

# **EQUIP - Abstracts Booklet**

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## **STUDY 1: REALIST REVIEW**

**Research Aims:** To examine how user involvement is operationalised within secondary mental health services compared to the theoretical principles upheld by contemporary mental health policy and to establish where, how and why challenges to user involvement occur.

**Research Methods:** Realist synthesis of evidence obtained from 14 electronic health and social science databases, grey literature sources (conference abstracts, policy documents and user-led enquiry) and hand searches of key psychiatry, medical and nursing journals.

Searches were limited to articles published in English from database inception to December 2012. Care planning was defined as any interaction between a user and health professional for the purposes of discussing or addressing that client's needs or treatment decisions. The scope of the review was international, examining user involvement in care planning across different secondary care settings. Study eligibility decisions and data extraction were carried out independently by two reviewers.

**Data Summary:** One hundred and twenty primary research studies were included in the review, with data derived predominantly from the UK (n=53) and US (n=28). Eighty one studies focused on community mental health teams and 49 on inpatient services. Eighty five reported on service user views, 22 on carers/family relatives and 29 on mental health professionals. Thirty provided 'rich' qualitative data descriptions.

**Key Findings:** Failures in partnership working occur at points where the frames of reference of users and providers diverge. Compared to professionals, users and carers attribute much higher value to the relational aspects of care planning. There is a marked mismatch between users' motivation for care planning involvement and information exchange, such that users and carers knowledge is often insufficient for shared need assessments and care negotiation to occur.

**Limitations:** Available data is biased towards service user views. The majority of data was deemed to be 'thin' i.e. lacking detail or failing to fully discuss the reasons for successful or failed user involvement. In depth data from carers and professionals remains sparse.

**What the study adds:** Synthesis shows that user involved care-planning has typically been reduced to a series of practice-based activities seeking to comply with auditors standards, rather than enhancing the quality of the user experience that these standards were originally designed to achieve. Organisations need to recognise and validate the time that professionals spend with service users, and display more tangible commitments to addressing their needs. Individuals need to demonstrate greater and more flexible engagement and communication skills.

## **STUDY 2: PROFESSIONAL DATA**

**Research Aims:** i) To develop a feasible and acceptable user/carer-led training package for mental health professionals to enhance user/carer involvement in care planning and ii) To develop a patient-reported outcome measure (PROM) that better meets user/carer requirements for quantifying the extent of their care planning involvement in UK mental health services.

**Research Methods:** Five focus groups (comprising four professional and one mixed user/carer/professional group) and 17 semi-structured individual interviews. All interviews and focus groups were audio-recorded, transcribed verbatim, anonymised, and analysed using Framework Analysis.

**Participant Summary:** The total number of professional participants providing data across study one (focus groups) and/or study two (interviews) was 35. Twenty-three (66%) were female, and sixteen male (34%). Thirty four (97%) were white. A good range of professional roles were represented. Eight (23%) were in management roles, the remaining (77%) were working directly with service users/carers. Host services included crisis teams; community mental health teams; later life/dementia teams; inpatient services; psychiatry; dual diagnosis and specialist drug/alcohol services; recovery services; mental health advocacy and occupational therapy.

**Key Findings:** A clear training need was identified and strong support for user/carer involvement in this training was evident. Consistent messages were apparent across a range of professionals. Whole team training was advocated to achieve greater impact. Individual barriers to user involvement included skill deficits and staff understanding of user-involved care planning. Organisational barriers include workload/resource pressures, the current KPI/target culture of the NHS and difficulties in balancing involvement with risk management procedures. Professional buy-in to effective, user involved care planning is likely to require greater standardisation of care planning models across services and a greater validation of the need and time required to achieve a more individualised, user-led approach.

**Limitations:** It is likely that the professional participants in this study were those who were motivated to achieve 'good' care planning and/or open to organisational and individual change. The data presented reflects the views of professionals within one Health and Social Care Trust and may not be generalisable to other individuals, settings and localities.

**What the study adds:** This study shows that a combination of individual and organisational factors currently hinder successful user/carer involvement in care planning. It highlights a clear need to deliver training to increase the quality and consistency of care planning procedures. Suggestions for the content and delivery of training are noted along with specific recommendations to ensure that training is aligned with implementation feasibility.

## **STUDY 3: USER AND CARER DATA**

**Research Aims:** i) To develop a feasible and acceptable user/carer-led training package for mental health professionals to enhance user/carer involvement in care planning and ii) To develop a patient-reported outcome measure (PROM)

**Research Methods:** Five focus groups involving 38 service users and carers and 28 semi-structured individual interviews. All interviews and focus groups were audio-recorded, transcribed verbatim, anonymised, and analysed using Framework Analysis. The analysis team comprised two service user/carer researchers and two additional researchers.

**Participant Summary:** The total number of users/carers providing data across study one (focus groups) and/or study two (interviews) was 47. Twenty-six (55%) participants were female, and twenty-one (45%) male. Forty-two (89%) were white, and 4 (8.5%) were from black/minority ethnic groups. Ethnicity was not recorded for one participant. Thirty participants (64%) described themselves as service users, 14 (30%) as carers and 3 (6%) as both service users and carers.

**Key Findings:** Care plans were described negatively as meaningless, not tailored to the individual and not taking account of service users'/carers' wishes, experiences or needs. Good service user/carer involvement is facilitated by good relationships with and between staff, effective communication, partnership working and allowing sufficient time for explanations to be given and understood. Barriers to involvement include frequent staff changes, staff workload, lack of knowledge about services (by both staff and users/carers), unhelpful staff attitudes, and periods of more severe illness. Data suggested that training should target all staff although it was felt that senior clinicians would particularly benefit. Training should prioritise skills in active listening and communication, multicultural issues, assertiveness and time for reflection. Training should be mandatory, accredited and updated regularly. Co-delivery of training was advocated to convey the reality of care planning and to value the expertise of service user and carers. Service users/carers want to make varied and flexible contributions to training whilst simultaneously being supported and having their own concerns acknowledged. Potential barriers to effective training include staff workload, staff attitudes, lack of accountability and a reluctance among service users/carers to be involved as trainers.

**Limitations:** We interviewed a self-selected sample of service users and carers, many of whom had particularly strong views on the short-comings of the care planning process. A minority of participants were from BME groups.

**What the study adds:** Service users/carers have concerns about the way care plans are drawn up and implemented. There is a shared perception that staff are reluctant to involve service users and carers. Recommendation for the content and delivery of training are provided.

## **STUDY 4: TRAINING INTERVENTIONS LITERATURE**

### **Research Aims:**

To identify relevant reviews which could inform the development, delivery and/or implementation of the training the trainers course or the health professional training.

### **Research Methods:**

A scoping review of the literature for relevant reviews about the effectiveness of training development, delivery and implementation.

### **Data Summary:**

Three key reviews identified:

- Robertson, R. & Jochleson, K. (2007) *Interventions that change clinician behaviour: Mapping the literature*. London, NICE
- Reeves, S., Zwarenstein, M., Goldman, J., Barr, H., Freeth, D., Hammick, M., Koppel, I. Interprofessional education: Effects on professional practice and health care out comes. Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD002213. DOI: 10.1002/14651858.CD002213.pub2
- Grol, R. & Grimshaw, J. (2003) From best evidence to best practice: Effective implementation of change in patients' care. *The Lancet*, 362(9391):1225-30 (included in Reeves review)
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### **Key Findings:**

- α) Small interactive groups more effective than large didactic groups
- β) Educational outreach is effective
- χ) Improving collaboration between health professionals might be helpful
- δ) Multi-faceted interventions likely to be better than single strand
- ε) Providing patient materials may help implementation

### **Limitations:**

No systematic search – significant work will be completed in work stream 3 (implementation).

### **What the study adds:**

The key implication for training (which we had not taken into account) is the potential of outreach work – in most other intervention studies we have conducted we have incorporated supervision.

## EQUIP Synthesis – (All responses)

### Synthesis Matrix

<i>Component</i>	<i>Realist Review</i>	<i>Users and carers (Focus groups and interviews)</i>	<i>Professionals (Focus groups and interviews)</i>	<i>Training interventions literature</i>	<i>Incorporated into the intervention</i>
<b>Training</b>					
<b><i>What content needs to be incorporated in the intervention</i></b>	Skills – not clear – goal setting problem solving smart goal setting. Process / ideal Care plan Flexibility of UI Opportunities. Engagement. Communication Skills Reversing stigma/perceived SU/C dis-interest. Thinking outside the box. Alternative methods of UI e.g. Skype. Pacing & Jargon – for understanding. Overcoming distance	Skills Listening Purpose – example. Active listening skills – Practical exercises. Factual information about confidentiality. Modules ID by user/carer quotes. Experiences of being over ruled/dismissed.	Skills – Purpose of CP – example model Standardisation/shared model (m/d working) Time management; Engagement & Listening skills; communication skills Evidence-Based Needs assessment Attitudes & values Balancing –Involvement alongside organisational needs/workload pressures. Shared CP Understanding. Shared decision making. Involving inpatients in CPs & managing crises. Focus on organisational implementation. Skills that staff feel they are missing. Balancing with Risk Responsibilities.	Multi-component patient materials. Collaborative working – working with wide range of networks. Multi-faceted interventions	
<b><i>Who should attend the training</i></b>	Whole Teams. Users, Professionals, Managers, Carers	GPS; A&E staff; Police; Courts. Professionals and SUs Carers (CP received). ALL 1, 2, 3 sector staff. Whole teams. Psychiatrists.	All Staff – Managers to frontline; GPs; H/SC profs in 3 <sup>rd</sup> sector; pre-registration nurse/sw/medic. Whole Team. Pre-reg students.		
<b><i>Where should the training take place?</i></b>	<b>Workplace</b>		<b>Multi-disciplinary Organisation based Whole Team</b>		

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<i>Training cont.</i>					
<b><i>What format should training take? (face to face/web based)</i></b>			<b>Pre-session 'E' learning; Face to face; graduated format (start with basics); practical skills (role plays); Case studies/digital stories</b>		
<b><i>How long and over what time period should the training be?</i></b>			<b>Mandatory; Not one off - Refresher Course</b>		
<b><i>What resources need to be developed?- e.g. user/carer podcasts (and for dissemination strand)</i></b>			<b>Case Studies / digital stories</b>		
<b><i>What are the systems training needs</i></b>			<b>Standardisation</b>		



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<b>Training the trainers</b>					
<b><i>Who should attend the training?</i></b>		SU's / Carers and professionals (co-delivered). Multiple trainers = sufficient capacity for flexible cover. Service users forco-production/ delivery. Not just the activists.	Need to have right skills as well as lived experience – don't select those with an axe to grind. Maybe have range of involvement roles – not all will want to 'teach'	Multi-disciplinary for staff trainers.	
<b><i>What should the training focus on?</i></b>	Teaching Care Planning Skills. Awareness of stigma. Assertiveness. Confidence. Value of course – hope/evidence for impact.	Assertiveness training. Listening skills & how to develop them. Ensuring capacity / responsibilities for delivery. Teamwork.	Teaching Care Planning Skills Challenging negative attitudes. Managing Classroom conflict. Presentation skills. Attitudes – positive impact of CP. Engagement Processes with senior / hard to reach Professionals	Small Group Teaching Don't just have opinion leaders Using patient-mediated interventions. Developing and delivering patient materials. Consensus Methods. Multi-faceted involvement	
<b><i>How long and over what time period should the training be delivered?</i></b>	Those with capacity to clearly express articulate range of needs	Updated not one-off. Ongoing support. Manageable chunks eg, 45 mins at a time.	Updated – not one-off. Short half day.		

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<i>Training the trainers cont.</i>					
<i>How do we select user and carer participants to deliver the training?</i>		<p>People lived experience and interpersonal skill training; Diverse cultural grps. Be aware of SUs/Carers who have training experience and have offered to help further.</p>	<p>Good sized team – so small number of trainers are not over-burdened. Diversity of experience/skills. Recruited from different Trust areas. Teaching skills and good interpersonal skills. Prioritising ‘teaching’ / presentation skills. Transparent /formal recruitment process.</p>		
<i>What resources need to be developed?</i>		<p>Facilities should be very good. Respite care for people being cared for. Support sheets</p>	<p>Appropriate payment &amp; recognition of time. Cover costs for respite care (to allow carers to attend) Support &amp; debriefing process for trainees – MH issues could be triggered by involvement; could be hard dealing with cynical/ challenging staff. E-learning off line &amp; online</p>		
<i>Other</i>					
<i>Anything else that is important not covered by the above?</i>		<p>Non-clinical training setting.</p>	<p>Considering cultural needs of trainee trainers – e.g., don’t schedule training on Fridays</p>		