

Psychosocial Care in Home Treatment

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All authors have agreed to the submitted version of the manuscript. NC designed, obtained funding and ethical approvals and led the delivery of the study. AC, CD, JP, LG contributed to recruitment, data collection, analysis and manuscript development. NC and GD refined the analysis and led the development of the manuscript.

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Two researchers were employed by the study funder (AC, CD) and the study lead has previously been employed by the study funder (NC). Other authors declare no conflicts.

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Title: Psychosocial care delivery in intensive home treatment during a mental health crisis: a qualitative thematic analysis.

Abstract

Community based Intensive Home Treatment (IHT) is delivered as an alternative to psychiatric hospital admission as part of crisis resolution services. People receiving IHT present with complex mental health issues and are acutely distressed. Home treatment options are often preferred and there is evidence of service fidelity, although less is known about psychosocial care in this setting. Underpinned by a critical realist epistemology, this study aimed to explore psychosocial care in the context of home treatment from the perspectives of staff, service users and family carers. Data were collected using individual interviews and focus groups in two NHS organisations in England. An inductive qualitative thematic analysis resulted in five themes focused on 1) the staffing model and effective care provision, 2) the organisation of work and effective care provision 3) skills and training and service user need 4) opportunities for involvement and personal choice and 5) effective communication. Findings suggest that co-production may improve congruence between IHT service design, what service users and carers want and staff ideals about optimal care. Service designs that optimise continuity of care and effective communication were advocated. Staff training in therapeutic interventions was limited by not being tailored to the home treatment context. Evidence gaps remain regarding the most effective psychosocial care and related training and supervision required. There is also a lack of clarity about how carers and family members ought to be supported given their often-crucial role in supporting the person between staff visits.

Introduction

Crisis Resolution and Home Treatment Teams (CRHTTs) provide community-based interventions for people experiencing a mental health crisis. Originating in the United States of America (USA) and Australia (Stein & Test, 1980; Houtt, 1991), CRHTTs have been implemented in the United Kingdom (UK) (Department of Health, 2000) and Europe (Hasselberg et al., 2011). CRHTTs typically make an initial crisis response to assess the urgency and nature of need. Following this, where deemed necessary, community based Intensive Home Treatment (IHT) may be delivered as an alternative to psychiatric hospital admission (Johnson et al., 2022). It is the IHT which is the focus of the current study.

People receiving IHT present with heterogeneous, complex mental health issues including suicidality, psychoses, mood, and personality disorders (van Asperen et al., 2022) and are acutely distressed (Morant et al., 2017). UK clinical guidelines for these mental health conditions, developed from international evidence (National Institute for Health and Care Excellence [NICE], 2011; 2014; 2015; 2022), advocate a combination of pharmacological, psychological and social interventions, commonly referred to as psychosocial interventions (e.g. Cella et al., 2023). The focus on this study was on psychosocial interventions defined here as including for example, ongoing mental health assessment, talking therapies (Bighelli et al., 2018; Jones et al., 2018), psychoeducation (Zhao et al., 2015), support for family (Pharoah et al., 2010) and with social issues (Almerie et al., 2015).

IHT provides greater intensity of support than other community mental health services, but less than the 24-h care provided by a hospital admission. IHT therefore relies on self-management often alongside support from family or carers (Olasoji et al., 2017; van Asperen et al., 2022). IHT involves multi-professional care, with the largest staff group being nurses

(Baugh et al., 2020), delivered via multiple visits daily and availability of 24-hour telephone support over a short duration, usually less than 6 weeks (Lamb et al., 2019).

Background

International studies have shown that IHT has a small beneficial effect on reducing rates of hospital admission (Holgersen et al., 2022) and that treatment costs are not significantly lower (Stulz et al., 2020). Clinically significant improvement in general wellbeing and depression (Lamb et al 2021) and improvement in Clinical Global Impression (CGI) have been observed (Huang et al 2018). Service user satisfaction is higher for IHT when compared with hospital admission (Holgersen et al., 2022; Lamb et al., 2021; Motteli et al., 2020).

A significant body of research in the UK and Europe has focused on development and evaluation of an evidence-based crisis services fidelity model; CORE-CRT (Lloyd-Evans et al., 2016; Morant et al., 2017; Lloyd-Evans et al., 2020; Holgersen et al., 2022). A cluster randomised trial tested the effect of a service improvement programme on model fidelity reported increased intervention fidelity, a small reduction in admissions, and no significant difference in patient satisfaction or perceived care continuity (Lloyd-Evans et al., 2020). Limitations in overreliance on the CORE CRT fidelity measure alone include a lack of focus on the components, effect, or mechanisms of action of the psychosocial care delivered within IHT and its *in vivo* reliability is not established (McHugo et al., 2007).

A UK national survey of 75 crisis services, conducted to test the fidelity to the CORE-CRT model, reported the lowest median score of 1 (very poor fidelity to the model) for item 17 “*provides psychological interventions*” (Lamb et al., 2019; p. 191), suggesting that psychosocial care represents a key area for intervention development. Supporting this, qualitative studies exploring service user experiences of crisis care have identified the

importance of continuity of care, emotional and social support and availability of a range of interventions (Morant et al., 2017); the importance of therapeutic relationships, a recovery focus, and a collaborative approach to treatment (DeLeo et al., 2022).

There are contextually important factors influencing delivery of psychosocial care in home treatment including the home-based setting, acuity of need, the need for self-management, and the emphasis on support from family, and carers where they are present, all previously identified as lacking in reviews of crisis care in England (Care Quality Commission, 2015). Whilst the evidence provides an overview of the need for recovery focused therapeutic care in crisis services overall, it lacks specific detail about the ingredients of psychosocial care that lead to optimal outcomes, or the skills and resources required by staff to deliver these during home treatment. Questions therefore remain about whether the IHT, as a component of crisis services, provides interventions that meet individuals' psychological and social (psychosocial) needs and whether related outcomes can be reliably measured. This study aimed to begin to address this gap by conducting a qualitative thematic analysis that aimed to explore staff, service user and carer experiences of receiving and delivering psychosocial care in the context of intensive home treatment.

Methods

Study design

A critical realist epistemology (Fletcher, 2017; Bhaskar, 2020), underpinned a qualitative study design. Critical realism facilitates conceptualisation of how the social context interacts with individual experience to generate understanding about what mechanisms are likely to produce optimal outcomes (Pawson & Tilley, 1997). Data collection was via focus groups and individual interviews and is reported according to the COREQ checklist (Tong et al., 2007).

Study Setting

The study was funded by one of the two NHS trusts in England within which data were collected. Both NHS Trusts predominantly provide mental health and learning disability community-based services. Trust 1 serves a geographically large, mixed urban and rural population with three locality based IHT teams embedded within a Trust wide CRHTT model. Trust 2 serves an urban population and has undergone reconfiguration from a locality-based to city-wide crisis services design.

Ethical considerations

The study was approved by a UK NHS ethics committee (IRAS: 278649). Service user and carer participants received remuneration in accordance with UK guidelines (National Institute for Health and Care Research, 2022).

Recruitment

A purposive sampling approach was used to recruit people with experience of IHT interventions for themselves or a family member; and professional staff with current or recent (past 2-years) experience of working in IHT. The sampling approach aimed to recruit a maximum sample of 24 participants (Hennick et al., 2016); saturation was defined as reaching a rich understanding with no new themes emerging. Equal representation of lived experience and staff participants and of participants from both study sites were identified via NHS health records, NHS carer champions and staffing data.

Data collection

Participants were offered a choice of participating in either individual interviews or focus groups to widen opportunity for participation. Data were collected by female registered mental health nurses. Two researchers (NC, GD) had previous experience of conducting qualitative research. Four researchers work in an NHS research department (AC, CD) and NHS

service improvement department (JP, LG). Four research team members knew some of the staff participants in the study (AC, JP, CD, LG); none of the research team had prior knowledge of, or contact with, the service user and carer participants. The focus groups and individual interviews were semi-structured according to a topic guide developed using the published evidence (Supplementary materials). Data collection was carried out between December 2021 and July 2022 in person either via audio-recorded videocall or face-to-face on NHS premises. Only consented participants and study team researchers were present during data collection. Handwritten fieldnotes were made during and immediately following data collection.

Data analysis and techniques to enhance trustworthiness.

Data were transcribed verbatim and formed the data corpus alongside fieldnotes to ensure nuanced contextual information was not missed and to provide a platform for researcher reflection as part of minimising bias in the analysis (Phillippi & Lauderdale, 2018).

Thematic analysis was carried out in six steps described by Braun & Clarke (2006). An inductive coding approach (Braun & Clarke, 2021) was used in a qualitative data management software package NVivo Version 12 (QSR, 2018). All researchers read and familiarised themselves with all transcripts. All transcripts were coded by the lead researcher (NC) and four transcripts were independently coded by three researchers (JP, CD, AC). Coding was then compared for divergence and consistency and discussed with (LG, GD) to configure the codes into themes (Braun & Clarke, 2021). In accordance with a critical realist stance, coding and development of themes included consideration of participants accounts of relationships between the context of IHT, the mechanisms provided by psychosocial aspects of the intervention, and outcomes (Braun & Clarke, 2021; Pawson & Tilley, 1997). A cyclical analytic process continued

until the themes provided a coherent account of all data by collating codes, re-reading the transcripts, and team discussion until all the data had been considered and supported by data extracts. Data saturation was assessed following coding of transcripts to establish when no new codes were identified (Hennick et al., 2016). All study participants were sent a draft version of the completed analysis and invited to check accuracy and resonance with their experience, no responses were received.

Results

A total sample of 21 participants consented to take part, shown in Table 1. No participants declined participation after giving consent. Two service user/carer participants took part in individual interviews via videocall lasting a mean 40 minutes. Five focus groups, with a total of 19 participants, two with staff and three with service user carer participants, were conducted (Table 2). The analysis resulted in five themes that reflect the link between service design contextual factors as described by participants and the experience of psychosocial care. Analysis resulted in five themes. Findings are arranged according to these themes together with illustrative quotes from participants.

<Table 1 Participant Characteristics>

<Table 2 Data Collection>

Theme 1- The staffing model and effective care provision

The shift patterns adopted by services were viewed, directly by staff and indirectly by service users and carers, as stifling the delivery of effective care. Primarily, for staff, this was because those patterns were responsible for a lack of relational continuity. The outcome of this was that contact with service users was typified by meetings with a series of different staff over the course of the IHT episode.

“...because we work across extended hours and seven days a week that an individual member of staff is unlikely to see somebody for several successive appointments...Service users see maybe five, six people from the team, and rarely the same person on two successive appointments.” [Staff focus group 2].

However, this mechanism was also the apparent nexus for multiple other suboptimal outcomes; chiefly, an overall sense that staff were constantly “*firefighting*” [Staff focus group 2] rather than achieving therapeutic aims. In addition, there was widespread, though not universal, service-user dissatisfaction due to the resulting lack of therapeutic rapport and the slow development of trusting relationships, and the need to repeatedly provide information to different staff members.

“To hear my mum have to repeat the exact same stuff each time...its quite traumatic...It’s not very nice...having to go over really personal thoughts and having to do that multiple times...” [Service user/carer- focus group 3].

From a relational perspective, staff felt they were starting afresh at each visit because they “*...don’t know them as well as everybody would obviously like to...*” [Staff focus group 2]. The lack of extended contact was felt by staff participants to run counter to the application and completion of any recognised therapeutic process. In contrast to this, when staff and service users had experienced consistency of contact, even over just two or three consecutive visits, this was experienced as an improvement of some magnitude.

“I had the consistency of the visits with the same person, ... it was a massive help to me. And he could see very clearly how I was each day without necessarily having to go through the same routine of questions....” [Service user/carer focus group 2]

“...when you do get to see somebody for a second or third time, on the rare occasions that happens... you’re not coming in cold with a quick read of the notes and having to build rapport the quality...just improves exponentially” [Staff focus group 2].

Importantly, this was not a universal sense and some service users described becoming accustomed to seeing different people and understood that this was how the service was structured and some preferred to see more than one staff member as this provided helpful alternative perspectives.

“I saw a variety of different people...I was fine with that. I wasn’t at first, I was a bit uncomfortable...but eventually it was fine.” [Service user interview 2].

Theme 2- The organisation of work and effective care provision

The organisation of work was commonly experienced by staff as leaving insufficient time to effectively co-ordinate care. This may have partly referred to workload since the term ‘clinical pressures’ was used to explain its occurrence. The mechanism by which this occurred was a reported reduction in time for clinical leadership. The outcome of this was that visits to service-users over the course of a day might be haphazard, a result of unnecessary travel time arising from inefficient planning.

“And the appointments are typically an hour, or by the time you’ve travelled, [your visit is reduced to] three quarters of an hour, or even just half an hour ...which is a real challenge for working psychologically with people, doing anything more than building rapport, checking out a few factual details and then you’re on your way again.” [Staff focus group 2]

On occasions, a lack of clarity about the timing of visits left the family unable to plan their day and this caused them stress.

“...it’s a lack of respect basically, if you’re not going to let someone know that you’re not turning up on time. That just makes her feel paranoid and more persecuted... sometimes they’ve been absolutely hours late...” [Service user/carer focus group 3].

In contrast, when staff had experienced effective co-ordination, they reported that this meant not just longer and more effective visits to service-users, but also provided them with the time to seek support and clinical supervision. The second outcome of workload organisation

was the perception by staff that they had too little time to deliver psychosocial interventions leaving them feeling ill-equipped to do so and, as a result, expressed dissatisfaction with their role.

“It’s the lack of time and the lack of time to step back, reflect, think ‘what am I going to do? how can we do things differently?’, that time would change the interventions and the quality of what we’re doing....” [Staff focus group 2]

Theme 3- The fit between skills and training and service user need

While shift patterns and other organisational issues were perceived to impact on delivery of therapeutic interventions, so too were they impacted by the training that staff had received. The issue was not always a lack of training given that some had *“forgotten more than they remembered”* [Staff focus group 1], more often, the training received *“...wasn’t really relatable to the home treatment team”* [Staff focus group 1].

Additionally, staff and service users agreed that formal programmes of therapy, including cognitive behaviour therapy and dialectic behaviour therapy, might help achieve therapeutic aims including building up confidence and self-esteem, and managing symptoms, but considered that the period of IHT during crisis might not be the best time to deliver this. Despite these concerns about the delivery of therapeutic care, staff described an array of psychosocial techniques as everyday practice tools, including psychoeducation, relaxation, breathing techniques, sleep hygiene and grounding (a range of mindfulness techniques to help the person focus on the present). This was viewed by staff as a sign of their ability to be *“adaptable”* and *“flexible”* in the face of rapidly changing needs [Staff focus group 1]. This approach was described as *“informal”* [Staff focus group 1] and seen by staff as more compatible in the IHT context than manualised approaches.

When staff applied training to their practice such as “*basic CBT*” [Staff focus group 1] they felt isolated as they did not have access to psychologically focused clinical supervision. These barriers to psychosocially focused care made working in IHT less satisfying for staff participants who believed that they may contribute to poor workforce outcomes such as staff recruitment and retention difficulties.

Theme 4- Service-user & carer involvement and personal choice

At a macro-level, service-users and carers expressed disappointment that service designs lacked co-production, especially involving carers. This, they said, had led to a service that ill-fitted service-users’ actual needs resulting in delayed recovery.

A mismatch between what is available and what service users and carers want related to both social and practical issues. Whilst participants described mixed experiences of social and practical support, they believed a lack of availability of such support hindered recovery.

“Specific [social] interventions that we asked for were denied... I said, ‘Could somebody come and sit with him in the evening for an hour and watch TV with him?’ [Staff replied] ‘No, we’re not allowed to do that’.” [Service user/carer focus group 2]

Staff provided a mixed picture regarding support of family and carers. Staff described helping them understand what was happening and building their resilience, but some staff described family and carer interventions as “*time consuming*” and as “*eating into their day*” [Staff focus group 1]. A perceived lack time and skills meant that staff prioritised the care of the service user and missed opportunities to support family and carers.

On a personal level, service users largely preferred IHT to hospital treatment because it allowed them to stay in familiar surroundings and as far as possible, maintain usual routines and important relationships.

“I was able to care for my children” [Service user/carer focus group- 1]

Treatment at home also avoided missed care when heightened distress meant individuals were unable to attend appointments away from home. The option of telephone contact with the home treatment team was also valued. However, service-users had preferences when it came to the identity of which IHT staff visited them. This might be based on visible identity, notably gender, or simply about their rapport with particular team member(s).

“They did usually tell me, ‘Oh it will be so and so coming next week’. But it wasn’t always them that turned up.” [Service user/carer -focus group 1]

While home treatment staff emphasised the centrality of assessment, multiple assessments by different staff led to carers feeling unable to control the situation. Service users talked about losing their dignity because of the intrusive nature of assessments. One person described being *“laid bare”* by assessments and found this *“soul destroying”* [Service user/carer-focus group 1]. Because people were already feeling bad, sharing their deepest feelings led to fears about being negatively judged, particularly when the staff were unknown to them. In these circumstances, people described a mechanism of taking back personal control by not being open with staff.

“To hear my mum have to repeat the exact same stuff each time...its quite traumatic...It’s not very nice...having to go over really personal thoughts and having to do that multiple times...” [Service user/carer- focus group 3].

Theme 5- The centrality of effective communication

Having a plan of care that was agreed between staff, the person and carers aided communication between all involved and gave people a sense of ownership that mitigated feelings of powerlessness. For service users, care planning provided a mechanism through which they could express their wishes.

“...when you’re not very well, you do feel that all your power...had gone, don’t you? And you’re on somebody else’s plan. [Having a plan of care] ...that just makes you feel a bit more in control as well” [Service user/carer- focus group 1]

Care plans were valued by service users and carers, but having different staff visit impeded their development and use. Time pressures meant that care plans may not have been read by

staff before a visit. Because people's mental health needs may change quickly, a plan made in one visit may not be appropriate by the next, risking discontinuity.

"...sometimes we've struggled from visit to visit for a plan to be followed. That's not just because a practitioner is not following the plan; it's just that sometimes you go out and it's a completely different presentation... So, their plan might not be something that you need to do right now." [Staff focus group 1]

The therapeutic relationship was central from the perspectives of staff, service users and carers. When staff focused on therapeutic engagement by moving from general chat to explore deeper issues, trust developed, and the carers experienced a sense of relief.

"And I think with my mum's illness as well, with there being sort of stuff under the surface, stuff that isn't reality, she doesn't put it forward because she thinks everybody knows about it. But this person that was great asked really detailed questions, you know, tried to get in and find out about her thoughts." [Service user/carer focus group 3]

Service users gave examples of unhelpful interventions. Whilst service users understood that they may not 'get on well' with every staff member, they believed that some staff doubted their accounts and thought they were *"faking it"* [Service user/carer focus group 3].

Medication management was a valued part of home treatment, but some service users believed that staff were overly focused on it and used this to avoid therapeutic engagement. A lack of depth in therapeutic engagement led service users to feel like staff were ticking boxes.

"I might as well stand at my door with a sandwich board that says, 'I've had a bath, I've done some cooking, I've done some cleaning up, you don't need to come in...'" [Service user/carer focus group 3].

Discussion

To date, there has been limited literature about the most helpful content of interventions delivered within the context of IHT. This thematic analysis provides a novel, multi-stakeholder perspective about psychosocial care in the IHT context. Analysis resulted in five themes emphasising the important link between the contextual factors surrounding IHT service design and the delivery of psychosocial care. While the themes suggest areas for service development and improvement, the general tenor of supporting quotes suggested a sense of dissatisfaction at the lack of congruence between the service is provided, what service is desired by service users and families and what staff feel enabled to provide. This manifested in themes as perceived mismatches between the staffing model, the organisation of work, staff skills, opportunities for user-involvement and effective communication and their relationship with care. While the views of various stakeholders differed, no single group seemed to believe that the current provision provided optimal care. It is notable however that despite the clear need for service improvement, service users here preferred home treatment over hospital care and were motivated to take part in the study by their desire to inform service development. All stakeholders identified positive experiences of therapeutic care that had contributed to recovery.

Continuity of care has been identified as important in IHT (Peters et al., 2023; Morant et al., 2017) and is addressed by the CORE Crisis Resolution Teams fidelity model (Lloyd-Evans et al., 2020) yet our findings suggest that systemic issues including the pattern of shifts (Suter et al., 2020) and caseload allocation (Morant et al., 2017) persist as barriers to delivery of psychosocial care. A lack of continuity may also pose risks to safety through gaps in communication between staff, and overly intrusive, repetitive encounters that people find unhelpful and traumatic (Hartley et al., 2020).

Service innovations aimed at improving continuity have included key worker systems to minimise the number of different staff involved (Clinch, 2019). Titherage & Galea (2019) reported evaluation data from one UK IHT service suggesting longer IHT episodes were linked to a higher number of staff visiting, suggesting that shorter IHT interventions may reduce service user dissatisfaction regarding continuity (Tithergae & Galea, 2019). These differences are of interest because short episodes of IHT may reduce the *perception* of a lack of continuity for service users and carers but do not address the need for therapeutic relationships, which take time to develop (Chouliara et al., 2023).

Our findings suggest that the IHT service design may act as a barrier to the development of therapeutic relationships which are considered a foundation for all psychosocial care (Gimenez-Diez et al., 2022; Chouliara et al., 2023). Previous research has shown that these relationships are not only beneficial to service users but also reduce stress and improve job satisfaction in staff (Gimenez-Diez et al., 2022). Logically therefore, improving the ability of staff to deliver psychosocial care may have equal importance for staff wellbeing as it has for improved service users and carer experience.

Staff participants presented conflicting notions of psychosocial care in the IHT context. On the one hand they wanted to improve their skills to deliver specific psychosocial interventions and be supported to do so. On the other hand, they questioned the appropriateness of delivering manualised therapeutic interventions during an IHT episode. Like the findings of Berry et al., (2022a) from a trial of therapeutic care in in-patient acute mental health wards, participants here identified that some form of talking therapy could be helpful but would require tailoring to the IHT context. Stepped care models developed specifically for acute mental health settings are often reliant on the availability of psychologists (e.g., Berry et al.,

2022b; Ebrahim, 2020). A report summarising quality standards for IHT in England identified that availability of psychologists for sessional work in IHT increased from 58% of IHTs in 2015 to 71% of IHTs in 2020 (Baugh et al., 2020). Whilst this increase is encouraging, it is unclear if sessional work such as this would be sufficient to deliver the range of roles participants identified, including psychological formulation, psychologically focused clinical supervision, and training for staff (Raphael et al., 2020; Berry et al., 2022b; Ebrahim, 2022).

A crisis toolbox, designed to support therapeutic care delivery by all crisis services staff, was manualised to incorporate flexible use of nine intervention components (that resonated with those identified by staff here) but the evaluation did not include data from delivery by non-psychology trained staff (Mulligan et al., 2022). Built-in flexibility has been identified as important to enable delivery of interventions by staff with different skills and training (Raphael et al., 2020; Berry et al., 2022b; Ebrahim, 2022). Peters et al., (2023) reported that access to therapeutic care was hampered by inconsistent skills and confidence amongst crisis services staff. A manualised intervention that retains a degree of flexibility, such as described by Mulligan et al., (2022), could provide an opportunity for more focused staff training tailored to the context of IHT that staff participants felt was lacking.

In addition to training, psychologically focused supervision (Berry et al., 2022a; Ebrahim, 2022; Marshman et al., 2021) sustains skills and wellbeing of staff and prevents compassion fatigue. Our findings reiterate the importance of clinical leadership (Marshman et al., 2021; Berry et al., 2022a) in providing role models for psychologically focused care.

Participants identified that the social support they needed was often not available suggesting that further consideration of support roles including peer support may be needed. A survey

of IHT in England showed that only three teams had dedicated peer support, although more had access to peer support workers from outside the IHT service (Baugh et al., 2020).

Care planning was valued by participants here despite experiencing systemic barriers to their development and use. This contrasts with a previous study of patient satisfaction with home treatment where participants did not mention care planning in crisis services (Hubbeling & Bertram, 2014). The *process* of developing recovery focused care plans in crisis services has been described as therapeutic by enabling normalisation and validation of crisis experiences but relies on the formation of therapeutic relationships (Ashman, Halliday & Cunnane, 2017; Simpson et al., 2016).

Care planning in IHT relies on involvement of family and carers, where they are present (Cree et al., 2015; Bee et al., 2016; Hasselberg et al 2022). Despite their central role in providing the bulk of care during an IHT episode, interventions to support family and carers in IHT are lacking (Hasselberg et al., 2022; Olasoji et al., 2017). A commonly unmet standard in a summary report of IHT in England related to involvement of service users and carers in service planning and development (Baugh et al., 2020). Notably absent from accounts here were descriptions of family/ carer interventions or guided self-management approaches, both may provide therapeutic structure and have potential to generate a sense of continuity when this cannot be provided by the IHT service design.

Strengths and limitations

A specific focus on the psychosocial aspects of IHT has highlighted important gaps in intervention development and links between psychosocial care and service design. Recruitment to the study was initially slow due to ongoing limitations on recruitment via the

NHS due to the impact of Covid-19. This also impacted on the size and diversity of the sample. None of the participants responded to the member check.

Conclusion

Having a service design that gives primacy to therapeutic relationships and relational continuity would improve service user and carer experience and have the potential to improve job satisfaction for staff. Limited evidence about the content or delivery of specific psychosocial approaches in the IHT context risks missing opportunities for recovery. Psychosocial care in the home treatment context needs to be developed with built-in flexibility to enable delivery in a rapidly changing care situation and the varied skills of the different professions delivering home treatment. The participants in this study were able to highlight examples of such interventions used flexibly within this context. Improvements may be achieved through a combination of co-production, context specific intervention development, staff training and psychologically focused clinical supervision. Clinical leadership has an important role in sustaining psychosocially informed services. Interventions focused on families and carers and guided self-management are notably lacking.

Relevance for clinical practice

Intensive home treatment services are positioned well to provide helpful psychosocial care in crisis mental health situations. Intervention development is needed to ensure that interventions are contextualised to the acuity and home-based setting. As family carers are often a constant presence throughout an IHT episode, development of guided self-management interventions that carers can support in partnership with staff, are a priority. The involvement of service users and carers in service development is essential alongside

psychosocially focused clinical leadership to drive service improvement and minimise systemic barriers to therapeutic relationships.

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Psychosocial care in home treatment

Tables and Figures

Table 1: Summary sample characteristics

Sample Characteristics	Number
Registered nurses	8
Psychiatrists	1
Service users	9
Carers/family	3
<i>Ethnicity</i>	
White	20
Non-white	1
<i>Gender</i>	
Male	8
Female	13
<i>Recruitment source</i>	
Study site 1	8
Study site 2	13

Table 2: Summary of data collection

Data Collection Method	Sample group	Platform	Participants (n=)	Study site	Duration (mins)
Focus group 1	Staff	In person	5	1	77
Focus group 2	Staff	Videocall	4	2	61
Focus group 3	Service user/carers	In person	2	1	72
Focus group 4	Service user/carers	Videocall	5	2	66
Focus group 5	Service user/carers	Videocall	3	2	68
Interview 1	Service user/carers	Videocall	1	1	36
Interview 2	Service user/carers	Videocall	1	2	45

Intensive Home Treatment Study

STAFF TOPIC GUIDE

Tell me a little bit about how home treatment services work?

What would you describe as the best psychosocial care in intensive home treatment?

Do you deliver specific psychosocial or therapeutic interventions as part of home treatment?
Could you describe these?

Could you describe the support provided for families or carers?

Do you use any particular interventions or approaches with family & carers?

Are there any barriers to delivering psychosocial care in home treatment services?

What training do you believe is needed for staff to deliver psychosocial care in home treatment?

What support do staff need to deliver psychosocial care in home treatment?

If you could improve or change anything about home treatment to make it more helpful/therapeutic, what might you change?

SERVICE USER/ CARER TOPIC GUIDE

What are your experiences of home treatment?

Did you have family or carer to support you? How were they supported or involved in your care?

What did the staff do to support or help you during home treatment?

What would you say was most helpful or therapeutic about home treatment?

Did anyone explain what therapy they were offering to you?

What did the staff talk to you about when they visited?

Did you feel supported by the staff? Did you feel you had developed a relationship with them that was helpful/therapeutic?

If you could improve or change anything about home treatment to make it more helpful/therapeutic, what might you change?