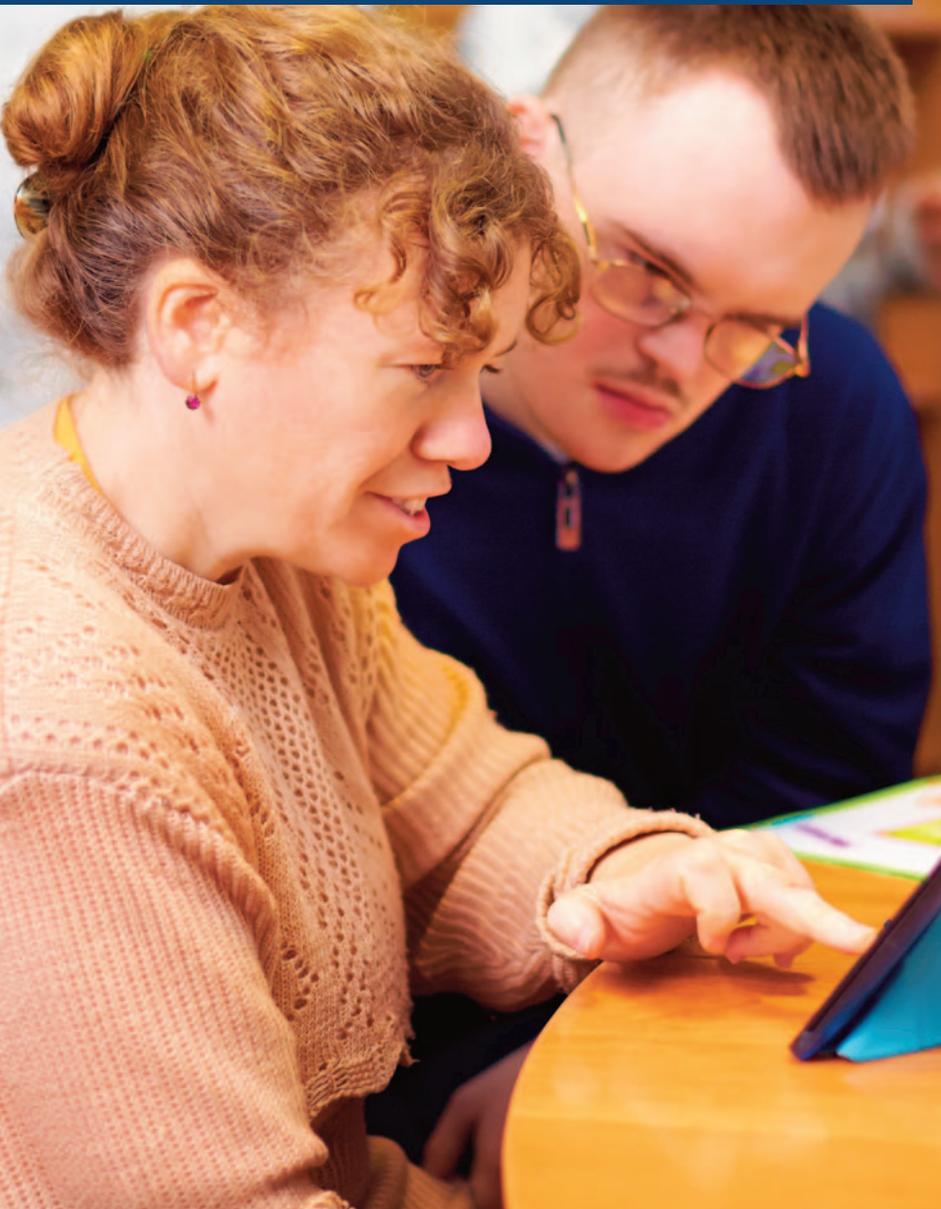


Connecting People Implementation Study



RESEARCH FINDINGS

The implementation of Connecting People did not fully occur and no differences in service user outcomes or costs were found.

Practitioners noted their high caseloads, understaffing and having to prioritise work with people in crisis often meant that there was not capacity to support service users with their social connections.

Community mental health teams (CMHTs) did not sufficiently engage with the local communities of service users to implement Connecting People.

Only a minority of service users said that they had had the implementation materials explained to them, indicating that practitioners did not fully engage with them.

Many participants in both the control and implementation groups reported improvements in their wellbeing over the course of the study from their increased social connections and/or awareness of local opportunities.



BACKGROUND

Loneliness and social isolation are widely recognised as significant problems for people with mental health problems. Community mental health teams (CMHTs) provide community support for people with severe and enduring mental health problems, though few evaluations of practice in CMHTs which improve service users' social connections have been conducted.

Connecting People is strengths-based social care practice (see Box) which assists people to engage more with their communities and enhance their social connections with others (Webber et al. 2016). The programme can improve individuals' access to social capital (the resourcefulness of someone's social network).

The Connecting People pilot study (2011–2014), funded by NIHR SSCR, found that when Connecting People was fully integrated into health and social care teams, service users enhanced their connections to family, friends and members of the local community. However, local authority and NHS teams found it difficult to implement Connecting People fully (Webber et al. 2018).

This study aimed to investigate if Connecting People could be implemented with high fidelity in community mental health teams (CMHTs) and improve outcomes for mental health service users.

CONNECTING PEOPLE

This is a programme that involves a worker:

- exploring an individual's existing connections with them;
- exploring new opportunities for engagement in activities, groups, networks, clubs, societies or resources in the individual's local community;
- developing an action plan and sourcing appropriate support for them to access their community;
- addressing barriers to social and community engagement; and
- reviewing progress towards achieving social goals

See connectingpeople.net for more information.



Methods

The study used implementation and comparison CMHTs teams in five mental health NHS Trusts to evaluate the implementation of Connecting People by practitioners using a pack of high-quality implementation materials – including practice guidance, training manual, service user's guide and implementation manual – co-produced by mental health service users and researchers.

Service users (n=159) were recruited and interviewed at the beginning of the study (n=151) and six-months later (n=127) using structured questions.

They were also asked about their experience of being supported to develop their social connections at the follow-up interview.

Practitioners were asked about their experiences in focus groups within the teams taking part in the study.

FINDINGS

Connecting People was not fully implemented in the community mental health teams (CMHTs) in this study. Full implementation required teams to fully engage with the local communities of service users to support the development of activities, networks and resources for people beyond mental health services. A focus on the mental health needs of those in crisis or highest need meant that community engagement received a lower priority than afforded in the Connecting People model.

As a result, there was no difference in outcomes for service users of practitioners who received the implementation materials and those that did not. The researchers measured their access to social capital (the resourcefulness of their social networks), mental well-being, experience of recovery, goal attainment and self-rated health.

Practitioners who used the Connecting People implementation materials found them helpful in framing or directing some of their work. Some found the tools for mapping people's social connections useful, while others found the intervention provided a useful structure to help people move towards their goals.

COSTS OF IMPLEMENTATION

The researchers also measured the costs of the implementation of Connecting People. They asked service users which services they used in the six months before and after implementation started. The cost of these were calculated using standard pricing tools. They also asked practitioners in the implementation teams about additional activities they undertook to carry out the programme.

They found no difference in cost between the implementation and control groups. On average, care co-ordinators met service users about once a month, with social workers having less frequent contact with them than community psychiatric nurses. There were a limited number of support workers assisting with the implementation of Connecting People in the participating teams. It is possible that more frequent than monthly contact may be required to implement Connecting People, at least in the initial phases of working with individuals.

Connecting People was partially implemented in three of the teams, though only one provided training to their staff in the model. The researchers provided a budget of £1,000 for implementation teams to use for training or consultancy to

support implementation, but there was no evidence that this was used. However, two of the teams offered additional supervision in Connecting People from a manager and a senior social worker.

BARRIERS TO IMPLEMENTATION

Practitioners who found it difficult to implement the model in their practice highlighted that their high caseloads, understaffing, and having to prioritise work with people in crisis often meant that they did not have capacity to support service users with their social connections.

Other barriers to implementing Connecting People included a lack of public transport in some rural and semi-urban areas which made it difficult for service users to engage with community activities. Additionally, in some local communities there were limited affordable resources for people to access.

For service users, barriers included social anxieties and financial constraints. For example, many opportunities for social contact required either payment for the activity or group, or for a coffee, which made them difficult for some people on low incomes to access.



Implementation
manual



Practice
guidance



Training
manual

FINDINGS



The implementation materials were designed to be used by any practitioner within multi-disciplinary CMHTs. In the study they were predominantly used by social workers, occupational therapists and support workers, who were a small proportion of CMHT members, though some community psychiatric nurses were also involved in some teams.

There appeared to be limited organisational support for the implementation of Connecting People. There was a lack of clarity about the model in most sites, due to teams not providing training on the Connecting People model.

There was also the question of whether community mental health teams are the most appropriate settings in which to introduce a model focusing on social connections when those who have most regular contact with mental health professionals are largely too unwell to focus on social connections and those who are well enough tended not to have sufficient contact with practitioners for the model to be implemented. Most of the CMHTs were operating in part as de facto crisis teams and thus practitioners did not have the time, resource or capacity to focus on developing or maintaining people's social connections.

Previous research has found that it can be implemented more fully within third sector organisations such as charities or social enterprises.

SERVICE USER EXPERIENCE

Service users in the implementation and comparison groups made similar comments about their experiences. Participants in both implementation and comparison groups said that they had received support from their practitioner to connect them with other people.

Those in the implementation group did not report receiving substantially different support from those in the comparison group. However, in the implementation team which organised and delivered training in Connecting People, most of the service users reported receiving support with their social connections in contrast to the comparison group in the same NHS Trust where most said that they had no support.

Service users in both groups offered many and varied examples of the types of activities they were supported to engage in, most commonly self-help or some form of therapy, exercise and fitness, education, training, employment, hobbies and skills, and volunteering. The majority of activities took place outside the home and involved making face-to-face connections with new people, usually in an organised setting. Most of the participants felt part of a community, which was variously defined but predominantly focused on the local area in which they lived.

Most of the participants in both groups stated that there had been at least some positive impact on their wellbeing from their increased social connections and/or awareness of opportunities locally. The positive impacts most commonly specified by participants (in both groups) were improvements in mental health, greater confidence and self-esteem, and an improved social life.

LIMITATIONS OF THE STUDY

The study was limited by having a short follow-up period (6 months) and recruitment period which placed pressure on teams who were also trying to implement the model.

CONCLUSIONS & IMPLICATIONS

■ This study demonstrated the challenges with trying to fully implement Connecting People in community mental health teams. The challenges lie with the implementation of it in busy teams which are oriented towards prioritising those experiencing mental health crises rather than those working towards recovery.

■ Social work leadership appears to be important in implementing Connecting People in contexts which are not oriented towards community or social care interventions.

Increasingly employed by the NHS as care co-ordinators, social workers need to consider the extent to which they can use their professional skills within generic roles and implement social interventions. This may require flexibility, a 'can do' attitude and creative thinking to support colleagues to identify opportunities for implementation, each of which are key attributes identified in earlier research as important in Connecting People processes.

There is potentially a role for social work educators and employers to support practitioners to acquire and utilise these attributes, which may assist implementation of Connecting People.

■ Social work practitioners and managers in CMHTs can implement Connecting People with high fidelity. This may require some external support, supervision and encouragement, but there is evidence that it can be achieved (see Webber et al. 2019).

■ Cited as an example of good practice in *The Community Mental Health Framework for Adults and Older Adults* (NCCNM 2019), it will become increasingly important for teams to consider the best way to implement models such as Connecting People.

Perhaps there is an ethical imperative for CMHTs to find ways to implement interventions like Connecting People with high fidelity, if there is evidence that it improves outcomes for mental health service users.

This study highlights key challenges but provides some indications how best to achieve this.

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