PORTADOWN
HOME RESPONSE

An Evaluation of the Home Response Scheme in Portadown

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CHAPTER 1

INTRODUCTION

1.1 Overview This report details an evaluation of the first 18 months of the Praxis Home Response Service based in Portadown. This is a domicillary model of care for individuals experiencing mental ill-health. The scheme is funded by Craigavon & Banbridge Health & Social Services Trust (CBHSST) and referrals to the service come from the Community Mental Health Team (CMHT). At the time of this report the service has been operational for 2 years.

1.2. The Evaluation Three main questions are addressed in this report.

i. How is the Home Response service provided/delivered and what are the operational issues from the provider perspective?

ii. Who uses the service and does their level of functioning change?

iii. How do service users, statutory key workers and the purchaser view the service?

1.3.. The Methodology

1.3.1. How the Service is Delivered

Interviews were carried out with:

- The Home Response Co-ordinator.
- The Home Response Co-ordinator's Manager and Praxis Senior Care Managers involved with the service.
- The Home Response Workers (HRWs). Areas covered included: their satisfaction with training and support, review meetings, areas of particular satisfaction in their work and areas of concern.
- The process by which service users passed through the service was examined in relation to a couple of individuals.

1.3.2. Who Uses The Service And Does Their Level Of Functioning Change?

- ***Who Uses the Service***

The following information was gathered on all service users:

- Socio-demographic characteristics
- Mental health history (characteristics)
- Diagnosis
- Hospital admissions in the year prior to using the Home Response service.

This information was obtained from the key workers on the CMHT through a postal questionnaire in relation to each individual they referred.

- ***Social and Behavioural Outcome***

Information on service users' social and behavioural functioning was gathered on entry to the service (base-line) and at 6 and 12 months after taking up the service. Social and behavioural functioning was assessed using

the Life Skills Profile (Rosen et al., 1989) which was developed to assess the functioning and progress of individuals with long-term mental health problems. The scale has been shown to be a reliable and stable measure when completed by individuals using the same professional perspective (Parker et al. 1991).

The scale consists of 39 items, rated on a 4-point scale, grouped into 5 sub-scales:

- ***Self-care:*** appearance, personal grooming, hygiene etc.
- ***Non-turbulence:*** reckless/offensive behaviour, violence etc.
- ***Social contact:*** interpersonal contact, social activities, friendships, leisure pursuits etc.
- ***Communication:*** interpersonal skills, coherence of speech etc.
- ***Responsibility:*** medication, treatment compliance etc.
- These sub-scales provide an overall ***total*** score.

(Shepherd et al., 1995)

The Life Skills Profile (LSP) was completed by statutory key workers at the 3 testing points: baseline, 6 months, and 12 months after taking up the service.

Key workers were also asked to make an overall rating as to how they felt the service had impacted on their client.

1.3.3. How Do Those Involved With The Service View It?

Interviews were carried out with a range of key informants who had contact with the service.

- ***Views of Service Users***

After the service had been in operation for approximately one year, service users were asked whether they were interested in taking part in an interview to express their views about the service. 15 out of the 33 individuals approached for the study agreed to take part. Two questionnaires were used:

- ***The Client Satisfaction Questionnaire***

7 of the 8 items from the Client Satisfaction Questionnaire (Larsen et al., 1979) were used. Individuals rated on a 4-point scale a range of aspects of the service including the overall quality: the extent to which it met their needs and whether it had helped them to deal more effectively with their problems.

- ***Semi-Structured Interview***

A semi-structured interview schedule was drawn up for the purposes of obtaining more detailed views on service users' experience of the service. The questionnaire consisted mainly of open-ended questions. With the permission of the participant, interviews were tape recorded and then transcribed. Areas

covered in the questionnaire included: how well informed individuals were about the service on taking it up, whether they had experienced the service as flexible, their satisfaction with their relationship with their HRW and whether their views about what they wanted from the service were listened to etc.

- ***Views of Key Workers from the CMHT***

After the service had been in operation for approximately 14 months, interviews were carried out with key workers who had referred clients to the service. A semi-structured interview schedule was drawn up for the purpose of the evaluation. Areas covered included: satisfaction with the referral process, reviews, communication of information, and the support given to their clients.

- ***Views of Other Key Parties***

Additional interviews were carried out with other key individuals from CBHSST who had contact with the service from a variety of perspectives: purchasing/service negotiation, liaison with Praxis in setting up the service, the clinical perspective, and the CMHT perspective. These interviews covered areas such as: perceived strengths and weaknesses of the service, satisfaction with communication and issues related to working with the voluntary sector.

CHAPTER 2

HOW THE SERVICE IS DELIVERED

2.1. Background on Praxis

Praxis is a voluntary organisation delivering mental health services throughout Northern Ireland. Services currently provided are:

- 13 accommodation and support schemes ranging from dispersed intensively supported housing to residential flat cluster and residential care homes.
- 'Home Response' operating from 4 sites, including the service currently being evaluated.
- Volunteer befriending. There are currently approximately 150 matches between volunteer befrienders and individuals experiencing mental ill-health.

The work of the organisation is primarily funded from:

- Contracts with Health & Social Services Trusts and funding from the Department of Health & Social Services
- Fund-raising activities.
- Tenants/Residents Rent.

2.2. The Home Response Model of Care

The Praxis Home Response service is a domicillary model of care for individuals experiencing mental ill-health. The aim is to provide a service which is an aid to the community statutory professional role, with the Home Response Worker complementing the role of community statutory professionals.

2.3. Funding of the Service

When Craigavon & Banbridge Health & Social Services Trust (CBHSST) extended a request to create a list of preferred providers for domicillary care, Praxis put forward the Home Response model. The service was purchased by CBHSST, initially as a 50 hour block contract basis. The number of hours purchased was increased to 100 hours, again as a block purchase after the service had been operating for approximately 18 months. A service agreement/service protocol was drawn up jointly between Praxis and CBHSST agreeing the aims and objectives of the service, criteria for referral, the process for referral and review, and monitoring and quality assurance.

2.4. Aims and Objectives of Service

As indicated in the service agreement/service protocol developed between Praxis and CBHSST, the aims and objectives of the service are as follows.

- ***Aims***

The scheme aims to:

- Offer a package that, as part of a total individual care-plan package, would enable adults who have experienced mental ill-health, to remain in their own home.

- Reduce the possibility of individuals becoming involved in a revolving door pattern of frequent re-admissions to hospital.

- Enable adults who require a high level of professional support in the short-term to return directly to their own homes on discharge from hospital.

- Ensure a more effective use of professional staff time by employing suitably trained Home Response Workers.

- Meet the needs of carers and relatives of individuals who have experienced mental ill-health by supporting, educating, involving and offering them practical help.

- ***Objectives***

The Home Response scheme strives to achieve the above aims by:

- Offering home support to people who have experienced mental ill health in the form of practical, social and emotional support.

- Ensuring service user involvement in the planning and delivery of the service they require.

- Ensuring individuals emotional, social and physical needs/plans are met as delegated by the statutory key worker/named worker in their individually tailored care plans.

- Fostering good relationships with the family and where appropriate the local community.

2.5. Criteria for Referral to the Service

The service agreement/service protocol set out the criteria for referral as follows.

- Referral by key worker/named worker from the Community Mental Health Team.

- Over age of 18 years.

- Clinically diagnosed as having experienced mental ill-health and have:

- as a result been admitted to some form of institutional care in the past 2 years

- may have had no prior experience of hospital admission and referral to the pilot scheme is a means of preventing this.

- Prospective individuals may be reluctant to accept referral to mainstream services such as day care, but who would require continuing support in the community to prevent deterioration in their mental health which could lead to hospitalisation.

- Will not be in an acute phase of mental illness

- The individual may need to receive support in order to ensure the personal well-being of the carers and relatives as well as that of the individual.

- Prospective individuals will not suffer from disability (mental or physical), drug or alcohol abuse to such an extent that it prevents them from coping with the emotional, practical and social demands of living at home.

- Prospective individuals should not have an on-going problem of violence or any other difficulty which may render themselves a danger to themselves or their community.

- Prospective individuals, and where applicable family members, should be aware of the nature of the pilot scheme and have a positive decision in agreeing to be considered for the service offered.

- Prospective individuals may be involved in programmes in day care and require support and practice to develop the skills in their own home.

- Prospective individuals may be moving from residential care setting and need to continue with these care plans in their new setting.

2.6. Current Praxis Facilities Within the Portadown Area

Since 1992, Praxis has had an accommodation and support scheme in Portadown (14 places) consisting of a 5 place Flat Cluster and 9 Dispersed Intensively Supported Housing (DISH) places. The Flat Cluster model consists of single person flats grouped together. The DISH model consists of houses or flats dispersed throughout the local area One of these houses is shared between two individuals and the others are single person accommodation. Praxis staff provide 24 hour cover for the accommodation and support scheme.

The decision was made to attach the new Home Response scheme to the accommodation scheme. This involved sharing office space and using accommodation staff for management support for Home Response.

2.7. Extent of Service

- ***Hours Available***

Craigavon & Banbridge Community Health & Social Services Trust initially purchased 50 hours per week of HRW time. The 50 hours per week also included HRW travel time between clients. It was agreed that the service would be available during the hours of 9.00am to 9.00pm, 7 days a week. The service agreement also added that:

'There may be occasion when it is necessary to facilitate hours other than this. This will be determined by the needs of the individual'.

- ***Geographical Area***

Initially, it was agreed that the service would focus on the urban areas of Lurgan and Portadown. Both of these areas have relatively high population densities. After the service had been in operation for a few months, the service was extended geographically, to meet the needs of some

individuals in the rural areas around Banbridge. Overall the service covers approximately 30 square miles.

- ***Extension of Service***

After the service had been in operation for approximately 18 months, the Trust agreed to purchase an extra 50 hours bringing the total to 100 hours.

2.8. Joint Working Between Praxis and CBHSST

There was collaboration between the Trust (primarily the CMHT) and Praxis on a range of issues to make the service operational. As indicated above, the service agreement/service protocol was drawn up jointly by the 2 organisations. Dissemination of information about the service to the CMHT was carried out jointly by a senior representative from Praxis and the CMHT. Representatives from the CMHT were also involved in the recruitment of the Home Response Workers. As part of their induction, the HRWs visited the CMHT at its base.

There were also existing communication links between the two organisations because of the Praxis accommodation and support scheme to which the CMHT referred individuals. There was therefore many points of contact through review meetings and phone contact.

Additionally, the Manager for the accommodation project (or in her absence one of the 2 Grade III staff) attended the fortnightly multi-disciplinary team meetings involving the CMHT and the psychiatrist with responsibility for the area.

2.9. Staffing of Home Response

Initially, to cover the 50 hours, the Home Response scheme was staffed by a part-time Co-ordinator and 3 Home Response Workers. When the scheme was extended to 100 hours, 2 new HRW posts were created. There are currently 4 HRWs covering 100 hours. At the start, the Co-ordinator was allocating 10 hours per week to Home Response. With the expansion of the service to 100 hours, the Co-ordinator is allocating 16 hours per week to the Home Response service.

- ***Skills-Mix***

The Co-ordinator post is a Grade III post. An individual who had been working full-time in the accommodation scheme was transferred to the Home Response on a part-time basis while remaining with the accommodation scheme on a part-time basis.

Grade III is a professional grade of staff, essential requirements for the post being a relevant professional qualification, a minimum of 2 years experience in adult mental health and experience of supervisory management. The role of the co-ordinator includes:

- Recruitment, induction and identifying training needs of HRWs
- Ongoing supervision and support of HRWs
- Processing all referrals to the service

- Liaison with statutory professionals
- Monitoring service provision

The Home Response Workers are Grade I posts. In terms of education and work experience, the minimum requirements are that post-holders have: a good basic education, a basic understanding of mental illness, one year's recent experience of work in a caring environment with an adult client group, and experience of working directly with individuals with mental ill-health (paid or voluntary, including family experience).

- ***Staff Turn-Over***

Three members of the original team of Home Response Workers left the service. One of these individuals, who had also been working in the accommodation scheme left to focus on that work. The current team consists of the Co-ordinator and 4 HRWs who have been with the service for a maximum of 16 months and a minimum of 8 months.

2.10. Induction of Home Response Workers

The HRWs undergo a three week induction programme. Topics covered include:

- Praxis Service Principles and Operational Policy
- Role of the HRW
- Effective communication skills
- Confidentiality
- Passing on crucial information
- Reporting and recording of information
- Mental ill-health
- Overview of CMHT
- Handling difficult situations
- Basic First Aid
- Health & Safety
- Food Hygiene
- Visits to other facilities including local Day Hospital, NSF Centre and other Praxis Home Response scheme.

2.11. Referral Process

Referrals are made by clients' key workers from the CMHT. At the time of the evaluation of the pilot Home Response scheme, there were very few service users being care managed as the introduction of the care management system in relation to the 18-65 age group had just begun.

An application form signed by the key worker and the individual being referred, is forwarded to the Home Response Co-ordinator for processing the referral. The following information is requested in the application form:

- Specification of statutory professionals involved with the individual
- Whether there is a carer involved
- A checklist rating the individual's daily living skills
- Brief mental health profile of the individual including, history of violence, aggression, alcohol or drug abuse or other difficult/challenging behaviour
- Dates of psychiatric hospital admissions in past 5 years
- Brief physical health assessment

- Medication
- Whether there is a history of a criminal record
- Specification of the duties which the HRW is being requested to carry out
- Number of hours and days per week the HRW is required
- Estimated duration of programme
- Requested review date of programme

When a referral has been accepted, there is a meeting of the service user, their statutory key worker, the allocated HRW and the Home Response Co-ordinator. This meeting is used to introduce the service user and the HRW and to ensure that there is clarity about what the service will provide. The HRW begins to visit and work with the service user after this introductory meeting has taken place.

2.12. Review Process

Reviews are scheduled depending on individual needs and the severity of the mental illness. The first review is usually carried out two months after the service delivery begins and thereafter at 6 month intervals, though some reviews are carried out more frequently. Reviews are usually carried out in service users' own homes. They are attended by the service user, their key worker, the HRW and the Home Response Co-ordinator.

2.13. Monitoring and Supervision

On each visit to a service user, the HRW (or the service user if they wish) records the activities carried out on that day. This log is kept in the individual's home. Entries are signed by both the service user and HRW. A copy is returned weekly to the Home Response Co-ordinator.

Each of the HRWs meet individually with the Co-ordinator on a fortnightly basis for supervision meetings. This meeting is used to review the work carried out in the previous week with each client and any important issues that have arisen in relation to the service user, provide feedback for the HRW, and to explore with the HRW ways of dealing with particular situations that they may be experiencing as difficult. A note is made of all the main points arising in the meeting. If any issues arise between meetings that the HRWs need to consult with the Co-ordinator about they phone or call into the office.

2.14. Formal Recording Procedures and Feedback to CMHT

The formal written recording procedures used by the service are:

- The daily work recording made by the HRW and kept in the service users home.
- The Co-ordinator, after each review, makes a record of any significant points raised and any changes identified in the support plan for the service user.
- Formal feed-back to the CMHT is through the review meetings.

2.15. Referrals to the Service

Over the first 18 months of the service, when the evaluation was taking place, there were 36 referrals (see page 17 for demographic breakdown). Throughout that time, no referral was turned down by the service. Of the 36 individuals referred to the service over the first 18 months, 8 have discontinued the service. The maximum length of time an individual has been using the service has been 2 years. The minimum length of time an individual was using the service before discontinuing the service was 4 weeks. In total, 3 individuals had been using the service for 6 months or less before discontinuing; 5 had been using the service for over 12 months before discontinuing.

Over the whole 2 year period the service has been in place, there have been a total of 49 referrals.

2.16. Support Received

Most commonly, service users are receiving 2 hours per week Home Response. The minimum amount of time being received was 1 hour and the maximum was 5 hours.

The duties to be carried out by the HRW were indicated by the service user's key worker in the referral form. For the purposes of the evaluation, these were categorised into different areas of support. Many of these categories are not mutually exclusive, rather they are simply intended to provide an overview of how key workers were using the service.

Table 1: Nature of Support Requested by Key workers for Clients (n=36)

Support Requested	% service users
Companionship & emotional support	67%
Encourage social interaction outside home & accompany on social outings	61%
Assist and motivate to carry out household & personal care tasks	46%
Accompany on shopping trips for a range of needs	36%
Assist in structuring day and using leisure facilities/developing hobbies	19%
Establish rapport	17%
Assistance with budgeting	11%
Develop confidence & self-esteem	8%
Child related	6%
Physical health promotion	3%
Carer relief	3%

The frequency with which different types of support were requested for clients are detailed in Table 1.

Companionship and emotional support and encouraging social and leisure activities and social interaction activities outside the home were most commonly requested.

HRWs carried out a wide range of activities with service users. Specific activities included: building up a routine of initially going with the service user for brief trips to local shops for essentials to longer trips

further away, education on healthy eating and assistance with cooking, going out with service users so that they can collect prescriptions or pay bills, going out for walks, going to church, accompanying to use leisure facilities etc.

2.17. Operational Issues From the Service Delivery Perspective

A number of interviews were carried out with the service Co-ordinator. Also, interviews were carried out with the service Co-ordinator's manager and Praxis Senior Care Managers. The process by which service users passed through the service was examined in relation to a couple of individuals. A number of issues were identified based on this information.

- There were a number of operational advantages to having the H.R service attached to an existing accommodation scheme. The H.R Co-ordinator worked on H.R on a part-time basis and the rest of his time was spent working on the accommodation scheme which operated from the same site. This enabled flexibility in relation to his availability for staff and liaison with the CMHT. Additionally there were two other professional graded posts in the accommodation scheme, who could cover any absence of the H.R Co-ordinator.

- Considerable emphasis was placed on ensuring the safety of HRW in their work setting. This was felt to be of particular importance in a service such as H.R, as the HRW worked off-base all day. Ways of creating as safe an environment as possible for staff were identified as:

  - Training HRWs to be aware of any changes in client.
  - Training in calming diffusing and breakaway techniques.
  - Use of personal alarms.
  - Ongoing regular supervision where work with each client is explored.
  - Telephone access to management outside normal office hours.

- In the initial steps of taking up the service, service users sometimes confused it with traditional home-help services. Clarification with the individual that the service is about 'doing things with rather than for' was felt to be important to ensure that expectations of the service were appropriate.

- Delivering a service with a small pool of workers meant that the unexpected absence of a worker can have a considerable impact. To date this had been managed successfully, primarily through a member of staff from the accommodation scheme providing extra hours.

- As would be expected, where HRWs were going into situations where complex needs were involved, the supervision and support the HRWs required tended to be greater.

- Operating a patch system was felt to lead to the most efficient use of resources, particularly when the service was being delivered in a rural area. However, this had to be balanced with appropriately matching service users and HRWs and also being flexible about changing the day/times when the HRW called depending on service user needs. As a result operating a patch system had not been particularly effectively

- It was acknowledged that where good relationships had developed between the service user and HRW, that the HRW leaving the scheme could have a considerable impact on service users. In a couple of situations, service users had been reluctant to engage with another HRW for a period. Being sensitive to this situation arising and supporting the service user were felt to be important.

- The geographical area covered is sectorized from a religious and political point of view. While this had not impeded service delivery, it was an ongoing issue to which the service needed to be sensitive.

- There was limited use of the service outside the hours of 9am-5pm Monday to Friday.

- There was felt to be good rapport with the CMHT and good communication links.

2.18. Views of Home Response Workers

Interviews were carried out with 3 HRWs. Areas covered included their satisfaction with training and support, review meetings, areas of particular satisfaction in their work and areas of concern. The following issues were raised:

- The induction was experienced as very helpful and a good introduction to, and preparation for the job.

- The induction and training sessions were helpful in building confidence about how to deal with aspects of the job. Two areas of training that were felt to be particularly helpful were dealing with aggressive and violent behaviour and accountability.

- There was a high level of satisfaction with the ongoing supervision and support received.

- Short visits with service users were sometimes experienced as rushed, though, long sessions could sometimes be experienced as very tiring and draining.

- HRWs attended review meetings and felt that their contribution was taken into consideration.

- One individual reported sometimes feeling under scrutiny at review meetings. Another reported that 2 service users had expressed dreading their reviews because

they feared the service would be taken away.

HRWs reported many aspects of their job that they particularly liked:

- There was a strong sense that they felt that service users experienced the service as useful.
- The variety of the work was enjoyable.
- There were many opportunities for learning, general personal development and developing experience.
- The opportunity of giving people some assistance was satisfying.
- When individuals made even small progress, it was very satisfying.

Areas of concern / aspects of the job they disliked were also identified:

- The job could sometimes be experienced as lonely and isolating because they were not working closely with other staff on a day-to-day basis.
- Although acknowledged as part-and-parcel of the job, service users' changeable motivation and mental state was sometimes experienced as frustrating.

CHAPTER 3

WHO USES THE SERVICE AND WHAT IS THE OUTCOME

3.1 Demographic Description of Referrals

36 referrals were made to the service during the 18 month evaluation period. All referrals took up the service.

- 31% (n=11) of referrals were male and 69% (n=25) were female.
- Average age was 48.8 years (S.D. 15). The youngest referral was 27 years old and the eldest 76 years.
- None were homeless; 8% (n=3) were living in 24 hour supported accommodation; the remaining 92% were in independent living settings, either alone, with family or friends.
- 44% (n=16) were living alone.
- 8% (n=3) were single parents living with their children; 14% (n=5) were living with their partner and children. Therefore, 22% of service users had parental responsibilities.
- 53% (n=19) of service users were described as having a carer, though in some cases the input and support was described as limited.
- None of the service users were currently involved in any kind of employment, including training and sheltered work.
- All referrals had a statutory key worker; 1 referral was being care managed.

3.2. Mental Health History

The mental health history forms were returned for 72% (n=26) of service users. Table 2 details mental health history for the 2 years prior to referral to the Home Response service.

Table 2: Mental Health History in 2 Years Prior to Referral

History of ...	Yes	No
Threatening behaviour / violence towards others	4% *(n=1)*	96% *(n=25)*
Criminal offence	0% -	100% *(n=26)*
Suicidal thoughts/non-accidental self-injury	38.5% *(n=10)*	61.5% *(n=16)*
Health / social problems associated with alcohol / drug misuse	23% *(n=6)*	77% *(n=20)*
Problems associated with physical illness / disability	42% *(n=11)*	58% *(n=15)*
Homelessness	0% -	100% *(n=26)*

3.3 Diagnosis

Information on diagnosis was returned for 75 % (n=27) of service users (see Table 3, below). Given that all 4 of the dual diagnosis had a depression component, depressive disorders were the most common diagnosis, followed by schizophrenia.

Table 3: Breakdown of Clinical Diagnosis

Diagnosis	%	
Schizophrenia	37%	*(n=10)*
Depression	41%	*(n=11)*
Personality Disorder	7%	*(n=2)*
Dual Diagnosis	15%	*(n=4)*

3.4. Hospital Admissions

Although the forms detailing hospital admissions were returned in relation to 72% (n=26) of service users, information on hospitalisation was not complete enough to make an assessment as to how using the service had impacted on hospitalisation rates.

3.5. Social and Behavioural Functioning on Referral

Life skills were assessed using the Life Skills Profile (Rosen et al., 1989) which was developed to assess functioning and progress of individuals with long-term mental health problems. To develop an overall picture of the life skills of the individuals using this service, the baseline LSP scores were compared to some published data:

- A group of individuals using Cambridge Psychiatric Rehabilitation Service (CPRS) (Shepherd et al., 1995).
- The original Rosen et al (1989) Australian sample (Shepherd et al., 1995).

Figure 1 contains the average (mean) LSP scores for each sub-scale for the Home Response sample and the 2 comparative samples. (Higher scores on LSP indicate better functioning).

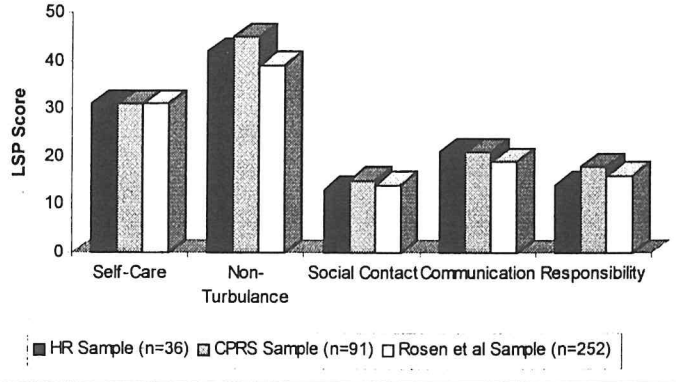
The sub-scale scores of the Home Response sample were very similar to the original Rosen et al. Australian sample. On each of the sub-scales the Home Response mean score fell within ½ a standard deviation of the Australian mean score (see Appendix A).

Although scoring slightly lower (functioning more poorly) than the CPRS sample on each of the sub-scales, the Home Response group fell within ½ to 1 standard deviation of the CPRS mean (Appendix A).

3.6. Change in Social & Behavioural Functioning

Key workers rated social and behavioural functioning at baseline, 6 months and 12 months after service uptake. Mean scores for each of the sub-scales across the 3 time

Figure 1: Home Response LSP Scores Compared to the Two Community Comparison Groups



periods are detailed in Table 4. To date, 12 month follow-up data is available on 20 service users. Change across the 3 testing times, for each of the sub-scales and total score, was explored using the Friedman non-parametric two-way analysis of variance.

There was statistically significant improvement on the social contact, communication and responsibility sub-scales. On the other 2 sub-scales there was no significant change, though there was a slight improvement in the mean scores. Post-hoc tests were carried out to examine at what time point/s significant improvement occurred.

- ***Social Contact***

  The significant difference occurred between baseline and 6 months and baseline and 12 months. There was no significant difference between 6 months and 12 months.

- ***Communication***

  The significant difference occurred between baseline and 12 month follow-up. There was no significant difference between baseline and 6 months and 6 months and 12 months.

- ***Responsibility***

  The significant difference occurred between baseline and 6 months and baseline and 12 months. There was no significant difference between 6 months and 12 months.

Table 4: Mean LSP Scores at the 3 Assessment Points

Sub-scale	Baseline	6 Months Post	12 Months Post
Self-care	30.2 (7.2)	31.7 (5.9)	32.1 (5.3)
Non-turbulence	42.1 (5.1)	43.7 (3.9)	43.8 (3.2)
Social contact*	12.2 (2.9)	14.4 (2.2)	14.9 (2.4)
Communication**	20.0 (3.2)	21.1 (2.2)	21.7 (1.9)
Responsibility*	13.6 (2.0)	18.1 (1.9)	17.6 (1.9)
Total*	117.0 (17.2)	128.8 (12.7)	129.9 (11.1)

* $p<.001$ **$p=.007$

CHAPTER 4

VIEWS OF SERVICE USERS

4.1. Participants 15 individuals agreed to participate in the evaluation; 9 females and 6 males. Participants had a mean age of 49 years (range 27-72). This was fairly representative of individuals using the service as a whole. The majority of individuals who took part in the study (53%, n=8) lived alone, 40% (n=6) lived with family/friends and 1 individual lived in a group home (with 24hr staff cover). At the time of the evaluation, 13 of the individuals were currently using the service and 2 individuals had recently left the service.

Taking part in the evaluation involved completing the Client Satisfaction Questionnaire and participating in a semi-structured interview.

4.2. Client Satisfaction Questionnaire

Individuals were asked to complete a short questionnaire assessing their satisfaction with various aspects of the service. The questionnaire included 7 of the 8 items from the Client Satisfaction Questionnaire (Larsen et al., 1979). (The question 'if you were to seek help again, would you come back to our programme?' was omitted).

On the whole, clients were overwhelmingly positive about the service. In each of the areas, all of the clients gave the service the top or second rating (Table 5). In particular:

- Almost all the clients said they would *'definitely'* recommend the service to a friend who was in need of similar help.
- Three-quarters of clients rated the service as '*excellent*'.
- Two-thirds of clients stated that the service has helped them *'a great deal'* in dealing more effectively with their problems.
- Two-thirds were *'very satisfied'*, in general, with the service they received.

However, it is common for individuals using mental health services to report high levels of satisfaction. Caution must be exercised in assessing whether the reported satisfaction actually reflects what clients really think about a service. Factors such as low expectations, acquiescence, being asked about aspects of a service that are not important to the client and limited response categories in questionnaires, may all impact on reported satisfaction.

Webb (1993) draws attention to these methodological factors that may impact on reported levels of satisfaction. The current evaluation used a number of methods to ensure as accurate a reflection as possible of clients views. For example:

- The interviews were carried out by a researcher who was not involved in any aspect of the service delivery.
- A semi-structured interview was used with a focus on using open-ended and follow-up questions to look in detail at individuals experience of the service as opposed to general levels of satisfaction. Stallard

(1996) in a review of the role and use of consumer satisfaction studies highlighted the value of open-ended questions *'which tend to produce more critical comments and routinely analyse and report areas of dissatisfaction'*.

- Use of questions such as *'What do you like best about the service?' and 'What do you like least?'* were included to ensure that clients had an opportunity to raise any issues important to them, which had not been covered in the questionnaire.

- Aspects of the service which individuals were satisfied and dissatisfied with will be further explored in the context of the information obtained from the open-ended interview questions.

4.3. Information About the Service

Individuals were asked how they first heard of the Praxis Home Response Service, whether someone explained the service to them before it commenced and whether they received a written information leaflet. All of the participants except one, reported that they had been informed about the service before taking it up. One individual could not remember how he/she first heard of the Praxis service. Only 1 individual reported that he/she had received both verbal and written information.

- ***Verbal Information***

14 of the 15 individuals received verbal information about the Praxis service before a HRW started to visit. The majority had the service explained to them by their statutory key worker and some had it explained by a member of Praxis staff.

Table 5: Client Satisfaction with Various Aspect of the Home Response Service

How would you rate the quality of the service you receive	**Excellent** 73% (n=11)	**Good** 27% (n=4)
Do you get the kind of service you wanted?	**Yes, Definitely** 60% (n=9)	**Yes, Generally** 40% (n=6)
To what extend does the service meet your needs?	**Almost all my needs met** 60% (n=9)	**Most of my needs met** 40% (n=6)
If a friend were in need of similar help, would you recommend the service?	**Yes, Definitely** 93% (n=14)	**Yes, Generally** 7% (n=1)
How satisfied are you with the amount of help you receive?	**Very Satisfied** 60% (n=9)	**Mostly Satisfied** 40% (n=6)
Have the Praxis services you've received helped you deal more effectively with your problems?	**Yes, helped a great deal** 67% (n=10)	**Yes, helped somewhat** 33 (n=5)
In an overall, general sense, how satisfied are you with the service you receive?	**Very Satisfied** 67% (n=10)	**Mostly Satisfied** 33 (n=5)

- ***Written Information***

2 individuals stated they received an information leaflet about the service, 6 said they did not receive any written information and 7 individuals could not remember whether they had received written material.

About half of the clients (n=7) felt they did not know enough about the Home Response Service before their HRW started to visit. One individual said:

'I wasn't quite sure what it would be like. I just thought somebody would be coming in for about an hour and then go again'.

However, others felt they had sufficient information about the service prior to it commencing, with one individual stating:

'I knew exactly what they were about'.

4.4. Care Plan In general, clients stated that their statutory key worker or the Praxis Home Response Co-ordinator organised the service in terms of how often a worker would come to see them and how long each visit would last. 2 individuals, who stated they were *'too sick'* to be involved at this stage, particularly welcomed the service being organised for them. On the whole, individuals were satisfied with the way in which the service was organised.

4.5. HRW Visits The majority of individuals (n=12) received one visit per week from their HRW and 3 individuals received two visits per week. It was reported that the average visit lasted approximately 1½ hours (range: 1hr-3 hrs).

Two individuals mentioned that their visits were slightly shorter than was indicated in their care plan. This was to enable their HRW to get to his/her next client on time. It was reported that this affected the kind of activities the client and HRW could do together. One individual stated:

'You worry that you are going to be out longer and put him/her behind with the other people'.

However, both individuals stated that they would prefer to work round this situation rather than having their visits extended.

- ***Changes in Visits***

At the time of interview, 3 individuals had their visits reduced from twice per week to weekly visits. One of the individuals felt s/he had improved since using the service and therefore no longer required two visits per week.

Another individual stated that Praxis felt he/she was doing well and no longer required two visits per week. The client described the change as follows:

'I think it was because they (Praxis) think I am doing well. Maybe they thought I didn't need somebody coming two days'.

The client stated that initially he/she would have preferred to have continued on with the two visits per week. However, since the change was made the client felt that things had worked out well and did not really miss the second visit as he/she had started to visit a friend on that day.

The final individual stated that the reduction in visits occurred when his/her first HRW, who came twice per week, left and another worker filled in on a temporary basis. During this time the visits were reduced to once per week. When the individual was appointed a new HRW the visits continued on a weekly basis. The individual was happy with this change as he/she had started going to the local day centre one day per week.

- ***Visits during Holidays***

Individuals stated they were informed in advance if their HRW was going to be on holiday. The majority of clients said they did not receive visits from another worker during this time. This suited most individuals as they had built up a personal relationship with their HRW and preferred to wait until he/she returned, rather than having someone new.

However, 2 individuals said they would like to have another HRW filling in while their HRW was off.

'I think it would be better if they had someone else to fill in if HRW couldn't make it...now that I only see her once a week, the rest of the week can seem awful long coming round.. and if HRW missed one (visit) it would be a fortnight...it's a long time.'

'I phoned them up (Praxis office) but he said there was no-one in the office but himself, so I couldn't have anyone...I would have preferred somebody coming'.

2 individuals stated they were not sure what would happen if their HRW was on holiday. Both individuals said they would ask their HRW.

4.6. Punctuality of HRW

On the whole, clients stated that their HRW was always on time. This generated feelings of trust and dependability between the client and HRW. One individual summarises this by stating:

'I can depend on her, she never let me down. That means an awful lot, for you really put your trust in people like that'.

3 individuals stated that sometimes their worker would be 5-10 minutes late if, for example they got held up in traffic. However, all of them said this did not bother them and if their worker was late in arriving, he/she would generally stay on a little after their time.

One client recounted a situation where a misunderstanding had occurred between

themselves and their HRW regarding the time of a visit. However, apart from this incident, he/she stated the worker was always on time.

4.7. Activities With HRW

Individuals were asked what kind of activities they were involved in when their HRW came to visit. As Table 6 indicates, individuals were involved in a variety of activities, ranging from going shopping, taking a trip to the seaside to getting help sorting bills. Each individual mentioned between 2-5 activities they were involved in with their HRW.

Table 6: Activities with HRW

Shopping: For clothes and/or food
~
Going for a drive
~
Taking a walk
~
A trip to the seaside
~
Having a picnic
~
Going out for lunch /coffee
~
Sitting in and have a chat
~
Visiting friends
~
Going to the graveyard
~
Help sorting bills
~
Being taken to and from appointments
~
Assistance with bathing
~
Help with household chores
~
Getting a break from looking after children

- ***Changes in Activities***

The two individuals who were no longer using the Home Response Service mentioned some changes whey would liked to have seen in the kind of activities they did with their HRW.

One of the individuals said he/she would have liked the opportunity to visit his/her parents' grave. The other individual, who had young children, said he/she would have liked to have gone out more with the children. The client and HRW had often tried to arrange this but it *'never quite worked out'*.

3 individuals, who stated they were happy with their activities at present, said if something came up which they wanted to do they would only have to mention it to their HRW.

- ***Deciding Activities***

In general, individuals stated that they, together with their HRW, would decide what to do during each visit. For the majority of clients, decisions were made on a day to day basis, sometimes depending upon the weather, how the person was feeling and children in the home. For others, weekly routines, such as hospital appointments determined how the visit would be spent.

Individuals valued having the choice to do whatever they wanted, but they also welcomed input and suggestions from their HRW. One individual stated:

'You like a bit of co-operation from the worker, because you don't always know what you want to do'.

4.8. Relationship with HRW

On the whole, clients reported very positive relationships with their HRW's. In particular, clients stated they could talk to them about any problems or concerns, they felt relaxed in their company and they were good fun to be with (Table 7).

Table 7: Relationship with HRW

'I get on well with HRW'

~

'HRW is very nice. She is very good... I can talk to her about things'

~

'HRW is like a mother to me. She is very, very understanding and keeps me relaxed'

~

'I can talk to her about anything'

~

' I could tell HRW anything. If anything was annoying me I could tell her'

~

'I think the world of HRW...more like a friend'

~

'It is good to have a wee chat with her and all, she is good crack'

~

'HRW is really easy going and I think the world of her. I look forward to her coming'

~

'HRW is easy to get on with, that the type of her.. you could tell her anything'

~

Three individuals also mentioned that their HRW got on well with other members of the family. For those who had young children, this was a very important part of the service. One client described how their youngest child reacted when the HRW came to visit:

'As soon as HRW pulls up, he says 'mummy, (calls HRW's name) and goes out running to meet her/him'.

However, three individuals reported having a difficult relationship with one of their HRWs. In each case, the client spoke to his/her statutory key worker, asking for a change of worker. For two of the clients, the HRW left the scheme and they were appointed a new worker. The other individual received a new worker within a short period of time of raising the issue with his/her statutory key worker.

- ***Changes in HRW's***

At the time of interview, 10 clients had received visits from a number of HRWs. Since using the service it was reported that:

- 2 individuals had 4 different workers
- 3 individuals had 3 different workers
- 4 individuals had 2 different workers
- 1 individual was about to have a change of worker.

Of the 10 individuals who had received visits from more than one HRW, the majority stated they were informed in advance of the change. However, 2 individuals stated they were not informed why the changes were taking place. One of these individuals said:

'I don't know why they changed...unless it is their policy. I would have liked to know why they changed'.

This individual said that if a choice had been offered, he/she would have preferred to continue with the first HRW.

Some of the clients said they found the whole process of changing workers quite disruptive. One individual said:

'Just as I was getting to know one HRW, they left and I had to start to get to know another person'.

One of the individuals who had received visits from three different workers felt that if their current worker left he/she would *'give Praxis up'* as he/she did not want to have to start the whole process of getting to know someone new. Another individual, who was about to have a new HRW, was nervous about the change. He/she had a good relationship with their current HRW and was afraid that he/she would not get on so well with the new worker.

2 of the females specifically stated they enjoyed having a female HRW, as they felt that there were things they could talk about more openly with another female. Likewise, one of the male clients, who was currently matched to a male worker also enjoyed having a same sex relationship. He stated:

'He understands you more...there are problems with a man that you can't talk to a lady or woman about, certain problems, but you can talk to a man about it'.

On the other hand, another male thought that it was a good idea and benefited from having a mixed match relationship:

4.9. Client Outcome Individuals were asked if, and in what ways they felt they had changed as a result of using the Home Response Service. 14 individuals felt a number of positive changes had come about as a result of using the service. Changes included: getting out of the house more, feeling more relaxed, having their mood 'lifted' and being more motivated (Table 8). One individual felt he/she was *'much the same as before'* receiving the Praxis Home Response Service.

Table 8: Changes in Self

'HRW makes me feel happy'.

~

'I feel a lot better knowing that I have them. I have the backing and I do feel a whole lot better in myself because of the outings and the contact'.

~

'It has lifted me a good deal...although I get a bit weepy, but not nearly as much as I was'.

~

'If you were in the house all the time and nobody comes to see you or you are not getting out much, the house could get on top of you and then you would become withdrawn and you would be stopping in more and more. So at least with them coming, you are able to get out a bit.

~

One individual who had just recently left the Home Response Service said:

'When I went out with her I felt more relaxed'

Another client, who had a young child at home said:

'I do find it nice having the company.. Plus HRW is driving. I just think I do like the company of going somewhere where I don't have to drive, plus he/she gets ...(child) into his seat, wee things like that there that give me a bit of a break'

4.10. Review Meetings

13 of the 15 individuals interviewed had previously attended a review meeting. One individual choose not to attend their reviews as he/she thought they were held early in the morning and he/she would have to arrange their own transport to and from the meetings. The other individual could not recall having a review meeting since using the service.

The majority of individuals said they were asked for their views and opinions during the review meetings and felt that their views were taken into consideration. However, 3 individuals did not feel they had a say at their review meetings. One individual said:

'(Statutory key worker) tried to explain what I felt like, when I knew best'.

Another client, whose visits were being reduced from twice per week to once a week, said:

'I agreed to have it one day a week, but I sort of got talked into it...one person was doing most of the talking and then just saying "do you agree with this, do you agree with that".

Another individual said of review meetings:

'To an extent you are ignored, not, I'm sure deliberately, but while they are conversing you are sort of sitting on the inside but it is like looking in from the outside'.

3 individuals suggested ways in which the review meetings could be improved. One individual, who reported that their consultant psychiatrist was sent a copy of the review notes, felt the psychiatrist could be more actively involved in the meetings. One individual suggested that the meetings could be improved if fewer people attended. The client stated:

'I'm not used with people... I'm all right maybe just with one but I get a bit uncomfortable when there is more...I would like less people there'.

Another individual felt too much emphasis was place on review meetings and also felt they were held too frequently. He/she suggested that 6 reviews per year would be sufficient, but then realised this was in fact the case at present.

4.11. Making a Complaint

The majority of individuals (n=9) were not aware that Praxis had a formal complaints procedure and 1 individual was 'not sure'. 5 individuals stated they had been informed of the complaints procedure; 1 individual reported that he/she was told verbally about the procedure and 4 were given a written information leaflet. Of the four who received written information, 2 individuals stated that they *'paid no attention'* to the information as they had no complaints to make.

When asked how they would go about making a complaint, the majority of individuals stated they would either speak to their HRW, the project co-ordinator or their statutory key worker. One individual said he/she would maybe speak to their doctor and another individual said he/she would put the complaint in writing.

2 individuals stated that the fear of upsetting people, being regarded as rude, or the complaint being held against them, would prevent them from making a complaint about the Home Response Service. 2 individuals stated that they did not like complaining in general and would try to sort the problem out by talking to their HRW rather than making a formal complaint.

4.12. Liked Best About the Service

When asked what they liked best about the Praxis service, individuals put forward a range of things. The majority of individuals mentioned more than one characteristic of the service which they particularly valued.

9 of the individuals particularly valued the visits they received from their HRW and the relationship which had developed between themselves and their worker.

'It's a nice way to have a friendly relationship'.

'HRW coming in. I can depend on her coming and I know I can talk to her and that just makes it'.

6 individuals enjoyed getting out and about with their HRW. One individual said:

'What I like best about the service is that they take me out....it is a really good start to the week'.

1 individual mentioned the availability of the Praxis staff and the support they provided. He/she said:

'They are there all the time and will help you if you need the help'.

1 individual welcomed the fact that he/she was in control of the service and no-one was telling him/her what to do. Another individual particularly valued having access to a service which was reliable.

Although individuals were not directly asked how flexible they found the service, a number

of comments from individuals indicated that they found the service to the client-centred and very flexible.

For example, 2 clients stated that their visits could be extended if they had an appointment to attend or if they wanted to go somewhere in particular. Another individual stated that he/she was able to change the time at which their HRW came to fit in with family life and another individual changed the day on which their HRW came. One client stated that if he/she did not require the service one week, he/she could phone the Praxis office in advance and the visit would be cancelled.

4.13. Like Least About the Service

Participants were asked what they liked least about the Home Response Service. Only 2 of the 15 individuals interviewed raised something which they did not like about the service. For 1 individual this was related to the fact that he/she thought the review meetings were held too early in the morning. The other individual disliked the disruption caused by having a high turnover of workers.

Three suggestions were put forward as to how the Home Response Service could be improved. These involved:

- Consultant psychiatrists having a more active role in Praxis review meetings.
- Another HRW being available to stand in if a client's HRW was on holiday.
- Having the option to change workers if the client experienced difficulties with a HRW.

4.14. Exit from Service

At the time of interview, 2 individuals were no longer receiving the Home Response Service. These individuals were asked about their experience of how the service was discontinued.

1 individual stated that their statutory key worker suggested that he/she would benefit more from a befriending relationship, rather than Home Response. However, the client stated that he/she would have preferred to have continued on with the Home Response Service as he/she had just developed a strong relationship with their HRW when the service was discontinued.

The other individual decided him/herself to stop using the Home Response Service. He/she stated there was no particular reason for stopping the service:

'I just decided I didn't want them anymore'.

The client spoke to the Home Response co-ordinator and the service was gradually withdrawn.

CHAPTER 5

VIEWS OF CMHT

5.1. CMHT Interviews

After the service had been running for approximately 14 months, interviews were carried out with 7 members of the CMHT. These individuals had referred clients to the service or had on their caseload clients using the service who had originally been referred by a colleague.

These interviews provided information in relation to 19 clients. The minimum number of clients a CMHT member had referred was 1 and the maximum was 6.

5.2. Referral process

- All 7 of the CMHT members were satisfied with the referral process. One commented that there was not a section for restricted information on the application form. Although sensitive information could be passed on verbally, it was felt that it would be more appropriate to put such information in writing.

- 4 individuals were satisfied with the time gap between referring a client to the service and the service actually commencing. 3 individuals were not satisfied. These 3 professionals had referred clients to the service after it had been in operation for some time and most of the 50 hours per week had already been allocated. This had led to a time gap which they felt was too long.

- It was reported that, in the case of one client this led to increasing levels of anxiety about the service commencing. Another client decided not to take up the service whereas, if it had been delivered fairly quickly on referral, it was likely that they would have taken up the service.

- All of the CMHT key workers interviewed were satisfied that the service was being targeted appropriately.

5.3. Flexibility

- 6 of the 7 key workers felt that the service was flexible in how it responded to their clients needs. Reported examples of the flexibility of the service included the focus on the individuality of service users and changing the timing of HRW visits to coincide with any appointments service users may have, to which they want the HRW to accompany them.

- However one key worker had experienced the service as being somewhat inflexible. This had been in relation to accommodating a client's hospital appointments and the days on which the HRW could call. However, this individual also gave examples where the service had been flexible and felt that this had been particularly evident in the support given to this service user over the Christmas period.

- 2 key workers felt that although the service was flexible, the flexibility could be further improved by providing support outside the hours of 9.00am to 5.00pm. As indicated in the service agreement, the Home Response service was actually available from 9.00am. to 9.00pm. However it was

clear from the interviews with the CMHT that some individuals were not aware of this.

- Another key worker felt that for service users living in rural areas there were limits to how flexible the service could be. It was felt that there was a more limited pool of workers available in the rural area than the town area if a member of the CMHT wished to match a worker and a service user for a specialised piece of work.

5.4. Care-plan Process As part of the referral process, the statutory named worker completes an application form which they and the service user sign. The application form requires the key worker to list the duties that the HRW will be required to carry out; specify how often and when the HRW will be required to visit; and identify the duration of the programme and length of time before first review. The Home Response service bases the care delivered on this information and the initial meeting between all the parties involved. This section of the application form is therefore regarded, by Praxis, as the care-plan for the individual, in relation to the Home Response service.

Amongst the CMHT there were very differing views about the level of involvement they had in the care-plan process.

- 4 of the key workers were very or fairly satisfied with their involvement and cited how review meetings were used to identify and discuss changing needs of the service user and that they had a good level of involvement in the whole process. They did not feel that any changes were required in the care-plan process.

- 3 key workers were somewhat dissatisfied with the care-plan process. One of these individuals felt that there could be closer collaboration between the HRW and the referral agent in planning a 'total approach' to the service user. It was felt that this could be achieved by the referral agent getting feedback from the HRW after their first few visits to the service user. The HRW was viewed as an important source of information in refining the care-plan as they are seeing the service user frequently in their home situation.

- The remaining 2 key workers who were dissatisfied, expressed the view that they had no involvement in the care-plan process. Both individuals felt that it would be useful to have a written copy of the care-plan. One of these individuals wanted more collaboration with the Home Response service in setting up care-plans. For the other individual it was a wider issue of having more feedback from the Home Response service and more information on what the aims of the service actually were.

- Neither of these individuals viewed the information given on the application form as part of the care-plan process. This may have arisen from making a comparison with the procedure in the Portadown Accommodation project run by Praxis. The

relationship between Praxis and tenants from the accommodation scheme is different to that between Praxis and the individuals using the Home Response service. For example, Praxis' level of responsibility in relation to tenants' care-plans is greater than it is with Home Response. This is reflected in the much longer lead in period when individuals are referred to the service and the level of collaboration of accommodation staff with the CMHT, regarding the tenant's care package.

- All 7 key workers reported being satisfied that the support being given to their client matched the areas they had identified for support on referring the individual to the service.

5.5. Review Process

- All of the key workers interviewed were satisfied with the frequency of review meetings. One key worker raised the issue that if very focused and specific goals were being worked on with a client, it may be necessary to have more frequent review meetings.

- 6 out of 7 were satisfied with the way review meetings were carried out. Most of these key workers emphasised as very positive features, the informal nature of meetings and the fact that they were carried out in the service users' home. However, one key worker felt that if a service user lives with their family, it can be difficult to have privacy when meetings are at home.

- The one key worker who expressed some dissatisfaction with how review meetings were conducted felt that they should be more formal and that this could be achieved by holding them in the Praxis office rather than the service user's home. It was acknowledged that a potential consequence of this could be more intimidating and less personal meetings and that this should be avoided. This key worker felt that the meetings would benefit from more structure and a more clearly defined view of the purpose of the meetings. Although satisfied with the review meetings, another key worker suggested changes related to how the meetings are structured. This individual thought that it would be useful to have a specific agenda for the meeting, covering areas such as, what had been achieved in the previous months; how the service could be developed for the individual concerned; and exploring ways of meeting unmet needs.

5.6. Communication

- All of the key workers interviewed were satisfied with the extent to which up-to-date information on their clients was made available to them. 3 of the key workers specifically referred to the valuable monitoring role that the HRWs play and how any negative changes in their client are rapidly communicated to them.

- Everyone was satisfied with the working relationship they had with the Praxis staff and the quality of the liaison between the Home Response service and the CMHT in

relation to the delivery of care to service users.

- From the comments of the CMHT, it appeared that most of the communication took place at review meetings or if there was a problem in relation to a service user. 2 of the key workers commented that an appropriate level of contact had been achieved as it was important that the service free up some of their time rather than result in them becoming 'bogged down' by the service.

- One key worker did feel however that more informal contact with staff outside the review situation would be useful and being updated by the Home Response staff even if there is no change in the service user. Another individual felt that in addition to the more problem focused contact with Home Response staff, it would be useful to receive a report on progress of the service user every couple of months.

5.7. Support Given to Clients

Key workers were asked to rate, on a 4-point Likert scale, their levels of satisfaction with the support each of their clients was receiving from Home Response staff. They were asked to rate satisfaction with support in relation to physical, mental health and social needs.

- ***Physical needs*** were reported as being targeted in relation to only 3 service users and their key workers were satisfied with the support received by these individuals.

- In relation to ***mental health needs***, key workers were very satisfied with the support received by 40% (n=8) of service users, satisfied with 47% (n=8) and somewhat dissatisfied with the support 10% (n=2) of their clients were receiving. (data missing on 2 individuals).

- In relation to ***social needs***, they were very satisfied with the support received by 60% (n=12), satisfied with 30% (n=6) and somewhat dissatisfied with the support 5% (n=1) were receiving. (data missing on 1 individual).

The dissatisfaction expressed was in relation to 2 issues.

- A key worker felt that a service user was uncomfortable talking to the HRW about personal issues as the HRW was from the local area. This limited the benefit the service user could obtain from the service.

- A key worker felt that there was a personality clash between the HRW and the service user and that the HRW was experiencing difficulty in understanding and dealing with the service user being 'manipulative'.

Key workers were asked, *'Overall, has the service helped your client deal more effectively with his/her problems?'* Responses were given on a 4-point Likert scale. (This information was obtained at 12 months in conjunction with the Life Skills Profile. Data was available on 20 service users).

It was reported that:

- For 30% (n=6) of clients, the service *'has helped a great deal'.*
- For 65% (n=13) of clients, the service *'has helped somewhat'.*
- For 5% (n=1) of clients, it *'has not really helped'.*

5.8. Impact on Key Workers' Time

Key workers were asked how much time they spent with their client while the client was receiving the Home Response service compared to prior to receiving the service. (This information was obtained at 12 months in conjunction with the Life Skills Profile. Data was available in relation to 19 service users). It was reported that:

- *The same amount of time* was spent with 68% (n=13) of service users.
- *Less time* was spent with 32% (n=6) of service users.

Key workers were asked <u>how</u> they now spent their time with their client compared with prior to their client receiving the service. It was reported that:

- In relation to 53 (n=10)% of service users, they used their time *'in much the same way'.*
- In relation to 47% (n=9) of service users, their time with their client *was 'more appropriately used'.*

5.9. Like Best About the Service

Each of the CMHT members interviewed identified a range of aspects of the service that they liked best about the service. Some of the issues raised overlap with points raised earlier.

- 3 valued the fact that HRWs frequent contact with service users enabled them to closely monitor any deterioration in mental health and inform the key worker of this.
- 2 of the key workers felt that the service could meet social needs more readily than key worker visits could.
- 2 individuals liked the very practical nature of the service, such as accompanying individuals to hospital appointments.
- 5 key workers referred to the flexibility of the service. Comments received included:

'Flexibility in timing of visits, for example can use allocated hours spread across a number of days or use in one session'.

'The service can react to situations of need effectively, the HRW is prepared to give more in times of crisis'.

'Clients are dealt with in their own homes and at their own pace, it is not an institutionalised service'.

- The client-focused nature of the Home Response service and the nature of the relationships developed between staff and service users was referred to by 5 individuals. Comments received illustrate this point.

'Clients are treated as equals and not in a paternalistic way. The success of the service depends on the relationship between the HRW and client and that appears very good'.

'A very open service with good client involvement'.

'The HRW is able to build up a relationship with the client that is not a key worker relationship'.

'They (HRWs) work with the client as opposed to do unto ... the HRW have a good approach and attitude'.

'The caring element ... the homeliness ... the client is not as threatened by the Praxis worker because they are not professionals, this creates a relaxation'.

- The '*approachable and friendly*' nature of the service and it's '*informality*' were also reported as being valued by a couple of members of the team.

5.10. Areas of Concern

In terms of what they liked least about the service, or any concerns they may have about the service, no common theme emerged. The following issues were raised:

- 2 of the key workers expressed concern that the HRW and service users working on a one-to-one basis may create a range of problems. For one individual it was the concern that where there is a good relationship with the HRW and the service user is very socially isolated, he/she may become dependent on that worker. Related to this, key workers referred to 3 service users where they felt that a change of HRW had been highly disruptive. For the other key worker, the concern was the risk of HRWs becoming over-involved particularly because they were not professionally trained staff. It was felt that over-involvement on the part of the HRW could lead to difficulties in coping with difficult or manipulative personalities. Training and support were identified as vital in preventing this happening.

- 2 key workers felt that the information they had on the service was limited, though there was acknowledgement that being informed about the service was a 2-way process. Both individuals felt somewhat uninformed about the capacity of HRW's in terms of the complexity of the cases they could take on. In particular they mentioned their lack of knowledge about what training the HRWs had been receiving. One also felt that G.Ps and psychiatry services could be better informed about the service. The other individual felt that, although the service was an approachable one and there was always an 'open door', it was felt that increased written feedback on clients and the Home response service goals and

objectives in relation to specific service users would be useful. It was also suggested that an information leaflet on the service would be useful both for the key worker and the service user.

- As discussed earlier, some key workers were not aware of the full range of hours the service was available and expressed a desire for an out-of-hours service.

- Additionally 4 key workers would have liked to have more hours for specific clients than was available. One individual specifically raised the issue that visits of 1-1½ hours were too short for visits that involved getting the service user 'out and about'.

- One key worker commented that because of the line management system used by the service, there was limited opportunity for direct contact with HRW's. They valued the good rapport that they had with management and would like to achieve the same with HRWs.

- 2 key workers focused on the provision of more personal care support such as bathing for service users.

- 1 key worker felt that the out of hours service should be extended, perhaps up to 11pm.

- 1 key worker felt that because application forms were being shared with service users, they could be made more user-friendly.

- 1 key worker felt it would be valuable to have a wider pool of HRWs to enable a good match to be made between HRW and client for specific pieces of work.

- Finally, a key worker felt that the social aspect of the service could be developed. For example, having a drop-in facility, service users would have opportunity to develop relationships with a wider range of individuals and decrease dependency on their one-to-one relationship with the HRW.

5.11. Development of Service

Key workers were asked whether there was anything that the service was not currently providing that they would like to see developing in the future. The following issues were raised.

CHAPTER 6

OTHER KEY-PARTY VIEWS

6.1. Other Key-Party Views

In addition to interviews with individual key workers from the local Community Mental Health Team, interviews were carried out with 5 individuals who had contact with the service from a variety of perspectives: purchasing; liaison with Praxis in setting up the service; the clinical perspective and the CMHT perspective. A range of issues were raised. Not all of the issues raised were necessarily unanimous, however the information obtained from the interviews will be presented collectively.

6.2. Existing Communication Links

- Praxis had been operating 2 Accommodation and Support schemes within the CBHSST area for a number of years. Therefore, there were good existing communication links and liaison both at senior management level and *'on the ground'*. This was particularly in relation to agreeing the service protocol and disseminating information about the service to the CMHT so that referrals commenced reasonably quickly after the service became operational.

6.3. Impact of Care Management

- At the time of the evaluation, only a few individuals in the 18-65 year old age group were being care managed. There was a strong feeling that the full implementation of care management would impact on how the service was used and expectations of the service.

- It was felt that feed-back systems, for example in relation to client progress, may need to become more formalised as care management is implemented. This was not specific to the Home Response service but was likely to be an expectation of all services used by the CMHT. As statutory key workers became more responsible for any service they are 'ordering in' for clients, it was felt that they will increasingly expect more formalised feed-back from those services.

- From the outset, it was felt that the Home Response service had been presented as a flexible one and the team had been using it to date in a flexible way. Referrals to the service were considered to have a broad spectrum of needs; from the seriously mentally ill, many of whom had very complex needs, to people who were vulnerable and needing to build up relationships. The service was a new style of service in that it was domicillary support specifically tailored for a mental health client group. The impact of implementation of care management may lead to further tailoring of the service to specific needs.

- It was felt that with the implementation of care management there may be more demand for Home Response Workers having specialist training tailored to the needs of particular service users. This was felt to be an area where joint working

between the Home Response service and the CMHT would be important.

6.4. Strengths of Service

A range of strengths of the Home Response service were identified.

- The particular skills-mix used for this service was one which was valued. It was felt that there were advantages of using staff who were not professionally trained, with the back-up and support of experienced and professionally qualified staff.

- There was considerable agreement that the main strength of the service model was the use of staff, to meet particular needs in this client group, who were not professionally trained. It was felt that there were many benefits to using non-professional, yet trained and supported workers, in engaging service users in ordinary every-day activities such as going out shopping, going to the hair-dressers, cleaning their homes, going to church and generally getting out and about. It was felt that service users would feel on a more equal footing carrying out these tasks with the HRW than they would with a professional worker who has an assessment role. It was also felt that it was important for service users to have an opportunity to interact with and to develop relationships with people who are not professionals. This was particularly the case with individuals who had social networks which were for the most part restricted to professionals and mental health settings.

- Another perceived strength was the fact that the service was available out of hours and at week-ends. At the time of the evaluation there was no out of hours service available from the CMHT.

- It was felt that service models of this kind which were successfully delivered promoted a good image for community care within local communities. Such services therefore play an important part in enabling community integration.

- There was a 'low-key and ordinary' aspect to the service which was felt to be important in enabling community integration of the individual.

- The small discreet nature of the project was felt to be an asset.

- The service was regarded as accessible, flexible and to date had been 'hassle free'.

6.5. Areas of Concern

- No specific concerns were raised about how the Home Response service had been operating to date. However, the risk for creation of dependencies was raised as a potential area for concern with this particular service model.

- Many of the individuals using the service were very isolated and apart from contact with the CMHT were reluctant to use other services. This could leave them particularly vulnerable to becoming dependent on the Home Response Worker.

6.6. Staffing Issues

- The quality of staff recruited for the Home Response Worker posts was seen as the key to a model such as Home Response working successfully. The personality of the workers was seen as vitally important in this type of informal care where the building up of a relationship between the service user and the worker was regarded as the key to enabling delivery of the service.

- Comprehensive induction and ongoing training were also regarded as an important aspect of the model.

- A male Home Response Worker had recently been recruited. Until then, all the Home Response Workers had been female. It was felt that this would be an asset to the service as there were some referrals where a male HRW would be particularly appropriate. Attracting males into this kind of work can be very difficult.

- Because most of the HRWs were local, it was felt that they were well orientated to the area which meant that from early on, after appointment, they could easily move between service users' homes and would be familiar with leisure, shopping and other facilities within the area.

- Given that HRWs were going into individuals homes to work on a one-to-one basis, regular and good quality supervision was felt to be vital. It was felt that this had been in place for this service. Supervision was felt to be important from a number of perspectives: to enable monitoring of staff to ensure that they are working in the direction intended by the statutory key worker, to provide support to staff as they carry out their work, and through monitoring and support to ensure that dependencies are not being created. The latter was felt to have negative consequences for the worker as well as the service user.

6.7. Communication

- Close meshing / integration between the service and the CMHT was felt to be particularly important in relation the seriously mentally ill group. It was felt that while links between the service and the CMHT were very good, there was always room for refining such relationships.

- Where a new service model is being implemented the process of informing key workers who would be making referrals about the service, it's remit and how it differed from other services was regarded as an important one. This was an ongoing process where there was staff turn-over.

- The current system of referral through the key worker was felt to be working well. However, keeping other members of CMHT who have responsibility for individuals being referred was identified as an area for development. This was in relation to the flow of information to psychiatrists when their clients were taking up the service and in relation to ongoing feed-back.

6.8. Working with Voluntary Organisations

- Positive aspects of working with the voluntary sector were identified. It was felt that voluntary organisations can bring with them flexibility and innovation.

- There is no direct management by statutory services when services are being delivered by a voluntary organisation or other outside provider. This has benefits in that a service is made available with limited impact on staff resources in a CMHT. The disadvantage is where a service may be of poor quality and being at a distance from the management point of view may make it difficult to get a handle on that situation.

- There was an acknowledgement that there may still be some prejudicial ideas around about working with the voluntary sector. Most of these issues were not specifically in relation to the voluntary sector but were in general to working with outside providers. It was felt that the kinds of views sometimes held included; working with voluntary organisations involved extra time on liaison and monitoring; that problems were sometimes created by using non-trained staff; that voluntary sector workers were had less training than statutory workers and that voluntary organisations are less accountable than statutory organisations.

CHAPTER 7

CONCLUSION

7.1 The Home Response Model.

The service being evaluated was a home-based system of support for individuals experiencing mental ill-health. The service used a skills mix of unqualified (with preparation and training on taking up post) paid staff visiting individuals in their homes, supervised by a professional grade of staff. Individuals were referred to the service by their key worker from the Community Mental Health Team. All aspects of the service were home-based. With service users permission, the introductory meeting and all review meetings were held in their home. Also, a daily work record of the activities carried out by the service user and HRW were signed by both parties and kept in the service users home.

7.2. The Evaluation

A range of stakeholders in the service were interviewed as part of the evaluation. From all perspectives the views expressed about the service were predominantly very positive ones. Outcome for the service user across a one year period was also examined. A range of issues were identified in relation to the delivery of the service. Many of the general issues raised are outlined below. Other important quality issues raised by participants in the evaluation will be addressed in the recommendations.

7.3. Use of Service

Demographic data on service users indicated that the majority were female. There was no other data gathered during the evaluation that would indicate why less than one third of service users were male. This is an important area for follow-up.

There was limited use of the service as a short-term support system. There was a tendency to use the service for long time periods, with most service users having used the service for at least one year before discontinuing.

Just over half of service users were living with others, primarily in some kind of family setting. Additionally almost one quarter had parental responsibilities. Therefore, while the service was very much focused on the individual with mental health problems referred to the service, much of the work was carried out in the context of a family setting.

Staff carried out a wide range of practical and leisure activities with service users. There was a strong focus on carrying out activities *with* service users as opposed to *for* service users. The 3 types of support most frequently requested by key workers were: companionship and emotional support, encouraging social interaction outside the home and accompanying on social outings and, assisting and motivating to carry out household and personal care tasks.

Most commonly, service users were receiving 2 hours Home Response time per week. The minimum amount of time being received was 1 hour and the maximum 5 hours. The restricting nature of short visits were mentioned by a couple of service users, a

HRW and a key worker. These visits could sometimes feel rushed for the service user and the key worker. The key worker felt that visits of 1 to 1 ½ hours were too short for getting the service user 'out and about'. Given that encouraging social interaction outside the home and accompanying on social outings was one of the primary reasons for referral to the service, the length of visits should be looked at in relation to this issue by the various stake-holders.

7.4. Outcome Measurement of social and behavioural functioning across a one year period as measured by the Life Skills Profile indicated significant improvement in relation to the sub-scales for social contact, communication and responsibility. Measurement occurred at baseline, 6 and 12 months. In relation to communication, the improvement did not become evident until the 12 month period. On the other 2 scales the improvement became evident at 6 months and this improvement was sustained at the 12 month period. However, given that individuals using the service had long-term mental ill-health, this is a relatively short-term assessment of outcome. How individuals fair in relation to social and behavioural functioning a period of time after they discontinue the service will be an important area for follow-up.

7.5. Out of Hours Service

This service was available 7 days a week from 9am to 9pm, with provision made in the service agreement for making the service available outside these hours if individual need required it. Despite this, there was very limited use of the service outside 9am-5pm Monday to Friday. It is likely that this was partly due to some of the key workers from the CMHT not being aware that the service was available out of normal working hours. Although a couple of key workers who were unaware of the out of hours service felt that the service could be improved by making it available out of hours, it is unclear the extent to which lack of use of the service out of hours led to unmet need.

7.6. Existing Structures Good existing communication links between Praxis and CBHSST in relation to other services provided by Praxis, provided a foundation for agreeing the service specification and getting the service operational. It was felt by both parties that communication links at senior management level and 'on the ground' were important in ensuring smooth delivery of the service.

The Home Response service was attached to an established accommodation and support service provided by the provider organisation. There were cost advantages to having existing management structures in place and being able to share office accommodation. Also, although the co-ordinator post was a part-time post, the individual also worked in the accommodation scheme. This enabled some flexibility as to how the co-ordinator's time was spread between the two services. An additional advantage to being sited with the

accommodation and support service was that in the absence of the Home Response co-ordinator, another qualified staff member was available.

7.7. Staffing

From the point of view of the service provider and the purchaser, the particular skills mix was working well. There was the dual advantage of service users being able to develop relationships with non-professionals while at the same time the workers have received training tailored to the post and are being supported in their role by a professionally trained individual.

From the purchaser perspective, some individuals suggested that, in the future, the skills mix could be further enhanced by HRWs receiving training tailored to the needs of particular service users. It was felt that CMHT should play a key role in this. Given how supervision of staff is currently structured, this is happening in a low-key way. Fortnightly supervision meetings between individual HRWs and the co-ordinator involve exploring issues on a service user by service user basis. This provides an opportunity for identifying areas where the HRW is experiencing difficulties in relation to specific service users and exploring strategies for dealing with these.

The service was being provided by a small number of staff. Presently 100 hours are covered by 4 HRWs. There were advantages and disadvantages to this arrangement. The disadvantage was that the pool of workers was small when trying to match the service user and worker appropriately. The primary advantage is that a small pool of workers is easier to manage and support particularly where a high level of supervision and support is a standard of the service. Indeed, the purchaser and provider felt that a high level of supervision and support for HRWs was a vital component of the service.

7.8. One-to-One Relationships

Both the purchaser and provider felt that the key to a service such as Home Response was the building of a good relationship between the HRW and the service user. The information provided by service users and their key worker indicated that except for a few cases this had been successfully achieved. However, concerns were expressed about the potential for creating service user dependencies, especially given that many of the service users were socially isolated. There were not any individual cases highlighted in the evaluation, where an unhealthy dependency had been created. However, a number of cases were highlighted where staff changes had been experienced as disruptive for the service user. This was particularly highlighted by a few service users themselves and also key workers. It is important that service users are supported through any transition between workers and any change is dealt with sensitively. However, staff turn-over is affected by factors external as well as internal to the organisation, therefore there is a limit to how much it can be prevented.

Considerable emphasis was placed, by the provider, on ensuring the safety of the HRW in their work setting. This was felt to be particularly important in a service such as Home Response where HRW worked off-base all day.

7.9. Communication Systems

There was satisfaction with the liaison between the CMHT and the Home Response service on both sides. However a few key workers were dissatisfied with the extent of collaboration between the two parties in relation to individual care-plans and a few felt that the review meetings could benefit from more structure. Also, the purchaser felt that as care management was implemented in the locality, more formalised written systems of feed-back may be required. In some respects the service is being provided at a time when there are developments taking place within the CMHT. This may have an impact in the future on expectations of the service.

7.10. Impact on CMHT Resources

One of the aims of this service was to enable a more effective use of staff time on the CMHT by employing HRWs. The impact the service had on key worker resources was variable between clients. There was not an overwhelming improvement in the use of professional staff time. The key worker was spending less time with their client in only one third of cases. However, it is positive that in relation to almost one half of cases, key workers felt their time with their client was more appropriately used. It may be useful as a follow-up to compare those cases where the service enabled more effective use of CMHT resources with those where it did not. A wider factor to take into consideration, is that, given that the service had initially been available for only 50 hours and then, more recently, 100 hours, it is unlikely that it would have an overall meaningful impact on the use of CMHT resources.

7.11. Like Best About the Service

Both service users and key workers were asked what they liked best about the Home Response service. The 2 aspects that service users particularly valued were having a friendly relationship with their HRW and being able to get out and about because of the service.

There was more variability between key workers in relation to what they liked about the service. However, the majority of key workers highlighted the flexibility of the service and the client focused nature as factors that they particularly valued in the service. Other stakeholders interviewed highlighted a primary strength of the service as its' 'ordinary' low-key nature and the focus it had on building ordinary non-professional relationships and engaging service users in ordinary everyday activities.

CHAPTER 8

RECOMMENDATIONS

8.1. Referral The number of female referrals was much higher than the number male referrals. This may be a reflection of the statutory key workers case-loads. However, it is important to ensure that it is not as a result of the service being less accessible to males (para. 3.1.).

It should be ensured that all referral forms have a restricted access section (para. 5.2.).

8.2. Family Context In a number of instances, staff were working in a family context. There should be an ongoing awareness of the practice implications of working in this context (para. 3.1.).

8.3. Outcome The long term impact of the service on social and behavioural functioning should be assessed (para. 3.6. & 7.4.).

8.4. Hours Allocated 2 individuals indicated that their visits were slightly shorter than indicated on their care-plan. It is likely that this is due to the fact that staff travel time is included in the number of hours an individual is allocated. It should be checked that this is the case in this instance (para. 4.5.).

Service users, statutory key workers and home response staff mentioned that shorter visits could place restrictions on activities, particularly getting 'out and about'. Where social interaction and social activities outside the home are a prime reason for referral, the time implications should be fully considered (para. 2.18., 4.5., 5.10.).

8.5. Staffing 2 individuals reported not receiving a replacement when their HRW was on holiday, when their preference would have been for a replacement. This should not happen. It is important that the issue of holiday cover is fully discussed with the service user (para. 4.5.).

The disruptive impact on the service user of having their HRW changed was highlighted by service users themselves, the statutory professionals and home response staff. This issue is an inherent problem in a service such as this. Staff turn-over and the impact it has on the service user can only be minimised but not eradicated. The service should continue to work on minimising the impact (para. 2.17., 4.8., 5.10., 6.5.).

8.6. Information It is positive that the majority of service users could identify appropriate ways of voicing their complaints. However, the majority of individuals reported that they were unaware of the Praxis complaints procedure. Knowledge in relation to the complaints procedure is an ongoing issue that is already being addressed on an ongoing basis across the organisation (para. 4.11.).

Almost half of the service users taking part in the evaluation felt that they did not know enough about the service before it commenced. This is an area that needs to be explored by the CMHT and the Home Response service (para. 4.3.).

There was variability between statutory key workers in relation to how well informed they were about the service. It is likely that this impacted on use of the service out of hours and may have impacted on how well informed service users felt about the service before uptake. This information issue should be addressed (para. 5.10. & 7.5.).

8.7. Review Meetings

A number of service users reported that they felt their views were not heard at review meetings. Enabling service users views to be articulated and heard is a vital role for statutory key workers and home response staff involved in review meetings. The recent project on self-advocacy -'Having Your Say' (Mawhinney & Mc Daid, 1996) highlighted the need for change and improvement in accommodation scheme review meetings in order to meet the needs of service users. The implications of this for home response review meetings should be explored. This is a responsibility for all those involved in review meetings (para. 4.10.).

Overall service users and their key workers were satisfied with the review meetings that were held. A number of suggestions were put forward as to how review meetings could be further improved. These should be noted as part of the ongoing debate as to how review meetings can be improved (para. 4.10 & 5.5.).

8.8. Support Received

Overall, statutory key workers were satisfied with the support service users were receiving from the service. It would be expected that the few areas of dissatisfaction expressed were resolved through other lines of communication such as review meetings (para. 5.7.).

8.9. Development of Service

A range of suggestions were made in relation to how the service could be further developed. These should be fed into any plans for the development of the service (para. 5.11.).

CHAPTER 9

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APPENDICES

Mean (S.D) Baseline Scores for Home Response Sample Compared with the Australian and CPRS Samples

	Home Response Sample *(n-36)*		**CPRS Sample** *(n=91)*		**Rosen et al. Sample** *(n=252)*	
Self-care	31.0	(6.0)	31.6	(6.5)	30.6	(6.3)
Non-turbulence	41.8	(4.7)	44.5	(3.8)	39.2	(6.7)
Social Contact	13.0	(3.1)	14.9	(4.7)	13.9	(3.9)
Communication	20.5	(2.8)	20.9	(3.0)	19.2	(3.3)
Responsibility	13.7	(3.1)	17.5	(2.7)	15.9	(3.5)
Total	**119.9**	(14.6)	**129.2**	(15.7)	**118.8**	(17.7)