

Locality Services in Mental Health

Developing Home Treatment & Assertive Outreach

THE NORTHERN BIRMINGHAM EXPERIENCE

Booklet 4



The Sainsbury Centre

for Mental Health

nb Northern
Birmingham
Mental Health NHS Trust



This is a time of enormous change and great opportunity for mental health care. The message has at last hit home that we need to develop mental health services that offer comprehensive and well integrated care, 24 hours a day, 7 days a week, balancing high quality care for service users with the wider needs of society. The Government's mental health policy emphasises the importance of access, engagement and treatment adherence for people with severe mental health problems. Essential services to achieve these aims are crisis and assertive outreach teams, backed up by a range of support services including 24-hour places of care.

This approach makes intuitive sense and is evidence based. Research has shown that users, carers and staff prefer this style of working, and that safety is not compromised. Nevertheless, only very few services in the UK have introduced this style of care. This means that dissemination of good practice is a priority.

An influential example of good practice is Northern Birmingham, where well-integrated community services have been run now for some 5 years, following the closure of the local asylum. Many lessons have been learnt, both positive and negative. All these have great relevance for others, whether they address how to configure services or how to achieve a competent workforce.

The importance of this publication is that it gives an honest account of how services were set up, run and sustained, as told by the people who did it. This should help managers and clinicians elsewhere to replicate the successes, but avoid the pitfalls.

I very much hope that it will achieve its aim: supporting people anywhere to improve care in a practical and accessible manner. Good luck!

Matt Muijen

*Director, The Sainsbury Centre
for Mental Health*

The Sainsbury Mental Health Initiative

In 1994, the Sainsbury Centre invited mental health services across the UK to bid for a share of £3 million, to establish innovative new services for people with severe and long-term mental health problems. The eight sites, selected from over 300 applications, were awarded a three-year grant as pump priming to get their services up and running. Each of the projects has undergone an evaluation by the Sainsbury Centre.

The range of services developed include assertive outreach, home treatment and intensive community support teams, joint health and social service initiatives, a carers' support team, an advocacy project and a rural out of hours intensive support service.

Many vital service development and evaluation lessons have been learnt from each of the sites. These will be published in a series of journal articles, resource manuals and reports. This is the first in a series of service development manuals providing practical guidance on setting up these services.

The Initiative was funded by the Gatsby Charitable Foundation, the Sainsbury Centre for Mental Health, the Department of Health in England and Wales and overseen by a Steering Group of national experts and leaders in the mental health field.

Acknowledgements

Northern Birmingham Mental Health NHS Trust would like to acknowledge the contributions of all those staff within the Trust who participated in the development of its services. In particular, it would like to make the following special note.

'Without the dedication, determination and co-operation of all the staff within the services in the Yardley and Hodge Hill Locality, the re-modelling and maintenance of the service could not have happened.

The pioneering work of Dr John Hoult – his passion and energy to make the changes happen was crucial.'

Edited by Helen Wood & Sarah Carr

The Sainsbury Centre for Mental Health



The Assertive Outreach Team: Making It Happen

Jenny Tasker

THIS BOOKLET IS Nº 4
OF A SERIES OF 5

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Defining the Service

The assertive outreach team within the locality of Yardley and Hodge Hill was set up in 1996, and represented the second phase of new adult services following the development of the home treatment team.

It is important to note that the assertive outreach team was developed as an integrated component in a wider range of locality based services including the primary care mental health team, continuing care and home treatment services. This was an important influence upon the development of the assertive outreach team, in terms of its operational criteria and functioning.

What influenced the service design process ?

Research evidence

Knowledge of the principles and aims of assertive outreach was derived from consideration of the literature and research related to such teams. The core components of assertive outreach were based on data related to the *Program of Assertive Community Treatment (PACT)*, developed and researched in Wisconsin, by L Stein, M A Test and colleagues in the 1970s and attempts at replication in the US and Australia thereafter (See: **Assertive Outreach: The Evidence Base**).

It was hoped that effective operational features of such teams could be embodied in a locally developed service, rather than duplicating the Madison model *per se*. In addressing the fidelity issues, the following features were identified:

Essential Service Elements

- *services provided within the community (within service users' homes and other community settings)*
- *assertive engagement mechanisms*
- *intensity of service – high total amount of service time as required*
- *frequency of contact – high number of service contacts as needed*
- *small caseload – keyworker: user ratio of 1:10*
- *team approach – provider group functions as whole team, rather than individual practitioners, staff know and work with all service users*
- *practising team leader – team manager also provides services as part of the team approach*
- *time-unlimited services*
- *work with support systems*
- *slow initial intake rate*
- *full responsibility for treatment services*
- *responsibility for crisis services – 24 hour cover*
- *multi-disciplinary team*
- *explicit referral criteria for a targeted population*
- *substance abuse services.*

(Adapted from: Teague G, Drake R & Ackerson T, 1995)

Local needs assessment

A stock take was carried out in 1995, in which all medical and clinical staff within the Trust, as well as social services staff participated.

They were asked to complete a questionnaire designed to identify all adults with enduring mental health problems who had contact with services at that time and who might benefit from an assertive outreach service. The key defining features of the people in this group were:

- diagnosis of enduring mental health problems
- experience of four in-patient admissions or an aggregate of 6 months in-patient care in the preceding two years (involvement of the home treatment team is equated with admission for referral purposes)
- detention in hospital under the *Mental Health Act* (1983) on more than one occasion
- history of violence or persistent offending
- failure to engage with treatment and support services
- history of unstable accommodation
- risk of serious self-harm or self-neglect
- combined serious substance misuse and enduring mental health problems.



Although a rather crude measure, this provided an estimation of the number of adults with such needs within each locality, giving a baseline for the requirements and function of such teams.

The stock take identified 83 people within the locality in 1995 who might benefit from an assertive outreach service.

Consultation and networking

Communication and networking with others who had experience of assertive outreach in the Trust and elsewhere, provided valuable information for subsequent planning.

Sources of information included:

- a visit and presentation to the Trust from Dr Leonard Stein and later, Dr Paul Polak.
- a visit to *Tulip*, a voluntary sector assertive outreach team in London (Gauntlett *et al*, 1996).
- Dr John Hoult provided a source of inspiration and valuable expertise for the planning and early development of the team.

Project leader

The recruitment and active involvement of the team leader prior to the operational planning and development stage, facilitated a personal investment in, and ownership of, team development.

Local management support allowed the team leader a greater sense of personal autonomy when shaping the development plans for the team.

Capacity of local service provision

Gaps had been identified within locality services for adults with enduring mental health problems.

A continuing care team, which focused on adults with enduring mental health problems, had existed within the locality since 1991. However, the team became increasingly constrained in their functioning, because they were attempting to meet a wide range of needs.

This included those adults with enduring mental health problems who had attained some stability and required less intensive follow-up and support as well as a smaller group of individuals who were being frequently admitted to hospital. The latter group presented greater challenges in terms of support and engagement, which was difficult for a small team who operated within the traditional nine to five, five days a week hours of operation.

This resulted in the team focusing predominantly on a smaller group of individuals who presented a greater risk of relapse and compulsory hospital admission. Less time was available to work with those who presented with more negative symptoms, social disability and risk of isolation and self neglect.

The development of an assertive outreach team to target the smaller group of individuals who were being frequently admitted to hospital and required more intensive interventions was considered an appropriate way forward to offering more effective services.

References

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Useful reading

- Brekke J S and Test M A (1987) An Empirical Analysis of Services Developed in a Model Community Support Program *Psychosocial Rehabilitation Journal* **10** (4) p51–61
- Burns B J and Santos A B (1995) Assertive Community Treatment. An Update of Randomised Trials *Psychiatric Services* **46** (7)
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- Olfson M (1990) Assertive Community Treatment: An Evaluation of the Experimental Evidence *Hospital and Community Psychiatry* **41** (6) p634–641
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Setting up the Team

The team commenced in August 1996, following several months of operational planning and recruitment of new staff who were committed to working within this framework of support.

Project leader

The team leader was the first to be recruited in March 1996 and so had the opportunity of being actively involved in co-ordinating the planning of the service over a five month period. This happened in conjunction with the locality management social services and the consultant psychiatrist, who had previous experience of setting up and working within such teams.

The key tasks were to:

- establish the framework for the operational policy
- hold planning meetings including health and social services, to gain agreed staffing levels and composition, day to day management and key operational procedures
- liaise with other existing mental health teams and keyworkers to identify an initial list of service users who were considered a priority for referral to the assertive outreach team
- familiarise staff from other teams with referral procedures and how the assertive outreach team would integrate with other services.

Operational policy development

The initial task was to develop an operational policy drafted by the team leader and modified following wider consultation within the locality. This consultation process included Trust staff within other adult services teams and social services, as well as the voluntary sector and local service user organisations.

The operational policy provided a framework and task list for the development of the assertive outreach team.

Operational policy key areas

- *aims and objectives of the team*
- *target population*
- *referral criteria*
- *staffing composition of the team*
- *core tasks/focus of the team*
- *principles of a team approach*
- *relationship to other functional teams*
- *specific measurement of change/outcomes*
- *training*
- *health and safety policy.*

Core aims and objectives

- *provision of support where people live*
- *flexibility of support, on a daily basis if needed*
- *seeking all possible means of engaging service users*
- *supporting each individual to obtain or retain the most suitable accommodation*
- *support for obtaining opportunities for social, leisure and occupational activity, including access to paid open or sheltered employment*
- *help to maintain family relationships and develop supportive social networks*
- *encouraging clients towards self-improvement*
- *time-unlimited access*
- *pro-active approach to treatment and follow-up, with the ability to respond rapidly to changes in need*
- *balancing the rights of the individual to self-determination*
- *provision of a wide range of practical support aimed at increasing clients' access to community resources.*

Target population

The target population for the assertive outreach team reflected local need and current gaps in the service. It was agreed that the team needed to focus on a smaller population of adults with severe mental illness who:

- were already in contact with services
- experienced frequent hospital admission due to relapse
- often suffered an associated increase in their risk status with relapse.

Their status resulted in the need for more intensive, flexible services to engage them and ensure they received the necessary support for the appropriate period of time. The aim of this intensive support is to assist such individuals in maintaining stability with regard to their mental state and social circumstances.

The identification of this target population was clarified through the referral criteria. Adherence to this criteria was considered crucial at the outset and has continued to remain so for the day to day functioning of the team.

This is considered an important factor to ensure that:

- those in greatest need of assertive outreach receive it
- the focus of the team does not dissipate to include individuals with less complex needs.

Referral criteria

Referral criteria were developed on a Trust wide basis to ensure consistency and a common baseline for assertive outreach services across localities as individuals are likely to move across locality boundaries.

Criteria are as follows:

- Adults identified as suffering from a severe and enduring mental illness, most typically presented as schizophrenia or manic depressive illness and aged between 18–65 at the point of referral.
- Clients will usually have had four or more in-patient admissions, or an aggregate of six months in-patient care in the preceding two years (interventions from the home treatment team will be equated with admissions criteria).
- Clients also need to meet at least three of the following:
 - failure to engage with the service
 - history of violence or of persistent offending
 - at risk of persistent self-harm or neglect
 - failure to respond to treatment

- combined substance misuse and serious mental illness (dual diagnosis)
- have been detained under the Mental Health Act (1983) on at least one occasion.

A provisional list of potential referrals to the service was compiled by the team leader in conjunction with other teams that were being encouraged to prioritise such individuals.

Referral processes

Source of referrals

The assertive outreach team is a tertiary service and accepts referrals from the primary care mental health team (PCMHT), and continuing care team (CCT).

The team will also accept some referrals directly from forensic services and the special hospital system, although these would usually still come through the PCMHT.

Screening

The team leader screens all referrals to determine whether they meet the inclusion criteria. Operationally, this involves a screening assessment, with much of the required information being provided by the current keyworker or referrer and consultant psychiatrist.

Team skill mix and size

Evidence from other assertive outreach services demonstrated the need for a multi-disciplinary service with a range of different disciplines working as integral parts of the team. Decisions about the size and composition of the team were jointly agreed by all involved in planning and were restricted by the mainstream funding available at the time.

It was agreed that initially all recruited staff would be professionally qualified, as some of the research related to such teams, indicated that higher ratios of qualified staff contributed to better outcomes. This decision was also influenced by the fact that all staff needed an appropriate qualification in order to hold

keyworker responsibilities within the Care Programme Approach (CPA).

Funding was available for seven qualified staff from different disciplines, in addition to the team leader. The proposed skill mix was to be:

- 1 Team Leader
- 2 G Grade CPNs
- 2 E Grade CPNs
- 2 ASWs
- 1 Senior I Grade OT
- 0.5 Psychologist

Unfortunately, the original and continued hope of recruiting two approved social workers (ASWs) to the team has not been realised. This has been due to on-going discussion between health and social services. These posts have been covered by two seconded community psychiatric nurses (CPNs). The current staffing composition is as follows:

- 0.5 Team Leader (Social Worker employed by the Trust)
- 2 G Grade CPNs
- 2 E Grade CPNs
- 1 Occupational Therapist (Senior I)
- 1 G Grade CPN (secondment pending recruitment of ASW)
- 1 E Grade CPN (secondment pending recruitment of ASW)
- 1 part-time administrator (5 mornings a week)

Recruitment strategies

There was a need to recruit new staff rather than pull staff together from existing teams.

Candidates needed to demonstrate:

- multi-disciplinary skills and approach to meeting a range of complex needs
- enthusiasm for working with adults with enduring mental health problems and experience



- a commitment to team working
- flexibility and an openness to learning and developing new approaches
- a range of life experiences and strong communication skills.

Medical staffing

Prior to setting up the team it was agreed that there would be one consultant psychiatrist who would work directly with the team and take on the role of responsible medical officer (RMO) for all those accepted into the service.

The consultant contributed actively to the planning and implementation process and his enthusiasm and commitment were an additional strength. It was considered a priority to have one consultant directly involved with the team. This would establish some continuity of care and consistency in treatment, which had previously been lacking for the some of individuals who were referred to the service.

The current medical support to the team is:

- 1 consultant psychiatrist – 3 sessions per week
- 1 senior clinical medical officer (SCMO) – 2 sessions per week

Immediate access to medical support as required is seen as essential for responding rapidly to

changes in need, which may involve medical treatment.

Training and induction programme

Prior to the successful recruitment of the staff to the team, a four week induction and training programme was developed and co-ordinated by the team leader, with contributions and input from a variety of sources.

The programme was designed to promote team building and allowed the newly developed team to gain a common understanding of their aims and objectives.

Training programme

- What is assertive outreach? – consideration of the core components drawn from research and discussion related to aims and objectives.
- Developing a team approach – including a consideration of unique disciplinary skills and the core knowledge base required for team operation. This involved team workshop activities to identify these essential elements and reach a common understanding.
- Operational issues related to developing a team approach and an extended hours service.
- Consideration of referral and assessment procedures.
- Identification of skills within the team and future training needs, in relation to particular assertive outreach tasks.
- Substance misuse and serious mental illness – local specialist services from across the Trust provided staff to talk to the team and provide a range of information on services and useful approaches.
- Risk assessment with input from medical staff.
- Employment, with the social services employment officer providing input and information. Pairs of team members visited all local resources over the four weeks.

- Dealing with welfare benefits and housing issues. A member of the local specialist Citizens Advice Bureau presented practical advice about benefits and information. Team members visited voluntary sector agencies who provide a range of accommodation in the area.
- Consideration of ethical and boundary issues that may arise within the work.
- Knowledge of community resources and demography of locality. Team visited a variety of local resources and familiarised themselves with the locality over the four weeks.
- Talks from service users and local service user organisations.
- Interventions considered effective in relapse prevention and crisis intervention.
- Health and safety issues. Team agreement on operational management and required protocols.
- Assessment tools to be used to measure change and outcomes.
- Care Programme Approach, including instruction on documentation and standards from the local CPA co-ordinator.

Useful reading

Carling P (1995) *Return to Community: Building support systems for people with psychiatric disabilities* The Guildford Press

Curtis L C Hodge M (1994) Old Standards, New Dilemmas: Ethics and Boundaries in Community Support Services *Psychosocial Rehabilitation Journal* **18** (2) p13–33.

Strathdee G (1995) Developing a community mental health team for the effective care of individuals with schizophrenia *Advances in Psychiatric Treatment* **1** p199–206

Stein L (1996) The Care Manager Re-visited *The Bulletin New Service Directions* **3** Birmingham: International Mental Health Network Limited p2–5



Implementation

A phased implementation of the service was planned and included:

Phase One

- *four week induction of staff*
- *provisional list of referrals identified*
- *people identified as most in need prioritised by local team.*

Phase Two

- *agreement of gradual acceptance of referrals on to team case load*
- *initial twenty referrals accepted and taken on by the team*
- *team development and revision of operational policy during first month of operation.*

Phase Three

- *gradual build up of case load to maximum of 1:10 staff: client ratio.*

The team currently work with 60 service users. Case load management strategies include:

- Each member of the team will act as keyworker for a maximum of 10 service users.
- Keyworkers will co-ordinate the services of the whole team and work with a co-worker to ensure the team approach.

Daily functioning

Hours of operation

A shift system is in place from Monday to Friday and includes:

- an early shift from 8.00am–4.00pm
- a late shift from 1.00pm–9.00pm

At weekends and on Bank Holidays there is one shift from 10.00am–6.00pm.

Organisation of daily tasks

Each member of the team has keyworker responsibilities and has a co-worker within the team. Key tasks include:

- jointly co-ordinating the work of the team for the individuals they are keyworking
- identifying daily and weekly tasks and ensuring that these are followed through
- co-ordinating regular reviews and the care planning process.

This is managed by the team using three large white boards, one for each keyworker/co-worker partnership, listing the names of all the service users seen by the team and key tasks to be undertaken. This is completed every week. It records the:

- name of service user and their review date
- Mental Health Act status (if applicable)
- risk status (i.e. if on Supervision Register or needs joint visits)
- daily breakdown over the 7 days of the week, outlining specific appointments or tasks.

WIPE BOARD HEADINGS				
Name/ Hospital Number	Review Date	Date Depot Due	Status (Supervision Register/ Joint Visits)	Visit Days Mon–Sun Dates

(currently 20 clients per board)

An illustration of the white board headings is given above.

Team communication

The team has a short hand-over period first thing in the morning to organise and clarify the work for the day shift. During the afternoon another hand-over takes place between the early and late shift to highlight any additional developments and outline the tasks for the late shift.

Clients and referrers can get in touch with the team on a direct line and calls are answered by the team’s administrator. Out of hours, there is an answer machine, with a message detailing alternative points of contact. The staff also have the use of two mobile phones and three pagers, one of which is used by the team leader. Clients can contact the team through the Trust switchboard, who then page the assertive outreach staff.

Twice a week a one and a half to two hour review meeting takes place with the consultant psychiatrist. Over these two afternoons, all the individuals the team has contact with are discussed. The opportunity exists for more detailed discussion about risk or team contributions to individual care planning. The agreed action of the team is clarified and changes in treatment discussed by the team as a whole.

Core services of the team

The team offers a range of assertive outreach services and interventions, which typically include:

- *delivery and administration of medication and treatment to service users who require intensive monitoring*
- *ensuring that service users keep important appointments (e.g with GPs, job interviews, regular commitments)*
- *practical support with daily living tasks such as shopping, domestic work, budgeting and dealing with the welfare benefits system*
- *support in coping with symptoms, providing information about medication and side effects and making available a range of psycho-social interventions designed to prevent relapse*
- *assistance in dealing with family difficulties, including supporting carers to maintain their relationship with the service user*
- *encouraging and assisting service users to access local community*
- *resources (these would include social activities and job or educational opportunities)*
- *crisis intervention where an individual receives intensive support in their own home during periods of psychiatric crisis*
- *liaising with a wide variety of agencies with and on behalf of the service users, particularly with the DSS and housing department.*

Frequency of contact

As the assertive outreach team operates the team approach they have the capacity to visit service users twice daily if necessary, 7 days a week. As a consequence the team can now:

- provide more intensive support to service users and administer and monitor treatment more consistently (only a very small number of service users require this on an on-going basis)
- respond quickly to changes in need and support individuals in crisis within their own homes.

In addition:

- the frequency of contact between team members enables team problem solving and care planning to take place
- service users can then have access to the skills of the whole team rather than just those of their keyworker
- the high frequency of contact with the team strengthens the engagement process and allows the team to be flexible and persistent in following up visits.

Assessment processes

Care Programme Approach (CPA)

In line with the requirements of the CPA all those referred to the team have a comprehensive risk assessment completed on a multi-disciplinary basis. The Trust have agreed risk assessment guidelines and core CPA documentation for recording information and decisions about risk.

The assertive outreach team

In addition to CPA documentation the team have their own assessment form which is completed over the initial weeks of engagement with a service user.

This assessment is based on the 'strengths' model and focuses on identifying individual goals and aspirations, rather than on the

difficulties (Rapp, 1992; Rapp, 1998). This focus is considered vital to the engagement process and the on-going relationship of the team with service users.

Core areas of comprehensive assessment

- Psychiatric/Mental State
- Health
- Accommodation
- Finances
- Employment
- Family/Social Activity
- Recreational/Social Activity
- Daily Living Skills
- Substance Use
- Legal Issues
- Spiritual/Cultural Issues
- Sexuality

Standard assessment measures

Standardised assessment measures are used to monitor change and identify progress. They are completed upon initial acceptance to the service and then repeated every 3–6 months. These include:

- Health of the Nation Outcome Scale (HoNOS)
- Life Skills Profile (LSP)

These particular measures were chosen, after careful consideration as they:

- can provide a realistic means of obtaining basic data about changes in mental state and social functioning over time
- were considered easy to complete and did not present too great a burden for the team, a fact which was likely to ensure their continued completion.



Reviews

Although the team operates a team approach to case management, this is integrated with the local CPA. Each individual referred to and accepted by the service will have an identified keyworker who will assess their needs and negotiate a care plan with them. This care plan will be formally reviewed every three to six months and a formal record of this is contained within the CPA documentation.

This will be circulated with the service user's agreement to all those involved with their care and support. The reviews, in addition to providing the service user and their family with a regular opportunity to discuss the provision of support, also help the keyworker to co-ordinate the work of the team.

Discharge and transfer procedures

The services provided by the assertive outreach service are defined as being time-unlimited, but this needs to be viewed within the context of the range of services available within the locality. This is coupled with the necessity for service users to be supported in the most appropriate and least restrictive environment.

Boundaries between teams therefore need to be permeable, so service users can move easily between the assertive outreach, continuing care and primary care mental health teams, according to current need. It should be possible for some service users to move out of the mental health system, to be followed-up and supported by their GP, when appropriate.

Service users must be able to transfer from the primary care mental health team and continuing care to assertive outreach, if they meet the referral criteria. Clear referral criteria for each component of the service aids the transfer process, as does regular communication between teams.

In addition to the review process, team discussion and a team approach to working with individuals is important for identifying the right time to reduce team input. Service users can achieve stability and increased community integration. Support which is unresponsive to changes in need will undermine the individual service user's recovery.

References

Rapp C A (1992) The strengths perspective of case management with persons suffering from severe mental illness In Saleeby D (Ed) *The Strengths Perspective in Social Work* New York: Longman p45–58

Rapp C A (1998) *The Strengths Model: Case management for people suffering from severe and persistent mental illness* Oxford: Oxford University Press



A Day in the Life

Staff, user and carer perspectives

Jenny Tasker, Team Leader

What is the team leader's role?

It's very different from traditional management. You're not distanced from the team, but directly involved. This is crucial. By being involved on a day to day basis you can keep a handle on the needs of both clients and staff. If, as a team leader, you were not actively involved, it would be impossible to make accurate decisions or contribute to team discussion about our work with clients.

It's rewarding and the involvement with the team gives a clearer sense of where the difficulties are, which is useful in leading the development of the service. I think the term 'team leader' is important as it describes the subtle difference between what I do and the traditional management role. Relationships with staff are less hierarchical and you need to have a flexible approach.

Being a team leader can also be isolating at times, as staff can sometimes experience frustration and look to the team leader for more directive guidance in, say, team processes and decision making. It's a difficult balance to get right sometimes.

I see the team leader role as partly leading through example by attempting to set a certain standard professionally and as an individual. It's sometimes difficult to get the balance right, but having a clear vision of the service as a whole and getting the team to keep a focus on the aims and objectives helps.

The relationship with the client group is both stressful and rewarding. When you have worked with someone who had no engagement with mental health services before, and then gradually become part of their lives through working with them and helping them through crises, it can be very satisfying.

There are boundary difficulties which need constant negotiation, though, particularly between the male clients and the female staff, but this is all open to team discussion. A while ago two female staff members were involved in a serious incident at the home of a client, during which one nurse was injured. The whole team dealt with this and risk was discussed and reviewed with an awareness of the negative effects of over caution. The team are open to making mistakes and learning from them.

What are the skills needed for successful team leadership?

- Listen to people and be approachable. Don't have an 'autocratic stance'. This style of leadership is also double edged, as staff can want directive guidance.
- Be an active team leader who is involved with the work of the team. Having an active clinical role is important.
- Flexibility is essential as you need to 'give and take' within the team. Staff can work beyond 9pm sometimes and this needs to be recognised.
- You need a clear idea of team aims and objectives, so you are equipped to look in from the outside at team operational elements and to keep the team on track with the operational policy.

- Good communication skills are vital as you will have to liaise with other services, teams and managers as well as supervise staff.

What are the most rewarding aspects of working in this type of team?

The team approach. It's less stressful when you're sharing the burden of work with the team, rather than working as an individual, and there's greater continuity and flexibility. This is especially good when you are working with people who have complex needs. The team approach can relieve a lot of personal anxiety you may have as a keyworker, knowing that the team are following up tasks in your absence.

Despite individual differences, staff have developed strong and trusting professional relationships. This trust means that team members can support each other through stressful periods, and they feel they can let off steam. The team also socialise and have fun together, which is very important.

What difficulties have you encountered?

Intensive contact with clients can be very stressful at times. The burden of work and pressure of maintaining the service can be difficult. We've been short of a full time OT for months now, and this has really made a difference. Stress upon the team increases when individual members are on annual leave or in training, and then we feel we're not able to operate as flexibly as we'd like, which is frustrating. Ideally we'd have 8 or 9 staff from different disciplines.

Over the past year two clients have died, one died from natural causes and one committed suicide. Suicide is the worst scenario for most mental health professionals, but the way the team work, has enabled them to support each other.

The team members that found him were able to openly discuss what had happened with their colleagues without the fear of blame. Such an incident was a tester of the team approach.

As there are only CPNs on the team at present, the nurses have had to expand their skills to meet the multi-disciplinary need. This

has had its benefits and drawbacks. The downside of this has been that, although they are getting new skills, they have also had to tackle too wide a range of tasks, and haven't always had the opportunity to make the most of their individual skills. However, despite being from the same discipline, individual CPNs bring a range of perspectives and experiences to the team, and as people are very different.

How do you think the team benefits service users?

The assertive outreach team can offer service users support which they value and consider a priority. This often includes more practically based support, rather than just supplying medication. We offer an all-round package.

Because users and staff spend more time together, they can establish more collaborative relationships, which helps break down barriers. Staff can become involved with service users as people and become part of their support network.

Users seem to have valued the support available from the team because it is flexible and more focused on their needs and preferences. I suppose this has been reflected in the relative ease the team have experienced in engaging the majority of people.

How have carers been helped by the team?

We are actively involved in supporting service users, their families and carers. Working with carers and users in their social context helps us develop ways to deal with crises, especially when these have been precipitated by that context. Most family members have valued their increased access to support, particularly when individuals are going through periods of crisis.

We are currently developing ways of working with families, influenced by Paul Polak's 'social systems approach' (see: **Sustaining the Service**)

Heather Duckworth, Seconded CPN

Heather is a CPN who has been on secondment with the team since August 1996. She previously worked as a CPN in the primary care mental health team with a mixed caseload under the keyworker system.

What are the most rewarding aspects of working in this type of team?

The team approach lets you share the burden of more difficult clients. It's also good to be able to share ideas with colleagues and get as much support as you need.

What difficulties have you encountered?

Working in this way can also have negative aspects, particularly if you are having to rely on others for organisation and you are not in full control of your work. Sometimes the task sharing can be chaotic. Your professional skills can become more specialised at the cost of generic skills, which can be limiting and frustrating in terms of professional development.

What helped you when you first started the job?

Assertive outreach was a new concept to me. The training and induction allowed us to consider assertive outreach as well as get to know each other better and build the team. When the team began operation we were able to take on clients slowly, which was unusual even for an assertive outreach team, and this was very helpful for building up caseloads and developing our approach.

What skills do you need to work in the team?

- You need to be a good team worker.
- People skills are as important as clinical skills. You have to be able to build relationships with clients, and they must want to see and work with you.



- Good organisational and communication skills are essential for the team approach.

How do you think the team benefits service users?

They benefit from a specialised outreach service which offers practical help and is designed around them.

How have carers been helped by the team?

The team helps them share the burden of care. Carers know you are there to help them, but they rarely call you out. It has taken time for some carers, who were used to standard mental health services, to get used to the out-of-hours availability of assertive outreach.

Has the team offered advantages to locality mental health services?

The team has allowed local CMHTs to unload their most difficult cases and concentrate on other client groups. If a keyworker had a caseload of forty clients, the potential assertive outreach clients were very demanding on the community service and were most often in hospital. Assertive outreach engages these revolving door clients and tries to sustain them in the community.

Theresa Ingram, E-Grade CPN

Theresa has been with the team from the start. She used to be a sister on a psychiatric ward.

What are the most rewarding aspects of working in this type of team?

It's easier to work in a small team and we all know how hard we've got to work so we're very supportive of each other, work-wise and personally. The work is equally divided and we're flexible with each other as well as the clients. We all like to laugh and joke together and sometimes it's like another family. You're not on your own and the team is supportive and caring.

What difficulties have you encountered?

The team is under a lot of pressure because it seems that there is a lot being done by the few, and sometimes it's hard to say 'no' to clients. It often seems that there's not enough time in the day to do what we want to do.

What helped you when you first started the job?

The introductory training helped me get used to the team after working on my own on a ward. It was very important to set our aims and objectives at that stage so we knew where we were going. The team quickly gelled together. The fact that we took clients on slowly let us build up our caseload gradually instead of having to deal with a huge caseload immediately. In that sense it allowed us to put people before paper.

What skills do you need to work in the team?

- You must have life experience as well as job experience.
- Communication.
- An ability to listen and understand.
- You need to be able to match and balance your skills within the team and work with difference. There's always someone to do something you can't and vice versa.

- Be 'a jack of all trades and master of a couple'.

How have you developed as a professional since joining the team?

Professionally, I've come on in leaps and bounds, from having worked in the ward situation. I'm now less stressed and isolated and can now share decisions and responsibility. I have benefited from the constructive criticism of my colleagues as well as their support and humour. In the community you can assess everything, and I've learned to look beyond the patient to his or her personal situation.

It's been important to have such a flexible team leader who's approachable and socialises with the team. You can be yourself with her, which is great when you're off-loading. There doesn't seem to be an official hierarchy and people seem to forget grades. It's the humane approach, and it works.

How do you think the team benefits service users?

Assertive outreach gives clients a flexible service which is tailored to their needs. It's for them, not to do with a budget or a bed and they have a say, unlike on a ward. We treat them holistically and as individuals. I would hope that, if I got ill, I would get help from an assertive outreach service. I think it's the best way of working in the community.

How have carers been helped by the team?

The team gives them support when they need it and they don't feel intimidated by the staff like they might on a ward round. In some ways it is like we are guests in their house when we visit. We try to be approachable to carers as well as clients. I'd like more time to spend with the carers and as the service develops we hope to provide more for them. Carers can be the most important source of information about a client's health and can give us the key to ask the right questions, but you must build up a relationship of trust.

Ron, Service User

Ron is 48 years old and suffers from manic depression. He also had a head injury when he was 19 which left him with some organic brain damage. He has spent many years in prison and in hospital as a result of the violent mood swings and sexual problems that were a consequence of his illness.

Over two years the team have helped him to understand, stabilise and balance his medication. He has also learned about acceptable social behaviour and mood control, as well as money management.

Ron lives alone in council accommodation, but has recently come back into contact with his brother through the intervention of the team.

- “I’d be lost without the A-Team. They help you with medication, benefits, gas bills...everything.”
- “I’ve had trouble with my neighbours so they’re going to help me move to a better place where more of my mates are.”
- “It’s good, it’s reliable. Without it I’d be hopeless.”
- “They’re like friends...They even got me Christmas cards and came to see me.”
- “I wasn’t thinking as brightly as I used to because of my medication...but they helped me with the side effects and bring me my tablets...”
- “Worst things? There’s nothing worse about them!”
- “You’ve got security because you know they’ll pop in 2 or 3 times a week, so you feel safer.”
- “I had trouble with the chemists and the doctor, so the A-Team came with me to sort things out.”
- “I used to get into trouble, but I’ve bucked my ideas up...no more swearing in shops.”
- “I was in locked wards for being violent and aggressive, but there’s none of that now...”

Pat, Service User

Pat is 58 years old and suffers from manic depression. At the time of interview she was on the in-patient ward following a crisis brought on by unsuitable living conditions and medication becoming ineffective. She was still being seen by the team while in hospital.

- “Because they’re on-call, I can phone them up and they’ll give me reassuring words as regards my health.”
- “All the team are so helpful to me...before, I felt like I was floundering in the sea, but they gave me a life-belt.”
- “I phone them when I need them and they always come with reassuring advice and my tablets. They always stay for a while...it all helps me.”
- “The nurses give you companionship when you feel in need of a friend...they’re like friends to you.”
- “I was desperate for attention and advice and that’s what they gave to me...they never ask for thanks.”
- “The team helped me decorate my bathroom, and they’re going to help me find a new flat that’s more me...”
- “I know more about my illness...I didn’t know how to tackle it before...”
- “I used to have a wallet of tablets, but I got mixed up and confused. The team came to see me everyday to give me tablets and to check I was alright.”

Mrs T, Carer

Mrs T is 78 years old and lives with her 53 year old son, who suffers from schizophrenia and *grand mal* epilepsy. She has osteoporosis and is currently being treated for anxiety. The team has been seeing Mrs T and her son for about two years, previous to which they were receiving help from the continuing needs service.

Mrs T is now more worried about her son's epilepsy than his mental illness, the latter having stabilised since the intervention of the team and the introduction of more suitable medication. Previous treatment had invariably involved prolonged periods of hospitalisation.

- "I couldn't do without the team because it means there's somebody for me to fall back on and at my age you can feel nervous having a son like this."
- "This is the longest time he's been out of hospital for years. It's been nearly 2 years now, before he'd usually be back within 3 or 4 months, at most 6 months."
- "I've got the phone number there to hand and I know if I'm in any sort of trouble I've only got to phone and they'll come."
- "They talk to me when there are problems, they're willing to talk over problems..."



- "One of the nurses takes my son to hospital for blood tests, which I couldn't do myself..."
- "The team we had before [standard CMHT and continuing care] were very good, but not as good as assertive outreach...they're so patient."

Case studies

Pat

Pat is 58 years old and was admitted to hospital after undergoing a mental health crisis. She has suffered from periodic manic depression for over twenty five years. Pat has been living alone in a dark flat, a situation which seems to have aggravated her illness.

The assertive outreach team are taking the opportunity to sort out more suitable accommodation while Pat is in hospital, which should speed up her discharge, and the team are investigating the possibilities of more meaningful day activities, at her request. Pat would also like to join a support group for people with manic depression, as she believes she can learn from the experience of others and how they deal with their illness.

She feels that, after spending many years in and out of hospital, she has 'no ammunition against the outside world'. She had three children, all of whom were taken into care. The team have managed to trace one of Pat's daughters and put her back in contact and have also reunited her with her 88 year old father, who visits her regularly.

Michael

Michael is 53 years old and lives with his 78 year old mother. He suffers from schizophrenia and *grand mal* epilepsy and also had problems with an eating disorder which interfered with his epilepsy medication. They have been living with his illness for over thirty years.

The assertive outreach team has been supporting Michael and his mother for two years, during which time he has not been admitted to hospital. Previous to the team's

intervention he had stayed out of hospital for no longer than six months at a time and Michael and his mother did not know that his illness was schizophrenia, even though he had been treated for mental illness since he was a teenager.

He had problems with aggression and maintaining a stable diet. Referral to a hospital dietician was not helpful, but the assertive outreach team managed to help him negotiate a diet which suited his lifestyle and aided weight control. This was necessary for his epilepsy medication to be effective.

The team also educated Michael and his mother about schizophrenia, medication and side effects and both now feel they have greater

control over his illness. Initially, assertive outreach was able to speed up Michael's discharge from the in-patient ward by providing intensive medication monitoring, visiting three times a day until he had stabilised. They now visit him once a week.

Michael's mother, who is his only carer, has been immensely pleased by the support she has received from the team and feels safer knowing that she can contact them at any time of the day or night. Michael can now support his mother in the home by doing cooking, cleaning and gardening, which she finds very helpful as she suffers from osteoporosis.



The Achievements of the Assertive Outreach Team

Engagement

Over the last eighteen months the team have gradually become responsible for working with 60 individuals. Most of these clients have been very difficult to engage and have presented a challenge to services, when attempts to maintain contact and treatment were previously made. The assertive outreach team have successfully engaged 58 individuals, with whom they have regular contact. Many of these service users have achieved a significant level of stability for the first time for many years.

Particular aspects of the team's approach to engagement have contributed positively to this process, including:

- High priority given to providing the services and support needed by individual users and carers during the initial stages of engagement. This often primarily involves the provision of practical support with housing, benefits, social activity, rather than a focus upon treatment. Such an approach has enabled the team to establish closer relationships with service users. Subsequent discussions about treatment become much easier and less threatening once such relationships had been secured.
- A persistent approach to engagement and flexibility is needed if this is to be successfully implemented. This requires repeated attempts at contact during the early stages of team involvement. This persistence (initially considered by some service users as intrusive) has mainly resulted in the gradual acceptance

that team members are not prepared to give up. This has enabled the team to negotiate the level of contact acceptable to the service user.

- The focus upon the strengths and interests of individual service users has provided valuable information about the most appropriate means of engagement. In conjunction with higher levels of contact, this has accelerated the engagement process. Many service users are now more quickly able to see how they can benefit from contact with the team.

Crisis support

- The team have achieved significant success in reducing the number of hospital admissions, with a significant number (38) of service users not having experienced any admission while involved with the team.
- Many service users and their carers have been successfully supported through periods of psychiatric crisis in their own home. This has been possible due to the team's extended operational hours, and their quick, flexible responses to changes in need.
- If an individual needs hospitalisation the team have been able to initiate admission at an early stage and prevented the escalation of risk. As a consequence, hospital admissions have often been of much shorter duration as the team can provide intensive support and accelerate the discharge process.

Provision of a range of social interventions

- Service users receive a great deal of support in dealing with their welfare benefits and finances. The team have developed strong links with the DSS and have given talks to local social fund officers. All those supported by the team have now maintained a regular income and financial stability. The team have taken an active role in helping some service users to manage their finances, a factor which had contributed to the stresses causing relapse in the past.
- The team have been actively involved in ensuring service users obtain a reasonable standard of accommodation and help them maintain housing stability. This has often involved practical support with daily living tasks, as well as developing relationships with a variety of housing agencies. The team have developed particular links with voluntary and private providers of accommodation and have attempted to raise the standards of local landlords.

Family interventions

The team are committed to developing their skills in working with families and service users' support systems. This has been particularly important as at least half of those supported by the team live in a family situation. A 'social systems approach' to working with families is currently being developed.



There are also plans to commence a programme of 'multi-family psycho-educational' group work later this year. This approach combines a psycho-educational approach with techniques derived from behavioural family therapy and continues over an extended period of time.

The Social Systems Approach

This framework and approach was initially developed in the 1970s by Dr Paul Polak in the US. This approach was found to be effective in supporting individuals through crises which were often seen to reflect disturbances within their social system. By directly involving the appropriate social system and addressing the disturbances by encouraging open emotional communication, families were empowered to re-negotiate their boundaries and relationships. This could assist in the resolution of the crisis.

This approach can assist teams to gain greater understanding of the importance of an individual's social system, not simply in terms of their immediate family, but within the wider context of the community.

Useful Reading

Polak & Kirby (1976) A model to replace psychiatric hospital *Journal of Nervous and Mental Disease* **162** (1)

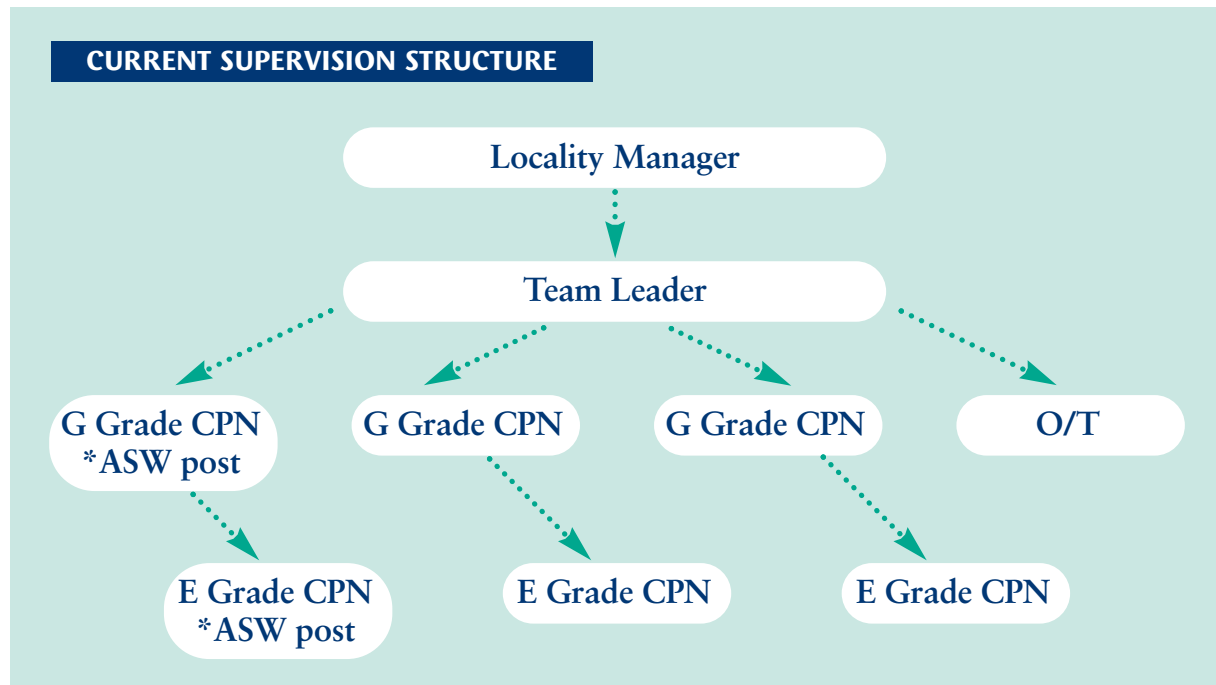
Polak P (1971) Social Systems Intervention *Archives of General Psychiatry* **25**

Flexibility

The team have been able to recognise and change processes that have not worked well for them.

Supervision

The supervision structure within the team is illustrated overleaf.



* When the approved social workers (ASWs) are in post, they will be operationally managed on a day-to-day basis by the team leader. Managerial support and supervision for statutory work as an ASW will come from the Social Services Team Manager.

- Much clinical supervision takes place within the team as a whole both on a formal and informal basis. As the team are all involved with most of the service users, this has been a more useful form of supervision. The team meet fortnightly to discuss particular issues or difficulties associated with their work. This includes medical staff.
- More formal managerial supervision includes the use of performance management techniques, which assist individual members of the team to identify their areas of strength and training needs, as well as their own role and personal development within the team.
- Individual clinical supervision for consultant staff does not fall within the locality. Consultants report to the Trust's clinical director.



Sustaining the Service

The need for a multi-disciplinary team approach

The assertive outreach team was originally planned as a multi-disciplinary team. Unfortunately this has not as yet been realised. At present all service users who are in contact with the team have an allocated social worker, who attends reviews and fulfils their statutory responsibilities. The absence of social workers as an integral part of the team, as well as a current lack of psychology input has resulted in certain difficulties and raises issues about future development, as listed below:

- Full multi-disciplinary discussion about individuals on an ongoing, day to day basis cannot yet be fully achieved.
- Discussions take place during regular reviews, but the team feel that service users are not benefiting from a range of different perspectives. Although the team strive to achieve this, there is a concern that over time interventions may become biased or narrower in their scope.
- As the team is primarily composed of nursing staff, this has meant that one discipline has taken on a very wide range of roles and tasks. Although there have been some benefits to this, particularly in terms of staff skills development, there is a danger that roles will become blurred and staff will be unable to make the best use of their specific skills.
- Levels of stress within the team have at times increased due to competing demands upon staff. Over time this may erode some of the benefits of a team approach.

Maintaining a team approach

Maintaining a team approach has required constant vigilance. Although it is one of the distinguishing factors of the assertive outreach team, each member of the team is also required to operate within the Care Programme Approach. The two approaches can combine well, but the team need to remain aware of both processes in day to day practice.

- When the team is under pressure there may be a tendency for members of the team to revert to a more traditional keyworking role, and accept higher levels of contact with those to whom they are keyworking. Although this may be appropriate at certain times, if a pattern develops, it could undermine the team approach. Service users could also lose the benefit of contact with the wider team and a wider range of skills.
- Team processes which encourage team problem solving and care planning need to be maintained and require the investment and time of the whole team. Any patterns which develop to undermine these team processes need to be checked to avoid a deterioration in team communication.
- When working with individuals assessed as presenting significant risk of relapse, the Care Programme Approach can work to increase individual keyworker accountability. This is reflected in Health Service Guidance (NHS Executive HSE[94]27). In order to help staff deal with such pressures, the team approach and team accountability need to be constantly encouraged.

- Staffing levels need to be realistic if the team is to provide a flexible, extended hours service operating on the team approach.

Legislation

There have been clinical and practice dilemmas associated with the particular use of *Mental Health Act* (1983) legislation. The use of Supervised Discharge (Section 25) has been found to place the team in a more coercive role in relation to a small number of service users. This has created difficulties with the task of ongoing engagement and the development of genuinely collaborative relationships.

Professional boundary issues

Because of the intensive contact team members have with service users it has been necessary to move beyond traditional professional roles. This has raised issues about professional boundaries, requiring ongoing discussion within the team as well as regular negotiation with service users. This is viewed as a day to day task which is crucial to the development of collaborative relationships with service users.

The team need to discuss and decide when it is appropriate to reduce the frequency of contact with particular service users and allow them to take greater control and responsibility for their lives. This is crucial for enabling service users to become more able to use and develop their own support networks, rather than becoming dependent upon high levels of contact from the team.

Interface with other teams

Because the assertive outreach team operates as part of a more comprehensive mental health service, the processes and relationships with other teams in the service need to be clear. It is essential that good communication exists to

ensure those in greatest need receive the most appropriate services. This also allows people using the assertive outreach service to receive more appropriate services when they have maintained stability for a significant length of time.

Factors which contribute positively to this are:

- Flexible boundaries between different teams and a clear understanding of team roles and responsibilities.
- Clear referral and transfer procedures.
- Opportunities for regular communication between the managers of different functional teams. This has assisted in the resolution of interface issues, as well as providing information about progress within each part of the service.

Training

The team need to keep up to date with evidence-based interventions. This requires a continuing commitment from the Trust to support staff in maintaining and developing their skills. This commitment has been available to staff. However, the issue of sustaining the service in relationship to training is complex because:

- only a limited number of staff can access training at any one time, because service levels need to be maintained
- consideration of how skills/new learning are disseminated within the team as a whole is required and time is needed for individuals to share knowledge and skills
- alternative methods of training for teams which work intensively may be required (this could involve trainers coming into the teams, rather than team members attending individual courses from which they may not be able to successfully transfer learning to the workplace).