# Correspondence

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**Letter to the Editor**

O'Keeffe & Russell (2018) conducted an interesting survey into the implementation of home-based treatment for acute psychiatric problems in Northern Ireland and the Republic of Ireland. One of their main findings was that ~30% of services did not have a dedicated home-based treatment team and that there was great variation in terms of staffing levels and operational procedures between the district mental health services which did have a dedicated home-based treatment service. It was striking to see that only 70% (14/20) of the home-based treatment teams were reported to be involved in gatekeeping admissions to psychiatric wards (gatekeeping was described as having a significant role in deciding whether a patient should be admitted to hospital or not), since gatekeeping is usually considered one of the vital elements of home treatment (Department of Health, 2001).

The authors rightly emphasised the need to evaluate services locally and mentioned that it is difficult to generalise findings to other localities. It could well be that home treatment teams are useful in some services and not in others depending on local funding arrangements and overall service configuration. Perhaps the variation in services found in the survey is justified. It could be that the particular service configuration is best for the specific locality. However, it could also be the result of *ad hoc* arrangements. The authors rightly mentioned some positive (Johnson *et al*. 2005) and some negative (Tyrer *et al*. 2010) findings from the literature and, although not emphasised by the authors, this could also well be because of the difference in the services overall and the patients included in the studies.

What the authors did not discuss and which in our view is important, is that home-based treatment is primarily a method of service organisation, a way to deliver evidence-based treatments. If somebody needs antipsychotic medication, it is essential that this is offered and it probably does not matter so much whether this is done at home or in a ward. The idea behind home treatment is that home treatment teams can offer more than hospital wards because they can also offer psychological treatment and social support in the patient's own environment. But, at present, this is a hypothesis without empirical evidence. However, it is important to check whether home treatment teams offer established evidence-based treatments such as medication and cognitive behavioural therapy as a minimum.

Currently, evidence-based treatments are delivered according to psychiatric diagnosis (Hubbeling & Bertram, 2012). And where the home treatment team model is good for patients with psychotic disorders, it is often considered less effective for patients with borderline personality disorder, who may find it particularly difficult to be seen by different members of staff. It remains an important task, to evaluate services based on initial diagnosis and severity, and compare the outcomes of home-based treatment with the outcomes of those who are treated on a ward or by a community mental health team.

## Conflicts of Interest

The authors declare that there are no conflicts of interest.

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