Elmore's Assistant Team Therapists

An evaluation of a Mentalization-based therapy (MBT) pilot project in Buckinghamshire and Oxfordshire, delivered collaboratively by Elmore and Complex Needs Service.

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Elmore / CNS collaborative pilot scheme for MBT programme

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Foreword

Elmore is proud of our partnership with Complex Needs Service to reduce waiting lists and increase the support available to people on a speedier basis. The project achieved its aim, freeing up CNS clinician time and demonstrating that Assistant Team Therapists (ATTs) could be recruited speedily, trained to run MBT group sessions, and able to take on most administrative tasks. The project has ended, having achieved what it set out to do, but the impacts will be felt for a very long time indeed.

It is testament to the skills and experiences of Elmore's wonderful ATTs and their approach to embedded practice that this pilot delivered more than envisaged and added greater value. Both CNS and Elmore team members benefited from a knowledge and skills transfer and managers learned more about the operational and legal side of running projects that span organisations.

Where patient wellbeing and satisfaction data has been collected, the groups clearly had a positive effect on patients. We must be cautious about drawing many conclusions from available evidence, but clearly improvement was achieved, on average, for all wellbeing measures and client satisfaction increased too.

There are important learnings from this joint project and study. We hope to see some of them shape the future of healthcare across the Thames Valley in the near future.

Tom Hayes

Chief Executive of Elmore Community Services

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1 Introduction

1.1 Complex Needs Service

The Complex Needs Service (CNS) is the tier three (specialist community) personality disorder service for Buckinghamshire and Oxfordshire. Approximately 95% of referrals will meet diagnostic criteria for personality disorder. All treatment occurs in groups and CNS does not offer any one-to-one treatment.

The service acknowledges that its users might have encountered abuse, neglect, trauma, or loss, often during their childhood and that they may struggle with self-worth and establishing fulfilling relationships. The goal of the service is to empower people to assume full responsibility for themselves while remaining considerate of their interactions with others.

CNS can only provide treatment for patients registered with GP practices who are members of either to Oxford Clinical Commissioning Group or the Buckinghamshire Clinical Commissioning Group. The Oxfordshire service is for adults of working age, whilst the Buckinghamshire service also provides services for older adults.

The Complex Needs Service provides a range of group therapy treatments running between 2 to 15 hours a week. CNS provides a locality-based service in Abingdon, Adderbury (near Banbury), Aylesbury, High Wycombe, Oxford and Witney. There are also support groups for family and friends in both Aylesbury and Oxford.

1.1.1 Why groups?

Current evidence points to interventions involving groups being most effective in personality disorder. Many of the people referred to Complex Needs Service have received individual therapy, sometimes over several years, without substantial effect.

1.2 Elmore Community Services

Elmore Community Services was founded in 1989 to support over 100 Oxford citizens who were deemed “difficult to place”, living on the margins of society, and in need of support. The founding principle of the Charity is to provide support to clients with a wide range of complex needs, many of whom are falling between the gaps of existing services.

More than three decades on, Elmore has expanded its client base and the range of services it offers, continues to find innovative ways to build trust, increase clients’ engagement with relevant agencies and deliver life-changing support, tailored to the people who depend on it. Since 1989, Elmore has helped to improve the lives of nearly 2,300 people in Oxford and the surrounding areas.

1.3 Mentalization Based Therapy

Mentalization-based therapy (MBT) is a type of long-term psychotherapy. Mentalization is the ability to think about thinking. It helps to make sense of our thoughts, beliefs, wishes and feelings and to link these to our actions and behaviours. Mentalization is a normal capacity that we all use in everyday life (1).

Mentalization-based therapy (MBT) is a type of psychotherapy developed for individuals with borderline personality disorder (BPD). However, its usefulness has been seen in treating other mental health disorders as well. The primary focus of this approach is on mentalizing, a concept which refers to the ability to understand the mental state, both of oneself and others, that underlies overt behaviour.

Mentalizing is a cognitive capacity that is typically developed during childhood, through relationships and interactions with caregivers. It involves understanding that others have thoughts, feelings, beliefs, desires,

and intentions that might be different from one's own, and it's crucial for effective interpersonal interactions and maintaining a positive and coherent sense of self.

MBT aims to enhance the capacity for mentalization, especially in emotionally charged situations. It works by helping individuals explore their own mental states and those of others, to improve their understanding of interpersonal interactions and to reduce symptoms.

The therapist's role in MBT is to create a safe, non-judgmental environment to explore mental states and to help the individual question and understand their own perceptions and beliefs. By fostering improved mentalizing ability, it is expected that the person will achieve better emotional regulation, increased stability in relationships, and reduced self-destructive behaviours.

1.4 CNS – Elmore MBT pilot programme

In a first for CNS, CNS and Elmore piloted a project whereby Assistant Team Therapists (ATTs) were recruited jointly by both organisations and embedded in the CNS team. The aim was to see if these ATTs could be trained to run MBT sessions, under the guidance of the clinicians at CNS, and perform much of the associated administration. The first ATT was recruited in June 2022, at a time when the need for the MBT programme was heavily outstripping demand, meaning the waiting list was high. By involving Elmore and swiftly recruiting ATTs, the hope was that the waiting list could be reduced, and more patients could receive the intervention they needed.

This pilot scheme ran from June 2022 to February 2024. During this time 8 ATTs were recruited, mainly during June and July of 2023. 4 ATTs were based in Oxford at Manzil Way and 4 in Aylesbury at The Wing Unit, increasing Elmore's geographical reach at that stage. One manager was also recruited in September. The recruitment process involved Gill Attwood from CNS, Adrian Childs from Elmore and a STAR present. A STAR is a Lived Experience Trainer, who has been through the Complex Needs with intense therapy. For a STAR to be able to facilitate MBT they will have had to been with STARS for at least 6 months and facilitated other trainings with TVI (Training Vocational Initiative) and had MBT training.

The primary aim of contract was to support the work of CNS, to reduce waiting lists and increase capacity, with a focus on the delivery of the Mentalisation Based Therapy (MBT) groups. During the contract, opportunities arose for the ATTs to support the facilitation of other therapeutic groups, including, Skills for Change and Therapeutic Communities, resulting in increased capacity and competencies and a better understanding of the capabilities of the ATTs and their expansive skills. The ATTs were also tasked with reintroducing the information sessions for clients, supported the screening process and assisted in reducing the waiting time for assessments. Furthermore, some ATTs were also involved in running the Friends and Family Group.

2 Findings

2.1 Summary

In the initial round of the MBT group programme, the ATTs predominantly shadowed the sessions. During the second round their confidence had increased, leading them to take on active roles as facilitators. By the third round, the new ATTs were able to independently conduct sessions, with pre and post session briefings from the clinicians. Additionally, throughout all interventions, the ATTs efficiently handled the bulk of the associated administrative tasks. This meant less clinician time was needed to run these programmes; therefore, more sessions could be offered, and the waiting list was reduced.

During the contract 6 ATTs were involved in the facilitation of 3 Skills for Change therapy groups and 2 Therapeutic Communities, 6 ATTs facilitated information sessions. All 8 ATTs assisted in triage and the screening process. A backlog had been created by an external care notes issue and the team worked flexibly and responsively with CNS colleagues to resolve the matter. This approach created increased capacity within CNS, opportunities for cross-fertilisation of knowledge and skills and provided the ATTs with a broader experience than originally envisaged.

Between May 2022 and December 2023, 9 online MBT sessions and 5 face-to-face sessions ran. Without the ATTs only 3 online sessions and 2 face-to-face sessions could have been run. Had there been funding to continue the employment of all ATTs in this role, this rate of MBT sessions could have continued. Instead, CNS are currently finding it challenging to set up MBT groups, due to impact of losing most of the ATTs, combined with clinician time being taken up with increased assessments.

Another advantage of this pilot scheme included increasing the skill set and confidence of the ATTs and their awareness of career opportunities within CNS and Elmore. The involvement of Elmore staff also allowed for the information sessions to be re-established within CNS. The information sessions were previously held prior to the covid-19 lockdown but, due to commitments of staff, CNS was unable to continue to facilitate these. They are 1.5-hour group sessions where 20 people are invited to the session. Two ATTs would facilitate the information session together with two STARs. CNS felt it was important for the information sessions to be re-established, due to the amount of people who were on both the Buckinghamshire and Oxfordshire assessment waiting list. They allowed these individuals to have a first connection with CNS.

The main challenge was the speed of the recruitment required to get the pilot scheme up and running in time, due to funding constraints. This had the effect, initially, of adding to the workload of the CNS team as the ATTs came onboard. Other technical challenges arose that were out of the control of both Elmore and CNS.

2.2 What worked well

Three ATTs were ex-service users of CNS, so they brought a unique perspective to the work through their lived experience of personality disorders and group therapy, offering insight and perspective rarely gained through traditional routes of entry to employment. Training and recruiting ex-service users, adds to the skilled workforce in this under resourced area. Many members of the team recruited by Elmore and CNS came with skills and expertise which exceeded expectations and were able to run MBT sessions independently.

It took a lot of mutual trust to work so closely together, and close links between the organisations, forged over many years, enabled CNS to feel confident working so closely with Elmore. The two organisations have a similar ethos which also helped them work together so efficiently.

The collaboration led to knowledge-sharing for the benefit of both service users and staff. For example, two ATTs from this pilot scheme have applied and been awarded clinical jobs in CNS and six ATTs have moved into roles within Elmore, thanks to the cross-fertilisation occurring as a result of this collaboration. Also, much was learned within CNS about subcontracting work; including aspects of employment law, performing necessary checks on interview candidates and induction, line management and supervision of embedded staff members. Staff members from Elmore who became ATTs also brought with them a wealth of knowledge around areas such as housing, benefits and local services. This proved helpful to a number of service users during the pilot scheme. CNS may not have been able to provide support in these areas had there been no pilot.

2.3 What challenges had to be overcome

As with any new project, there were challenges in the early days which should be acknowledged to better design future programmes. The start of this collaboration required a swift initiation, resulting in limited input from clinicians in the recruitment decisions, possibly not aligning with their desired level of involvement and creating frustrations in the CNS team. The necessarily tight timescale meant that when the ATTs initially began working within the CNS team, they were without a direct line manager at Elmore, this resulted in extra time pressure on some members of the existing team. Thankfully, in time, the value of the ATTs became clear, and people embraced the partnership. Whilst it's acknowledged that the interview process could have involved more of the CNS team, considering the time pressure, the interview process was deemed the best that was possible within the constraints.

Elmore staff needed honorary NHS contracts to access electronic health records of patients. This proved problematic due to the ATTs being employed by Elmore, rather than CNS, and meant processes, such as gathering risk information and finding contact details, were slowed. It is hoped that this process could be streamlined in the future by setting the process up prior to ATTs starting, such that they can hit the ground running when in post.

There were some challenges that were outside the control of both CNS and Elmore, namely, the electronic health records system, called care notes, was unavailable from August 2022 to December 2022, due to a cyber-attack. This meant that no-one in Elmore or CNS could access the clients' records. In December 2022, CNS made the decision to change to an alternative electronic health records system, called Rio, but the ATTs hadn't been trained on this system, so found it initially problematic to use. The effect of these technical challenges was mitigated by getting information from other sources, which was time consuming and added to the stress and workload of this pilot. This challenge was dealt with well and is unlikely to be a problem in the future. Had the system been working, it was considered straightforward for embedded Elmore workers to obtain access to the system and to receive training, pending they had honorary NHS contracts.

There were significant challenges with collecting questionnaire data which was used to assess patients' wellbeing and satisfaction and consequently, to evaluate the impact of the MBT groups. The ability to collect the measures data using POD is highly dependent on a patient's ability and willingness to complete the questionnaires. Links were sent, usually via email, to the patient, along with a username and password. This allowed the patient to complete these measures online. Staff resource for following up these patients, until they have completed these measures, was also lacking. The reason being that the main focus of Clinicians and ATTs is the effective delivery of group therapy and tangible therapeutic outcomes/ move-ons for service users.

2.4 Anecdotal findings

2.4.1 ATT, CNS and Elmore manager feedback

Some workers cited that there was a disparity between the induction processes of the ATTs, depending on when they were hired. This added stress, on top of the ATTs workload, as there were times they were

unclear of certain processes. However, fortunately they all got inducted on different parts of the system, so were able to help each other by sharing information, although this did slow the processes.

Members of the CNS team felt that the timescale of recruitment of ATTs felt hurried and contributed to them feeling stressed. They suggest a more phased recruitment in future, with more involvement of the CNS team early on in the decision making and the recruitment process. It was also thought that the process would have gone more smoothly if Elmore had had a dedicated manager for this project from the outset. However, the manager was recruited later on than the majority of the ATTs, and there were some managerial difficulties as she was not as embedded into CNS as the ATTs. This individual could have monitored inductions and had discussions about the expectations of CNS in terms of the involvement and contributions of the ATTs.

Some ATTs, who were recruited slightly later, felt like they had missed parts of the induction and that there wasn't space for them to join sessions that they needed to observe, because the team was already feeling overwhelmed by inducting the ATTs hired previously. It was also thought that the roles and expectations of the ATTs could have been made clearer from the outset. Some ATTs also missed training, due to being hired slightly later, which would have benefited them significantly in their post.

Obtaining an honorary contract from the NHS was problematic and in fact still not forthcoming. This meant that the ATTs couldn't get access to a lot of systems within the service that would have been hugely helpful. This was considered "not for the want of trying" on the part of the CNS team.

Where there was capacity in CNS to support the ATTs during their induction, training and stages of development this was deemed helpful, supportive and conducive to the development of therapeutic competencies. A more planned approach to a buddy system could have developed self-confidence and agency across the team potentially leading to greater impact.

The general consensus amongst ATTs and managers is that this pilot scheme was really starting to bear fruit, and relationships were being forged between the ATTs and the CNS members, and that the collaboration is ending too early. ATTs refer to the pilot as enabling them to "bridge the gap" between Elmore and CNS.

The ATTs came to help CNS in a crisis situation, for the most part around the MBT waiting list. The consensus is that MBT is now in a better position, by a long way, than it was before Elmore became involved. Despite the challenges that have arisen, and the struggles that have been overcome, as a team and as individuals, Elmore has done an amazing amount of work to help the CNS team.

The ATTs, the CNS team and the Elmore managers have all developed relationships, skills and competencies that they wouldn't have had before being part of this contract.

2.5 Quantitative findings - Impact on waiting list

Referrals are received into CNS at an average rate of about 50 and 35 per month for Oxfordshire and Buckinghamshire respectively. It is estimated that about 90% of these referrals end up on the MBT waiting list, once they have been assessed by clinicians.

From the beginning of 2022, the waiting list for MBT group sessions was high for both Oxfordshire and Buckinghamshire. When the ATTs were recruited, throughout June and July 2022, they were able to call people on the waiting list and get them assigned to MBT sessions. This manifested as a drop in the number on the waiting list between July and August and again between August and September. Over both sites, the number on the waiting list for face-to-face sessions dropped by 77, or 50%, from 155 to 78. Over both sites, the number on the waiting list for online sessions dropped by 34, or 45%, from 75 to 41. A further drop was observed in January / February 2023, when more MBT groups were available because the ATTs could run them, with input from the clinicians in CNS. This led to the lowest waiting list figures for years,

with only 87 people on the MBT waiting list for Oxfordshire and Buckinghamshire combined. This is compared with an average of about 220 in the months before the recruitment of the ATTs. See Figure 1, Figure 2 and Figure 3 showing numbers of patients on the MBT waiting list for Buckinghamshire, Oxfordshire and both combined, respectively.

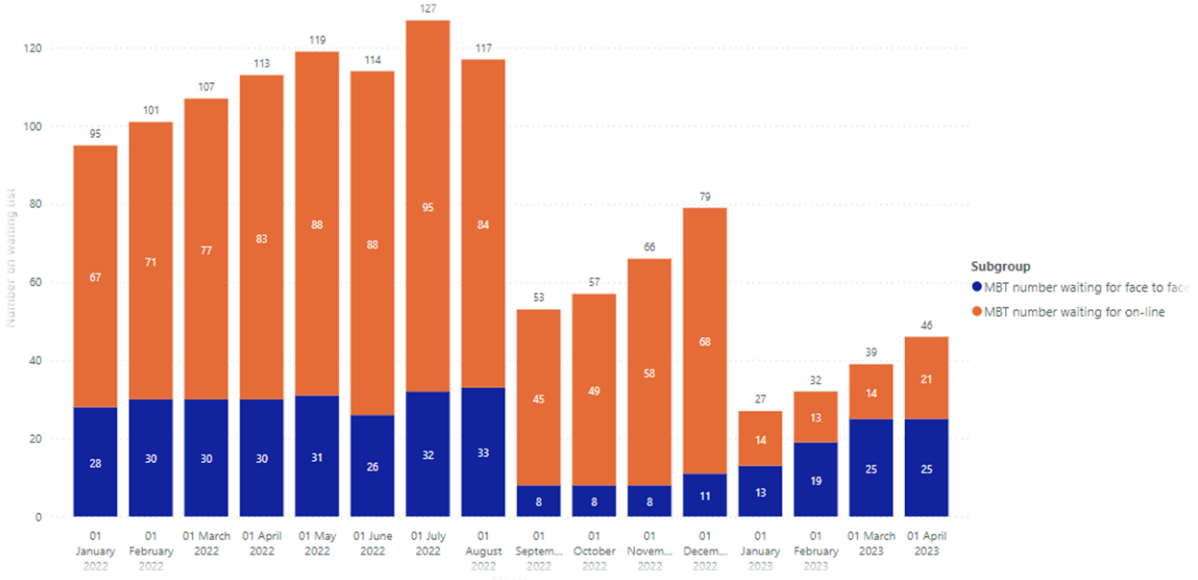


Figure 1 Number of patients on MBT waiting list by month - Buckinghamshire.

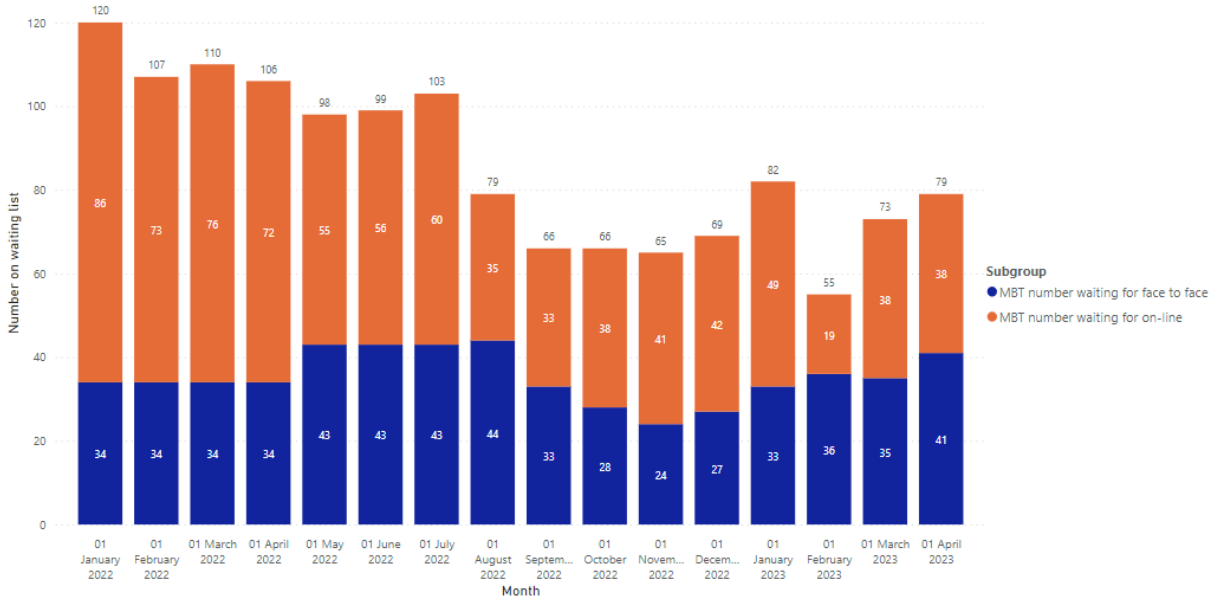


Figure 2 Number of patients on MBT waiting list by month - Oxfordshire.

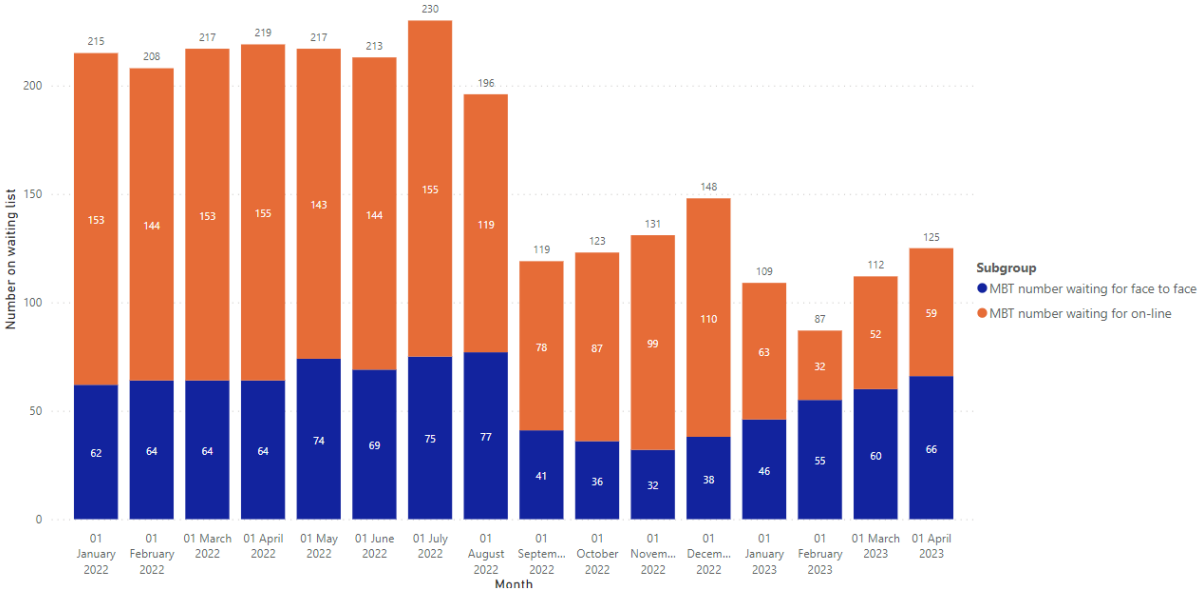


Figure 3 Number of patients on MBT waiting list by month - Oxfordshire and Buckinghamshire combined.

2.6 Quantitative findings - Wellbeing and satisfactions measures impact analysis

2.6.1 Measures used in CNS

The following wellbeing and satisfaction measures are used by CNS to understand more about the patients they are supporting and to assess the impact of the MBT groups. The aim is to ensure that the questionnaires are filled in near the start and end of the MBT groups:

- The Maclean instrument for borderline personality disorder (BPD) is a 10-item questionnaire, where each item is rated 1 if present and 0 if absent. Hence the maximum possible score is 10 and a score of 7 or higher is considered indicative of diagnosable BPD (2).

- The General Health Questionnaire (GHQ-12) is a mental health instrument used to access a patient's level of psychological distress and their current well-being. The questionnaire has 12 items about how challenging a patient is finding many aspects of life e.g. sleep, making decisions, feeling confident etc. The scores for each item range from 0 to 3, depending on how much it is affecting the patient's life, relative to usual level. Hence, the maximum possible score is 36. The higher a patient's score, the more likely they are to be experiencing psychological distress (3).

- The Social Functioning Questionnaire (SFQ) assesses how well individuals are relating to people both at home and in work. It is an 8-item questionnaire with each question being scored from 0 to 3. Hence the maximum possible score is 24. The higher the score, the more challenging the patient is finding it to function socially (4).

- The Client Satisfaction Questionnaire (CSQ-8) is used for feedback on a service. It has 8 items, each with a possible score of 1 to 4, hence the maximum possible score is 32. The higher the score, the more satisfied the client/patient was with the service (5).

2.6.2 Analysis methodology for measures data

Measures data for MacLean BPD, GHQ-12, SFQ and CSQ-8 have been analysed for all MBT participants who have these scores reported on CNS' POD 6 database. For the score to be included in this analysis, the measure must be close to the start and/or end date of the MBT group. Criteria, based on date, have been established with CNS:

- To be classed as near start date, the measure must have been recorded >= 100 days before MBT start date and <= 20 days after.
- To be classed as near end date, the measure must have been recorded >= 20 days before MBT end date and <= 100 days after.

Measures can be taken in the assessment period, before the MBT commences, or just on or after the start of the MBT group. At the end of the group, patients are encouraged to complete the questionnaires shortly before the group is due to finish and also prompted to do so at follow-up, after the group has ended. Hence, the criteria above aim to capture most of the relevant measures, without including ones that are too far from MBT start and end to be used to assess impact of the MBT.

2.6.3 Measures results

2.6.3.1 Summary

125 clients have been supported during the CNS/ Elmore MBT programme, over 14 different MBT groups (see Table 1). Two clients attended two different groups. Earlier sessions always had a CNS clinician present in the group, whilst, as time progressed, there were examples of ATT only MBT groups.

Table 1 CNS/Elmore MBT group details

Clinicians (CNS)	ATTs (Elmore)	Start Date	End Date	Category	CNS clinician in MBT	Number of Patients
JW, LF		31 May 2022	16 August 2022	F2F Oxford	1	5
JT, MA		09 June 2022	25 August 2022	Bucks Online	1	11
KA, SW	ZJ	13 June 2022	15 September 2022	Bucks Online	1	7
SL	KS	19 August 2022	04 November 2022	Oxford Online	1	10
JW, LF	MH, SC	20 September 2022	16 December 2022	F2F Oxford	1	5
JW	MH, KS	17 January 2023	11 April 2023	F2F Oxford	1	6
MA	SC, GL	09 February 2023	27 April 2023	Bucks Online	1	9
HC	MH, JH	20 February 2023	25 May 2023	Oxford Online	1	12
	AI, ZJ	21 February 2023	09 May 2023	Bucks Online	0	12
CC-S	GL, CL	24 February 2023	19 May 2023	F2F Bucks	1	9
	KS, JH	24 February 2023	19 May 2023	Oxford Online	0	8
	MH, CL	30 August 2023	01 December 2023	Oxford Online	0	14
JT	GL	06 October 2023	15 December 2023	Bucks Online	1	8
MA	AI	06 October 2023	16 December 2023	F2F Bucks	1	11
Total					**0**	**125**

34 (27%) patients attended MBT groups run by ATTs alone, sparing CNS clinician time. Seeing as this programme was only able to run for a short time, this implies that the ATTs were trained quickly and efficiently (see Figure 4).

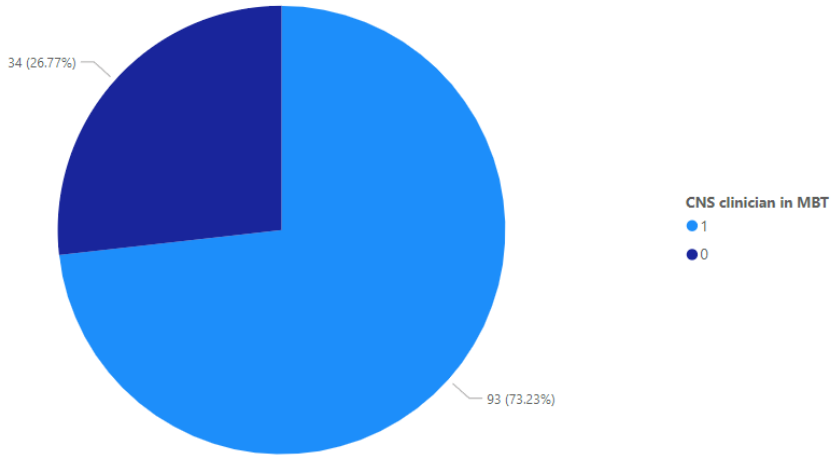


Figure 4 % of clients in groups with/without CNS clinicians in attendance.

MBT groups fell into the following categories:

- Buckinghamshire online
- Oxfordshire online
- Buckinghamshire face-to-face
- Oxfordshire face-to-face

Which category individual patients were allocated to was dependent on their location and personal circumstances, for example some participants were allocated to face-to-face MBT groups because of digital poverty or may have had online MBT already, and were subsequently recommended for face-to-face groups. Individuals were not only categorized based on their geographical location and personal circumstances, but the decision-making process also factored in the imperative requirements of the service, such as room booking space. These decisions were made on a case-by-case basis.

By category, most of the patients were online (71% split almost equally between Oxfordshire and Buckinghamshire), 16 % of patients were face-to-face patients in Buckinghamshire and 13% were face-to-face in Oxfordshire (see Figure 5).

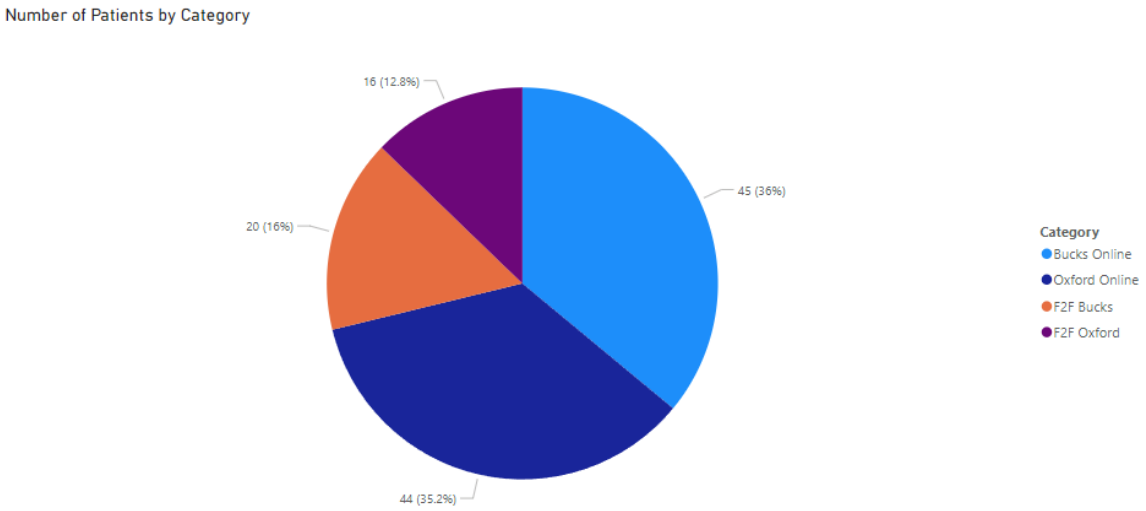


Figure 5 Number of MBT patients in each category.

2.6.3.2 Measure mean scores

For measures near the start of the MBT group, the mean scores are shown in Table 2. The range is wide for all measures, showing a large variation in patient wellbeing and satisfaction. Patients may have more than one measure record that falls into this start window, in which case they are both included. On average, patients came to the MBT programme with the following categories for well-being measures:

- GHQ -12 – In the middle of the range for probable psychological disturbance or mental ill health at 24.5 (range: 12 – 36)
- MacLean BPD – above the cut-off for BPD at 8.0 (range: 7 - 10)
- SFQ – well into the range for poor social functioning at 15.7 (range: 10 - 24)

Table 2 Mean measure scores for records recorded near MBT group start date.

Measures Near Start of MBT Group

MeasureName	No. Patients	No. Measures	Mean Total Score	Min Total Score	Max Total Score	Min Possible Score	Max Possible Score
CSQ-8 (CCOTC)	42	42	19.90	8	31	8	32
GHQ-12	50	51	24.47	8	36	0	36
MacLean BPD	49	50	8.02	3	10	0	10
SFQ	49	50	15.72	8	24	0	24

For measures near the end of the MBT group, the mean scores are shown in Table 3. The range is wide for all measures, showing a large variation in patient wellbeing and satisfaction. Patients may have more than one measure record that falls into this end window, in which case they are both included. On average, patients leave the MBT programme with the following categories for well-being measures:

- GHQ -12 – not far into the range for probable psychological disturbance or mental ill health at 15.4 (range: 12 – 36)
- MacLean BPD – just below the cut-off for BPD, where further evaluation for BPD is recommended, at 6.9 (range: 5 - 7)
- SFQ – into the range for poor social functioning at 13.0 (range: 10 - 24)

Table 3 Mean measure scores for records recorded near MBT group end date.

Measures Near End of MBT Group

MeasureName	No. Patients	No. Measures	Mean Total Score	Min Total Score	Max Total Score	Min Possible Score	Max Possible Score
CSQ-8 (CCOTC)	10	12	24.83	17	31	8	32
GHQ-12	10	12	15.42	1	30	0	36
MacLean BPD	10	12	6.92	0	10	0	10
SFQ	10	12	13.00	4	23	0	24

Fewer patients have measures recorded near to the end of their MBT group, than near to the start (50 vs 10). On average, scores have decreased for all wellbeing measures, which is a positive outcome. The client satisfaction scores increased on average, which is a positive outcome. However, caution should be taken comparing these two samples, as many of them only have a measure for near start and therefore we are extrapolating from the end measures, which is error prone.

2.6.3.3 Measure score comparison

To understand if scores have improved, as a result of the MBT programme, patients with scores recorded both near start and near end date measures need to be compared. Unfortunately, only 6 patients met this criterion. The results for this sub-set are displayed in this section but the small sample size means that only cautious conclusions can be drawn.

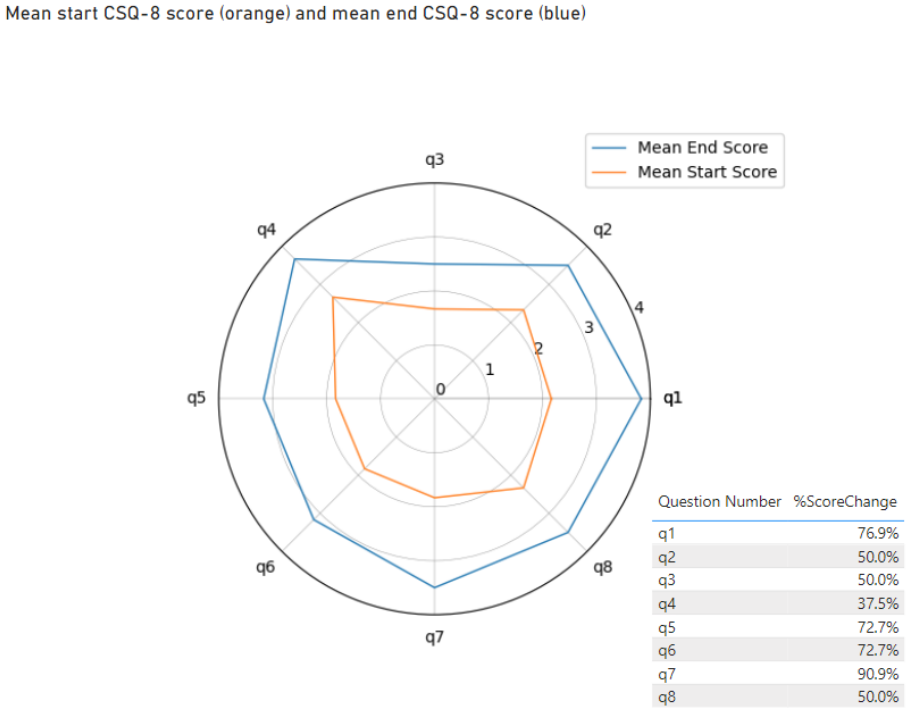
There were significant challenges with collecting questionnaire data, used to assess patients' wellbeing and satisfaction and hence the impact of the MBT groups. The ability to collect the measures data using POD is highly dependent on a patient's ability and willingness to complete the questionnaires and the availability of sufficient staffing resource to follow-up when data is incomplete.

CSQ-8 Measure

Mean client satisfaction (CSQ-8) has increased, on average, by 63% from pre to post MBT group, from a mean total score of 16.7 to a mean of 26.8.

Improvements were seen in every question answered (see Figure 6). The largest percentage improvement, 91%, was seen in question "In an overall, general sense, how satisfied are you with the service you received?" which essentially sums up client satisfaction. This means the responses from this question went from "quite dissatisfied - indifferent or mildly satisfied" to "mostly - very satisfied".

For the subset of patients in this analysis, client satisfaction increased substantially from pre to post MBT group.



Question Number	%ScoreChange
q1	76.9%
q2	50.0%
q3	50.0%
q4	37.5%
q5	72.7%
q6	72.7%
q7	90.9%
q8	50.0%

Figure 6 Mean per question scores for CSQ-8 measure for subset of 6 patients which had these recorded near the start and the end of their MBT group.

GHQ-12 Measure

Mean general health questionnaire scores (GHQ-12) have decreased, on average, by 63% from pre to post MBT group, from a mean total score of 23.7 to a mean of 8.8. This is a dramatic positive change in health and wellbeing, as the higher a patient's score, the more likely they are to be experiencing psychological distress. The mean score has gone from "probable psychological disturbance or mental ill health" to the "normal range".

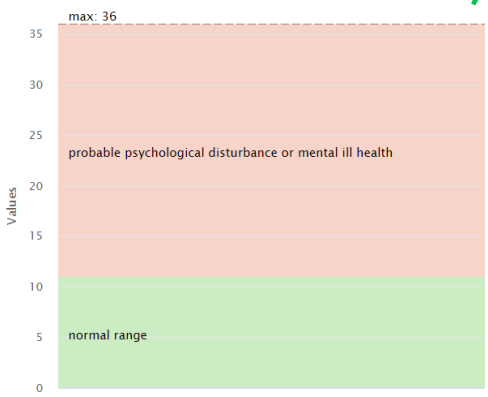


Figure 7 GHQ-12 score range.

Improvements were seen in every question answered (see Figure 8). The largest percentage improvement, 82%, was seen in question "Felt you were playing a useful part in things?". This means the responses, on average, went from near "less useful than usual" to close to "more so than usual".

For the subset of patients in this analysis, patient wellbeing increased substantially from pre to post MBT group.

Mean start GHQ score (orange) and mean end GHQ score (blue)

Question No	%ScoreChange
1	-60.0%
2	-69.2%
3	-81.8%
4	-63.6%
5	-53.3%
6	-63.6%
7	-40.0%
8	-66.7%
9	-53.8%
10	-76.9%
11	-70.0%
12	-53.8%

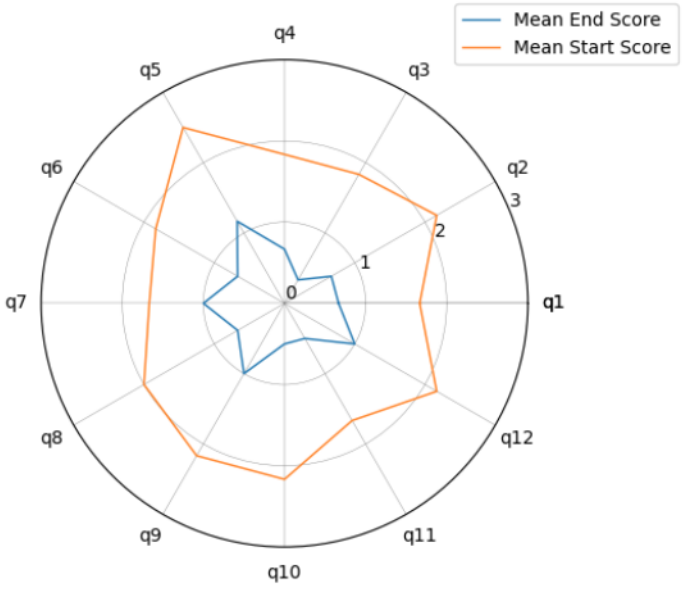


Figure 8 Mean per question scores for GHQ-12 measure for subset of 6 patients which had these recorded near the start and the end of their MBT group

MacLean BPD Measure

Mean MacLean BPD scores have decreased, on average, from a mean total score of 7.2 to a mean of 5.8. The scoring of the MacLean score is 0 if the item is absent, and 1 if present. Hence, on average, patients had fewer indicators of BPD post MBT group. This means the mean score has moved from just above the "cut off for borderline personality disorder" to in the middle of the "further evaluation for BPD is recommended".

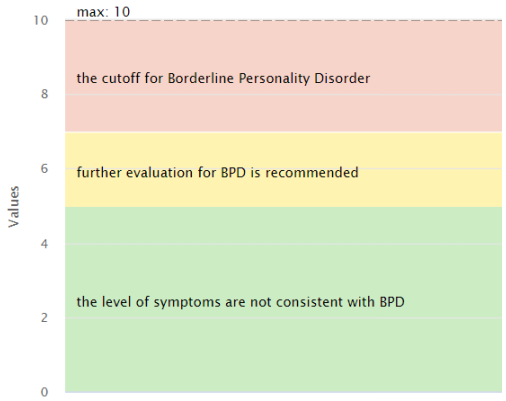


Figure 9 MacLean BPD score range.

Improvements were seen in 7 out of the 10 items (see Figure 10). The 3 questions that didn't see improvements stayed the same mean value, hence the mean scores did not get worse for any item on the questionnaire.

Mean start MacLean BPD score (orange) and mean end MacLean BPD score (blue)

Question No	%ScoreChange
1	-25.0%
2	-25.0%
3	-20.0%
4	-20.0%
5	0.0%
6	-33.3%
7	-25.0%
8	0.0%
9	0.0%
10	-33.3%

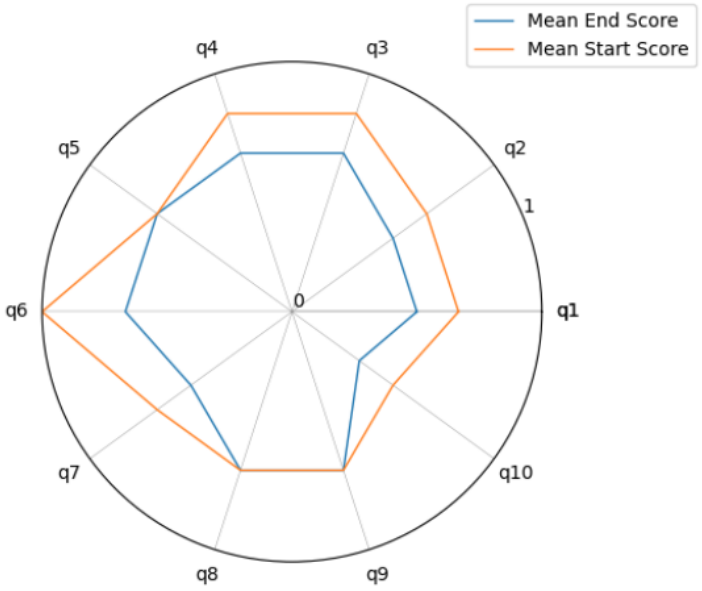


Figure 10 Mean per question scores for MacLean BPD measure for subset of 6 patients which had these recorded near the start and the end of their MBT group.

SFQ Measure:

Mean social functioning questionnaire scores (SFQ) have decreased, on average, by 28% from pre to post MBT group, from a mean total score of 14.5 to a mean of 10.3. This is a positive change in social functioning as the higher the score, the more challenging the patient is finding it to function socially. This takes the mean value from "possible poor social functioning" to almost the "normal range".

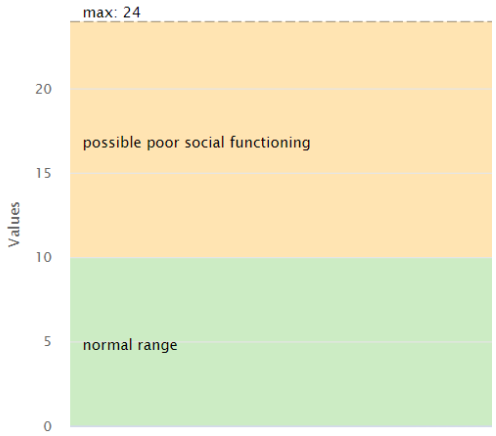


Figure 11 SFQ score range.

Improvements were seen in 7 out of the 8 items (see Figure 12). The 1 question that didn't see an improvement stayed the same mean value, hence the mean scores did not get worse for any item on the questionnaire. For the subset of patients in this analysis, patient social functioning increased from pre to post MBT group.

Mean start SFQ score (orange) and mean end SFQ score (blue)

Question No	%ScoreChange
1	-55.6%
2	-20.0%
3	-9.1%
4	-38.5%
5	-20.0%
6	0.0%
7	-37.5%
8	-40.0%

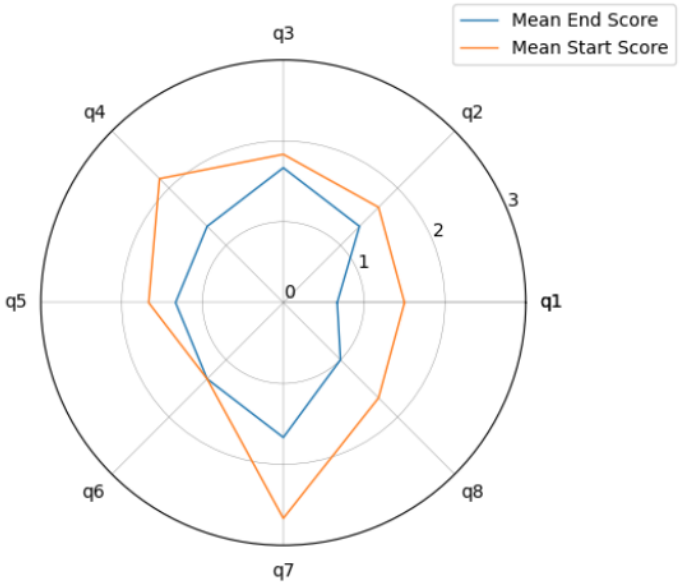


Figure 12 Mean per question scores for SFQ measure for subset of 6 patients which had these recorded near the start and the end of their MBT group.

3 Business case

Before the involvement of Elmore ATTs, clinicians were needed for a 30 min pre-brief, followed by a group MBT meeting from 10:30 to 12:30 and then from 12:30 to 1:00 for the debrief. This pilot has shown that ATTs can be quickly trained to run MBT groups themselves, with clinician input for about 30 mins during debrief. This allows more MBT groups to be run at a lower cost.

We have estimated the potential cost savings of Elmore ATTs running MBT groups using the following assumptions:

Each MBT group would require 2 workers, each spending their time doing the following:

- About an hour admin per patient to enrol
- 12 X 2 hour MBT sessions per group
- 12 x 0.5 hour pre-brief per group
- 12 x 0.5 hour de-brief per group
- 1 hour for review per patient
- 2 hours for summaries per patient
- 12 x 1 hour of group supervision

A factor of 1.5 has been added to all these times to account for travel, set-up and put away time etc.

There would still need to be modest clinician input, maybe 1 clinician for 15 mins at pre and de-brief and would still need to spend about an hour on each patient's gatekeeping.

The clinicians are either band 6 or 7 and have an average fulltime salary currently of about £41,600. ATTs salary at present is about £28,900.

If we model the case where there are no ATTs, so that clinicians do all the tasks listed above, the estimated cost is about £585 for the clinician to perform the MBT group (12 sessions), per patient. This is solely including the cost of clinician time when actively engaged in MBT work. If ATTs performed most of the MBT related tasks, with limited involvement from clinicians, then the combined cost of ATT and clinician time is estimated to be about £430 per patient. This is a cost saving of 27%. For an average MBT group of 9 patients this would save about £1400 per group.

4 Conclusions

In conclusion, the Elmore-CNS pilot scheme was very successful. It demonstrated that ATTs can be trained to run MBT group sessions, in a short space of time, and take on most of the administrative tasks. This had the effect of clearing more patients from the waiting list, than would otherwise have been possible, and freeing up CNS clinician time. It is testament to the skills, experience and competencies of the ATT team, and their approach to embedded practice, that this contract delivered more than was originally envisaged and added greater value to the contract. Both CNS and Elmore staff benefited from the knowledge and skills transfer that occurred and managers learned more about the operational and legal side of running projects that span organisations.

Where patient well-being and satisfaction data was collected, the results showed the MBT groups to have a positive effect on patients. Improvement was shown, on average, for all 3 well-being measures and, on average, client satisfaction increased. However, due to the lack of available statistics, only cautions conclusions can be drawn from this data.

As with all pilot schemes, challenges were encountered along the way. The main ones are listed here, along with some possible solutions:

- Frustrations and stress caused by the speed of the hiring of ATTs. Possible solution: more transparency, time and consultation during the hiring process for future projects.
- Difficulties acquiring Elmore staff NHS contacts. Possible solution: CNS are already looking into ways to expediate this process for possible future projects.
- Software outages making patients' data acquisition more challenging and time consuming. Possible solution: this was a temporary issue with an external software provider and is not expected to affect future projects.
- Challenges with the ATT manager being recruited so late in the contract. Possible solution: Recruit and train earlier in the process.
- Challenges in collecting patient well-being and satisfaction scores via POD. Possible solutions:
    - Check patients are receiving links and can log on to POD.
    - More staffing resource to follow-up.

Main successes of the pilot scheme:

- During the project there were more MBT therapy groups offered, and the waiting list was significantly reduced, meeting the overall project's aim.
- The partnership approach between CNS and Elmore was strengthened, enabling CNS to gain confidence in working with Elmore.
- ATTs ran MBT groups which led to increased capacity within CNS, enabling clinicians to focus on completion of assessments and screening.
- The project enabled opportunities for cross-fertilisation of knowledge and skills, and provided the ATTs with a broader experience than originally envisaged.
- Ex-CNS service users were recruited into ATT roles and brought a unique perspective to the work through their lived experience of personality disorders and group therapy, offering insight and perspective rarely gained through traditional routes of entry to employment.
- The collaboration led to knowledge-sharing for the benefit of both service users and staff.
- Two ATTs have gained clinical roles in CNS and six ATTs are in Elmore roles, thanks to the cross-fertilisation of skills, knowledge and experience gained as a result of the collaboration.

5 References

1. **Tavistock and Portman NHS.** MBT. [Online] https://tavistockandportman.nhs.uk/care-and-treatment/treatments/mentalisation-based-therapy/#:~:text=Mentalization%2Dbased%20therapy%20(MBT)%20is%20a%20type%20of%20long,all%20use%20in%20everyday%20life..

2. **Salters-Pedneault, Kristalyn.** McLean Screening Instrument for Borderline Personality Disorder. *https://www.verywellmind.com/.* [Online] Apr 2023. https://www.verywellmind.com/mclean-screening-instrument-borderline-personality-disorder-425178.

3. **General Health Questionnaire (GHQ-12).** ***https://www.carepatron.com/.*** **[Online] Dec 2023. https://www.carepatron.com/templates/general-health-questionnaire-ghq-12.**

4. Social Functioning Questionnaire. ***https://www.apa.org/.*** **[Online] https://www.apa.org/depression-guideline/social-functioning-questionnaire.pdf.**

5. Client Satisfaction Questionnaire (CSQ-8, v. TMS-180S). ***https://www.recoveryanswers.org/.*** **[Online] 1979. https://www.recoveryanswers.org/assets/csq.pdf.**

6. ***A Screening Measure for BPD: The McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD).*** **Mary C. Zanarini, A. Anna Vujanovic, Elizabeth A. Parachini, Jennifer L. Boulanger, Frances R. Frankenburg and John Hennen. s.l. : https://guilfordjournals.com/doi/10.1521/pedi.17.6.568.25355, 2005.**

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