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Interdisciplinary Assertive Outreach Teams. State Of The Art, and a Norwegian solution.

Flexible Committed, Community Collaboration - The C-Flex Mod

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The next 30 minutes..

- Less about state of the art - more about;

- C-Flex model/framework - Flexible Committed Community Collaboration
- And that the team
- In large extent reaches their target group (as def in the white Paper IS-1554, 2008)
- Stabilizes the users
- Establishes and re-establishes the patients in ordinary services
- Housing the homeless
- Offer an alternative when their no obvious solution
- Reduces the number of admissions
- Reduces the number of days of hospitalization
- Has a sustainable project organization
- Affects the ordinary service system practice
- Offering a place on the bench for those without a chair…

Backdrop 2011

- White Paper IS -1554 (2008) ”People with severe mental illness in need of special facilitated services”

- Roots and ideas are similar to other AO teams;
- ACT
- CMHT
- FACT
- But C-Flex also differ in some important areas…

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Well known obstacles

- “This is not our responsibility!”
- ” Its too severe - someone else is better qualified to do this” or
- “Its not enough to fulfill our inclusion criteria”
- ”In our service we do it like this and not like that”

- Fragmented organization, institutionalized practices and ways of working are hindering high quality treatment

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Where did that leave us?

- Several important questions regarding our viewpoint of;

- What is the actual problem?
- Who is our target group?
- What do we need to solve the tangle?
- What are the goals in short and long term?
- Is it about what we have, or what we do?

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Target group

- Norwegian Directorate of Health:

  ” The target group includes people with severe mental disorders alone or in combination with alcohol or drug abuse, cognitive impairment, mental retardation and / or significant disability which is in need of particularly adapted and long-term services. (IS-1554 2008: 10 – my translation)

- For the C-Flex team this is specified to:

- inhabitants of Baerum municipality with:

- severe mental illness (SMI) and/or severe addiction (SUD)
- severely disabled
- weak or non-existing contact with public treatment services

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Calculations of the target group

- IS-1554:

  Estimated number in the target group per 10 000 inhabitants(data: IRIS, SINTEF):

Average:	10,6
Oslo:	14,3

- C-Flex team:

  Mapping autumn 2011 gave an estimate in Baerum (120 000 inhabitants) of between 80 and 120 (7-10 per 10 000).

  After 3 years experience the result shows 16,3

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Inclusion criteria - target group

- Those who ”fall between chairs” and fulfill all other services´ exclusion criteria
- Unstable or total lack of connection to the ordinary service system
- No diagnostic criteria
- No age criteria

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The C-Flex team in Baerum

- Started January 2nd 2012
- Interdisciplinary collaboration team comprised of employees from both primary and secondary mental health and addiction services
- The staff are all in fractional positions also still staying in their initial positions in the ordinary services – in that way we kept the project economic sustainable and spread our work method and philosophy

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Services represented in the C-Flex team

- Primary mental health services
- Primary addiction services
- Primary social services
- Primary housing services
- Employment services
- Specialist mental health services
- Specialist addiction services
- Peer expert - a former user of services
- **Totally 13 persons in 4.8 positions**

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3 levels of effort

Direct patient contact

"..no or little contact with primary or secondary health services.."

All at the same time

Shoulder-to-shoulder

"If they already receive some kind of treatment, we often use a method we call shoulder-to-shoulder"

Supplement the existing competence

Counseling

"ad-hoc and systematically"

Support the services to maintain stable and long-term contact

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Philosophy - Methodology

- Recovery perspective
- Assertive outreach
- Flexibility
- Perseverance
- Continuity
- User involvement
- One meeting room - no offices
- Long but individually assessed perspective
- A broad range of peoples lives are evaluated
- Psychiatric and addiction assessment and treatment when needed and possible

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Main goals – both to the team and cons effect

Establish patients in the ordinary services

Prevent disruption of treatment alliances

Make the *patient* able to keep in contact with the services

Make the *services* able to keep in stable and long-term contact with the patient

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The evaluation 2011-2014

- To investigate the effect of establishing a assertive outreach team based on the C-Flex model, on changes in patients recovery and practice in the service system

- Data in the survey are obtained from:

- PAS in municipal and specialist health
- Our own register in the team
- Semi structured interviews

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Design and methods

- Intervention study with a prospective / retrospective cohort with interrupted-time series design
- Mapping/measuring related to outcomes 24-0 months before first contact compared to 0-24 months after
- Parts of the study is closely related to the national evaluation of 12 ACT team N = 187/143 (Data collected 2010-2014)
- Major challenges related to the data collection, N=30

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The patients in the C-Flex team

- 67% are male, 33% female
- Age span: 17-65 years - the most prevalent group 30-45 years
- 84% have both addiction and SMI
- 13% have psychosis (6% only psychosis)
- 10% have only addiction
- Totally 214 patients in the project period, selection with consent N=30
- To identify system weaknesses related to service offerings and/or lack of opportunities, the project also offered the option for inquiries from the ordinary service system when the case was serious but in lacks of a clear direction or direction at all
- The aim has been to map the level of availability of our services

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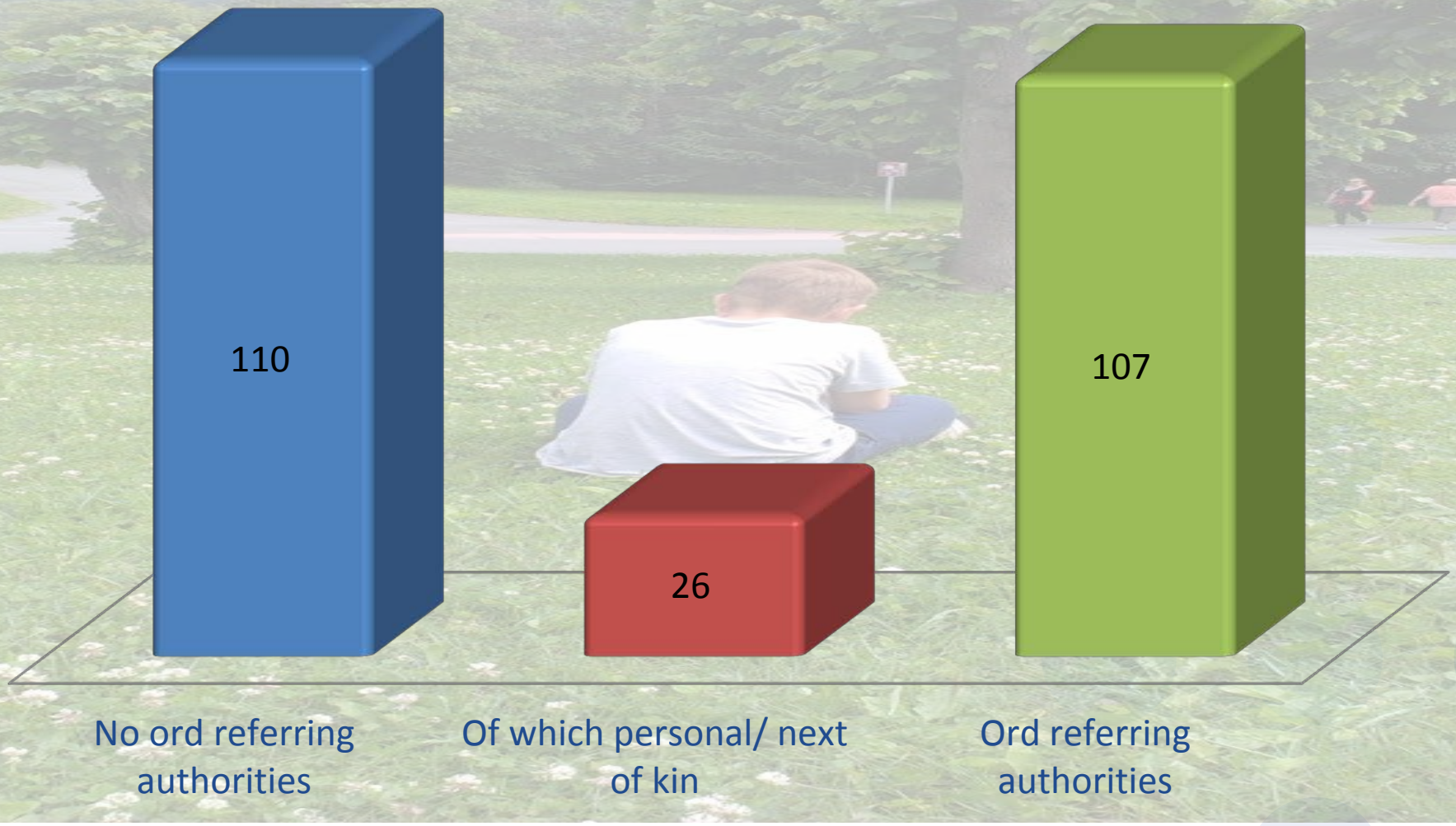
Availability in service offerings after 36 m (217 / 34)



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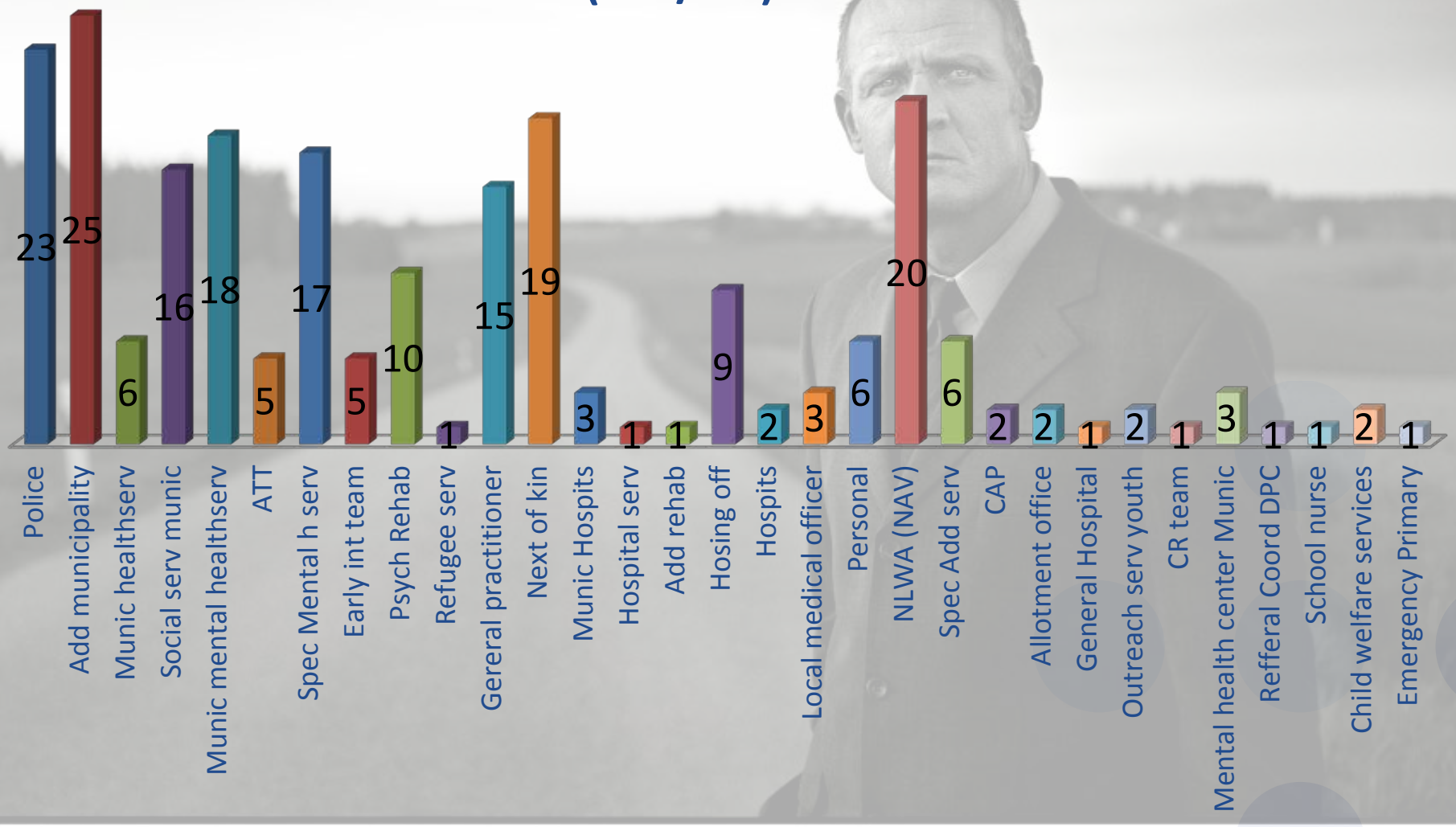
Who´s contacting the C-Flex team?
After 36 m (217/ 31)



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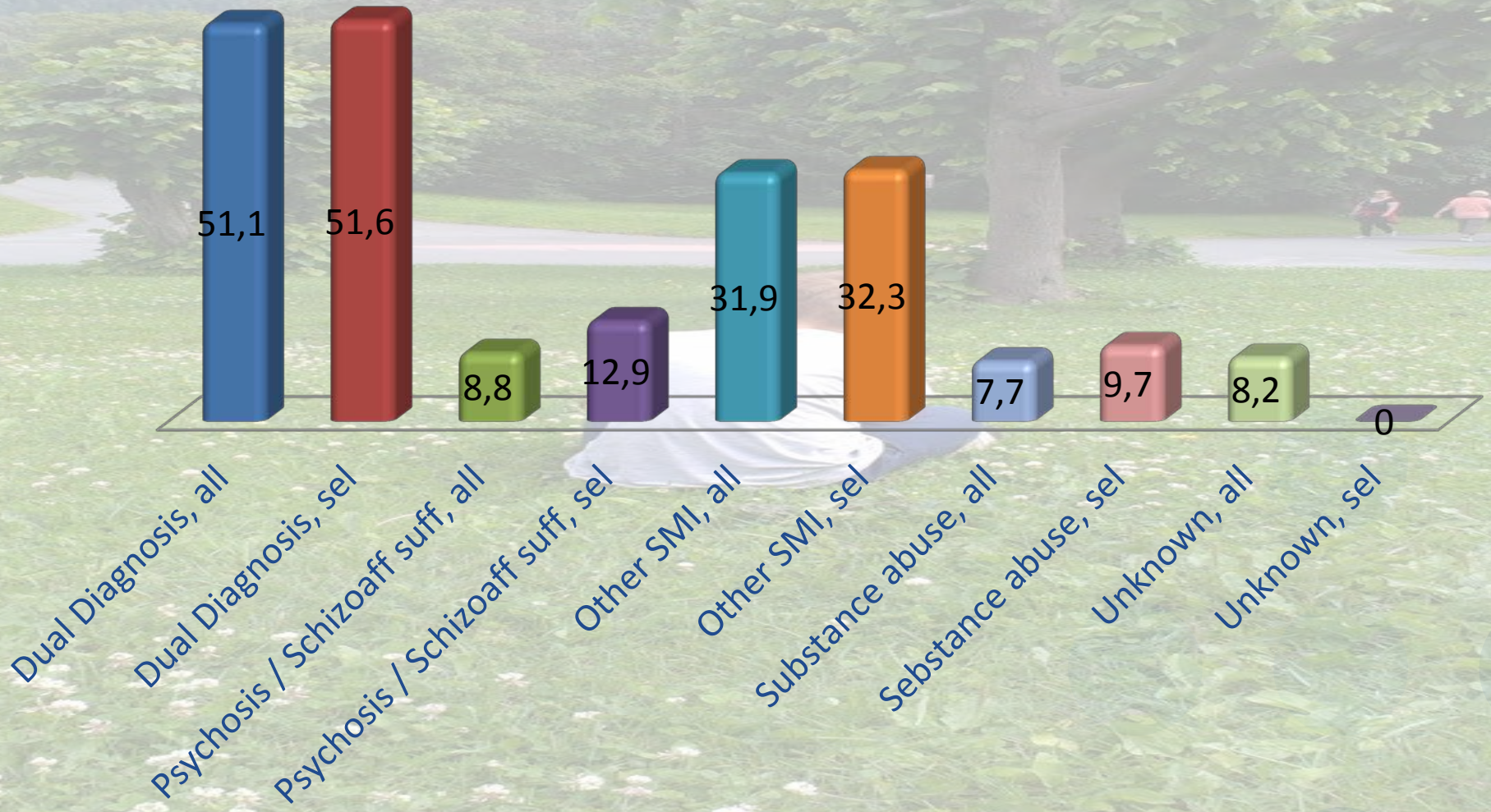
Patients devided in diagn grouping by first contact. All and sel. %



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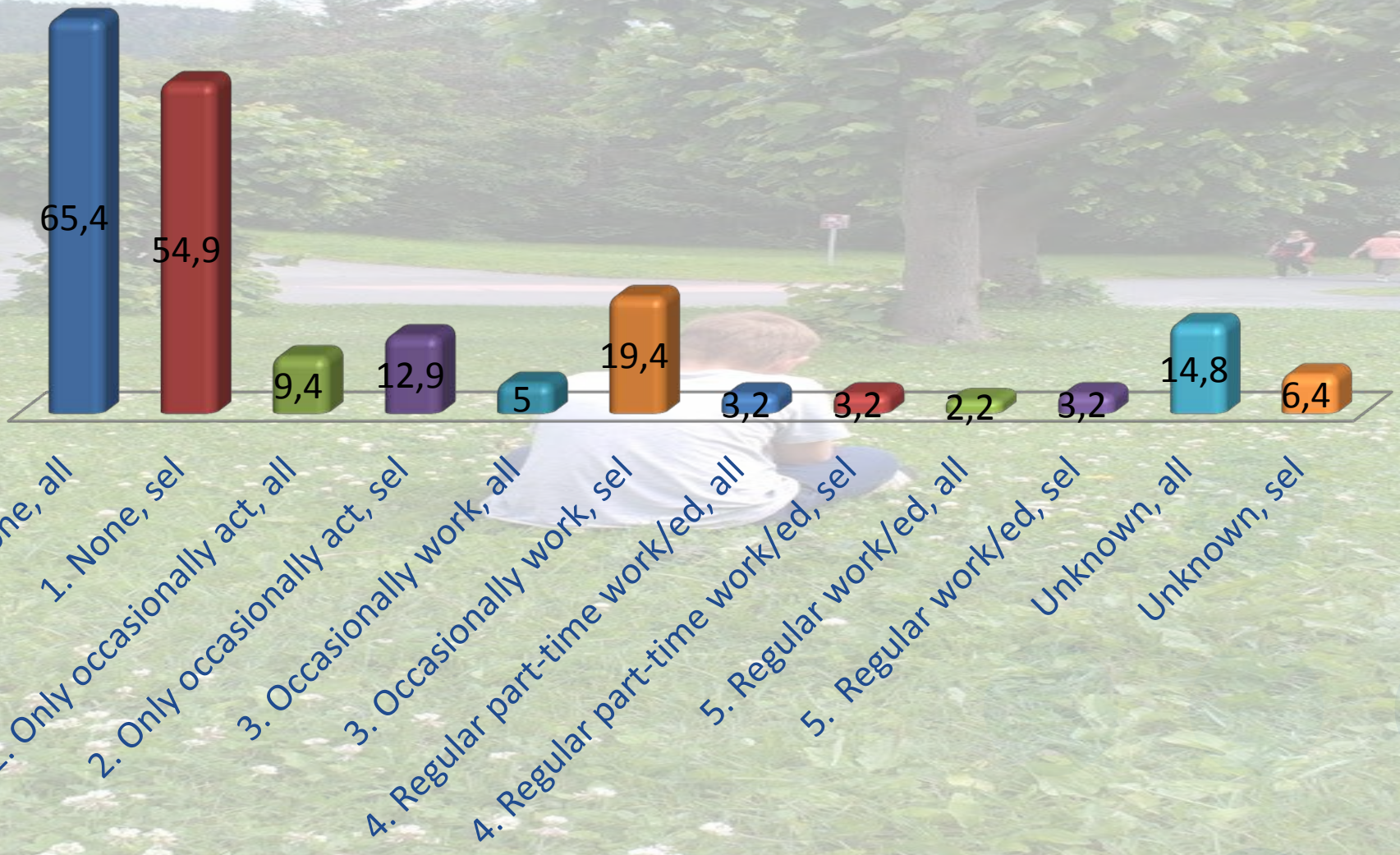
Activity and/or work by first contact. All and sel.%



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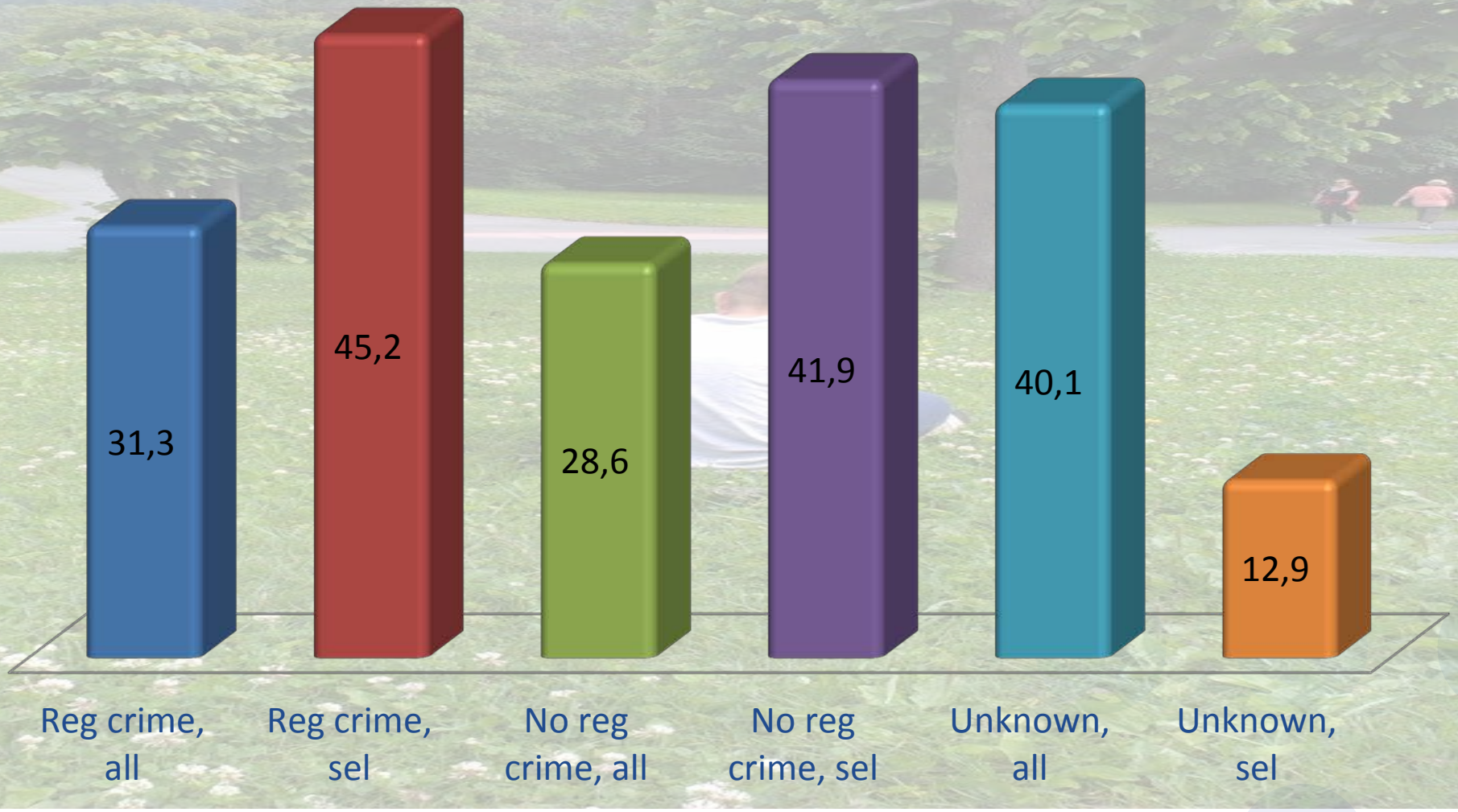
Criminality reg by first contact C-Flex team. All and sel. %



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Achievement regarding the working methods

Working method	All cases after 36 months	Re-established in ordinary services	Av time followed by C-Flex team	Achievement
Direct patient contact	64	21	6.5 months (Var 0.5 – 20)	33 %
Shoulder to Shoulder	43	15	3.5 months (Var 1-8)	35 %
Counseling	32	19	2.5 months (Var 0.5 – 7)	59 %
Total	139	55	4.2 months	**40 %**

After 36 months totally 40%, of those initially having no contact or an unstable situation has been stabilized and re-established in the ordinary service system (25 of the reported cases got in contact within the last 12 months)

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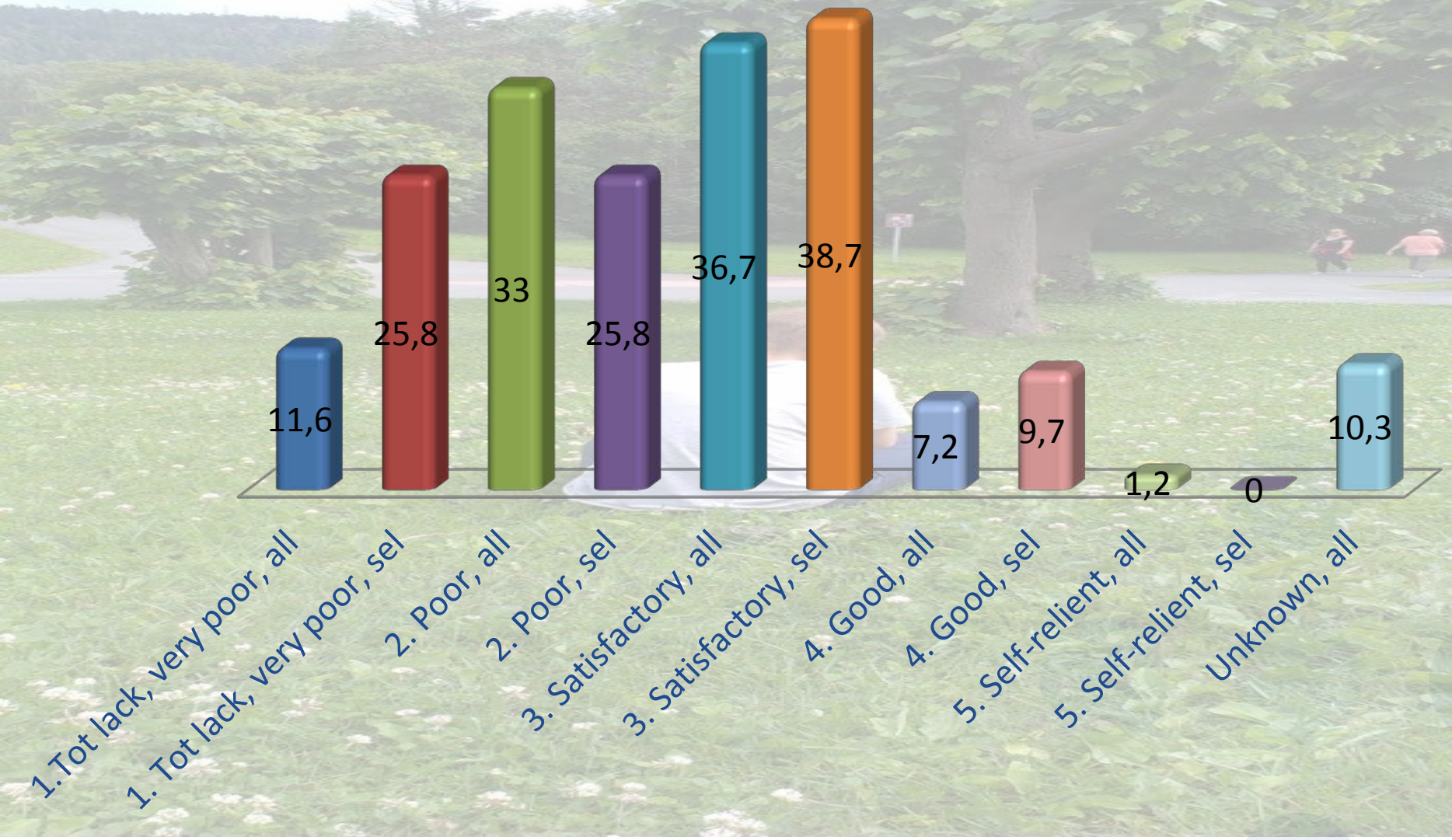
Housing capability by first contact. All and sel. %



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Achievement regarding safe and stable housing

- By first contact:

- 13% of all cases had no housing at all
- 5% lived in their parents house/garage

- After 36 moths with C-Flex these numbers are 0 and 80% of the patients with no stable income (group 1 and 2) at first contact have established a stable income

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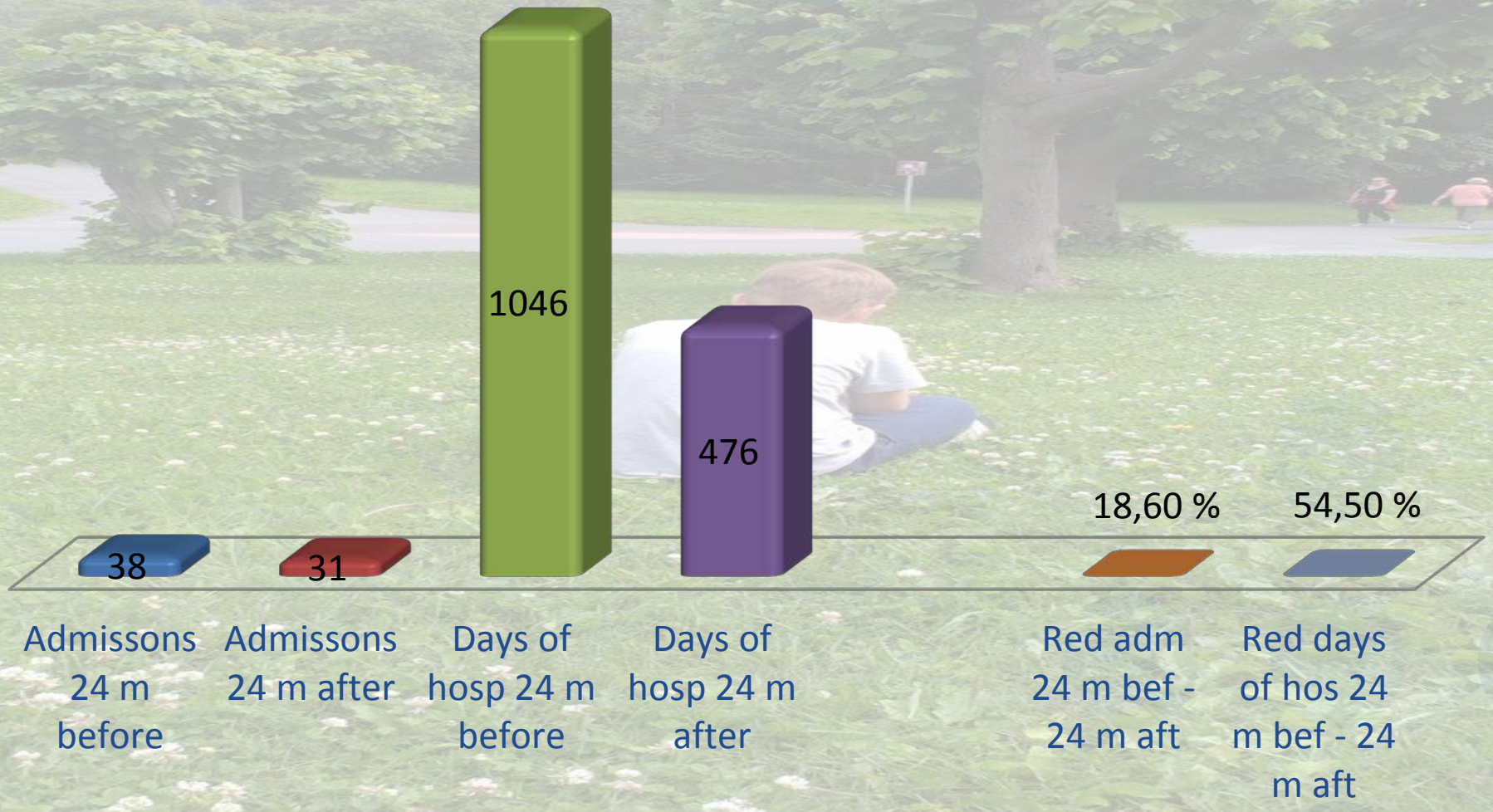
Admissions and days of hospitalization 24 m before – 24 m after, sel. N=30



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- **The C-Flex team have during the project period;**

- largely reached the target group 91.6% (as defined in IS-1554, 2008)
- stabilized users (large reduction in fracture treatment)
- established / reestablished 40% of users into ordinary services
- 18.3% reduction in admissions
- reduced the number days of hospitalization from 24 months before to 24 months after by 54,5%
- given all the 62,3% with addiction problems treatment offerings
- decreased the reported criminality by approximately 40%
- had a sustainable project organization
- widespreadly affected the ordinary services practice

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The C-Flex model?

- The C-Flex is focusing on the framework prerequisites;

- Local problem identification gives the guidelines for the needs
- Admission criteria
- Team organization(with fragment positions)
- Staff from the existing services (with good knowledge to the service systems)
- Assertive outreach practice
- Focusing on contact / relation
- Focus on stabilization (covering primary needs, distribution of responsibility and collaboration about direction in each case)
- Always (when possible) one from the municipality and one from the specialist health or addiction services working together (optionally supplementing the expertise already involved)
- “Open hour” to discuss cases without direction
- Economic sustainability i.e. no additional costs in the transition to an ordinary service
- Dividing cases into levels of effort

- The risk of confusion of the objectives related to the fidelity scale on one hand and the target for therapy rises with the system requirements in the model implemented

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When both primary and secondary mental health and addiction services are sitting around the same table the chance of filling the needs of "all at the same time" is quite bigger than if not

C-Flex - It´s a question of culture change

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From january 2015 the C-Flex team is an ordinary service offering in Baerum ☺

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