Mayview Regional Service Area Plan
Engagement Workgroup Report
October, 2009

Overview

With the closure of the Mayview State Hospital in December 2008, the Mayview Regional Area Service Plan (MRSAP) Steering Committee identified two key areas of concern for those who had been discharged into the community. The two key questions/areas are 'how do front line staff effectively engage consumers in treatment/services' and 'how do front line staff identify early signs of disengagement in order to intervene to prevent a crisis'. These continue to be reoccurring themes throughout various Root Cause Analyses (RCAs) as well as the tracking of critical incidents, and demonstrate that by understanding the nature and intervention of engagement, it is possible to prevent many crises.

In response to these considerations, a workgroup was formed by volunteers from the MRSAP Steering Committee to explore these issues in our region. Workgroup members include advocates, county and state representatives, clinicians, researchers, and representatives from the managed care organizations in the MRSAP region.

Note, other initiatives continue to review issues of consumer engagement, such as the Single Point of Accountability (SPA) initiative in Allegheny County, and how service coordinators / case managers interact with and provide direct services to consumers. Understanding issues of consumer engagement and addressing needs for enhanced training, support, and financial considerations in providing these services are critical to effectively engaging and/or re-engaging consumers in the community.

The MRSAP workgroup hopes to complement these other initiatives by providing additional feedback from consumers, family members, and providers on these issues. In addition, included in the appendix of this report is a literature review which summarizes some of the lessons learned from a scan of the extant literature on engaging clients with severe mental illness.

Approach

The workgroup agreed to document perspectives on consumer engagement and disengagement from the consumer, family member, and provider points of view through a series of focus group sessions conducted in the MRSAP region. A standard set of open-ended questions were posed to the groups to generate discussion. Common themes and tangible recommendations were identified to support recommendations to the MRSAP Steering Committee regarding policies and practices pertaining to the identification of

consumer disengagement, as well as intervention strategies for addressing disengagement. These standard questions include the following:

- What engagement approaches or techniques work?
- What approaches do not work?
- Who should approach you, your family member, or the individual who receives services if you/they are not doing well?

Views of Engagement – Common Themes

The following is a summary of common responses and themes that were shared by participants throughout the focus group sessions. Similar comments were made by consumers, family members, and provider staff and just differed on each person's orientation to the question being asked. These comments have been combined for this summary – please see the appendix for the actual results.

- Engagement is effective when:
    - A person is shown respect as an individual and not as a mental illness and when people are not nonjudgmental.
    - The interaction is individualized. For instance, doing things that interest individuals, such as seeing new places, holding to a routine, or having an engagement / assertive outreach plan in place. This also includes personalized ways of communication based on what makes me comfortable – for example, giving notice prior to visiting or conducting pop-in visits, telephone or email/text message contacts.
    - It is timely - not delayed but is done in a timely fashion, especially not just when a person is doing poorly but before a situation turns into a crisis.
    - It focuses on positives, provides hope, helps individuals get their needs met, develops common interests, validates feelings, and is empathic.
    - It involves someone you trust and who cares about you, i.e., family member, spouse, friend, peer, service coordinator/ case manager, direct service staff, therapist, or Dr. This involves keeping promises and being kind, caring, friendly, compassionate, and sincere. It takes time to get to know individuals and what make them feel most comfortable. These groups were also consistently identified as those who should approach an individual if they are not doing well.
- Engagement is <u>not</u> effective when:
    - Interactions occur only when a person is in crisis.
    - There is yelling and punishing behaviors.

- Individuals are demanding or authoritative, lose patience, are critical, condescending or patronizing, or are cold, detached, authoritative, and rude.
- Interactions focus on faults or weaknesses or past mistakes.
- Expectations are too high.
- Someone pushes their own beliefs and values.
- Interactions involve labeling or stereotyping.
- People are not dependable.
- Interactions ignore the consequences/risks of an individual's behavior.

Many of the comments throughout the focus group sessions rolled-up to issues of establishing rapport, trust, respect, and individualization and cultural sensitivity, and not having others take a punitive approach, such as being intimidating, threatening, judgmental, or critical.

Many participants also reported isolation as a sign of disengagement, although others reported that just because they may want to be left alone, this does not mean that they are necessarily disengaging. In addition, it was commented that transitioning to a different level of care or during critical treatment junctures is a time when disengagement may occur given that significant changes occur in routine and relationships. Other risk areas for potential disengagement were reported to be related to the coordination and follow-up activities for individuals involved in multiple systems of care, including those with co-occurring drug/alcohol and mental health disorders and the coordination of physical health and behavioral health services. It was reported that these issues can be complex, overwhelming, and time consuming for consumers and staff alike. It was noted that peer support, partnering with PCP offices and the use of physical health care managers all help to keep individuals engaged in the coordination of physical health and behavioral health services.

Recommendations to MRSAP Steering Committee

The results of the focus groups support recommendations on training in assertive engagement strategies and motivational interviewing that address the following areas for more effective consumer engagement:

1. Establishing relationships and rapport given the emphasis on the increased effectiveness of engagement with individuals who are familiar, trusted, and safe. In addition, it may be helpful to explore strategies and engagement techniques for situations that may not allow for adequate time to develop relationships or rapport.

2. Setting clear expectations and having a shared common understanding and engagement plan that is deliberate, purposeful, and jointly developed by the individual being served, their service providers, and/or family members. This plan should be individualized as to what works, what does not work, and how and who should approach or outreach to them when they find themselves withdrawing.

3. Being proactive and creative in how engagement occurs. There is value in "going the extra mile" when trying to engage individuals.

4. Understanding how changes in service providers, levels of care, and/or the complexities associated with the coordination of care with multiple systems, i.e., drug & alcohol or physical healthcare, can affect an individual's increased need for proactive engagement.

5. Offering motivational interviewing techniques to not only direct service staff (Allegheny County SPA initiative noted above), but also to family members and other individuals in direct contact with those receiving services - helping them to develop relationships and provide intrinsic motivation for individuals to engage.

   The motivational interviewing techniques discussed in the following excerpt from the Allegheny HealthChoices Report, "Motivational Interviewing: What it is and Why it Works – Spring 2008", are consistent with many of the comments and concepts reported throughout the focus groups:

   > …Motivation is better understood as a state that can be influenced and as a key factor in helping people change [to be engaged]. Ambivalence about change [disengagement] can be considered a normal part of one's interactions. **Motivational interviewing** (MI) is a counseling method for enhancing a person's internal motivation for behavior change [engagement] through exploring and resolving ambivalence. MI is person-centered. Clinicians meet people "where they are." It's collaborative, and focuses on the person's goals and values and what the person feels confident and ready to tackle.

Appendix A: Literature Review on Engaging Individuals with Severe Mental Illness

This report summarizes some of the lessons learned from a scan of the extant literature on engaging clients with severe mental illness.

The following relevant Cochrane Reviews are of especial interest. One particularly notes ACT as superior to case management in engagement (Marshall & Lockwood, 2000). A second (see next paragraph) review of intensive case management is underway. People receiving ACT were clearly more likely to stay in care, and had fewer hospital days.

It is of note that a Cochrane Review of 2000 reports negatively on case management overall. This review notes that consumers who received case management compared to "usual care" were more likely to be in contact with services, but that they also had more inpatient days, and no measurable effects on quality of life or any other clinical or social variable.

1. There is evidence that ACT is the most engaging service model

The literature is consistent that ACT models are more engaging than alternatives, including "case management", although case management was supported as more engaging the "usual care" in a Cochrane review (Marshall & Lockwood, 2000). Importantly, that Cochrane Review was negative overall about case management, noting that although clients were more likely to stay in contact with services than when offered "usual care", they were also more likely to have hospital admits, and had more hospital days. It is difficult to determine the range of services provided under "usual care" in the review, and the lack of description of various models, including ACT and case management, is noted.

Another recent Cochran review (Malone, D., Marriott, S., Newton-Howes, G, Simmonds, S & Tyrer, P, 2007) addresses the success of "Community Mental Health Treatment Teams". These are possibly quite similar to SPA in construction. The review states that there is not yet enough evidence to clearly assess these teams, but they extant engagement results are promising.

It seems likely that ACT may be the best model because it embodies trust, patient-centeredness, and patient-choice. Some work has particularly addressed why patients stay engaged, and trust, cooperation, partnership and lack of coercion are cited as the primary factors (Watts & Priebe, 2002; Priebe, et al., 2005). Elements of ACT appear to be adopted and adapted rather liberally. There is also interest in a "Flexible Access" model based on ACT in the alcohol treatment field, with promising results (Passetti et al. 2008).

The UK has adopted ACT widely, primarily because it is considered such a successful engagement strategy. It is referred to as "Assertive Outreach". A number of articles published in the UK and America support ACT's success in engaging clients.

A recent randomized trial in England compared ACT to usual care from community mental health teams. ACT did not have clinical advantages; however, ACT clients were more engaged with services and more satisfied with services. Interviews with providers suggested that ACTs smaller caseloads led to more frequent, less formal contact with clients, and to greater staff satisfaction, both associated with better engagement. (Killaspy, et al, 2009).

A recent American review (Kreyenbuhl, Nossel, & Dixon, 2009) also concludes that client-centered communication and shared decision making can promote engagement, although it notes ACT as only one strategy. This review suggests that the most vulnerable demographics (young males, particularly of ethnic minority groups) and dangerous times (especially the initial periods of treatment, and following ER visits and hospital stays). People with co-morbid substance use problems are also more vulnerable to dropout. .

Empirical work conducted in America specifically testing the effects of ACT on engagement also point to ACT as a successful model of engagement. For example, an American a study of 116 patients who received treatment from one of two ACT teams and 58 patients who received "usual care" 68% compared to 43% of patients were retained over the observation period, which extended over up to 870 days (Herinckx et al., 1997).

The ACT model is recognized as demanding for staff and requiring considerable commitment and training (McAdam & Wright, 2005).

Authors addressing this issue have specifically addressed when "assertive outreach" borders on or becomes "coercion", a difficult issue with broad implications for the kinds of staffing and training issues faced by case management/service coordination department. (Williamson T, 2002).

2. Good relationships are the foundation of good engagement

A set of articles especially notes the importance of good relationships in engagement. This is noted above – ACT is considered by some authors to be successful because its structure permits the trust, collaboration, and patient-centeredness that a variety of authors note is needed. A few more articles are mentioned below.

Engagement is higher when interactions with case managers are rated as more positive. Interactions are rated more positively when they are rated as less coercive. Interactions are rated as more coercive when they are shorter. A good pattern of interactions includes longer interactions in the beginning of a relationship. Good interactions are seen as non-coercive (Stanhope, Marcus & Solomon, 2009).

Trust and choice are important to consumers, and choice in particular may influence engagement; a recent review reports this result, and also notes that it is not completely consistent across studies (Laugharne & Priebe, 2006).

Articles addressing why ACT is successful emphasize the importance of the relationships and interactions that are possible with this well-staffed model, particularly the importance of a partnership model without undue focus on medication compliance (Priebe, et al, 2005).

3. Good organizational climate affects outcomes and engagement.

There are some indications that a good organizational climate is associated with better rapport between clients and providers, with attendant improvements in engagement and functioning; the article cited notes this for substance abuse programs (Greener, et al., 2997; Simpson et al., 2009). Two studies from the same group show this across a fairly large number of substance abuse treatment studies (more than 200 in both studies). Suggestions are also shown in Melnick et al., 2006, who address "consensus" within client and staff groups, and "concordance" between client and staff groups, and show that where these are higher, engagement is better.

4. The difficult and important issue of coercion and engagement

Medication adherence has been convincingly shown to be associated with favorable clinical outcomes, and has also been reported to be associated with greater engagement in mental health outpatient care; Asher-Svanum and colleagues (2009) report this in a study that also showed that medication adherence improved following hospital stays.

A recent review is provided by Link and colleagues. It distinguishes between "The Coercion to Beneficial Treatment" perspective, identified with E. Fuller Torrey, and the "Coercion to Detrimental Stigma" perspective, associated with Pollack and others. This review reports that both perspectives find some support. Improvement in symptoms leads to improved quality of life, even when treatment is mandated. However, *perception* of coercion is associated with decreased quality of life, increased stigma, and decreased self-esteem. These authors recommend that attention continue to be devoted to ensuring that people receive needed treatment, but in such a way that perceptions of coercion are minimized. Swartz and colleagues recent empirical work (2003) with providers and consumers echoes this dilemma. These authors report that providers do not feel that mandated care in its many forms is detrimental to engagement; however, consumers sometimes report that indeed, mandated care is associated with reluctance to seek care. Coercion appears to be associated with more care, but can in some cases also be associated with reluctance to seek care.

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Appendix B: List of Focus Groups

- Consumers Focus Groups
  - Allegheny County
    - WPIC Transitional Recovery Unit (TRU) – Extended Acute Care program
    - CTT Advisory Committee
  - Beaver County
    - Wellness Group – Beaver County Mental Health Association
    - The Aurora Psychiatric Rehabilitation Group
    - Dual Recovery Anonymous (DRA) Co-occurring Group
  - Washington County
    - Washington Hospital Behavioral Health Unit
    - Southwestern PA Human Services Social Rehabilitation and Drop-in Center
    - Southwestern PA Human Services Partial Program
    - Can Do Transition Age Housing
    - Southwest Behavioral Care - CRR and Supportive Housing
    - Washington MHA - Enhanced Personal Care Home (EPCH) and Long Term Structured Residence (LTSR)
    - Anna's Home – EPCH
    - Residential Recovery Services - CRR and Supportive Housing
    - Washington MHA – Circle Center Drop-in-Center
    - AMI, Inc. Psych/Social Rehabilitation and Clubhouse
    - Washington Communities MH/MR Partial Hospitalization Program

- Provider Focus Group
  - Allegheny County
    - MRSAP Direct Service Provider Meeting
  - Washington County
    - Washington Communities Blended Case Management unit
    - Residential Recovery Services - CRR and Supportive Housing staff
    - Washington MHA - EPCH and LTSR staff
    - Southwestern PA Human Services - CRR staff
    - Southwestern PA Human Services - Case Management staff
    - Can Do Transition Age Housing staff
    - Centerville Clinics Blended Case Management staff
    - AMI, Inc. staff (Clubhouse and Peers)
    - Anna's Home EPCH staff

- Family Focus Group
  - Allegheny County NAMI
  - Washington County NAMI