

* **57 Evidence & Practice for Team Composition**

Routine ACT 'survival' interventions can be delivered by non-professionals yet 70% of workers in English teams are professionally qualified. United States National and State standards for team composition vary considerably in requirements for psychiatrist time, master's degree professionals, bachelor degree case managers, peer specialists and aides. How can a balance be achieved between the evidence, practice, consumer satisfaction and affordability? CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 40% DIDACTIC, 40% PARTICIPATORY, 20% EXPERIENTIAL.

Presenter: Mike Finn, RMN, BA, Chair, National Forum for Assertive Outreach (NFAO), Clinical Service Development Lead South West London & St. George's Mental Health NHS Trust, London England

Saturday Morning • May 14, 2011

7:45 - 8:45 AM

Breakfast
(Prepaid Admission Only)

9:00 - 10:30 AM

Concurrent Workshops 58 through 67

58 Provider-Client Relationship in a Client-Driven ACT Model: Collaboration or Boundary Violation?

The Orange County Behavioral Health Services has transformed our system of care by moving our service philosophy to the Recovery Model. With the Mental Health Services Act (MHSA) funding we have integrated ACT program as one of the levels of care in our county outpatient clinics. This workshop addresses the issues of client-centered care where the client is an essential part of the whole treatment team. We hope to share our experience of success and barriers in implementing a recovery oriented ACT program. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 50% DIDACTIC, AND 50% PARTICIPATORY.

Presenters: Clayton Chau, MD, PhD, Associate Medical Director, Orange County Health Care Agency, Santa Ana, California Assistant Clinical Professor, Department of Psychiatry, University of California Irvine, Irvine, California; Nicole Demedenko Lehman, MSW, Education Director, Recovery Education Institute, Executive Director, Youth in Mind, Orange, California; Jenny Hudson, MSW, LCSW, Program Manager for Adult & Older Adult Outpatient Services in Orange County, Orange County Health Care Agency, Santa Ana, California

59 Individualized Person Centered Treatment Planning

Treatment planning is a genuine partnership with the individual served through dialogue and negotiation. Treatment planning is directed by the individual and centered around their identified goals. The treatment planning goals inform consumer schedule cards, direct daily team interventions, and ensure consistency. Benefits of this process and partnership include treatment occurring in the context of the person's life, family, and work; sharing history of coping, strengths, and challenges; and a focus on the individual's recovery. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 70% DIDACTIC, 20% PARTICIPATORY, 10% EXPERIENTIAL.

Presenters: William E. Hughes II, BA, MDiv, Team Leader, Transitional Age Community Treatment Team; Michael S. Tabachnik, MS, Team Leader, Adult Community Treatment Team; Susan Wolfe, MA, Program Director, Community Treatment Teams, all of the Western Psychiatric Institute & Clinic, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania

60 Social Skills for Mental Health Intensive Case Management (MHICM)

Improving social skills of SMI Veterans through evidenced based practices. CONTENT IS BEST SUITED FOR PARTICIPANTS AT THE BEGINNER LEVEL; 80% DIDACTIC, 10% PARTICIPATORY, AND 10% EXPERIENTIAL.

Presenters: Jeanne Gabriele, PhD, MS, MA, LCP, Local Evidence-Based Psychotherapy Coordinator & Staff Psychologist; David R. Jordan, MSW, LCSW, MHICM Case Manager, both of G.V. Sonny Montgomery V.A. Medical Center, Jackson, Mississippi

South West London and St George's **NHS**
Mental Health NHS Trust

Evidence and Practice for Team Composition

Mike Firm
Chair NFAO / **NFAO** National Forum for Assertive Outreach
Clinical Service Development Lead

Evidence & Practice for Team Composition

Routine ACT 'survival' interventions can be delivered by non-professionals yet 70% of workers in English teams are professionally qualified. US National and State standards for team composition vary considerably in requirements for psychiatrist time, master's degree professionals, bachelor degree case managers, peer specialists and aides. How can a balance be achieved between the evidence, practice, consumer satisfaction and affordability?

So many questions?

1. If we were designing a community based mental health system from scratch would we end up with the clinical/professional groups that we see today in ACT teams?
2. Can we reach a consensus on the skill mix needed for effectiveness in a typical ACT team?
3. Can we evidence that?
4. If we haven't got it right now are we wasting money and compromising efficacy? - Can we afford to be complacent?
5. Can we understand the factors that have contributed to the variations we see between counties/ states/ countries?

Learning objectives

1. Identify, validate and benchmark the workforce profile in your team
2. Compare factors that determine and influence workforce profile variation nationally and internationally
3. Examine the evidence base relating to ACT workforce and the efficient (cost) and effective (quality) delivery of outcomes

Workshop structure

- For your teams use the template to produce a workforce Christmas tree of your team composition/skill mix. ~10 mins
- Vote on whether you think your team has got it about right currently ~5 mins
- Look at factors and variation in US and internationally ~15 mins
- Go through the evidence on cost, quality, effectiveness (ranking exercise) and debate ~45 mins
- Second vote at the end to see if anyone has changed their opinion ~ 5 mins

Workforce profile template

TEAM PROFILING: ACT team Staffing May 2011 US team name:	number	WTR	%	Estimated	USD salary / hr/mo
Administrators					
Non professionally qualified - Support worker/ consumer worker/ Aide					
non professionally qualified - Degree/ or Honored Case manager/ consumer worker					
Other non professionally qualified (please state)					
Master's Qualified Social Worker					
Master's Qualified Nurse					
Master's Degree/ Moral Therapist					
Trainee Psychiatrist					
Team Leader/ Manager (including clinically active)					
Other Qualified (please state)					
Middle grade Psychiatrist					
Clinical Psychologist/ master's qualified counselor					
Consultant Psychologist					
Consultant Psychiatrist					

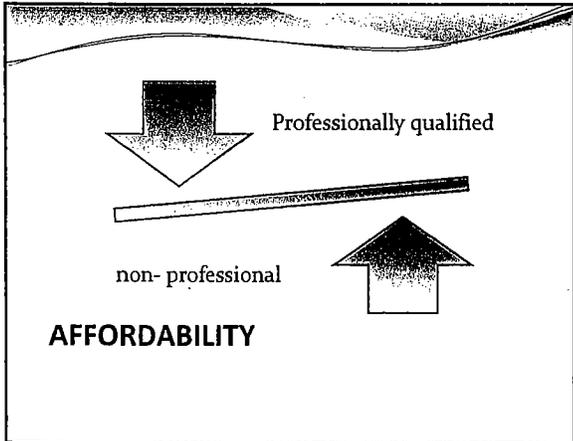
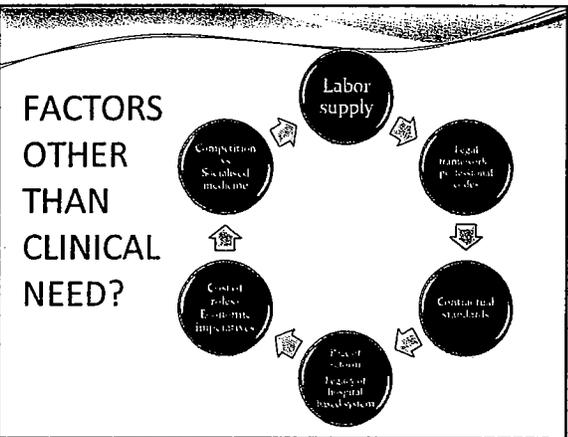
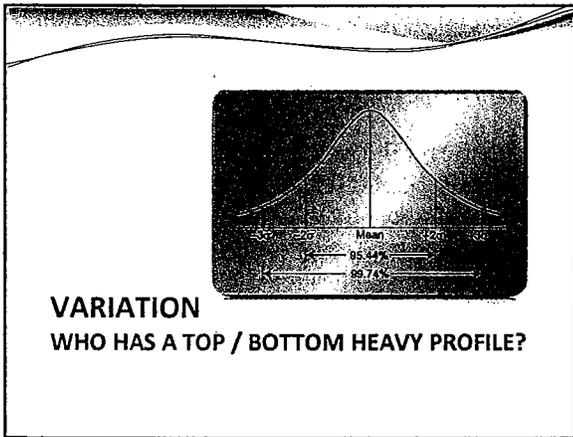
Consultant Psychologist	
Consultant psychologist	
Clinical Psychologist / manager qualified counsellor (BSc)	
Career grade psychologist	
Other Qualified (please state)	
Team Manager (including clinically trained staff)	
Trainee psychologist	
Masters Occupational therapist	
Masters Qualified nurse	
Masters Qualified Social worker	
Other non professionally qualified (please state)	
non professionally qualified, "Degree" or Licensed Case manager /	
Non professionally qualified - support worker / consumer worker / Aide	
Administrative	

Has your team got the correct balance of professional and non-professional staff skills for the work you do and results you get?

- YES - definitely, good fit
- NO - too many professionals
- NO - too many non-professionals

VOTE

Ignore for now what is considered 'right' by the state /PACT standards. Ignore ethnicity / gender mix. Ignore vacancy freezes and under-resourcing just consider the team establishment mix of these 2 groups.



Trust Spending Reports.xls - Microsoft Excel

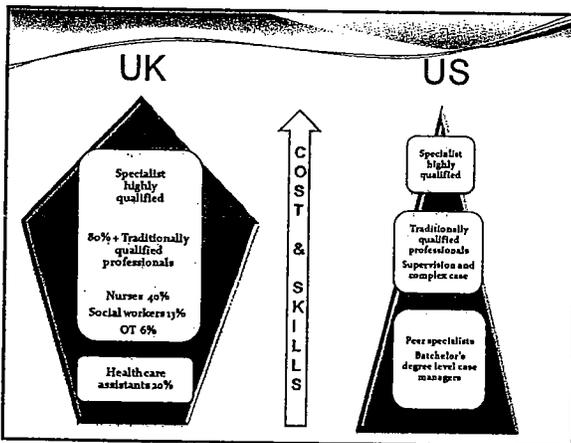
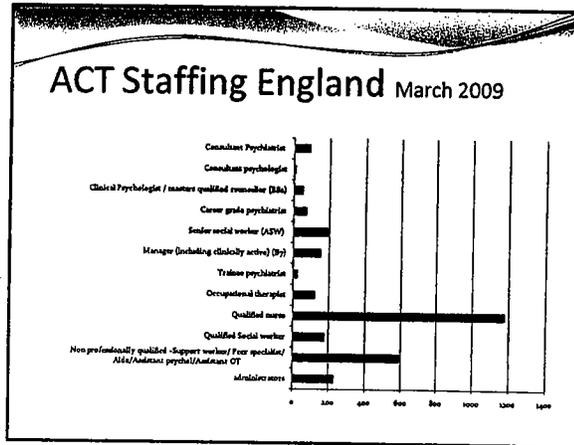
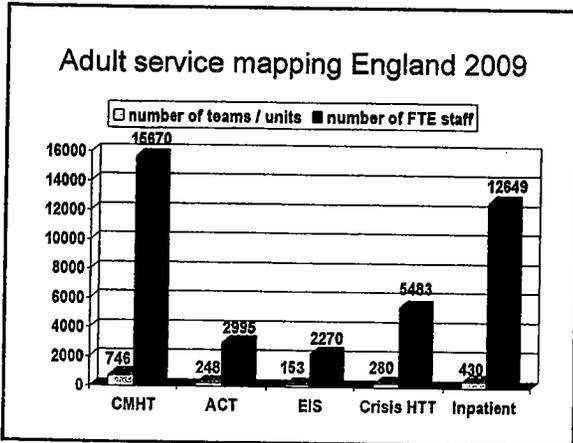
NHS Trust Operating Expenses

Select financial year: 2006/07 2007/08 2008/09

Select local NHS Trust: Org Code:

Account	Operating Expenses 2008/09 (£000)
Salaries (from other NHS Trusts)	8,011
Salaries from PCT	6,311
Salaries from other NHS Trusts	15
Salaries from Foundation Trusts	15
Purchase of hardware from non-NHS bodies	180
Contractor costs	180
Rent costs	18,185
Rentals and services - other	3,185
Rentals and services - general	13,111
Contract work services	6,285
Equipment	1,071
Transport	1,171
Pharmacy	8,285
Impairment of financial assets	0
Change in fair value of financial instruments	0
Depreciation	6,285
Amortisation	0
Financial investments and investments	6,285
Investment in debtors	0
Bank fees	211
Other medical administration	0
Clinical negligence	211
Redundancy	0
Education and Training	711
Other	1,171
TOTAL	68,011

70%



EFFECTIVENESS QUESTION

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Effectiveness opinion

A survey of managers of English ACT team managers (n=104) were asked which interventions they considered most important for overall effectiveness.

Ghosh & Killaspy (2010)

Importance of team activities & interventions

10 point Likert scale (104 ACT team managers)

Activities of daily living	0 1 2 3 4 5 6 7 8 9 10
Developing a structure to the day	0 1 2 3 4 5 6 7 8 9 10
Engagement	0 1 2 3 4 5 6 7 8 9 10
Medication management	0 1 2 3 4 5 6 7 8 9 10
Practical support	0 1 2 3 4 5 6 7 8 9 10
Psychoeducation	0 1 2 3 4 5 6 7 8 9 10
Psychological interventions	0 1 2 3 4 5 6 7 8 9 10
Support with accommodation	0 1 2 3 4 5 6 7 8 9 10
Supporting carers	0 1 2 3 4 5 6 7 8 9 10
Support with finances	0 1 2 3 4 5 6 7 8 9 10
Social support	0 1 2 3 4 5 6 7 8 9 10

Importance of team activities & interventions
10 point Likert scale (104 ACT team managers)

Engagement	9.83
Support with finances	9.14
Support with accommodation	8.91
Psychoeducation	8.30
Supporting carers	8.21
Medication management	8.21
Activities of daily living	8.17
Social support	7.97
Developing a structure to the day	7.88
Practical support	7.71
Psychological interventions	7.28

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Ghosh & Killaspy (2010)

“The survey concluded that the areas of intervention rated as most important (engagement, accommodation and finance) could be delivered by non-professionally trained staff.”

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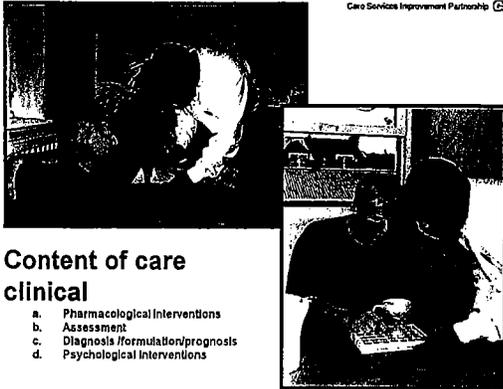
Ghosh & Killaspy (2010)

“The relative lack of focus on medication management and other evidence based interventions for psychosis (psychological interventions).....may explain the poor effectiveness of ACT in England.”

Diary exercise 24 London ACT teams.

PLAO focus of event	mean
Medication	20.5%
Mental Health Intervention	14.9%
Engagement	14.7%
Daily Living Skills	10.3%
Housing	9.1%
Out of Hours	9.3%

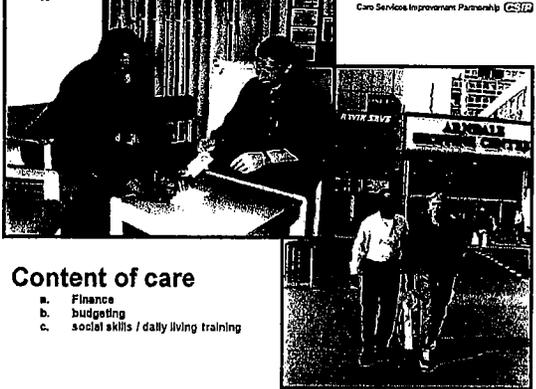
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Content of care clinical

- Pharmacological Interventions
- Assessment
- Diagnosis /formulation/prognosis
- Psychological Interventions

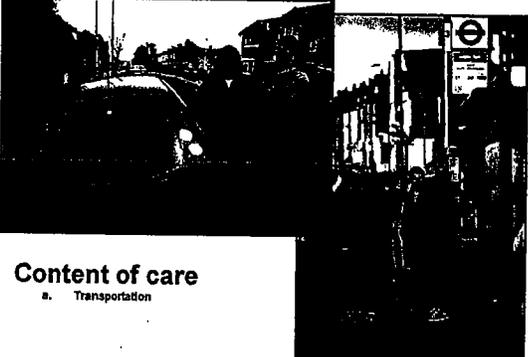
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Content of care

- Finance
- budgeting
- social skills / daily living training

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Content of care
a. Transportation



Content of care
a. Engagement
b. Housing

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Wright et al (in press).

Studies of team characteristics and predictors of outcome identified the very low level application of evidence based psychological interventions such as cognitive behavioural therapy and family interventions.

Evidence

BMJ Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression

Tom Burns, Jocelyn Catby, Michael Dash, Chris Roberts, Austin Lockwood and Max Marshall

BMJ 2007;335:336-; originally published online 13 Jul 2007; doi:10.1136/bmj.39251.699259.55

Social Psychiatry Group, University of Oxford

Trials identified

- 42 included trials with 7817 participants
- 9 trials were multi-centre
 - 8 disaggregated into a further 23 eligible trials with fidelity data for each
- Individual patient data obtained for 2084 participants in 5 trials
 - UK700 (n=708, 4 centres)
 - Rosenheck et al (n=873, 10 centres)
 - Drake et al (n=223, 7 centres)
 - Marshall et al (n=80, 1 centre)
 - McDonel et al (n=200, 2 centres)

Social Psychiatry Group, University of Oxford

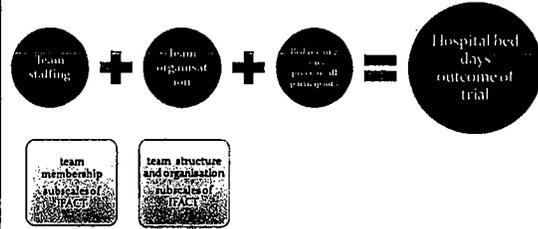
Meta-regression used to test for impact on variation of:

- Date of study
 - Earlier studies more reduction?
- Size of study
 - Smaller studies bigger effect size as evidence of publication bias
- Baseline hospitalisation rates
 - Higher rates permits greater reduction
- Model fidelity
 - Higher model fidelity greater reduction

Meta-regression used to test for impact on variation of:

- Date of study
 - Earlier studies more reduction? **No**
- Size of study
 - Smaller studies bigger effect size as evidence of publication bias **No**
- Baseline hospitalisation rates
 - Higher rates permits greater reduction **Yes**
- Model fidelity
 - Higher model fidelity greater reduction **Yes**

HYPOTHESES USED IN META-REGRESSION ANALYSIS



IFACT scale (McGrew et al 1995)

- Expert consensus:
 - 20 experts rated importance of 73 program features
- 14 item scale tested in 18 "ACT" programs
- Items specified three domains
 - membership,
 - structure & organisation
 - care practices

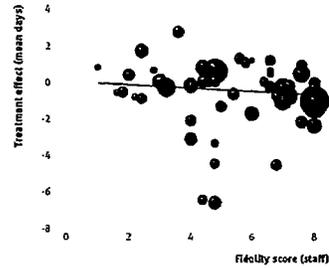


Fig 3 | Scatter plot of IFACT team membership subscore v mean days per month in hospital. Each circle is proportional to size of centre it represents. Negative treatment effect indicates that intensive case management achieved reduction in mean days in hospital relative to control

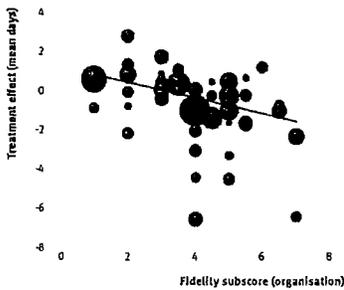


Fig 2 | Scatter plot of IFACT organisation subscore v mean days per month in hospital. Each circle is proportional to size of centre it represents. Negative treatment effect indicates that intensive case management achieved reduction in mean days in hospital relative to control

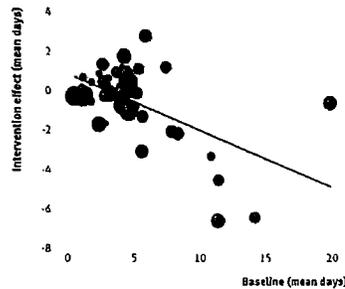


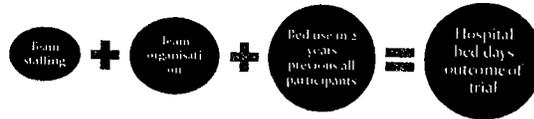
Fig 4 | Plot of baseline hospital use v mean days per month in hospital. Each circle is proportional to size of centre it represents. Negative treatment effect indicates that intensive case management achieved reduction in mean days in hospital relative to control

Meta analysis conclusions

- Intensive case management works best in trials where participants tend to use a lot of inpatient care
- The effectiveness of intensive case management teams is increased as their organisation reflects the assertive community treatment model
- *There is less evidence for the benefits of increased staffing levels*

Effect sizes

- Relative importance to effect on bed days
- Context more than content



The Rise and Fall of ACT

Burns T. International Review of Psychiatry April 2010

RCTs only show a positive effect on bed use for ACT where standard care has long lengths of stay
Standard care has improved and in fact benefited from the intense research scrutiny and experience of ACT
Low caseloads (expensive) do not correlate with reduced bed use in meta regression analysis
Organisational aspects of ACT team working such as multi disciplinary teams, regular meetings and home visiting account for almost all the gains.
These are no longer exclusive to ACT but found in standard community mental health care

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Have non-professionals and/or consumer workers been welcomed by the professions or seen as a threat?

Are the professions suspicious that the motives for these newer roles is mainly about money?

What skill mix do consumers find preferable?

- 3 main themes were identified:
- 1) Social support and engagement without focus on medication
 - 2) Time and commitment
 - 3) Partnership model of therapeutic relationship

Consumers' Goals "in their own words"

- "Find a doctor to get rid of germs that the Sheriff's Department infected me with"
- "Get some money so that I do not have to eat out of trash cans and sell drugs for food"
- "Eat three meals a day"
- "Stay out of jail and the hospital because people are out to get me"
- "Have a good place to live for a while"
- "Earn money in order to get things that I want"

Has your team got the correct balance of professional and non-professional staff skills for the work you do and results you get?

- YES – definitely, good fit
- NO – too many professionals
- NO – too many non -professionals



Ignore for now what is considered 'right' by the state /PACT standards. Ignore ethnicity / gender mix. Ignore vacancy freezes and under-resourcing just consider the team establishment mix of these 2 groups.

Conclusions

Balancing evidence, practice, consumer satisfaction and affordability

