Clinical Psychologists and Assertive Outreach

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Caroline Cupitt Bexley Assertive Outreach Team, Oxleas NHS Foundation Trust, London. Caroline.Cupitt@oxleas.nhs.uk

Ben Frayne West Hampshire Community Treatment Teams (Assertive Outreach Psychology Function Specialist), Southern Health NHS Foundation Trust. Ben.frayne@southernhealth.nhs.uk

Stuart Whomsley Assertive Outreach Team for Cambridgeshire and Peterborough NHS Foundation Trust. Stuart.Whomsley@cpft.nhs.uk

Morna Gillespie North Assertive Outreach Team, Birmingham & Solihull Mental Health NHS Foundation Trust. Morna.gillespie@nhs.net

Sara Meddings East Sussex Assertive Outreach Teams, Sussex Partnership NHS Foundation Trust. Sara.Meddings@sussexpartnership.nhs.uk

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This briefing paper aims to update the previous one of 2006 by

- Looking at the changing policy context
- Critically reviewing the evidence for assertive outreach
- Reviewing models of assertive outreach
- Highlighting the importance of using a psychologically informed model of care and delivering evidence based psychological interventions
- Making specific recommendations about the employment of psychologists.
Policy and research context

- No longer a national requirement
- But PbR includes an ‘assertive outreach’ cluster (17) and a dual diagnosis cluster (16)
- Draft new NICE guideline recommends ICM (includes AO)
- Equivocal research evidence
  - Research Design Problems – short follow ups are unhelpful
  - Interpretation of Evidence – needs an international perspective
  - Selection of Measures / outcomes – focus needs to shift to social recovery
  - Context effects – across both place and time
- Renewed focus on the effective elements, which includes delivery of evidence-base interventions such as CBT and FI.

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Service models

- Designated assertive outreach teams – recommended and a model which allows for specialist psychological work across a whole team caseload.
- Hybrid teams – can work, if there are enough shared characteristics (e.g. AO and community rehab).
- Flexible assertive community treatment (FACT) – emerging as a potential new model, but needs evaluation in the UK context.
Ceasing to provide any form of assertive outreach carries a number of risks, not least that of recreating the very problems that were identified by Keys to Engagement (SCMH, 1998) and led to the inclusion of assertive outreach teams as a key element of the 1999 National Service Framework.

If the needs of this vulnerable group are not proactively met in the community, they will simply manifest in other ways such as through acute admissions, homelessness and the criminal justice system.
Assertive outreach can provide high quality psychologically informed care, for example through

- Team working, which supports a truly multi disciplinary process of assessment and intervention.
- Psychological formulation of engagement difficulties based on someone’s interpersonal history.
- Focus on strengths as well as problems.
- Ability to work with families and social networks
- Use of psycho-social approaches to address every level of need.
Role of clinical psychologists

- Direct Clinical Work - delivering recommended interventions such as CBT and FI, but also other approaches as appropriate and according to client need / preferences.
- Indirect Clinical Work/Working with the whole team – facilitating case formulation, reflective practice, team support.
- Research & Evaluation – routine evaluation and researching the innovative aspects of the work
- Training & Supervision – for psychological therapists, but also all team members interested in delivering psycho social approaches.
- Service Development – especially as reconfigurations occur and models change.
Service user and carer involvement

- Devising methods to elicit user feedback, especially as high satisfaction has been an important and stable finding of research.
- Supporting user and carer representatives at a strategic level in the organisation.
- Supporting the development of peer worker posts, including training and supervision.
The recommendation is

- A ratio of one whole time (1.0 WTE) Band 8a or above clinical psychologist for a team caseload of 90 clients to meet need.
- Where designated teams do not exist, whatever model is used there should be a psychology post with an assertive outreach specialism.

In reality few teams have ever had sufficient psychology resource and this has been a factor in limiting their effectiveness (Brugha et al., 2012)
Challenges of Preserving Assertive Outreach Function in Amalgamated Teams

- AO consultants/champions/specialist - not sole responsibility (informs team approach)
- Training/supervision/shared formulations/reflective practice
- Function being deprioritised due to the intensity of work (e.g. travel from base/duration of work required)
- Hybridisation of caseloads (e.g. AO≈15%) protecting a proportion of caseload dedicated to AO - side effect: reducing numbers of service users able to be seen.
- Hybridisation of policies (e.g. DNA policies)
- Quieter disengaged service users risk losing battles for community team’s attention in hybridised services
- Commissioning based on contacts/outcomes leading to pressures to discharge disengaged service users.
Conclusions

- We have moved away from mandated service delivery and into an era of innovation and integration.
- Don’t ‘throw the baby out with the bathwater’
- NICE guidelines continue to demand evidence-based practice.
- We need to build practice-based evidence for our service models
- Clinical psychology involvement can help teams enhance their effectiveness and demonstrate this – we are not just therapists!
- Assertive outreach is neither a team, nor a service nor a collection of specific staff, but a function.


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