rating scales has already allowed an examination of the clinical effectiveness of the care delivered by the Home Care service. The data available from the pilot year confirms that acutely ill patients demonstrate a marked decline in symptom levels across symptom domains (although the patient numbers are sufficient to allow statistical analysis only on the depression scores: c.f. Table 5). The ongoing use of symptom rating scales is important to facilitate continuing audit of the clinical effectiveness of the service, and an improvement in the completion and documentation rates for these scales is desirable. As both medical and nursing staff rotate between different areas of the service on a regular basis, the need for an ongoing and rolling education programme is required to maintain

the skill levels of staff newly appointed to work with the Home Care Team.
Involvement of patients and carers in developing services:

As greater emphasis is placed on service user preference in health care development, as outlined in Government documents such as “Quality and Fairness: A Health System for You” (2001) and in various position papers from the Mental Health Commission (for example, “Quality in Mental Health – Your Views”, 2005), meaningful ways of assessing patient and carer preferences in relation to mental health care delivery need to be developed. Both the qualitative and especially the quantitative data from patients suggest that home care provides an acceptable, and in many cases preferable, mode of care provision in acute illness than inpatient care. The weight that can be attached to this expressed preference should not be underestimated, in identifying priorities for future development in the mental health field. The data presented in this report suggest that in meeting the urgent need for increased capacity to provide acute psychiatric care, investment in the development of home care services throughout the Kildare/West Wicklow service should take priority over increasing the inpatient bed complement in the short term.

Impact of Home Care on staff:

For staff, the experience of working in home care has been reported as largely positive. In part, this has been related to the systematic up-skilling of staff prior to the commencement of the project, and the increase in clinical autonomy that has been intrinsic to the way in which nursing and non-consultant hospital staff participate in the home care service. A fundamental condition for facilitating this development of the clinical role of the Home Care Team staff has been agreement on a comprehensive set of protocols to guide staff in the management of specific issues that may arise along the management algorithms for acute care in the community. These protocols need constant revision in the light of new developments in clinical care, and the expressed preferences of patients and their carers as to how care is delivered to them.

Impact of Home Care on relationship with G.P.s:

Family Practitioners play a vital roll in the provision of mental health care in the community, and act as gatekeepers for access to secondary or specialist care for the more severely ill patients. In order that acutely ill patients obtain timely and convenient access to emergency specialist assessment by the Home Care Team when appropriate, but that this service is not swamped with inappropriate referrals, it is vital that G.P.s have sufficient understanding of the relevant criteria for emergency referral as well as of the appropriate procedures for making the referral. It would be useful to involve a G.P. representative in ongoing review of the home care service (and indeed of other aspects of specialist psychiatric care in the community setting) to ensure that the mechanisms for two-way communication between primary care and the specialist service are fully functional and compatible with existing communications and information technology systems operated by G.P.s.

Review of procedures and protocols governing provision of care:

An issue of concern that has arisen from the review of the home care service is that fact that there are possible gaps in the transfer of care from acute care (Home Care or Day Hospital) and the ongoing Community Care Team, a risk previously documented in relation to Assertive Community Outreach in the review by Kent and Burns (1996). A small number of cases were identified where OPD appointments and follow-up were not arranged in a timely fashion, and protocols need to be reviewed in this area to ensure a smooth transfer between the different levels of care within the mental health service. A further potential cause for concern is the possibility that the nursing skills of the community staff providing long-term care to enduring mentally-ill patients may be under-utilised if acute care is seen as being the province of the Home Care Team only. This fear may arise from a lack of clarity around the appropriate role and remit for acute versus long-term care teams, and the boundary between the two. Associated with this is the understandable concern that as the Home Care initiative is a new and innovative project, it might absorb the attention and energy of the psychiatric team as a whole, to the detriment of the longer-term rehabilitation needs of the enduring mentally ill. In North Kildare, the service plan for future development includes a need to review the care provided for the longer-term treatment needs of patients in the same rigorous and systematic way which lead to the development of the Home Care Project. It is expected that this review process will lead to the reorientation of the Community Mental Health Team towards a more actively rehabilitative role rather than the maintenance role that it currently has, and is likely to require a reconfiguration of multidisciplinary staffing in community care and the up-skilling of staff in rehabilitation field, as occurred in developing the Home Care Team.

REFERENCES

- Altman EF, Hedeker DR, Janicak PG et al. (1994). *The Clinician Administered Rating Scale for Mania (CARS-M): development, reliability and validity*. *Biological Psychiatry*; 36: 124-134.
- American Psychiatric Association. (2000). *Handbook of Psychiatric Measures*.
Bracken P, Cohen B. Home treatment in Bradford. *Psychiatric Bulletin*, 1999; 23: 349-52.
- Brimblecombe N, O'Sullivan GH. (1999). *Diagnosis, assessments and admission from a community treatment team*. *Psychiatric Bulletin*, 23: 72-4.
- Begley C.M. (1996a) *Triangulation of communication skills in qualitative research instruments*. *Journal of Advanced Nursing*; 24(4): 688-693.
- Carroll A, Pickworth J, Portheroe D. (2001) *Service innovations: an Australian approach to community care*. *Psychiatric Bulletin*, 25: 310-13.
- Collaizzi P (1978) *Psychological Research as the Phenomenologist views it*. In Vaile, R & King, M. Eds: *Existential phenomenological alternatives for Psychology*. New York. Oxford University Press.
- Department of Health and Children. (1984). *Planning for the Future*. Government Publications Office, Molesworth St., Dublin 2.
- Department of Health and Children. (1992). *Green Paper on Mental Health*. Government Publications Office, Molesworth St., Dublin 2.
- Department of Health and Children. (2001). *Quality and Fairness: A Health System for You*. (http://www.dohc.ie/publications/fulltext/quality_and_fairness/)
- Department of Health (U.K.) (1998). *Modernising Mental Health Services: Safe, Sound and Supportive*. (http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003105&chk=psls3f).
- Hamilton M (1959). *The assessment of anxiety states by rating*. *British Journal of Medical Psychology*; 32: 50-59.
- Harrison J, Poynton A, Marshall, J et al. (1999) *Open all hours: Extending the role of the psychiatric day hospital*. *Psychiatric Bulletin*; 23: 400-04.
- Harrison J, Alam N, , Marshall, J et al. (2001) *Home or away: which patients are suitable for a psychiatric home treatment service?* *Psychiatric Bulletin*; 281: 310-13.
- Hughes SL., Ulasevich A., Weaver FM., Henderson W., Manheim L., Kubal J.D. & Bonarigo F. (1997) *Impact of home care on hospital days: A meta-analysis*. *Health Services Research Vol 32*, pp415-432.
- Joy CB, Adams CE, Rice K. (2000) *Crisis intervention for people with severe mental illness*. *Cochrane Database Syst Rev*; (2): CD 001087
- Kay SR, Fiszbein A, Opler LA (1987). *The Positive and Negative Syndrome Scale (PANSS) for Schizophrenia*. *Schizophrenia Bulletin*; 13: 261-276.
- Kent A, Burns T. (1996) *Setting up an assertive community treatment service*. *Advances in Psychiatric Treatment*; 2(4): 143-49.
- Keogh F, Roche A., & Walsh D. (1999) "We Have No Beds...." *An enquiry into the availability and use of Acute Psychiatric Beds in the Eastern Health Board region*. Dublin: Health Research Board.
- Knight S. & Tjassing H. (1994). *Health care moves to the home*. *World Health No. 4*, pp413-444.

- Krueger RA. (1994). *Focus Groups: a practical guide for applied research (2nd ed.)*. Sage : California.
- Lang, MA,, Davidson L., Bailey, P. & Levine, MS.,(1999) *Clinicians' and Clients' Perspectives on the Impact of Assertive Community Treatment*. *Psychiatric Services* Vol 50. pp1331-1340.
- Marks IM, Connolly J, Muijen M et al. (1994). *Home-based versus hospital-based care for people with serious mental illness*. *British Journal of Psychiatry*, 165; 179-194.
- Mental Health Commission. (2005). *Quality in Mental Health:Your Views*. (<http://www.mhcirl.ie/qualityassurance.htm>)
- Montgomery SA, Asberg M. (1979) *A new depression scale designed to be sensitive to change*. *British Journal of Psychiatry*; 134: 382-389.
- Muijen M, Marks IM, Connolly J et al. (1992). *Home based care and standard hospital care for patients with severe mental illness: a randomised control trial*. *British Medical Journal*, 304; 517-521.
- North Eastern Health Board. (2001) *A model for a New Community Health Service*. Monograph presented at the conference "Planning for a New Community Mental Health Services in Ireland", Cavan., September 2001.
- Ruggeri M. & Dall'Agnola R. (1993) *The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community-based psychiatric services to patients, relatives and professionals*. *Psychological Medicine*, 23, 511-523
- Russell M, Czarnecki DM, Cowan R et al. (1991) *Measures of maternal alcohol use as a predictor of development in early childhood*. *Alcohol Clin Exp Res*; 15: 991-1000.
- Pawson R. and Tilley N. (1997). *Realistic Evaluation*. London: Sage
- Pelosi AJ, Jackson AJ. Response to: 'the home treatment enigma' (Smyth & Hoult 2000): *Enigma and fantasies*. *British Medical Journal*; 320: 310-11.
- Smyth MG, Hoult AJ. (2000) *The home treatment enigma*. *British Medical Journal*; 320: 305-09 .
- Stein LI, Test MA. (1980) *Alternative to mental hospital treatment. I. Conceptual model, treatment programme, and clinical evaluation*. *Archives of General Psychiatry*, 37; 392-397.
- Taylor, C. "Hermeneutics and Politics," in *Critical Sociology, Selected Readings*, P. Connerton (ed.), (1976) Penguin Books Ltd, Harmondsworth, pp. 153-193
- Zarit SH, Zarit JM. (1990) *The Memory and Behavior Problems Checklist and the Burden Interview*. (Pennsylvania State Universtiy, Gerontology Center Reprint Series No. 189, part 3). College Park, PA, Pennsylvania State Universtiy Gerontology Center.

APPENDIX 1

Comparison of Patient satisfaction with acute care in Home Care (North Kildare, n=33) and in-patient care (Mid East Kildare, n=34):

VERONA PATIENT SATISFACTION QUESTIONNAIRE	Sector	Mean	p-value
* the effectiveness of the service in helping you deal with your problems	North Kildare	4.24	*0.02
	Mid East Kildare	3.65	
the behaviour and manners of reception staff over the phone or when you meet them	North Kildare	4.58	0.18
	Mid East Kildare	4.27	
the professional knowledge and competence of your psychiatrist	North Kildare	4.42	0.61
	Mid East Kildare	4.53	
* the appearance, comfort level and physical layout of the waiting room, interview room etc.	North Kildare	4.21	*0.02
	Mid East Kildare	3.62	
the ability of psychiatrists to listen to and understand your problems	North Kildare	4.21	0.79
	Mid East Kildare	4.15	
the personal manner of psychiatrists	North Kildare	4.39	0.67
	Mid East Kildare	4.48	
* the punctuality of the professionals when you come for an appointment?	North Kildare	4.27	*0.04
	Mid East Kildare	3.79	
the effectiveness of the services in helping you get well and preventing relapse	North Kildare	4.24	0.12
	Mid East Kildare	3.88	
the confidentiality and respect shown for your rights	North Kildare	4.42	0.11
	Mid East Kildare	3.97	
the amount of help you have received	North Kildare	4.39	0.27
	Mid East Kildare	4.15	
the explanations of specific plans for your care and why they are being made	North Kildare	4.09	0.099
	Mid East Kildare	3.65	
the effectiveness of services in helping to relieve your symptoms and reduce problems	North Kildare	4.15	0.27
	Mid East Kildare	3.88	
the response of the service to crises or urgent needs during the hours from 9:00 to 5:00	North Kildare	4.27	0.14
	Mid East Kildare	3.85	
* the arrangements made for after hours and weekends	North Kildare	4.24	0.05
	Mid East Kildare	3.73	
the thoroughness of psychiatrists	North Kildare	4.33	0.44
	Mid East Kildare	4.15	
the thoroughness of psychiatrists	North Kildare	4.16	0.16
	Mid East Kildare	3.77	
the professional knowledge and competence of your nurse(s)	North Kildare	4.48	0.10
	Mid East Kildare	4.06	

the recommendations made to your relative/carer about how they could help you	North Kildare Mid East Kildare	3.79 3.53	0.37
the effectiveness of the service in helping you improve your knowledge and understanding	North Kildare Mid East Kildare	3.94 3.44	0.09
the personal manners of nurses	North Kildare Mid East Kildare	4.67 4.38	0.14
the effectiveness of the service in improving the relationship between you and your relative/carer	North Kildare Mid East Kildare	3.82 3.85	0.90
the effectiveness of the service in helping your relative/carer improve their understanding of your problems.	North Kildare Mid East Kildare	3.73 3.68	0.83
the nurse's knowledge of you and your medical history	North Kildare Mid East Kildare	4.18 4.09	0.71
how information was given to you about your problem (diagnosis) and what to expect (prognosis)	North Kildare Mid East Kildare	3.88 3.39	0.11
the ability of psychiatrists to listen to and understand the worries your relative or carer may have?	North Kildare Mid East Kildare	4.18 4.00	0.45
the effectiveness of the service in helping you improve your ability to establish good relationships with people outside your family	North Kildare Mid East Kildare	3.58 3.50	0.80
how information was given to your relative/carer about your problem (diagnosis) and what to expect (prognosis)	North Kildare Mid East Kildare	3.45 3.65	0.51
* the instructions on what to do on your own between "visits", were they clear, practical and useful?	North Kildare Mid East Kildare	4.12 3.64	*0.04
the effectiveness of the service in helping improve your capacity to look after yourself	North Kildare Mid East Kildare	3.79 3.59	0.82
the thoroughness of nurses	North Kildare Mid East Kildare	4.30 4.35	0.28
the effectiveness of the service in helping your relative/carer improve her/his capacity to deal with the problems you have.	North Kildare Mid East Kildare	3.06 3.39	0.28
the ability of nurses to listen to and understand your problems	North Kildare Mid East Kildare	4.09 3.91	0.55
the effectiveness of the service in helping you improve your ability to work	North Kildare Mid East Kildare	3.88 3.55	0.21
the help you received for unexpected outcomes, discomfort or side effects from drugs	North Kildare Mid East Kildare	3.88 3.56	0.30
the continuity of care (seeing the same staff) you have received	North Kildare Mid East Kildare	3.94 4.03	0.77
professional's punctuality on home visits	North Kildare Mid East Kildare	4.18 N/A.	N/A

Note: $p < 0.1$ indicated in bold type, $p < 0.05$ indicated with bold type and asterisk.

APPENDIX 2

Comparison of scores for the Verona Satisfaction Questionnaire (modified for relatives) between Home Care (North Kildare, n=30) and in-patient care (Mid-East Kildare, n=26):

VERONA PATIENT SATISFACTION QUESTIONNAIRE	Sector	Mean	t-value	p-value
The overall effectiveness of the Psychiatric Team in helping your relative deal with their problems/crisis situation	North Kildare Mid-East	4.2 3.6	1.7	0.09
The ability of the home care nurse's to listen to and understand your relative's problems.	North Kildare Mid-East	4.5 3.9	2.6	*0.01
The professional knowledge and competence of the Psychiatric Team nurses	North Kildare Mid-East	4.5 4.1	1.7	0.09
The effectiveness of the Psychiatric Team in helping your relative recover and in preventing relapse	North Kildare Mid-East	4.3 3.6	2.4	*0.02
The confidentiality and respect shown for your relative's rights	North Kildare Mid-East	4.6 4.3	1.4	0.16
The amount of time and help your relative received	North Kildare Mid-East	4.5 4.0	1.9	0.07
The explanations of specific plans for your relative's care and why they were being made	North Kildare Mid-East	3.9 3.5	1.3	0.21
The response of the Psychiatric Team to crises or urgent needs during the hours from 9:00 to 5:00 pm	North Kildare Mid-East	4.3 3.8	1.8	0.08
The arrangements made for your relative for after hours and weekends	North Kildare Mid-East	4.2 3.6	1.8	0.08
The effectiveness of the Psychiatric Team in helping you improve your knowledge and understanding of your relative's problems	North Kildare Mid-East	3.7 3.2	1.6	0.12
The effectiveness of the Psychiatric Team in improving the relationship between you and your relative	North Kildare Mid-East	3.6 3.4	0.6	0.56
The professional's punctuality on home visits	North Kildare Mid-East	4.4 3.9	1.6	0.13
The ability of the Psychiatric Team nurse to listen to and understand your worries	North Kildare Mid-East	4.1 3.6	1.6	0.13
The recommendations made to you about how you could help your relative: whether suggestions are clear, practical and useful.	North Kildare Mid-East	3.6 3.3	1.0	0.34
The effectiveness of the Psychiatric Team in helping you improve your ability to establish good relationships with people outside your family	North Kildare Mid-East	3.5 3.4	0.35	0.73
How information was given to you about your relative's problem and what to expect	North Kildare Mid-East	3.5 3.4	1.0	0.68

The instructions on what your relative should do to manage symptoms between visits by the Psychiatric Team nurse: were they clear, practical and useful	North Kildare	3.9	0.23	*0.03
	Mid-East	3.2		
The overall effectiveness of the service in helping your relative improve their capacity in dealing with the problems they had	North Kildare	4.2	0.35	*0.04
	Mid-East	3.5		

Note: $p < 0.1$ indicated in bold type, $p < 0.05$ indicated with bold type and asterisk.

APPENDIX 3

Comparison of Family Burden score between Home Care (North Kildare, n=29) and Inpatient Care (Mid East Kildare, n=25)

FAMILY BURDEN QUESTIONNAIRE	Area	Mean	t-value	p value
Do you feel that your relative asks for more help than he/she needs?	North Kildare Mid-East	1.10 1.25	0.4	0.66
Do you feel that because of the time you spend with your relative that you don't have enough time for yourself.	North Kildare Mid-East	1.55 1.92	1.2	0.25
Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?	North Kildare Mid-East	2.00 2.36	0.9	0.36
Do you feel embarrassed by your relative's behaviour?	North Kildare Mid-East	.90 1.44	1.7	0.09
Do you feel angry when you are around your relative?	North Kildare Mid-East	1.00 1.44	1.5	0.15
Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?	North Kildare Mid-East	1.00 1.60	1.6	0.12
Are you afraid what the future holds for your relative?	North Kildare Mid-East	2.28 2.48	0.6	0.56
Do you feel your relative is dependent on you?	North Kildare Mid-East	2.10 2.64	1.5	0.13
Do you feel strained when you are around your relative?	North Kildare Mid-East	1.38 1.56	0.5	0.59
Do you feel your health has suffered because of your involvement with your relative?	North Kildare Mid-East	.97 1.72	2.1	*0.04
Do you feel that you don't have as much privacy as you would like, because of your relative?	North Kildare Mid-East	1.04 1.24	0.6	0.56
Do you feel that your social life has suffered because you are caring for your relative?	North Kildare Mid-East	.93 1.44	1.5	0.15
Do you feel uncomfortable about having friends over, because of your relative?	North Kildare Mid-East	.59 1.36	2.4	*0.02
Do you feel that your relative seems to expect you to take care of him/her, as if you were the only one he/she could depend on?	North Kildare Mid-East	1.30 2.08	1.9	0.06
Do you feel that you don't have enough money to care for your relative, in addition to the rest of your expenses?	North Kildare Mid-East	.67 1.64	2.7	*0.01
Do you feel that you will be unable to take care of your relative much longer?	North Kildare Mid-East	.48 1.20	2.1	*0.04

Do you feel you have lost control of your life since your relative's illness?	North Kildare Mid-East	.74 1.20	1.5	0.13
Do you wish you could just leave the care of your relative to someone else?	North Kildare Mid-East	.85 1.24	1.1	0.27
Do you feel uncertain about what to do about your relative?	North Kildare Mid-East	1.00 1.48	1.4	0.17
Do you feel you should be doing more for your relative?	North Kildare Mid-East	1.52 1.24	0.9	0.38
Do you feel you could do a better job in caring for your relative?	North Kildare Mid-East	1.26 .88	1.2	0.22
Overall, how burdened do you feel in caring for your relative?	North Kildare Mid-East	1.33 2.12	1.9	0.06
Total Family Burden Score (sum)	North Kildare Mid-East	25.3 36.9	2.1	*0.04

Note: $p < 0.1$ indicated in bold type, $p < 0.05$ indicated with bold type and asterisk.



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Further copies of this report can be obtained from:
Dr. Pat Gibbons, Celbridge Health Centre, Maynooth Road, Celbridge, Co. Kildare.
Telephone 01 6303 163.