Assertive Outreach in Mental Health in England

Report from a day seminar on research, policy and practice

7th October 2005
Attendees at the seminar

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Carol Bell                      College of Occupational Therapists
Jed Boardman                    Royal College of Psychiatrists
Terry Brugha                    University of Leicester
John Carpenter                  University of Bristol
Clair Chilvers                  Department of Health
Michael Clark                   Department of Health
David Daniel                    Department of Health
Tom Dodd                        NIMHE
Sharon Fairhurst                Greater Manchester & Lancashire Directorate, Turning Point
Mike Firn                       National Forum for Assertive Outreach
Martin Flowers                  NIMHE
Moira Fraser                    MIND
Gyles Glover                    University of Durham
Mike Hartley                    Rethink
John Hoult                      NIMHE
Helen Killaspy                  University College London
Peter Kinderman                 British Psychological Society
David Kingdon                   University of Southampton
Barbara Kyei                    Department of Health
Max Marshall                    Lancashire Care Trust, University of Manchester
Claire McCombie                 NIMHE
Pat McGlynn                     NIMHE
Kwame McKenzie                  University College London
Carol Molloy                    South Staffordshire Healthcare NHS Trust
Paul O'Halloran                 NIMHE
Stefan Priebe                   Queen Mary University of London
Iain Ryrie                      Mental Health Foundation
Chiara Samele                   Sainsbury Centre for Mental Health
Trevor Sheldon (Chair)          University of York
David Shiers                    NIMHE & Rethink
Jane Smith                      University of Leicester
Geraldine Strathdee             Bromley MH Directorate, Healthcare Commission
Nick Taub                       University of Leicester
Jacqui Thomas                   Hammersmith and Fulham MIND
Alison Tingle                   Department of Health
Peter Tyrer                     Imperial College London
Roberta Wetherell               ARW Training and Consultancy
Christine Wright               St George's University of London

Alan Glanz and the Department of Health Policy Research Programme commissioned most of the research discussed at the seminar. We thank each of the presenters for their contributions and Trevor Sheldon for Chairing the seminar. We also thank Heidi Gaffney for her work in organising the seminar.

Cover photo – ‘The Fun-Gi at Penn Hospital’
Introduction

Louis Appleby presented the policy background to the development of Assertive Outreach Teams (AOTs) in mental health in England. The National Service Framework for Mental Health (Department of Health (DH) 1999) explicitly stated a role for Assertive Outreach (AO) services in comprehensive mental health care. The NHS Plan (DH 2000) confirmed that by April 2001 there would be 170 AOTs across the country and that an extra 50 would be created over the following three years. The intention was to make community care work better for those with severe and enduring mental health problems who have difficulty in engaging with existing services by ensuring services would be more responsive to their needs.

At the time of the NHS Plan, it was recognised that the evidence base for AOTs in England was not strong. It was agreed that there was a need for more rigorous evaluation of AOTs in real clinical practice. Hence, the Policy Research Programme (PRP) of the DH commissioned a programme of research aimed at improving the evidence base to inform both policy and service development. This work is reaching fruition and the intention of this seminar was to hear the results of this work and discuss it in a context of seeking to inform policy and practice development.

The focus of the day was on the practical realities of the operation of AOTs, drawing themes from recent and ongoing research and discussing these in the light of the experiences of people working in AO.

Research Presentations

A series of presentations of research related to assertive outreach were given. These represented some older research, some other research views and, in the main, findings from the research commissioned by the PRP. The following are brief summaries of the presentations.

1. The Pan London Assertive Outreach project (PLAO) – Stefan Priebe

This study of 24 AOTs across London included 187 staff and 580 service users and was conducted in 2001. It found that fidelity to the formal AO model varied greatly. There was moderate satisfaction amongst staff and low to average burnout amongst them. Admission rates at 9 months were 39%. The study described some characteristics of those using the services and found generally significant levels of social exclusion. The study showed that characteristics of teams, had little influence on outcome. A number of factors related to patients were predictive of poorer outcome. (Publications: Billings et al 2003; Priebe et al 2003; Wright et al 2003).

2. The REACT study; a randomised evaluation of assertive community treatment in North London – Helen Killaspy

REACT is a randomised trial of care through AOTs compared to care by Community Mental Health Teams (CMHTs) from 1999 until 2004. Eighteen months follow-up data are available. Overall, the AOTs in the study had moderate to high fidelity to the AO model. There was no difference between the two
modes of service delivery in terms of bed use (the primary outcome) or any differences in clinical or social function, or in quality of life after 18 months. It did, though, find that those receiving AOT care were more engaged with care provision and were more satisfied with it. A qualitative sub-study suggested that AOTs were working felt to be less coercive, and more informal and family orientated way than CMHTs. The sense is that sharing ideas and concerns with other team members through the team based approach and the opportunity for more frequent contact with clients facilitates a more flexible style which is more acceptable to both clients and staff working with this group.

Ongoing data collection will examine longer term impact on clinical and social outcomes of AOTs compared to CMHTs and a cost-effectiveness analysis will soon be completed.

3. Operational and individual predictors of outcome of assertive outreach throughout England – Terry Brugha

This study is an observational evaluation of predictors of outcome of AO in a national cohort throughout England. The hypothesis being studied was that team characteristics (such as caseload and multi-disciplinarity) would predict (i) admission rates, and (ii) the use of evidence based treatments such as CBT and family intervention. No team characteristics predicted the levels of admission rates. Relatively few clients in the study received evidence based interventions. Inputs and process data did not predict outcomes, but inputs (team characteristics conforming to the AO model) did predict the use of evidence based interventions by AO teams. However, it is very good news that hardly any patients were lost without trace by AO teams.

4. A meta-regression study to explain the heterogeneity in assertive outreach study outcomes – Max Marshall

Trials of AO published up to 2003 were included in the analysis. Previous studies using bed days as the outcome measure show substantial heterogeneity in their results. This analysis of all trials examined more deeply the whole set of results and found that the closer to fidelity an AOT is to the model of AO, the more likely it is to reduce bed days, have higher engagement with clients and support more independent living amongst service users. Also, closer fidelity tended to show there to be greater service user satisfaction associated with the team. Of crucial importance would seem to be the ‘team approach’ of managing caseloads as a team, regular team meetings etc.

5. Assertive Outreach in England; a national survey of service organisation – Christine Wright

This study of the characteristics of AOTs in England, examined 186 AOTs and 36 teams where the AO function is integrated into other teams. On many attributes, the specific AOTs scored well in terms of fidelity to the AO model, such as small individual caseloads, a team approach and responsibility for hospital admissions and discharge. In some instances case loads were very low. There were some notable fidelity attributes where these teams did not score so highly, notably having vocational support workers and substance abuse specialists, having responsibility for crisis services, dual disorder treatment groups and establishing a role for service users on the team. Generally teams had low psychiatric and psychological input. Often there was a low range and specialization of specific therapeutic interventions available - especially in integrated teams. Dedicated teams were more likely to have a diversity of mental
health disciplines represented in their staffing and more integrated health and social care staff. Levels of cultural awareness training and of team literature in languages other than English were generally low.

6. A summary of the trials of AO and the lessons for clinicians – Peter Tyrer

This overview of research on AO work highlighted some caveats to be considered. These included the fact that the AO model of fidelity was developed in the US, and, hence, may not be as readily applicable in England as is sometimes assumed, and that in the early US trials of AO the comparison intervention was virtually nil community services, unlike in England. The conclusions drawn from examining older studies of AO were that UK services do not reduce the number of bed days used, that they do promote engagement (but dependency needs to be avoided), and that they are liked by both service users and staff working in them. It was argued that there was a group of clients, those with impaired cognitive functioning (either as a result of a learning disability or as a consequence of the mental condition), who respond best to the assertive approach. The concluding message was that continuity of care is the essential point to achieve.

7. A caseload survey of all 29 AO teams in the North east – John Carpenter

All 29 AOTs in the area covered by the Northern & Yorkshire Research and Development Consortium were included. It is a census of 837 users of these teams between Sept 2002 and April 2003. The data have been compared to two (pre-AO) censuses of CMHT users (n1=1128; n2=407). The research is ongoing and will report analysis of baseline data before contact with an AOT and follow-up data afterwards, plus an examination of some wider system effects of developing AOTs in the localities being studied.


This is a qualitative study of why and how users of AOTs first disengage with services and then re-engage with AOTs. From in-depth interviews with service users the study found three key themes informing disengagement. These were, (i) a desire to be an independent person, (ii) a lack of active participation and poor therapeutic relationship, and (iii) a loss of control due to medication and side effects. Similarly, there were three key themes for engagement, namely (i) social support and engagement without a focus on medication, (ii) time and commitment from the staff, and (iii) a partnership model to the therapeutic relationship. The study emphasises the importance of: a) comprehensive care with social and practical support and avoidance of a single focus on medication; b) committed staff with sufficient time; c) stronger focus on relationship issues with patients as partners.

It was argued that admission to hospital and length of stay should not be the primary outcome, and that more attention should be given to the quality of care given.

Each of the studies in presentations 2-8 will be the subject of individual, more detailed publications in the future.
Discussion

Following the presentations, the whole seminar group discussed the overview emerging from what they had heard. This was followed by smaller group discussions on what key points ought to be made from this seminar. The following summarises what were felt to be these main points.

Key messages for AOTs

- There is a great deal of satisfaction and belief in AO amongst service users and staff. There is good success at engagement. This enthusiasm and success needs to be built on to make AO even more effective.
- A partnership approach to the therapeutic relationship with users and carers is central to the work of the teams. This should be allied with good team working and continuity of care for individuals. Working flexibly, in terms of visits, time, and issues being addressed, seems to help with engagement.
- Teams should continue to do those things which help with engagement, such as social recovery support, assistance with bills, housing etc., but should also do more clinical interventions.
- There is evidence of the under use of evidence based interventions by AO teams, even though many teams include appropriately qualified staff. Teams should have an appropriate mix of expertise, including ability to deliver specialist interventions, and should make best use of these. When doing the clinical interventions it is important to follow the evidence base where it exists, such as for medications and CBT, and implementing NICE guidance. Teams and individuals within them should reflect on what they are doing, why they are doing it, and how best to do it. Too explicit a focus on medication can adversely impact on engagement with more empowered service users, but too little focus misses an important evidence based intervention highly associated with relapse rates. Best practice would indicate use of NICE guidance on atypical anti-psychotics and a titration of the explicit emphasis on medication throughout the engagement and treatment cycles to maximise collaborative engagement.
- Good ‘clinical governance’ of teams is crucial, encompassing good supervision and critical reflection on how the team and individuals are working. Teams should routinely monitor what they do and outcomes, and audit their work.
- Close fidelity working enables good clinical working, as team working and regular team meetings facilitate good continuity of care and a team approach to focusing on clients as individuals with health and social needs. Effective management of team processes, good team work and supervision contribute to team satisfaction in their work and, hence, the ability to develop good, flexible therapeutic relationships.
- There is a need to ensure that AOTs are culturally inclusive in their work.
- Teams should know what they being expected to achieve in their localities.
- Teams should have clear, agreed criteria for how they work.
- There is a continuing need for networking amongst those involved in AO work to share good practice.
- AOTs should continue to evolve, with a focus on outcomes for users.

Key Messages for Policy Makers, Commissioners and Managers

a) Outcomes of Assertive Outreach

- The main message from the AO Research Programme is that AO is remarkably successful in engaging service users, and that loss of contact with clients is a relatively rare event. This is a considerable success given that the service
users are among the most difficult to engage and maintain contact with.

- There are high levels of satisfaction with services, particularly the service-user focus and co-ordination of activity across health and social care services. There are also good examples of collaborative working with the voluntary sector.
- AO should continue as a central element of comprehensive community mental health care for people with severe mental illness.
- The Research Programme was set up with reduction in bed-days as the primary outcome. Judged against this outcome cost-effectiveness has not been established. However, with hindsight this may not have been a realistic choice of primary outcome for the measurement of cost effectiveness given the nature of the client group.
- Compliance with a pre-determined model based on US experience is less important than considering what works in the UK context.

**b) Delivery of Interventions**

- AO is not an intervention, but a platform from which interventions are delivered.
- AO is still relatively new. The length of time needed to establish engagement with service users and to put services in place for them suggests that starting interventions (such as CBT) with an individual client may take longer than expected.
- Although delivery of interventions was much lower than expected, teams have now been in place for long enough that the expectation should be that interventions would be delivered more intensively. This may demand some consideration of team roles, and more staff who are qualified to deliver psychological therapies.

**c) Recommendations**

- Promotion of engagement should be central to the ethos of AO.
- AO teams should have a good mixture of mental health and social care disciplines. Good supervision and training is essential. Individual competencies should be recognised and made best use of.
- There are concerns that too much of the time of team members is spent in work other than in contact with service users. This suggests that hard questions need to be asked about time spent on such activities as bureaucracy and form filling by team members, and whether systems can be streamlined.
- Monitoring of performance of AOTs should be a mix of quality assurance (self-assessment) and inspection by those with knowledge of this work. This should include measures of cultural competence amongst the team.
- The Policy Implementation Guidance on AO would benefit from a review.
- At a local level a systems wide approach to AO and its links with other services (such as 24 hour services, crisis resolution teams) should be taken.
- AOTs should be judged on what they are established to achieve with this very difficult client group, and this should be clearly agreed by stakeholders. Any change in emphasis to simply increase the number of clients by taking on people who are not suitable for AO should be avoided.
- Consideration should be given as to how the successful features of AO working should be extended to other parts of mental healthcare.
Research Recommendations

The group identified the following points to consider in terms of further research:

- The fidelity model for AO has usefulness, but it was developed in the US in a very different context of community care. The fidelity model needs to be understood against a context of AO evolution in the UK and the likely continued evolution of AO as the environment of mental health care changes (including new legislation and policy developments such as ‘choice’ and ‘payment by results’). There may be need for a UK fidelity model.
- Social inclusion and quality of life issues are important and should be an important focus for research in to AO working. Existing evidence suggests that AO does not influence quality of life for service users, but this may be a problem with the scales used, given the finding of satisfaction with services. There is a need for longer time frames for outcome measurement in AO research. If interaction with clients does pass through different stages (e.g. year one – coping/engagement, year two – social needs, year three – intervention), this has implications for the timescale of any research/evaluation and measures used at each point.
- We need to know more about how to deliver the best interventions through AO, building on the strengths of AOTs. We can have some intuition about translating the evidence of interventions for specific interventions from other contexts, but AO does present a particular context requiring some specific research. There are research challenges in this, and more evidence is needed.
- It is not clear what the whole system impact of AOTs is in terms of links to other services, staffing, and what happens to service users after they move from AOTs to other services.
- We need to know more about the interaction of AO and primary care.
- Can we identify successful elements of AO and see how they transfer to other service delivery models? It would seem a rationale argument that integrating AO in CMHTs in some way is a good model of practice, yet the evidence thus far does not support this view. More investigation of this theme is needed.
- There may be scope for greater clarity about who is suitable for AO and particular interventions to better focus AO work and target resources. Those with cognitive impairments are an example of a group who might benefit from AO.
- What is it about the therapeutic relationship that benefits clients and how can it be sustained?
- How can AO workers best support families and carers?
- We need a closer examination of factors influencing the use of evidence-based psychological treatments by teams and of how to bring the best out of the multi-disciplinary mix in teams.
- Qualitative research needs to be given higher value.
References


