Assertive Outreach Handbook
Editors: Rob Macpherson and Nathan Gregory
Dedication

This handbook is dedicated to George Lott who worked as a Community Psychiatric Nurse in the Gloucester and Cheltenham assertive outreach teams.

George dedicated his 35 year career to working with people with severe mental health problems. He personified the human, caring and kindly face of nursing and he will be greatly missed by all those fortunate to have known him.
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Preface

Personalisation of care, individual budgets, plurality of provision, transparency of outcomes and consumer satisfaction all set the backdrop for determining which services will be successful in being chosen by service users and carers as most likely to achieve their desired outcomes.

Assertive Outreach Teams evolved to provide a recovery focussed, personalised approach to engaging with individuals for whom mainstream Community Mental Health Teams had failed. So, nearly nine years on from the publication of the National Service Framework for Mental Health, how have services measured up?

The question for all of us who work within mental health services must be, “would I be happy for a member of my family to access this service, safe in the knowledge that they would receive the very best services possible?”

This handbook provides examples showing that assertive outreach services “do exactly what they say on the tin”. They provide individualised care which is evidence based, recovery focussed and valued by its recipients.

I would recommend this handbook to any practitioners who are considering a role within an assertive outreach team or who simply want to learn more about achieving effective and valued service provision.

Shaun Clee
Part I – Introduction to the Handbook

The purpose of the Handbook and how to use it

Rob Macpherson and Nathan Gregory

This handbook has been developed to help professionals who work in or are associated with the work of assertive outreach teams, to understand the theoretical background to this type of work and to support best clinical practice in this challenging and rewarding field. It is hoped that clinical staff at all levels will find the handbook of interest, and it may have a value in team-based training and induction of new members to assertive outreach working.

We have developed the handbook so that it can be available in electronic or printed form and we have tried to involve service users and carers at all stages, with the intention to provide a real-life, genuine reflection of the work involved, from all perspectives. It is broken into six sections.

Part II provides perspectives from service users and carers on this type of work. Part III covers the theoretical background and philosophy underpinning assertive outreach, including the concept of ‘fidelity to the model’. It describes relevant United Kingdom health policy and summarises evidence from research on assertive outreach carried out in the United Kingdom and other countries to date.

Part IV focuses on the service user and the typical mental disorders which require an assertive outreach approach. It covers the assessment of service users referred for assertive outreach and describes some models which explain how psychotic illnesses occur. Part V describes the care pathway through assertive outreach services covering the phases of engagement; treatment; recovery / discharge and the typical interventions required. Part VI highlights the importance of the team approach and how this can be supported by management, supervision and training. Part VII describes the ‘whole systems approach’ to understanding the context of assertive outreach and how these teams work with other teams and services.

The handbook can be used whole or in parts, with staff in a number of settings. It may help to explain the philosophy and ‘style’ of assertive outreach work (with its challenges and dilemmas) to service users or carers. It may be useful to refer to some of the case discussions and vignettes in the handbook as a part of training, either individually or team based. However, to learn and develop services and practice, there is much to be gained from using real situations and cases actually dealt with and we recommend a focus on cases known to local services wherever possible.

Although we hope this handbook will help professionals and support good practice, we believe that the essence of good practice relies on the development of positive, trusting relationships with service users and carers, and relies on careful, reflective, professional judgment. We hope the handbook will help colleagues to develop the skills, values and attributes, which are essential in effective assertive outreach work.
Part II: Service user and carer perspectives on assertive outreach

Assertive outreach through the eyes of the service user

Jason Bloodworth, Margaret Gilroy and Karen Luckett

Service User 1

“I can’t say enough in favour of the assertive outreach team. I was transferred to them from my previous consultant because he thought I wasn’t getting better. But my new care co-ordinator and the team were amazing.

The advantage this group has over others in the mental health service is that they are able to give intensive help and visit someone every day if necessary. I needed this for a short while. My current key worker, in particular, went the extra mile. Nothing is too much for her, whether I am desperately depressed, anxious and despairing or cheerful and sociable. She genuinely cares and empathises, avoiding being judgemental.

Going out for regular coffees with her, for long walks with the team every Monday, playing badminton with them and more recently, helping on the allotment, are all helping to keep depression and the voices at bay.”

Service User 2

“I am a 49 year old white male with a diagnosis of both manic depressive and schizoaffective disorder. I’ve had hospital admissions for the past 18 years and had care at home for the past 10 years. Thoughts about the care I have received are as follows:

In the early years from 1990 to 1998, I had several admissions yet received no out-patient care. It would have been useful to have had someone to talk to – to help me understand mental illness and help me manage my life better. Since 1998 I’ve been seen by a number of nurses, both male and female.

I have had real problems with loan sharks – I almost fell prey to a finance company who was trying to get me to remortgage my house. Thankfully the nurse intervened and told them to leave me alone. I used the “phone preference” facility which prohibits people from cold calling. I fell into debt after my last job 10 years ago, before the benefits started. The nurse replied to my doctors on my behalf before the Citizens Advice Bureau took on my case. Since, the nurse has helped me claim the various benefits I am entitled to.

I have been in minor trouble with the police and the Council. The nurse attended an interview and made phone calls to save me from prosecution. I was taken to Bristol prison a few times and to Durham once, to visit my ex-wife and also to Newport for a deportation hearing. The female nurses used to take me out for a meal once a week which was much appreciated as I’m an awful cook.
I’ve enjoyed the convivial company of most of the nurses I’ve talked to, both in and out of hospital. They use the approach of “unconditional positive regard” which is so nice when some members of the public treat you as a leper. Another reason for visits is of course to check up on my mental state and advice on the treatment I need.”
Service User 3

“I became ill in 1997 after the death of my mum. At first I was diagnosed with depression but as my symptoms escalated that changed to Schizo-affective disorder. I spent the next seven years in and out of hospital mostly in Lincoln but later in Gloucester. My symptoms would improve, but that improvement never seemed to last. After a prolonged admission to hospital I was fortunate to go to a rehabilitation unit in the community. Here I learnt all the necessary skills to embark on an independent life. I was discharged from the unit into the care of the assertive outreach team.

At first my support was quite intense. My care co-ordinator visited three times a week. The care I received was highly individualised. At first I was quite difficult to engage with, but with time that improved. I was very impressed by the approach of the team. It was a multidisciplinary approach in the comfort of my own home. The main aim or goal was to lessen or eliminate my symptoms and to minimize or prevent episodes of the illness.

Over time the quality of my life was dramatically enhanced as was my ability to live independently. The whole ethos of the assertive outreach team seemed to suit me well. I spent far less time in hospital even though my mental state fluctuated a little. The ‘blips’ that would see me returning to hospital in the past were managed very successfully in the community. The help I received was both comprehensive and flexible. The assertive outreach staff seemed to have more time for me, which I guess was because of the staff to recipient ratio being higher than in other teams.

I think the most important benefit from being under the care of the assertive outreach team was to avoid crisis situations in the first place, or if that was not possible resolve my crisis without going back into hospital. The strengths and positives of the assertive outreach team speak for themselves. Personally, I was helped by the assertive outreach team for five years. During that time I grew as a person and my strengths and needs, hopes and desires were all catered for.

Eventually I became more able to solve my own problems and the assertive outreach team started to take a more back seat role. Knowing there was someone on the other end of the telephone if I couldn’t manage was enormously comforting. The assertive outreach team helped me find voluntary work and gave me belief in my own abilities. Today, I have come a long way and much of this is due to the ground work that the assertive outreach team did with me. I am working nearly full time in the mental health field, helping and encouraging people in the same way I was helped.

What would I do differently? Not much is the answer. I would promote independence as much as possible, whilst at the same time preventing over reliance on the team. I would encourage people to live for the future and not to ponder on the past.”
Carer perspectives on assertive outreach

Kathy Holmes

“I never get a proper break...even if I go out she’s ringing every five minutes... she gets so anxious, I don’t feel like I’ve got a life of my own.. I’m so tired.”

The burden of caring for someone with a mental health problem is well documented and there is much evidence to suggest that carers face lasting adverse affects on their own mental health, physical health, finances, family relationships careers and leisure time. (Rethink 2003, Princes Royal Trust for Carers 2004, Carers UK 2007).

The population of individuals using assertive outreach services are drawn from those people who experience severe, chronic and relapsing psychosis with a history of poor compliance to treatment, disengagement from services who also carry a significant risk of harm to themselves or others. Carers of people using assertive outreach services therefore find themselves in the situation of coping with behavioural problems, including violence, verbal aggression, mood changes, withdrawal, obsessions, self harm, phobias and paranoia.

“Sometimes he gets really angry even if I put the Hoover on – he says he can’t stand the noise – it makes the voices worse.”

Loss and feelings of bereavement for the person before they were ill, loss of hope for the future, including worry and anxiety about who will care for their loved one if they (the carer) become ill or die.

“I just wish I could wave a magic wand and it would all be better – but that’s not going to happen is it?”

Guilt about the cause of the illness – was it something they could have prevented or that they may have contributed to? Also, carers feel guilty if they feel resentful or angry about the burden of caring and can feel guilty about taking time for themselves.

“I don’t go away anymore – the last time when I got back he was back in hospital again – the police were involved and everything – it’s just not worth it.”

There may be constant worry for the present, for the future, how to respond to behaviours, continually thinking about how best to respond or to avoid upset or crisis.

“I lie awake at night going over the day in my head - is she getting worse, should I contact the mental health team, am I overreacting. Sometimes I just wish someone else would make the decisions.”

Social isolation and stigma - experienced through lack of understanding by friends and family. Planning everything around the needs of the person you care for – missing out on family functions, days out and having to give up work or education.

“Thank goodness for 24 hour shopping. He likes going to the shops, but can’t cope if there are a lot of people around so we go at 1, 2 or 3 in the morning.”
Emotional burden – this can affect the mental health of the carer causing stress, anxiety and depression. This not only affects the carers relationship to the cared for but affects relationships between other family members as they try to cope with what is happening in their own way. Family work can help families to understand how mental illness affects the sufferer and to recognise their own feelings, their hopes, fears, worries for the future and to develop strategies to cope.

Financial hardship - this may be because the person with the mental health problem was the main wage earner. It may also be because the carer has to reduce their hours of working, or does not feel able to take on demanding work roles because of the stress of what is happening in the family.

Children- they can find it hard to understand and accept what is happening to a parent, brother or sister. Their confusion and distress can be expressed in many different ways, either at home or at school, depending on their age. Living in an unpredictable environment may lead to difficulties at school, such as poor concentration.

The general household routine is often disrupted, with family members having to take on extra or different tasks to those they normally carry out.

Carers Legislation and Policy

Carers and Disabled Children’s Act (1995, 2000) - carers aged 16 or over who provide a regular and substantial amount of care for someone aged 18 or over have the right to an assessment of their needs as a carer.

Carers Equal Opportunities Act (2004) - carers must be informed that they are entitled to an assessment of their needs. Assessments must consider the carer’s needs in relation to work, study or leisure.

The National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should have:

- an assessment of their caring, physical and mental health needs, repeated on at least an annual basis
- their own written care plan which is given to them and implemented in discussion with them

Practice Point

Substantial care is when the care provided is essential for the service user’s safety, basic life needs and quality of life.

Regular care includes needs which may vary over time but which have a significant impact for the carer at specific times.
Identifying carers – what questions do you ask?

The person closest to someone or the person they live with isn’t necessarily the person who provides the most support. For example, Michael lives with his mum but spends all his time at his sister’s house. However both Michael’s mum and his sister will be affected by Michael’s illness and both maybe entitled to a carer’s assessment.

Practice Point

Most people who use mental health services will not identify the person who gives them the most support as their carer. The term does not sit comfortably with relatives or friends either who would not recognise themselves as a carer but as a close friend, partner, husband, wife, son, daughter or parent. Ask the questions:-

Who helps you at home?
Who do you call when you feel unwell?
Who do you see most often?
How do you spend your time?

NB: Carers who do not live with the cared for can become invisible to mental health services and are less likely to have informal contact with mental health workers. More effort is required to identify and make contact with these carers to avoid isolation and breakdown for the carer.

Involved and supported carers within mental health services have a better experience and are more effective carers than those who are uninvolved and without access to support and information (Under Pressure, Rethink, 2003). Consider carers as part of the care team, work with them as you would with colleagues, keep them informed and recognise their contribution to the care plan.

The following is a list of the kinds of support that is provided by relatives, friends, family members (you may be able to think of others).

- Social support
- Providing information (e.g. recognising change, providing a family history)
- Financial support
- Help with keeping appointments
- Personal Care – laundry, cooking, cleaning
- Love
- Support with physical health needs
- Encouragement
- Monitoring medication
- Advocating
- Assessing risk
- Never giving up hope

All this and without training! It is not surprising therefore that sometimes carers get it wrong and develop unhelpful ways of coping that can be detrimental to themselves and to the person they care for. Not all caring relationships are positive ones; sometimes the support that carers provide compromises and undermines the independence and well being of the service user. There may be many reasons for this, ranging from inadequate involvement
and support in the early days by mental health services, through to someone who is resentful at finding themselves in a caring role owing to a poor relationship that existed between the service user and the carer prior to the service user becoming ill.

**Practice Point**

The most useful skills that practitioners have in supporting the service user and carer in these kinds of situations are communication, problem solving, negotiation and achieving consensus.

**Working collaboratively with carers - what helps?**

- BEING TREATED AS PART OF THE TEAM
- Information and education about the illness and approaches to treatment
- Being involved in care planning and review
- Good engagement and support from mental health services for the person they care for
- Carer’s assessments
- Carer’s Support Workers
- Breaks from caring
- Financial help
- Someone to talk to, especially other people in similar situations – opportunities to share experiences

**Practice Point**

At the first point of contact offer a Carers Information Pack and referral to a Mental Health Carer Support Worker as well as an opportunity to tell their story – you may learn valuable information about the needs of the service user.

Providing carers with general information about mental health services, illnesses and treatments and listening to carers does not break patient confidentiality.

**Information sharing with families and carers**

We need to understand what the triggers of a relapse are and what the treatment will be, and get early intervention and quick responses. This stops the illness getting out of control. So if information is not shared with us, we won’t know when to seek help.

**Practice Point**

Help service users to understand the benefits of sharing appropriate information with their carer(s) including helping them to distinguish between general, personal and sensitive information.

Regularly confirm service user’s wishes around information sharing and support the use of advance statements.
Offering a carers needs assessment

Despite the legislation research indicates the number of carers receiving an assessment of their needs is low. (Carer UK 2003, Rethink 2003)

The carer’s needs assessment

Practice Point

Consider how the service user would manage without the input of the carer. Think about how the assessment is offered to the carer.

Offer support early on and if refused repeat the offer at a later stage. Sometimes in the early stages of caring it is difficult for carers to think about their own needs- they may not identify themselves as carers.

Think about how you can offer a carers needs assessment without using the word carer or assessment!

“We recognise that caring for someone with mental illness can be very difficult. Sometimes we can offer you a chance to discuss how this affects you, this will help us to understand the support you need and how best we can work together in supporting … name….”

Obtain permission from the carer to make a referral to a Mental Health Carer Support Worker who can spend time with the carer to explain the purpose and value of a Carers Needs Assessment.

The carer should be involved in the discussion of how, when and where the assessment might take place. The carer should be given a copy of any assessment forms and a leaflet “A Guide to a Carers Assessment” to help them think through the issues in advance of:

- An assessment based on a face to face conversation.
- The carer being told they can have a friend or advocate (Mental Health Carer Support Worker) present at the assessment.
- Consideration being given to the need for an interpreter or signer or other communication aids.
Who should carry out the carer’s needs assessment?

The responsibility for a carer’s needs assessment lies with the Care Programme Approach (CPA) care coordinator: this is a statutory duty and an essential part of care planning.

Practice Point

Whilst the care coordinator is best placed to carry out the assessment, in some circumstances it may be more appropriate for another team member to carry out the assessment – the important thing is that this is agreed in discussion with the carer.

Mental Health Carer Support workers do not have the authority to conduct carer’s needs assessment but they can provide support to the carer before, during and after assessments including with the implementation of the carer’s support plan.

What are the desired outcomes of a carer needs assessment?

The aims of a carer’s assessment are:

- To build trust and confidence in mental health services
- To enable the carer to consider how their life has changed or been affected by caring for someone
- To support the carer to recognise the right to have their own needs met
- Recognition of the caring role
- A chance to think about self and own well being
- Identify needs for information about illness, treatments and coping strategies
- Identify need for carer breaks, grants and carer support services
- Identify needs in relation to work, leisure and education
- Identify need for support – emotional and practical
- Finance/benefits check
- Develop Crisis/Emergency plan for the carer and the cared for
- Agree a plan for ongoing communication with the care coordinator (e mail?)

Practice Point

Confidentiality: The carer may wish to discuss information they have not revealed to the person they care for. Such information can only be shared with the service user with the carers consent.

The support plan should be agreed with the carer and they should be given a copy. With the carer’s consent a copy can be given to a Mental Health Carer Support Worker, the Trust Carer Participation Worker, the carers GP and the person they care for.
Young carers

Children and young people living with a parent or sibling with mental illness can suffer lasting long term affects on their education, health and wellbeing. When assessing young carer’s it is important to consider capacity to understand and to establish what support is available to them already from family, friends, school and social care organisations.

Practice Point

10 messages from children and young people to mental health professionals:

- Introduce yourself - tell us who you are and what your job is
- Give us as much information as you can
- Tell us what is wrong with our parents
- Tell us what is going to happen next
- Talk to us and listen to us. We are not aliens
- Ask us what we know and what we think. We live with our parents. We know how they have been behaving
- Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame
- Please don’t ignore us. Remember we are part of the family and we live there too
- Keep on talking to us and keeping us informed. We need to know what is happening
- Tell us if there is anyone we can talk to

MAYBE IT COULD BE YOU

Barnardo’s Action with Young Carers Liverpool

Supporting parent to parent

Work with the parent to identify what information about their illness/disorder they wish to remain confidential from their children and what information would help their children to understand. Encourage and enable the parent to talk with their child about their illness. Sometimes children’s fears are often worse than the facts. Consider who is best to assess the needs of the young carer, i.e. health professional, childcare social worker, joint assessment. Seek advice or make a referral to a Young Carers organisation.
Further Reading

Carers and Disabled Children’s Act (1995, 2000)

Carers Equal Opportunities Act (2004)


Part III: United Kingdom health policy and assertive outreach practice

Definitions, philosophy and aims of assertive outreach

Rob Macpherson

Service user’s comment:
‘It took a long time to get to know Jenny (care co-ordinator) and it has been difficult at times, but when you realise they really want to help and they are not ‘just part of the system’ it makes a real difference. Jenny came to see me even when I was in prison and so did Dr Jones, and that really made me think they care’.

Carer’s comment:
‘the team kept coming to see him even when he was at his worst, and would not go out or even talk to anyone. In the past we used to feel completely on our own until he ended up getting into really bad trouble locally and getting sectioned’.

Assertive: definition - Oxford English Dictionary: ‘cause others to recognise (one’s authority or a right) by confident and forceful behaviour’

Assertive outreach has developed in the United Kingdom to support service users who are considered to be at high risk of disengaging from services. The traditional community mental health team model was felt to provide insufficient support for the needs of some individuals, and tended to discharge some very ill service users at high risk of relapse, resulting in revolving door admissions and high levels of social and health needs, among many people with severe mental illness. It has become clear from experience and research that this form of service benefits primarily individuals with severe, chronic or relapsing psychosis. The assertive outreach team typically adopts a certain style of working, as shown in the box below

Assertive Outreach Style of Working

- an individualised approach
- progressive from working on basic needs (food, accommodation, finance) to higher level needs (relationships, work)
- needs led with an emphasis on access to normal activity (gym, pub, bookies), rather than engagement in day care / other services
- co-ordinated by identified care coordinator
- strengths-based to assess and focus on individual strengths
- focussed on development of social functioning and family involvement
- persistent and attempts to continue to support the service user even if the service user wants to disengage from services
- in the community and not traditional day centre / hospital settings
- about using optimal treatments, promoting treatment concordance, aiming to minimise symptoms of psychosis
- a way to support the service user to develop skills and independence about starting to look at problems around substance abuse, over time
The development of assertive outreach and fidelity to the model

Nathan Gregory

The assertive outreach model (initially referred to as assertive community treatment) was first developed in the United States during the 1980s by Len Stein and Mary Ann Test. It was intended to meet the complex health and social care needs of people with severe mental health problems living in the community and to counteract sharply rising readmission rates following the rapid process of hospital closure and de-institutionalisation in the United States. The model was dramatically successful in terms of reducing hospital admission rates and improving engagement with service users, and the idea that more intensive community based case management, focussing on people with complex needs, has been progressively developed from this early work.

Subsequently the assertive outreach model was taken up in Australia where it has demonstrated improvements in quality of life and reductions in hospital admission rates. The model is now delivered internationally with experts suggesting that there are a number of critical features of assertive outreach teams which are sometimes referred to as ‘fidelity markers’. These are:

**Assertive Outreach Fidelity Markers**

- A service delivered by a discrete multi disciplinary team able to provide a full range of interventions
- Most services are provided directly by the team and not brokered out
- Low staff to service user ratio of 1-10 to 1-12
- A majority of interventions provided within the community
- An emphasis on engagement and maintaining contact with service users
- The caseload is shared amongst the team although a care coordinator is allocated in line with the principles of the Care Programme Approach
- A highly coordinated intensive service with brief daily handover meetings and weekly clinical reviews
- Extended hours 7 days a week service with the capacity to manage crisis and increase contact daily according to need
- Time unlimited service for continuity of care

In the United Kingdom the model of assertive outreach is focused on those people who are difficult to engage, have a long history of severe and enduring mental health problems, have high levels of social chaos, have high usage of in-patient beds and present with multiple, complex needs. The assertive outreach model became enshrined in government documents including The National Service Framework for Mental Health (Department of Health 1999) and The National Health Service Plan (Department of Health 2001a); with estimates that 14-200 per 100,000 of the general population required this form of mental health service (Sainsbury Centre for Mental Health 1998). Through the development of the Policy Implementation Guide (in which standard fidelity markers for assertive outreach teams are described), United Kingdom health policy has strongly promoted the implementation of assertive outreach in every region of England and Wales and at the time of publication there are now approximately 250 teams working nationally.

However, British research into assertive outreach did not appear to replicate the original positive American and Australian findings. United Kingdom studies suggested that assertive outreach had little impact on hospital admission rates and led to little
improvements in clinical wellbeing. Evidence has been more favourable regarding social functioning / quality of life. More recent research suggests that assertive outreach teams are using less evidence based interventions than their American and Australian counterparts, including family work and cognitive behavioural therapy. High levels of satisfaction are reported by service users who appear to enjoy the supportive, socially based, flexible and creative approach employed by assertive outreach teams.

There appear to be several key messages for the continued development of assertive outreach in the United Kingdom. Importantly, teams require good governance arrangements incorporating clinical supervision and reflection, ideally supplemented by the use of routine outcome measures to promote better understanding and audit of the team’s work. Teams should be culturally inclusive and clear about expectations in their locality, with agreed operational criteria. Although assertive outreach is still a relatively new model with the engagement process taking time, the increased provision of interventions such as cognitive behaviour therapies requires attention.

For the future, assertive outreach teams in the United Kingdom will need to focus on improving outcomes for service users, including social inclusion and quality of life. Teams will require greater clarity about who will benefit from using their services in order to target resources effectively. Teams will need to address the difficult balance of providing regular contact, monitoring and maintenance in relation to nurturing, empowering and fostering independence of its service users.

Further Reading


National Forum Assertive Outreach Website: [www.nfao.co.uk](http://www.nfao.co.uk)
The evidence base for assertive outreach: international research and recent United Kingdom research

Attila Sipos

Stein and Test described their new community treatment programme as an “Alternative to Mental Hospital Treatment” in a series of papers published in 1980 (Stein and Test 1980; Test and Stein 1980; Weisbrod et al 1980). This marked the beginning of an ever growing research literature into the effectiveness of what became eventually known as assertive outreach. Most of the initial studies took place in the United States and focussed mainly on reduction in inpatient stay as the main outcome measure.

Marshall and Lockwood published the first systematic review of randomised controlled trials about the effectiveness of Assertive Community Treatment (ACT) in the Cochrane database in 1998 (Marshall and Lockwood 2000). Their meta-analysis of studies confirmed that service users allocated to ACT were significantly less likely to be admitted to hospital and more likely to remain in contact with services than those receiving standard community care and these findings had considerable impact on mental health policy makers world-wide. However, the vast majority of studies included in this review at the time were from the United States and this led to calls for similar trials to be conducted in the United Kingdom and other countries.

The first studies of “intensive case management” (ICM) in the United Kingdom failed to produce any significant differences in hospital admissions or other outcome measures (Muijen et al 1994; Marshall et al 1995; Tyrer et al 1995; Ford et al 1997; Holloway and Carson 1998). These findings prompted the design of the largest randomised controlled trial in the United Kingdom of this kind: The UK-700 trial examined the effectiveness of “intensive versus standard case management” in a large multi-centre trial involving more than 700 service users with psychosis (Burns et al 1999). Once again the results failed to show any significant decline in hospital use nor were there any significant gains in clinical and social functioning. The authors concluded that in “well-coordinated mental health services” a decline in case load alone does not lead to an improvement in outcome for service users. They sparked an intensive debate about the possible reasons for this apparent lack of effectiveness.

One school of thought was that these trials failed to show any improvements in outcome because of the unique characteristics of the United Kingdom National Health Service. They argued that United Kingdom standard care (involving free universal access to community psychiatric nurses and GPs) is superior to United States standard care and that these trials of ICM had failed to work in the United Kingdom because they were only capable of achieving a level of care that had already been achieved by United Kingdom standard care. Some of those holding this view also argued that assertive outreach and ICM were so similar that assertive outreach was also unlikely to work in the United Kingdom (Tyrer, 1998).

However, others argued that these findings were due to the fact that these trials on ICM in the United Kingdom were not sufficiently similar to the assertive outreach model (Marshall and Creed 2000). They pointed out none of the early United Kingdom studies had ever made use of an assertive outreach fidelity scale; so that it was hard to prove that they were indeed similar to the assertive outreach model. They also argued that United States trials comparing assertive outreach to ICM had shown that assertive outreach was of
superior efficacy, which would be hard to explain if assertive outreach was not somehow different to ICM (Marshall and Lockwood 2000).

Subsequent trials of assertive outreach in the United Kingdom have tried to address the issue of fidelity to the model much more explicitly (Priebe et al 2003). However, a randomised controlled trial involving 251 service users in London (Killaspy et al 2006) still failed to show any significant differences in inpatient bed use, clinical or social outcomes. This study did show that service users receiving assertive outreach treatment seemed better engaged and that those who agreed to be interviewed were more satisfied with services.

This inconsistency in the results of these trials on the effect on hospital use led Burns and Marshall to conduct another systematic review and meta-regression analysis of all ICM trials (Burns et al 2007). Their main finding was that trials with high hospital use at baseline or in the control group were more likely to show a reduction in hospital care. They also found that teams with higher fidelity to the assertive outreach model were more likely to reduce the use of hospital care, but this finding was less robust and differences in staffing levels did not explain variations between trials. The authors concluded that the introduction of ICM in itself is not going to lead to a reduction in hospital use in settings where average hospital use is already low. They suggested that teams could optimise their ability to reduce hospital use by organising themselves in the manner recommended for assertive community treatment and by focusing on service users with a high history of hospital use. However, only replicating staffing requirements for assertive outreach without implementation of the full assertive outreach model does not confer any measurable benefits.

The initial focus on reduction in the use of inpatient services as the main measure of success of assertive outreach teams has unfortunately distracted attention from the arguably more important success of these teams, in enabling staff to work with service users that community mental health teams had failed to engage for years. There is strong evidence that assertive outreach teams are able to maintain engagement with these service users and that this model is popular with both staff and service users (Killaspy 2007).

**Further Reading**


Further Reading (cont)


Part IV: Who is assertive outreach for?

The typical assertive outreach service user

*Pradeep Peddu and Rob Macpherson*

Each person is unique and will be assessed and treated in this way, but assertive outreach teams are highly staffed, specialist teams and need to focus clearly on the difficult to engage, challenging service users who are in greatest need of this type of approach. Team assessment of referrals will seek evidence of the need for assertive approach and that a standard approach can not meet those needs, for example documentation of attempts / frequency of contact or concerns expressed by other agencies.

Table 1 shows the characteristics of typical assertive outreach service users:

**Table 1. Service users who may benefit from assertive outreach**

| Typical features of assertive outreach service users | • Suffering from chronic / relapsing psychosis  
• Poor social functioning  
• History of poor compliance with treatment  
• Dual diagnosis  
• Disengagement from standard services  
• Moderate or high risk of self harm, neglect or risk to others  
• Several in-patient admissions  
• Live in unsuitable accommodation or stressful living conditions |
| More likely to benefit: possible emerging indicators (Burns & Firn 2002) | • Belonging to a black or minority ethnic group  
• Severe bipolar disorder  
• Borderline learning disability |

In order to use the team’s specialist approach effectively, it is important to identify presentations which are unlikely to benefit from an assertive approach, as indicated in Table 2.

**Table 2. Presentations not likely to benefit from an assertive outreach approach**

• Primary problem is a learning disability  
• Service user is in crisis at the point of referral and in need of a crisis / home treatment team approach  
• Significant offending behaviour, where the primary management is in the criminal justice system  
• Organic brain disease such as dementia  
• Primary problem is personality disorder  
• Substance abuse in the absence of a severe mental illness
Accepting and declining referrals to the team

The decision about accepting a referral is based on careful clinical judgment which will take account of the above factors, the pressure on the team, and awareness of the functioning of the referring team and most importantly, whether the team feels that an assertive approach may bring about a better outcome for the service user.

The following table gives a snapshot of the decisions made in three cases referred to an assertive outreach team. It is felt to be particularly important to communicate clearly and fully with referrers, when referrals are declined. Experience suggests that treating a referral like a second opinion assessment has many benefits, in that colleagues in other teams may benefit from the advice / support recommended in complex cases.

Outcomes from three referrals to an assertive outreach team

<table>
<thead>
<tr>
<th>Name</th>
<th>Details</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>John was a 23 year old man who had 3 admissions with paranoid schizophrenia since first getting ill 2 years ago. He has refused follow up after each discharge and he is believed to be using crack and cannabis, living in a neglected state in a bed and breakfast accommodation. He is recovering from his latest acute episode on an acute ward.</td>
<td>John was accepted by the assertive outreach team and in-reach started on the ward.</td>
</tr>
<tr>
<td>Jane</td>
<td>Jane was referred by a Community Mental Health Team (CMHT) consultant psychiatrist with a diagnosis of borderline personality disorder, with brief episodes of odd behaviour triggered by problems with family relationships, and repeated overdoses.</td>
<td>Jane was fully assessed but not accepted by the assertive outreach team. A detailed letter was sent to the consultant psychiatrist explaining reasons and recommending that a range of approaches should be considered including: a dialectic behaviour therapy approach; changes to ensure the prescription of psychotropic medication was made safer regarding risk of overdose; calling a multi-agency adult at risk meeting to manage risks.</td>
</tr>
<tr>
<td>Josie</td>
<td>Josie was a 27 year old female service user referred by the crisis team with problems of longstanding alcohol abuse, complicating personality difficulties of impulsivity and low frustration tolerance, 3 admissions for episodes of acute psychosis in the past 2 years, with increasing frequency pattern.</td>
<td>Initially assessed and agreed for the assertive outreach team to co-work alongside the CMHT for 6 months, to complete assessment and try to establish a community support package. At this stage, greater stability established and the assertive outreach team withdrew contact.</td>
</tr>
</tbody>
</table>
Common features of psychotic illness

Severe mental illnesses are major mental health conditions which cause a significant level of distress and disability to an individual, requiring a high level of support from mental health services. They commonly include psychotic conditions such as schizophrenia, schizo-affective disorder and severe mood disorders like bipolar affective disorder (manic depression). These conditions can affect the thoughts, feelings and behaviours causing distress and disability. Typically, they distort the nature of reality for the individual, for example due to hearing voices giving a critical message to the individual or frightening beliefs about being watched, spied on or persecuted.

A psychotic illness is a syndrome of multiple symptoms of illness, which can only be made by careful assessment over a prolonged period, by a clinician with training, skill and experience in making diagnoses, generally a psychiatrist. In the United Kingdom a diagnostic framework called the International Classification of Diseases - Version 10 (ICD-10) is used which describes all the categories of major mental illness and gives guidelines on making a diagnosis.

Other mental illnesses include neurotic illness such as anxiety and panic disorder, mood disorder such as depression, personality disorders and organic disorders like dementia. These illnesses are unlikely to be treated by assertive outreach teams, although many service users supported by assertive outreach teams have very complex illnesses, which include neurotic and personality problems, and often difficulties linked to substance misuse.

The traditional view of illnesses like schizophrenia was of a poor prognosis, which was probably linked to earlier models of care such as the asylum model and a lack of modern treatment approaches. It is now known from extensive research that there are many helpful physical, psychological and social approaches to helping individuals recover from even the most severe forms of psychosis ensuring a more optimistic and positive approach to treatment.

Epidemiology and rates of severe mental illness seen in assertive outreach teams

The total number of cases in a given population at a given time (prevalence) for schizophrenia is about 1.4 to 4.6 per thousand population. The life time risk for schizophrenia is approximately 1% and the life time risk of bipolar affective disorder is 0.6% to 1.1%. Assertive outreach teams specifically focus their work on these illnesses and are often the most ill service users, with complex treatment resistant illness. Typical rates are as follows:

<table>
<thead>
<tr>
<th>Primary diagnosis</th>
<th>Pan London Study 3 24 assertive outreach teams Total sample: 580</th>
<th>The Gloucester assertive community treatment team Total sample:79</th>
<th>UK700 Group Total sample: 353</th>
<th>29 ACT Teams in North East England Total sample: 836</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>74%</td>
<td>73%</td>
<td>35%</td>
<td>95%</td>
</tr>
<tr>
<td>Bipolar affective disorder</td>
<td>11%</td>
<td>8%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Schizo-affective disorder</td>
<td>17%</td>
<td></td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The causes of psychosis: a bio-psycho-social model

It is now widely accepted that there is no single cause for developing a major mental illness such as schizophrenia. The current thinking is that a mixture of biological, psychological and social factors plays a cumulative role in predisposing an individual to develop a mental health problem. Biological factors determine how an individual is made up, based on his / her genes, physiology, biochemistry and physical constitution. The evidence (summarised below) suggests that biological factors are important in predisposing people to schizophrenia.

Evidence of the importance of biological and genetic factors in causing schizophrenia

1. Twin, family and adoption studies have consistently demonstrated a genetic contribution in the development of schizophrenia.

2. The lifetime risk of developing schizophrenia is increased in relatives of people with schizophrenia.

3. There is also some evidence that people with schizophrenia have some abnormalities in brain structure.

4. It is widely believed that psychotic symptoms occur due to the imbalance of certain neurotransmitters (chemicals in the brain) like dopamine and serotonin, in the parts of the brain which are considered most important in schizophrenia (particularly the limbic system). Some modern antipsychotic treatments have been developed to try to target these chemical imbalances specifically.

The importance of social and developmental factors in causing schizophrenia

1. Psychological factors such as an individual’s early experiences, his / her upbringing and the individual’s personality also determine vulnerability to a mental illness.

2. Identical twins have about a 50% chance of developing schizophrenia if their twin has the illness showing that even when it is known someone has genes which can predispose to the illness (these twins have the same genes), there is no certainty that it will occur.

3. Social factors such as culture, occupation, social class and place of residence are some of the important factors that could contribute to development of a severe mental illness.

4. There is evidence that people who develop schizophrenia show in their childhood poor social competence compared with experimental controls. Some people have difficulties in information processing (cognitive difficulties). This could also affect their memory, attention and process of perception. This can result in misinterpretation of experiences such as hearing a laugh as an auditory hallucination.
The stress-vulnerability model

Not all people who have the above biological and psychological predisposing factors develop psychosis. It is proposed that only those people who have high vulnerability to environmental stress are likely to develop illness. The stress could be related to acute life events such as bereavements, physical health problems, pregnancy or trouble with the law. It also could be related to other environmental factors such as the use of illicit drugs/alcohol, accommodation problems or debts. There are certain protective factors such as having good coping skills, good social support and concordance with medication which can reduce the vulnerability to stress and therefore reduce vulnerability to psychotic illness.

Case example

Mr. B has a long history of schizophrenia and is currently under the care of the assertive outreach team who are visiting on a weekly basis. He was improving on 15mg of Olanzapine, when his elderly mother died last week. He started to show acute symptoms of psychosis. After a medical review his medication was increased to 20mg and the team increased support by visiting him on a daily basis. After a couple of weeks his psychotic symptoms resolved.
Further Reading


Part V: Working with the assertive outreach service user: principles of intervention

Engagement with a service user

*Bill Newton and Debbie Gorman*

The causes of disengagement from services

For over a decade assertive outreach teams have developed in the United Kingdom to reach out to individuals who have been ‘difficult to engage’ in mainstream mental health services (Department of Health 2000). Research in this area to date has focused on how service design and delivery influences outcomes such as hospital admission rates and symptom improvement (Burns et al 1999, Priebe et al 2004), yet little is known about what mental health professionals should actually do to engage individuals with serious mental illness and what psychosocial processes might cause previously disengaged service users to engage with assertive outreach teams (Lang et al 1999).

Some comments from assertive outreach service users:

“Being under the care of the assertive outreach team is reassuring as team members are always willing to spend as much time as you need”.

“I don’t want to be visited as often as this and I don’t need anyone to help me sort my life out”.

These two quotes from service users clearly capture the challenge of forging and maintaining successful relationships with individuals with serious mental illness: how often does someone want to be visited? How do people feel about a team of professionals becoming involved in their care? How much help should each individual be offered? What do we do if someone with psychosis tells us that they do not wish to be seen by anyone? All very real dilemmas experienced by anyone who has ever worked in trying to engage people with serious mental illness.

What is engagement?

Traditional definitions of the word engagement are not particularly helpful when applied to the care of people with serious mental illness. Definitions in the Oxford Paperback Dictionary and Thesaurus (2007) include: to take into one’s employment; to occupy the attention of; having promised to marry; a battle (we’ll come back to this later!). Roget's II: The New Thesaurus (2008) is a little more promising, and defines engagement as: a commitment to appear at a certain time and place. This latter definition, by virtue of it containing the word commitment, may be nearer to the spirit of what mental health professionals are trying to articulate. However, the definition remains inadequate.

The Sainsbury Centre for Mental Health (1998) state that assertive outreach teams have the potential to achieve engagement with 95% of people who have the greatest difficulty. However, even in this context, the term engagement is not clearly described, and it is thought by some to be a particularly overused and yet under-defined term (Burns & Firn 2002). Semantics aside, there is encouraging evidence that indicates individuals whose
relationship with mental health services has broken down can become re-engaged if they feel listened to and have a genuine say in decisions about their care.

The current approach of assertive outreach teams with protected caseloads is useful as it enables team members to give time and commitment to service users (The Sainsbury Centre for Mental Health 1998). This approach can enable team members to form positive, trusting relationships with service users and familiarise themselves with the particular circumstances of their day to day lives, which can promote a sense of greater independence for the service user. The gaining of autonomy, the loss of which has often been a crucial factor in disengagement, is further strengthened if people are given the chance to be involved actively in making decisions about their treatment (Weaver et al 2003). Building the necessary relationship often requires time, patience and reliable commitment. The broadly encompassing, bio-psycho-social, multi-disciplinary approach of assertive outreach teams is well suited to help service users avoid a sense of being confined to the role of “psychiatric patient”, and the practical assistance beyond a purely medical focus can enable individuals to regain some control over their lives.

Factors affecting engagement

In a key document, Keys to Engagement (The Sainsbury Centre for Mental Health 1998), much is written about why service users find it difficult to engage with services and why services find it difficult to engage with service users. Assertive outreach professionals should be sensitive to the following factors:

**Person specific**

- Culture / values / beliefs
- Previous experiences
- Support network – positive or negative
- Personality
- Perceived need for treatment / insight – “I do not need help"
- Developmental issues
- Homelessness / social problems / other agencies involved

**Illness specific**

- Psychotic symptoms – positive / negative
- Substance misuse / history of offending
- Paranoia / fear
- Mania – grandiosity
- Irritability / anxiety / depression

**Treatment/service specific**

- Previous bad experiences of services – the person may have experienced:
  - Negative attitudes from staff
  - Racism / or staff lack of knowledge of other cultures
  - Service too focussed on outcomes / or medical treatment alone
  - Staff may lack appropriate skills
- Staff may have little time
- Poor resources
- Concerns about stigma or discrimination
- Compulsory treatment, which may have included restraint and forced treatment

- Treatment setting may be seen as
  - Too restrictive
  - Too clinical
  - Inflexible

How do we engage people?

The Sainsbury Centre for Mental Health (1998) states that:

“The foundation for effective assertive outreach services will be engagement and persistence with a constructive rather than restrictive approach to keeping track of people”.

It is important to remember that engagement is a term used by mental health professionals rather than service users. The term may be met with suspicion when used in the context of preventing people from “falling through the net”: a net can provide safety but it can also be used to catch things in (Burns and Firn 2002). Remember the Oxford Dictionary definition of engagement as a battle, and put yourself in the shoes of someone who is being engaged? Consider what this might mean to someone with significant perceptual and thought disorders. Engagement should not be seen only as a means to an end; as supporting people in social and recreational activities can have a positive and lasting effect on quality of life. Evidence suggests that a range of quite basic psychosocial approaches is helpful in improving engagement with people with serious mental illness (Hannigan et al 1997, Billings et al 2003, Priebe et al, 2005). Examples are shown in Box 1 below.

Box 1. Psychological approaches to engagement

- moving away from an exclusive focus on medication and symptom control is a crucial element in improving the therapeutic relationship
- the interest of assertive outreach team members in the day to day lives of service users is regarded as a welcome remedy against individuals being viewed as just “patients with symptoms”
- efforts to increase social and recreational activities can significantly improve the quality of life of service users
- support with educational and work opportunities gives meaning and structure in day to day life, and hope for the future
- practical help with basic domestic problems is seen as a vital aspect of recognising the everyday difficulties of service users lives
The way in which an effective assertive outreach team aspires to making engagement work is captured in the ten simple principles as shown in Box 2:

**Box 2. Ten simple principles to engagement**

1. Be collaborative and work together with the service user; be ‘normal’ and use language which is understandable and common to the service user
2. Concentrate on strengths focused interventions
3. Be prepared to give as much time as the service user needs; know when to back off / give space but remain available to the person
4. Encourage as much independence as possible
5. Encourage and support “mainstream” social, recreational, educational and occupational pursuits
6. Be prepared to give assistance with practical tasks
7. Offer problem solving approaches to service users and their carers
8. Be consistent; use low key, unobtrusive persistence to attempt to engage someone
9. Be flexible
10. Be supportive

**Case illustration**

Adam is a 21 year old man with a four year history of florid psychosis, marked by unremitting persecutory delusional ideation and significant perceptual difficulties. Over the years, Adam’s problems had been compounded by poor concordance with medication, substance misuse issues and a chaotic domestic lifestyle in which he regularly physically assaulted family members with whom he was living. Prior to referral to the assertive outreach team in 2006, Adam had been unwilling to see anyone from the Community Mental Health Team (CMHT), and had been admitted numerous times to the local mental health inpatient unit under section 3 of the Mental Health Act.

At the point of referral to the assertive outreach team, time was spent discussing the right approach to Adam’s problems. This reflective, multi-disciplinary focus allowed the team to collaboratively work out such issues as: who would be best to take on the role of care coordinator? Was a team based or individual approach best initially? How could meaningful care plans and risk assessments best be undertaken? In what way should family members be involved? What lessons could be learned from previous approaches?

A significant issue relating to Adam’s unwillingness to engage with mainstream mental health services was his risk of aggression and violence to health care professionals. He had consistently threatened to “smack” those who came to his door, a situation which, perhaps understandably, led to a reluctance of the CMHT to attempt visiting.
Consequently, Adam’s father increasingly became his primary care provider, and although this was beginning to affect his own health, no-one had attempted to approach him with a view to addressing these difficulties.

An action plan was drawn up which included the following principles:

- A member of the assertive outreach team was identified to make contact with Adam’s father and arrange a carers assessment.

- With his consent, it was decided to visit Adam’s father when Adam was actually at home, in order to involve him in any discussion that might ensue. The rationale for this was to open up a transparent dialogue with Adam, rather than compound his suspicions and anxieties by making decisions without him being present.

- Daily visits to Adam by one consistent team member, who would offer to meet him on his terms, at a venue of his choice.

- Visits / meetings to be as “non-clinical” and unthreatening as possible, with the aim of talking to Adam as a “person” rather than a “patient”.

- No formal assessments to be undertaken, and to allow Adam to control the timing, nature and course of any conversations and meetings.

- Assertive outreach team member to be absolutely consistent, warm, genuine, non-judgmental and non-threatening.

Assertive outreach team member to have access to support via mobile phone, as well as regular clinical supervision.

Over a ten week course of adhering to the fidelity of this proposed model (and many trips to buy MacDonald’s food!) Adam became more accepting of visits and agreed to an informal admission to the local inpatient unit for further assessment and treatment. Eighteen months on, and Adam has spent almost a year in a specialist recovery unit and is now working towards semi-independent accommodation. He is taking his medication, accepting regular contact with the assertive outreach team, and is considering a college course later this year. Adam continues to experience significant problems related to psychosis in his day to day life. However, his quality of life has greatly improved, and he has something that he never had until very recently: hope for the future.

How do we measure engagement?

The above case illustration highlights the need to accurately assess levels of engagement at the point of initial contact with the service user. However, as engagement is an organic, ever-changing process, assessment should take place at regular intervals with the use of a reliable measurement tool. At the point of initial assessment, we would encourage the referring key worker to complete the Engagement Measure (Hall et al 2001, see Appendix). This is an 11-item measure focusing on 6 specific areas: appointment keeping; interactions with professionals involved; communication / openness; perceived usefulness of treatment; collaboration with treatment; compliance with medication. Scores of 33 and above indicate progressively good engagement. This measure is best repeated at appropriate junctures (for example, prior to CPA review meetings), depending on each individual’s stage of engagement with the assertive outreach team. At the point of entry into the team, Adam’s engagement score was 17; eighteen months on and this has increased to 36. Studies utilizing the Engagement Measure suggest that it is a reliable
method of establishing how well service users are engaged with assertive outreach teams (Macpherson et al 2007). Other studies focusing on engagement suggest that engagement (often measured as a proportion of face-to-face contacts) is greater within assertive outreach teams of caseloads of 10-15 (Burns et al 1999). Other tools used in the measurement of engagement with assertive outreach teams include: the Service Engagement Scale (Tait et al 2002); a 14-item measure consisting of statements that assess engagement with services. The total score ranges from a minimum of zero to a maximum of 42. Higher scores indicate lower engagement. The scale has high internal consistency and retest reliability in an assertive outreach team context (Tait et al 2002): The Dartmouth Assertive Community Treatment Scale (Teague et al 1998) specifically measures fidelity markers, including drop out and engagement mechanisms (see Appendix 2).

In conclusion, there is evidence that simply focusing on the content of an individual’s psychotic symptoms is not particularly helpful in the process of engagement (McCabe et al 2002). Understanding people’s own concerns about their illness and day to day practical difficulties is a more helpful approach, and may be crucial in initiating and building on positive relationships.

**Further Reading**


Further Reading (cont)


Needs assessment in assertive outreach

Mike Slade

What is needs assessment?

The requirement for a needs led approach to providing mental health care was first established by the National Health Service and Community Care Act (1990). Three principles have emerged from nearly two decades of implementation:

- Service users with the most wide-ranging and severe health and social needs should receive the most specialist mental health care. This has led to the tiered care approach used in National Institute of Clinical Excellence (NICE) Guidelines.

- Assessment of need is a separate process from decisions about what care or treatment to provide. Assessing whether the person has access to enough activities which are meaningful (to them) each day is different from assessing whether they need to attend a day centre.

- The process of assessment and care planning for service users should consider their individual circumstances, problems and, in an era of recovery-focussed care, their personal goals rather than clinical imperatives.

Needs assessment is now established as an important component of mental health care internationally (Andrews and Henderson 2000).

Measurement of need

The most widely used assessment internationally is the Camberwell Assessment of Need (CAN, Slade et al 1999). The CAN assesses the health and social needs of people with severe mental health problems in 22 domains, shown in Box 1.

Box 1. Need domains assessed by the Camberwell Assessment of Need

<table>
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<td>3. Looking after the home</td>
<td>11. Safety to others</td>
<td>19. Telephone</td>
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<tr>
<td>7. Psychotic Symptoms</td>
<td>15. Intimate relationships</td>
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<tr>
<td>8. Information</td>
<td>16. Sexual expression</td>
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Four principles governed the development of the CAN. First, everyone has needs, and although mental health service users have some specific needs, the majority of their needs are similar to those of people who do not have a mental illness. Second, the majority of people with a severe mental illness have multiple needs, and it is vital that all of them are identified by those caring for them. Therefore a priority of the CAN is to identify, rather than describe in detail, serious needs. Third, needs assessment should be both an integral part of routine clinical practice and a component of service evaluation. Therefore the CAN
should be useable by a wide range of staff. Fourth, need is a subjective concept, and there will frequently be differing but equally valid perceptions about the presence or absence of a specific need. The CAN therefore records the views of staff and service users separately.

A need rating is made for each domain: unmet need (current serious problem), met need (no / moderate problem due to help given) or no need. A key feature is that separate assessments can be made by staff, carer and by the service user.

**Needs assessment in assertive outreach settings**

Using the CAN to assess needs is especially relevant to assertive outreach settings, for three reasons.

1. Unlike more staff oriented assessment measures, the CAN is suitable for completion with the service user. It can provide a safe start point for engaging with the individual, and by focussing on needs which are predominantly not related to mental illness, it encourages discussion related to the priorities of the service user rather than the concerns of the clinician. Since relationships are central to assertive outreach work, jointly completing and then discussing points of difference in perceptions about needs can contribute to the development of a good working alliance. This leads to greater engagement with services (Lasalvia et al 2008).

2. The consideration of a wide range of health and social needs allows most problem areas to be identified, following which decisions can be jointly made about which to prioritise. This ensures that assessment of need is comprehensive, rather than being shaped by the clinical background of the clinician. This does not necessarily mean having a paper copy of the CAN on show – the challenge is to undertake a comprehensive assessment of need whilst maintaining the focus on the service user and their story. One approach is to use the CAN domains in Box 1 as a mental check-list of areas to cover during assessment.

3. There is empirical evidence that providing care on the basis of the service user’s perspective about their unmet needs has a stronger impact on quality of life (Slade et al 2005) and on therapeutic alliance (Junghan et al 2007) than basing care on staff assessment. This provides an evidence base for good assertive outreach practice: focussing assessment and treatment planning efforts on identifying and working towards the individual’s goals.

The systematic and ongoing assessment of need can meet many requirements of assertive outreach services: facilitating engagement, ensuring regular risk assessment, considering social functioning and substance misuse issues in addition to mental illness-related difficulties, and making sure that attention is given to everyday needs such as housing and daytime activities, rather than solely focussing on symptoms and diagnosis.
Further Reading


Risk assessment and management

Amjad Uppal

Risk assessment and management is a fundamental part of mental health work and has had a high profile for some years now. While it can be perceived as less important than other aspects of the clinician’s work, maintaining a thorough, up to date, systematic record of risk assessment and management is now mandatory. Mental Health Trusts are required not only to develop and implement policies for the assessment and management of risk but also to ensure that staff receive appropriate training to enable them to do this.

The concept of risk, its assessment and management

Risk is a complex and multidimensional concept; it is dynamic and varies with time, context and intervention. Risk assessment involves the collection and collation of all relevant information from epidemiology, history, current mental state and circumstances in an attempt to predict and alter possible outcomes. Pragmatically, risk management must be thought of in terms of minimization of dangers to and from mental health service users.

A mental health professional having identified a risk has the responsibility to take action with a view to ensuring that risk is reduced and managed effectively. Also, the management plan should change the balance between risk and safety, following the principle of negotiating safety. When an appropriate risk management plan has been agreed by the multi-disciplinary team it should be appropriately documented and disseminated to all the professionals involved in the service user’s care. The plan should also be monitored for adherence by the staff and reviewed at appropriate intervals.

Positive risk management

Positive risk taking is described in ‘Best Practice in Managing Risk’ (Department of Health 2007). This means being mindful that risk can never be eliminated and that management plans will inevitably have to include decisions that carry some form of risk. These should be clear in the decision making process and should ideally be discussed with the service user. The document sets out principles of risk management, summarised as follows:

- Involving the service user in determining what is feasible
- Involving the carers and any significant others in deciding a future course of action
- Weighing the pros and cons of one action over another
- Being prepared to take a decision even if it involves an element of risk because the potential benefit outweighs the risk.
- Clear communication to all involved about the potential risks and benefits
- Agreeing plans that maximize the positive potentials and priorities of the service user and minimize any risks to the service user or others
- Making sure that the service user and all others involved in their care are familiar with the plan and the rationale

Making full use of all the available resources to strike a balance between achieving the desired outcome and minimizing the potential harmful outcome.
Risk assessment and management in assertive outreach

Risk assessment and management in assertive outreach has its challenges. Risk may comprise risk to self in the form of self harm or suicide, violence towards others, risk of self neglect or of exploitation by others. The identification of risk is crucial to the process of assessment and management. Risk assessment is an integral, constant and fluid process rather than a one-off duty. It combines ‘actuarial’ and ‘clinical’ approaches.

An actuarial approach is a formal method using statistics to arrive at a probability of an outcome. It provides us with clues to broad populations at risk but informs us inadequately on the individual. For example, being single and male with a diagnosis of schizophrenia is associated with a high risk of suicide. While this is useful to know, it does not inform a risk management plan and the risk will not in fact change whatever clinical management plan is put in place. The clinical approach on the other hand is based on informal, subjective conclusions reached by clinical judgement. There is a consensus that sole reliance on unstructured clinical assessment is inadequate and structured approaches are advised.

Risk assessment should include a comprehensive psychiatric assessment focusing on:

**History:** previous violence or suicidal behaviour, previous relationships, frequent moves, poor concordance with treatment or lack of engagement with psychiatric services, alcohol excess or substance misuse, social background promoting violence, any stressors or changes in mental state that have occurred prior to violence or relapse.

**Environment:** access to potential victims, particularly individuals identified in an abnormal mental state.

**Mental State:** evidence of any threat / control override symptoms, any persecutory delusions or any delusions of passivity, emotions related to violence, for example, irritability, anger, hostility, suspiciousness or any specific threats made.

A formulation should be made based on these in light of the information gleaned from other items of the history and mental state. This formulation should aim to address the following questions:

- what is the seriousness of the risk?
- is the risk specific or general?
- how immediate and volatile is the risk?
- what plan of action can best reduce the risk?
Frameworks supporting Risk Assessment and Management

**Mental Health Act (2007):** The Act allows for compulsory admission to hospital for those who are considered to be in need of treatment because they are a danger to themselves or others.

**MARMAP:** (Multi Agency Risk Management and Assessment Process) Providing care to people with a mental illness and with complex needs can be challenging. MARMAP conferences are held to decide whether a person’s behaviour presents a risk and if so whether they should be recognised by registration. The conference will also generate a ‘care plan’ to try to reduce the risk presented. This is reviewed at regular intervals of not more than 6 months.

**MAPPA:** (Multi-Agency Public Protection Arrangements) This supports the assessment and management of the most serious sexual and violent offenders. The aim is to ensure that the management plan drawn up to reduce risk is informed by the information, skills, and resources by the individual agencies being coordinated through the MAPPA. It was introduced in 2001 and brings the Police, Probation and Prison Services together to form the MAPPA Responsible Authority.

**Further Reading**


Developing therapeutic relationships in assertive outreach

Rachel Freeth and Caroline Jennings

Few mental health professionals would disagree that the therapeutic relationship they form with service users is an important component of effective practice. What is debated, perhaps, is the degree of importance attached to it and whether it constitutes a primary helping tool, especially in settings that rely heavily on physical treatments such as medication.

In what follows, we suggest that the relationship mental health professionals develop with service users is a crucial topic deserving much closer scrutiny and reflection than it tends to receive. Indeed, it is commonplace for the term ‘therapeutic relationship’ to be used with little attempt to tease out its characteristics. We will begin, therefore, by exploring briefly the nature of the therapeutic relationship. This is followed by considering therapeutic relationships in the context of assertive outreach, highlighting in particular some of the special challenges commonly faced by assertive outreach professionals. Finally, we include some user and carer perspectives, since it is from them that most of our real understanding develops.

What is a therapeutic relationship?

In its broadest sense it could be regarded as any relationship in which help or healing takes place, whether a longstanding relationship or fleeting encounter. The helper has a clear aim of being helpful or healing in the way he or she establishes a relationship with the service user. This can be viewed as a means to an end (e.g. to aid concordance with medication or negotiate other treatments and thereby improve outcomes), or as an end in itself because relationship just is important and necessary for well-being.

How the relationship is developed will probably depend on the particular professional role of the mental health worker. For example, care co-ordinators, or those professionals who are in more regular contact with service users, will have far more opportunities to get to know service users and find ways of relating and developing trust, than, say, psychiatrists whose contact may be limited to more formal reviews every few months, or contact only at points of crisis. However, regardless of frequency of contact or the precise role of professional, the quality of relationship is in most cases likely to be heavily influenced by the way service users are related to. Here we would like to make an important distinction between relating and interaction. Whilst interaction concerns communication skills and observable behaviours, relating involves adopting certain attitudes, for example, of respect, warmth, hope, active interest, compassion, curiosity, a desire to understand and honesty. In other words, the therapeutic relationship is not simply the outcome of what we do (e.g. how we communicate), but of how we are with people, reflected in our willingness to listen and other basic attitudes.

From what we have said so far then, it should be clear that the development of the therapeutic relationship is a highly conscious activity which time for focused reflection (for example, on our values, attitudes, cultural influences), could greatly enhance. This is especially so when we are struggling to develop therapeutic relationships because of, say, a clash of values or differences of cultural background. We also believe that we should not be afraid to speak openly about our relationships with service users and to find ways of asking them what they think and feel about us, what is important to them about their contact with us and what is unhelpful. It is important to get a sense of whether we are
trusted, for trust is the special glue of the therapeutic relationship. How we go about having these conversations will vary enormously according to the service user, our own personality and communication style, experience and expertise.

**Therapeutic relationships in the assertive outreach context**

Assertive outreach settings present particular challenges for mental health professionals seeking to develop and establish therapeutic relationships with service users. In the first instance, many service users may not want a relationship of any kind with mental health professionals, hence their referral to the service, being described as ‘difficult to engage’. The nature of service users’ psychopathology may also interfere with the development of the relationship and they often have a long history of contact with mental health services which can negatively influence their attitudes towards mental health professionals, especially if much of that contact has been difficult. What follows are several brief, fictitious (but realistic) vignettes that illustrate the particular challenge for assertive outreach professionals developing therapeutic relationships.

**Vignettes: developing a therapeutic relationship and examples of particular challenges**

- Rebecca has had a diagnosis of paranoid schizophrenia for over 20 years. She has a long-standing delusional belief that her psychiatrist works for the secret service and all other team members are working to the psychiatrist’s instructions. All are to be feared and hated because, in her thinking, they are trying to control her and prevent her from having any pleasure in life.

- Julie is a 36 year old single woman who frequently demands members of the team to give her lifts to the shops or to visit various relatives. When the team are not able to assist she becomes abusive and threatening. As well as having a severe illness, Julie also demonstrates little willingness to take responsibility for many aspects of her day to day life and she is someone members of the team find it difficult to warm to and relate to with patience and understanding.

- Michael is a 22 year old man who has been convicted of several drugs related offences. He also has a diagnosis of schizophrenia for which high doses of antipsychotic medication in depot form are prescribed. He has little insight into this illness. He views the assertive outreach team with contempt, believing that they unnecessarily interfere with his life and “pump me full of your drugs”. When under the influence of illicit substances he has been known to be violent.

- Nicole is in her 60s and has been under the care of mental health services all her life. She was previously under the care of the rehabilitation team, living in a group home. She generally prefers to be on her own and lacks any interest in others. This, and a severe formal thought disorder, makes it difficult to have a conversation with her, let alone build a therapeutic relationship.

- David has just been placed under section 3 of the Mental Health Act and brought into hospital again. Each time members of the team see him he expresses rage that they have taken away his freedom and, in his eyes, are infringing his human rights.
It is also important to be aware of how organisational pressures influence our relationships with service users, for example, case load size, paperwork and the need to demonstrate effective throughput between clinical teams. Team working, although an important aspect of assertive outreach work may also possibly hinder the development of a therapeutic relationship between the service user and individual clinicians.

In conclusion, development of the therapeutic relationship is not something that just happens. Neither is it just having good communication skills. It is something that needs to be a disciplined and conscious activity. In assertive outreach settings it can be particularly demanding and we believe strongly that this vital aspect of our work should be supported through adequate training and supervision arrangements. However, despite the challenges, developing relationships with people who find it difficult to trust others, or who have other severe difficulties that may have led them to be shunned by society, can be a very rewarding aspect of assertive outreach work, which makes the investment of time and energy worthwhile.

Important characteristics of the therapeutic relationship identified by service users and carers

- Empathy
- Honesty
- Trust
- Equality

“What makes a relationship helpful?” Quotes by service users and carers

“Honesty, being on a level with that person, feeling equal.”

“Trust, honesty, not withholding information. Don’t lead me up the garden path.”

“Empathy and good practical suggestions based on knowledge and experience.”

“Listening to me and believing what I’m saying.”

“Knowing someone is available and will respond to my concerns”

“Being listened to and knowing action will be taken…..accepting that we are important even though we don’t have expert knowledge.”
The importance of personality factors in assertive outreach work

Ruth Thompson

The term personality is a difficult concept to define. However most people would have some idea of what it means. Personality can be described as that which makes us the person we are, but it is a vague concept: it cannot be located in any one place in the brain; it has been formed and changed due to our experiences when growing up. It is what makes us individuals, as no two personalities are exactly alike (Geraghty 2002).

“Personality is that which makes us who we are and leads us to behave in certain way”.

“Today, personality is seen as a complex pattern of deeply embedded psychological characteristics that are expressed automatically in every area of functioning. That is, personality is viewed as the patterning of characteristics across the entire matrix of the person”.

(Millon, 2004; p 2).

The concept of “personality disorder”

If you were asked to describe someone who is important to you, the chances are that you would describe them in fairly general terms and probably according to broad characteristics. For example: kind hearted or mean, outgoing or shy, energetic or laid back. In contrast, “personality disorder” has a number of specific definitions. A description of these is provided later on in this section.

Millon (2004) describes a personality trait as ‘a long standing pattern of behavior expressed across time and in many different situations’. Where a group of dysfunctional personality traits typically occur together, and lead to harm to the individual or others, they may be said to constitute a personality disorder

However, this is a difficult concept to understand and one which lacks consensus. For example, how can something as fundamental as a personality be disordered and does a diagnostic classification really give a clear understanding of “personality disorder”?

Some key points about personality disorder

- “Personality disorder” is a psychiatric diagnosis. According to the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV), there are ten personality disorders. The International Classification of Diseases (ICD-10), which is used in the United Kingdom, however states that here are nine categories. Despite this difference both classification systems advise that in order to be diagnosed with personality disorder, the symptoms must be persistent, pervasive, inflexible, inappropriate, and cause distress to the individual or to others. The following is a table showing the main types of personality disorder:
Personality Disorders – DSM IV Clusters and Description

| Cluster A | Paranoid Personality Disorder | • Shows mistrust and suspicion  
| | | • Feels other people have harmful motives |
| | Schizoid Personality Disorder | • Shows no desire or need for human attachments  
| | | • Appears indifferent to own and others’ feelings |
| | Schizotypal Personality Disorder | • Shows eccentric behavior  
| | | • Uncomfortable in close relationships |

| Cluster B | Histrionic Personality Disorder | • Excessively emotional  
| | | • Easily overreacts to minor events  
| | | • Attention Seeking |
| | Narcissistic Personality Disorder | • Sees self as admirable, superior and special  
| | | • Needs to be admired  
| | | • Egotistical with fantasies of success, beauty or achievement |
| | Anti-social Personality Disorder | • Disregards the rights of others  
| | | • Impulsive and irresponsible  
| | | • Disrespects social customs and rules |
| | Borderline Personality Disorder | • Shows instability in moods, relationships and self-esteem  
| | | • Impulsive and unpredictable  
| | | • Disrespects social customs and rules |

| Cluster C | Obsessive-compulsive Disorder | • Preoccupied with orderliness and control  
| | | • Compelled within lifestyle to stick rigidly to certain rules |
| | Avoidance Personality Disorder | • Feels self-conscious, socially inhibited and inadequate  
| | | • Hypersensitive to negative comments  
| | | • Feels alone and empty |
| | Dependent Personality Disorder | • Submissive and clinging  
| | | • Helpless and in need of care and reassurance from others |

- These classification systems are intended to aid communication, so that clinicians can identify and discuss groups of similar people with the same diagnosis. Treatment approaches can also be determined.

- Personality disorder has been associated with exclusion from certain services. In many cases this has led to a stigmatizing effect for the person and there is concern about the validity of the term personality disorder, which it is sometimes argued conveys a more negative impression than any other diagnostic label.

- It is important to recognize that personality disorder is often associated with other mental illnesses and it is possible to have co-morbid personality disorder and psychotic illness. In these cases, the two disorders tend to interact in complex ways, making
assessment and treatment more complicated and difficult. Such cases are probably more likely to be referred to assertive outreach teams, although it is generally accepted that primary personality disorder cases are not well suited to the assertive outreach approach, as boundaried care and psychotherapy are the main treatment approaches.

**Working with personality disorders**

Although the treatment of primary personality disorder is generally seen as a role of the community mental health team, people with co-morbid personality disorder and psychosis may be under assertive outreach care and are likely to pose particular challenges in treatment. In such cases, the basic principles embraced by the assertive outreach team are:

- Personality Disorder is not regarded as a diagnosis of exclusion. The team has a good awareness of the issues around this diagnosis and have a clear understanding about the very real distress faced by sufferers. They also understand that personality disorder is associated with high levels of disruption in the person’s everyday life. This can place a heavy burden on family and friends and those who provide care.

- As explained above, assertive outreach service users often present with complex problems in addition to severe mental illness (such as alcohol / drug misuse, homelessness, personality disorder, or learning disability), and the team approach has been to develop specialist skills accordingly. This is described in the Sainsbury Centre for Mental Health (2001) guidance for assertive outreach teams. The most common diagnoses of personality disorder within the typical team caseload are borderline and anti-social personality disorder.

- It is helpful to recognize the importance of specialist skills in working with individuals with personality disorder. This may be provided through appropriate training opportunities or specialist supervision. Examples of specialist skills include: expertise in handling therapeutic relationships and supervision of multi-disciplinary team work, where problems such as ‘splitting’ (where staff are polarized into adopting different ways of working with the individual) can be very destructive to the teams function. It is also important to have team members skilled in particular approaches and treatment interventions. The assertive outreach team also ideally needs to have access to a Psychological Therapies Service which enables clients to receive a number of evidence based therapies specific for complex mental health difficulties and personality disorder.

**Further Reading**


The Sainsbury Centre for Mental Health (2001). *Mental Health Topics - Assertive Outreach*. 
Psychosocial interventions in assertive outreach

James Davidson

Major advances in the treatment of severe mental illness (SMI), particularly psychotic illnesses, have been made since the 1950’s. This is often attributed to the advent of effective pharmacological treatments. However just as important, if not more so, has been the shift in society’s attitudes towards severe mental illness and the development of more effective psychosocial interventions.

In recent years there has been a greater emphasis on using psychosocial interventions in SMI, often as an adjunct to medication treatment, although sometimes to a lesser or greater degree as the primary treatment. The National Institute of Clinical Excellence (NICE 2002) guidance for schizophrenia states that “psychological treatments should be an indispensable part of the treatment options available for the service users and their families in the effort to promote recovery”.

What are psychosocial interventions (PSI’s)?

A psychosocial intervention is an umbrella term for a range of interventions including social skills training, cognitive approaches, psycho education, vocational recovery or discovery, life skills, physical health promotion and family interventions. Some interventions are very specific and structured, for example cognitive behavioural therapy (CBT) used to manage auditory hallucinations or negative thought processes. However, many interventions which professionals may take for granted because they seem so simple and general, are in fact very important. These include listening to someone’s concerns, giving advice, accompanying someone to a stressful meeting, going for a walk in the park – all of these are PSIs. A well functioning assertive outreach team will be using PSIs all the time – in fact, one could argue that this is one of the defining features of assertive outreach- a diverse range of interventions aimed to improve things for the individual.

The overall aim of PSIs is to promote the individual’s recovery and help people to regain control over the illness, ultimately increasing the chance of reaching their potential and having a full life. Within this overarching aim are a number of more specific goals listed in the following box:

The goals of psychosocial interventions

Developing a better understanding of the illness
Learning about treatments including different medication options
Increasing concordance with appropriate medication
Learning to monitor mental health and act early when there are signs of relapse
Finding a purpose or role – which can include vocational and other activities in life
Improving the understanding and communication between the individual and family and / or social supports
Managing co-morbid conditions such as substance misuse, mood disorder and anxiety
All goals can be interlinked and are modifiable entities. Just as in finding the right medication for the individual, the PSI should be tailored towards the needs of the individual. Over time these needs may well change so it is important to have a flexible approach with access to a variety of interventions.

**The Interventions**

**Psycho education**

Psycho education is about increasing the understanding and knowledge of the illness, thus enabling more effective coping. A good psycho educational intervention would not only look at the illness itself, but would include learning about treatment options including coping strategies and medication options. Often psycho education will also involve the person’s family and / or social network and can be viewed as an important part of a family intervention.

Sometimes there may be concerns that knowledge about mental illness and medication side effects may potentially destabilise mental health and reduce medication concordance. However, in a controlled study on education about drug treatment in schizophrenia, where direct education was given about movement disorders including tardive dyskinesia, Macpherson et al (1996) found that the education did not lead to instability or a reduction in medication concordance.

In a systematic review of psycho educational interventions versus standard levels of knowledge provision in schizophrenia, Pekkala and Merinder (2004) concluded that psycho educational interventions were associated with a significant reduction in both risk of relapse and readmission rates when followed up at 9-18 months, compared to standard care. It was suggested that psycho education may have a positive influence on the person’s well being.

For the large part the implementation of psycho education by members of an assertive outreach team should be reasonably achievable within the standard engagement and initial treatment approach - many of the interventions are inexpensive and time efficient, and the very nature and knowledge involved in becoming a mental health worker could be transferable to psycho education.

**Concordance therapy**

Medication concordance is often a problem in psychiatric conditions, but also a feature to some degree in all medical care. In working with people who have severe mental illness, optimising concordance can be further compromised by the complex nature of the illness, with its potential effect on cognitive function and insight. In people with schizophrenia the risk of relapse over a 2 - 3 year period is increased from 20% to 80% when medications are stopped (Jones and Marder 2008).

Concordance therapy is an intervention spanning a number of techniques including psycho educational and cognitive approaches. The aims are summarised below (after Kemp et al 1998):
Principles of concordance therapy

Indirect benefits of medication addressed- e.g. ‘getting on better with other people’

Differences between symptoms and illness side effects openly addressed

Highlight the risk that stopping treatment may affect individual goals such as getting a job

Challenge common misnomers- e.g. medication is addictive, or medication leads to loss of personality

Symptoms / problems used as targets for treatment

Meanings attached to medication explored

Discussion of the protective nature of medication concordance, e.g. reduced risk of hospitalisation or losing work

Discussion of the natural wish to stop medication if well

In a literature review, Dolder et al (2003) found that combinations of educational, behavioural and affective (e.g. discussing emotional responses to the issues) strategies were most effective in terms of improving concordance and other important outcomes like relapse and readmission to hospital rates.

Family interventions

The family and significant others involved with the person with SMI play a significant part in the therapeutic outcome. Unfortunately the relationships between people with SMI and their families are often damaged as a consequence of the illness and resultant problems such as disputes, hostility, co morbid substance misuse and other damaging complications. The resulting stress is referred to as ‘high expressed emotion’ (Vaughn and Leff 1976) and this has been shown to lead to higher rates of relapse and admission. It has also been shown that family intervention can reduce expressed emotion (Tarrier et al 1988).

Family interventions, an often neglected therapeutic tool in the past, are today more widely used and accepted. There are a number of approaches which Jones and Marder (2008) suggest can be broken down into three specific components:

- Engaging and building an alliance with the family
- Educating and informing the family about the illness and treatment
- Addressing their individual needs as a family and finding solutions to problems

As one can see, there is overlap here with psycho education, as described above. The skills required for family intervention vary along a continuum from simple informative teaching sessions to formal family therapy provided by a specialist ‘systems’ therapist (e.g. someone who can work out why the communication problems are happening and how they can be unlocked). The main purpose of family intervention is to decrease the stress and tension within the family.
Dolder et al (2003) examined a number of randomised studies of family intervention for schizophrenia and concluded that there is evidence for the effectiveness of family intervention, as summarised

**The effects of family intervention**

- Decreased relapse rates
- Decreased rates of hospital admission
- Improved medication concordance
- Improved social functioning
- Decreased expressed emotion below:

**Cognitive Behavioural Therapy (CBT)**

CBT is a specialised therapeutic approach that in many services is often difficult to access because of resource deficiencies. This approach involves making links between the person’s feelings and internal experiences and the patterns of thinking underpinning their distress. For example, in the case of delusions the individual is encouraged to actively examine the evidence for and against the distressing belief and challenge habitual and debilitating patterns of thinking.

Jones et al (2004), in a Cochrane review of CBT for schizophrenia found mixed evidence for effectiveness of CBT compared to other talking therapies. CBT plus standard care did not significantly reduce long term relapse although it did decrease the risk of staying in hospital. The authors concluded that “CBT is a promising but under evaluated intervention”, and it is generally agreed that there is a need for further clinically meaningful trials.

It is recognised however that many of the co morbid conditions that commonly occur in psychosis e.g. anxiety, distress and depression, can respond to CBT. Thus the treatment of these conditions (which could be viewed as secondary to the primary illness or part of the syndrome) will help in the overall recovery from psychosis. Jones and Marder (2008) point out that the firmest evidence for benefit of CBT in psychosis comes from studies of individuals with chronic positive symptoms (i.e. delusions and / or hallucinations) that are resistant to medication treatment, in particular, resistant to Clozapine treatment. Therefore in assertive outreach teams, an argument could be made for prioritising CBT to such individuals.
Skills Training

This broad area of interventions can be broken down into three main components: social skills training, life skills training and vocational approaches.

Severe mental illnesses such as schizophrenia and bipolar affective disorder often begin in early adulthood at a critical time in life for developing social skills. This, along with the possibility of neuro-cognitive impairments in such illness, can have a devastating effect on social functioning. Social skills training aims to address these problems by enhancing social performance in a variety of settings. It involves initial assessment of a range of social and interpersonal skills, followed by focused work on identified deficits, for example, how the individual sees and processes relevant social cues.

Life skills training, although often paired with social skills training, is a distinct intervention (Adams 2000) covering quite specific skill areas such as personal self care, budgeting, domestic skills and running a home. The aim is to promote daily living skills and independent living.

Vocational approaches are increasingly recognised as one of the central aims in recovery from severe mental illness and have recently received more attention in the United Kingdom. The Patient Survey by the Healthcare Commission (2004) found that the majority of people with severe mental illness were not currently in paid work and of those who felt they needed support in finding work only 47% had received any. It is important to note that whilst paid employment as an outcome may be high up on the recovery hierarchy, vocational activity is not confined to paid employment and can include other activities such as voluntary work or training. These also provide purpose, structure, development and identity. The type of vocational support will vary according to the individual's needs and motivation.
Further Reading


Family interventions

Lorraine Morris

Families and informal carers play an essential role in supporting people with mental illness in the community (Barrowclough 2003). Over recent years formal care interventions have shifted towards community care and shorter hospital admissions, therefore potentially increasing the ‘burden of care’ on families (Barrowclough and Tarrier 2001). The stresses of caring for a family member can be high and could have a negative impact on the family / carer and the person being cared for possibly inducing feelings of low mood, anxiety, exhaustion and feelings of being overwhelmed (Smith et al 2007).

Early research studies identified that the emotional climate, within a service user’s home, was an influential factor affecting the outcomes of their mental health (Brown et al 1962, cited in Smith et al 2007). If the climate is emotionally highly charged with higher levels of criticism, hostility or over involvement, then the risk of relapse is increased. These findings introduced the concept of ‘Expressed Emotion’ (EE) (Brown and Rutter 1966, cited in Smith and Velleman 2002). An assessment called the Camberwell Family Interview (CFI) was developed by Brown and her colleagues to identify the level of EE within an environment; it is useful in determining the nature and degree of a family’s feelings. This assessment has evolved over the years and now includes the three elements associated with high EE – critical comments, hostility and emotional over involvement (Smith et al 2007).

The Stress Vulnerability Model (Zubin and Spring 1977) highlighted the links between environmental stress factors, an individual’s vulnerability to illness and the course of the illness. It has been found that using joint family work over a period of time, often meeting with a more formal ‘agenda’ (compared with other forms of therapy) to work on understanding the problems and communication, can help families to reduce levels of EE. The concept of Family Interventions has developed from these ideas (Fadden 1998, Gamble and Brennan 2006).


Family interventions are based on broad psycho educational and / or behavioural approaches. They use a collaborative, cognitive-behavioural approach to resolve difficulties within the family and build on strengths (Gamble and Brennan 2006). The aim of Family Interventions is to ‘help the family to cope better with a relative who is suffering from a specific illness’ (Kuipers et al 2002). The family is seen as having an influential role in the treatment of the illness, which can be utilised to enhance the recovery and support the person on their journey.
The main characteristics of Family interventions (as identified by Lam 1991 and Fadden 1998) include:

- **Promoting a collaborative therapeutic working relationship.** This involves mental health workers working alongside families, in a non-judgemental and empathic approach – so as to reduce the feelings of blame and stigma that a family may feel. The assessment phase allows for the individual family members the opportunity to tell their story and be listened to (Drage 2006 cited in Velleman et al 2007), which is paramount in building a therapeutic relationship.

- **Gathering information and providing education.** During the assessment process the individuals experiences, together with their expertise through their lived experience, are collated highlighting the existing strengths and coping mechanisms within the family. This is completed using various assessment tools including the Relative Assessment Interview (Barrowclough and Tarrier 1992) and the Knowledge about Schizophrenia Interview (Barrowclough et al 1987). These assessments highlight the level of knowledge that the person has regarding the illness and identifies the level of education required. This could be around understanding the diagnosis, medication and prognosis.

- **Enhancing problem solving skills, communication and goal setting.** A simplistic six step problem solving model is used collaboratively with the family to achieve positive change and identify needs led goals (Falloon et al 1984 cited in Kuipers et al 2002). This same model can encourage and potentially enhance communication within the family.

- **Behavioural and/or Cognitive-behavioural approach to problems.** This approach can be helpful in addressing and modifying beliefs and unhelpful thoughts. It is also seen to enhance problem solving and normalising experiences (Kuipers 2007).

The evidence to support Family Intervention as part of a comprehensive package of care is vast. It helps to reduce relapse rates and hospital admissions, enhance family relationships, lower Expressed Emotion and improve social functioning.
Further Reading


Prescribing in assertive outreach: medical and non-medical

Fiona Cranmore, Margaret Wilson, Andrea Clarke and Georgie Mackie-Forrest

Medication is one of the major therapeutic strategies in assertive outreach. However, for many it does not provide total relief from symptoms and unwanted effects influence health and quality of life. Medication and how it is used is a shared process aiming to achieve a balance of wanted and unwanted effects. These outcomes are best achieved when based in a therapeutic relationship and can take time and commitment for all involved. Furthermore, medication regimes in assertive outreach are frequently complex and involve augmentation strategies that are carefully tailored to an individual’s need.

Non-medical prescribing

Non medical prescribing evolved (with the necessary legislative changes) to allow service users better access to medication they need and maximise services (Department of Health 2006). Suitably qualified, experienced and registered practitioners (currently this is nurses with a prescribing qualification) are able to prescribe independently within their area of expertise. Many nurses in assertive outreach teams have taken this opportunity and are now registered as independent non medical prescribers.

One aspect of non medical prescribing is supplementary prescribing. This is often used in assertive outreach as it is complemented by the team approach and recommended for managing long term conditions. In supplementary prescribing there is an independent prescriber (usually the consultant or senior doctor) and one (or more) supplementary prescribers (usually nurses). This is a voluntary arrangement and treatment occurs with service user agreement.

A plan is drawn up – called a clinical management plan, and an example of what a clinical management plan might look like is shown below. This outlines the type, dose and indication of medication that can be prescribed by any of the prescribers on the plan. A review date is agreed and the prescribers all sign this document. The service user’s agreement is recorded in the health record. Each prescriber is responsible and accountable for what and how they prescribe just as when independent prescribing occurs.
Clinical management plan for: John Brown

**Condition To Be Treated**
SCHIZOPHRENIA

**Aim of Treatment:** TO PREVENT RELAPSE OF MENTAL ILLNESS and MAINTAIN MENTAL STATE

**Independent Prescriber (IP)**
Dr Smith

**Supplementary Prescriber (SP)**
Jane Jones

**Current medication**
RISPERRIDONE 5 mg nocte

**Medical History (including allergies)**
No significant medical problems. ECG, bloods including glucose and lipids checked 6 monthly

### Preparation

<table>
<thead>
<tr>
<th>Preparation</th>
<th>Indication</th>
<th>Dose Schedule Within BNF</th>
<th>Indications for referral back to IP</th>
</tr>
</thead>
<tbody>
<tr>
<td>RISPERRIDONE</td>
<td>PSYCHOSIS</td>
<td>RECOMMENDATIONS SECTION 4.2.1.</td>
<td>POOR RESPONSE TO TREATMENT. NOT RELIEVED BY SHORT TERM TREATMENT</td>
</tr>
<tr>
<td>LORAZEPAM</td>
<td>ANXIETY</td>
<td>SECTION 4.1.2.</td>
<td>Frequency of Review</td>
</tr>
</tbody>
</table>

**Frequency of Review**

| SP | monthly |
| IP | six monthly |

**Shared record for IP &SP**

**CLINICAL NOTES**

**Process for reporting ADR's**

IR1 / BNF YELLOW CARDS / DRUG INFORMATION OR WEBSITE / TRUST POLICY

**Guidelines & Protocols Supporting Clinical Management Plan:**

TRUST PRESCRIBING POLICY, NICE GUIDELINES, MAUDSLEY PRESCRIBING GUIDELINES.

**Agreed/Signed by IP (& contact telephone)**
(Signed)

**Agreed/Signed by SP (& contact telephone)**
(Signed)

**Date**
1/8/08

**Date agreed with patient**
1/8/08
Medication is often delivered as a core part of an assertive outreach package. This may be weekly, several times a week or on a daily basis. The team approach of assertive outreach makes this possible. Non medical prescribing enhances this tailoring and allows adjustments to be made in a timely manner which is essential for complex conditions and medication regimes and for those who find it hard to access services.

Non medical prescribing in practice

Whilst the Supplementary Prescribing role relieves some of the workload for the Medical Prescriber e.g. repeat prescribing, initiating and titrating new medication regimes, it also supports the team in responding effectively to service users in crisis and / or at risk of relapse. This is because the Clinical Management Plan is tailored not only to prescribe current medication but also for other indicators such as anxiety, increased distress and poor sleep which within a crisis and relapse prevention treatment plan can help to prevent an admission to hospital.

Owing to the team approach and high level of service user contact Supplementary Prescribers are able to cover a large geographical area and regularly review efficiency of the prescribing and receive service user feedback. This enables the team to respond more promptly and appropriately to concerns or issues the service user may have, and prevents delays in treatment and prescribing. Service users report they value no longer having to wait until their next outpatient appointment to have their concerns addressed and medication reviewed.

Service users confirm that within this process they feel more in control and involved in their treatment and because problems such as side-effects and poor response to medication are being responded to promptly there is less likelihood of poor concordance with medication.

Further Reading


Medication management

Liam Dodge

Working in assertive outreach often involves working with service users whose illness has been difficult to treat, for a variety of reasons. Although there are many other ways to help these individuals, optimising their medical treatment is an essential aspect of this work and can on occasions help people on their path to dramatic, life changing recovery. Medication must always be seen as one part of an overall package of care addressing clinical, emotional and social needs.

This handbook can not hope to convey all the necessary information about prescribing and the reader is encouraged to become familiar with the following two continually updated books which support health professionals in all aspects of treatment:

The British National Formulary (updated 6 monthly, contains a complete list of all medicines which can be prescribed (and proprietary medicines) in the United Kingdom.

The Maudsley Prescribing Guidelines (Taylor et al 2007) and the Psychotropic Drug Directory (Bazire 2007) contain advice on prescribing all psychotropic medication, including treatment in special circumstances such as differing medical conditions and treatment resistance.

In practice, it is also recognised that close working with pharmacist colleagues will help to share expertise and can often address practical or theoretical questions relating to treatment.

Antipsychotics

- Evidence suggests that antipsychotic medication reduces the risk of relapse in schizophrenia by around 60% (Kissing 1991).

- Recent trials suggest no significant difference between typical and atypical antipsychotics (i.e. the Clinical Antipsychotic Trials of Intervention Effectiveness CATIE Investigation, Lieberman et al 2005, Jones et al 2006).

- However NICE guidelines (2002) recommend the use of newer antipsychotics as first-line treatment and offer the following guidance:
Relapse and recovery

Concordance with medication prevents relapse and promotes recovery. However, service users’ ‘ranking’ of what improves concordance often differs from professionals, as in the table below:

Table 1. Service users’ and professionals ranking of factors in medication compliance

<table>
<thead>
<tr>
<th>Factors influencing compliance</th>
<th>Service User</th>
<th>Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy of medication</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Side effect self management</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Positive medication attitudes</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Side effects</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

Ranking: 1-most important, 10-least (Kikert et al 2006)

- NICE Guidelines (2002) recommend that switching from typical to newer atypical antipsychotics should occur if side effects or symptom control are unsatisfactory. They also emphasise the importance of providing information to service users and information leaflets can be a valuable means to share information and promote informed choice (for example, leaflets provided by this U pharmacist-led web site: www.nwmhp.nhs.uk/pharmacy)

- Adherence can be improved by actively managing side effects (by adjusting doses or timing, or if necessary switching medications) and educating the service user about their medication.

- NICE guidelines recommend the use of long-acting injectable (depot) medication when the service user prefers this method, or when concordance has become a clinical priority.

Treatment resistance

- Treatment resistance is defined as a lack of clinical improvement despite the sequential use of at least two antipsychotics, including one atypical, at the recommended dose for 6-8 weeks.

- Treatment resistance is estimated to occur in around 20% of service users (Kane 1988).

- It is important to rule out other causes of treatment resistance, as recommended below.
Assessment of Treatment Resistance

- Review history
  - Is the diagnosis correct?
  - Rule out an organic illness
  - Address psychosocial issues
  - Current symptoms?
  - Substance misuse / dual diagnosis.

- Review medication
  - Previous treatments, dose and duration
  - What worked best?

- Review concordance
  - Are side effects an issue?
  - Have depots been trialled?
  - Blood medication levels checked?

Adapted from Roberts G et al, Enabling Recovery (Gaskell 2006)

Clozapine

- NICE recommends the early identification of treatment resistance and initiation of Clozapine, which has been shown to be the only antipsychotic which is significantly more effective in this situation (Davies 2003).

- Clozapine requires close physical monitoring and blood tests before and after initiation due to the potentially serious side effects (see below for a table of the common and serious ones). At least monthly blood tests continue throughout treatment, due to the risk of agranulocytosis (estimated to be approximately 1%).

- Normally service users will start on a very low dose of Clozapine and build up gradually over a number of weeks to reduce the incidence of side effects.

<table>
<thead>
<tr>
<th>Common Side Effects (%)</th>
<th>Serious Side Effects (less than 1%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drowsiness (39%)</td>
<td>Agranulocytosis (low white blood cell count)</td>
</tr>
<tr>
<td>Salivation (30%)</td>
<td>Myocarditis (inflammation of heart muscle)</td>
</tr>
<tr>
<td>Fast heart rate (25%)</td>
<td>Seizures</td>
</tr>
<tr>
<td>Dizziness (19%)</td>
<td>Orthostatic hypotension (low blood pressure)</td>
</tr>
<tr>
<td>Constipation (14%)</td>
<td>Thromboembolism (blood clots)</td>
</tr>
</tbody>
</table>

Data from [http://www.drugs.com/sfx/clozaril-side-effects.html](http://www.drugs.com/sfx/clozaril-side-effects.html)

- Occasionally Clozapine resistance is encountered. If this occurs, one should go back and assess as for treatment resistance.

- Ensure adequate dose (by checking serum drug levels) and duration (may take several months for full response) of treatment.

- Switching to a previously untried atypical may be of benefit (e.g. Risperidone or Olanzapine).

- Adding another antipsychotic (often Amisulpiride, Risperidone or Sulpiride) or mood stabilising medication (Lamotrigine) has been shown to convey some additional benefit (Kerwin and Bolonna 2005) in some individuals.
• Long term follow up should include regular physical checks, ECG and blood tests; to check for side effects such as excessive weight gain, diabetes, liver and heart problems.

Case Vignette

Joe is a 35 year old male with a history of schizoaffective disorder since his late teens. Previous attempts to treat his symptoms of paranoid delusional ideations and vivid auditory hallucinations had little benefit. Treatment regimes tried included the use of Olanzapine and Risperidone alongside mood stabilising drugs. Joe had also spent time at an inpatient rehabilitation unit and attended a course of Cognitive Behavioural Therapy.

On moving to the local assertive outreach Team, Clozapine was commenced alongside his Lithium therapy. Although Joe gained some insight and improvement in symptoms, facilitating readmission to a rehabilitation unit, there remained a prominent affective component to his condition and his level of function and cognitive abilities remained poor.

A further antipsychotic, Sulpiride, was added to his treatment and over a period of months his symptomatology, cognition and level of function improved, resulting in greater engagement with staff and the rehabilitation process.

Further Reading


Further Reading (cont)


www.nwmhp.nhs.uk/pharmacy (patient information leaflets and useful website)
Physical healthcare

Jim Russell

There is extensive evidence from large population based studies that severe mental illnesses are associated with an increased risk of premature death, mostly due to natural causes (Harris and Barrowclough 1998). It is inevitable that assertive outreach service users will have high rates of physical health problems, linked with higher rates of substance misuse and tobacco smoking, poor nutrition and sometimes their psychiatric treatment.

As these service users are often disengaged from conventional primary care services, it is essential that the assertive outreach clinician is familiar with key United Kingdom health promotion targets and can support service users with their physical health needs. Lecomte et al (2005) have written about goal setting to improve physical health, advising the following goals which may be a useful guide when working with service users:

<table>
<thead>
<tr>
<th>Setting goals to improve mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self care</strong></td>
</tr>
<tr>
<td>Clean teeth regularly</td>
</tr>
<tr>
<td>Bathe regularly</td>
</tr>
<tr>
<td>Monitor weight regularly</td>
</tr>
<tr>
<td>Care of skin</td>
</tr>
</tbody>
</table>

**Access to services**
- Register with GP
- Annual health check with GP
- 6 monthly dental check

**Smoking**

Smoking tobacco is strongly associated with psychiatric illness, but in keeping with national guidance our aim as health professionals should be to try to support cessation, which may be a lengthy and episodic process for many tobacco addicts. West et al (2000) have produced advice on smoking cessation which can be useful for any professional. Cessation clinics and nicotine replacement therapy have a place and can help some. There is some, limited evidence that programmes can be of help in psychiatric populations (Addington et al 1998).

**Physical activity**

Regular physical exercise is good for all aspects of physical health and has shown evidence of benefits on mental health (Department of Health 2004). A calculation by key worker of body mass index (BMI) may be a useful start. BMI = weight / height x height, and is defined as overweight if more than 25 and obese if more than 30. It is important to start in a slow and careful way. When resuming physical activity after a long period of inactivity, sports therapists or gym instructors may be available to give specific advice on this. Hillsdon et al (1999) found that encouraging walking was more likely to be successful.
Weight management

Obesity is increasing in most countries of the developed world, as standards of living improve. It is associated with diabetes, cancer and premature mortality. A particular concern in assertive outreach is the association between medication and weight gain. This is most clearly established with Clozapine and Olanzapine but there is probably some risk with all antipsychotics, as with other psychiatric drugs. Information from the pharmacist or in the Maudsley Guidelines (Taylor et al 2007) on drug treatments in psychiatry can be useful. Even where weight gain has occurred due to medication, weight management approaches can be of help and the strategy should be dietary modification, increased physical activity and psychological support. Regular monitoring of weight is important.

Access to primary care services and healthcare screening

United Kingdom general practitioners are expected as part of chronic disease management and healthcare targeting, to monitor the physical health of those with severe mental illness at least annually. However, service users in assertive outreach teams may need considerable support to enable this to occur. There are cases where careful working alongside GPs and District nurses is the only way, for example to ensure that simple but essential checks on weight, blood lipids and glucose occur regularly. Primary Care Trusts have introduced health facilitators within general practice; these workers may also be a resource to support service users in the community.

The Maudsley Guidelines (Taylor et al 2007) contain detailed information on what form of monitoring is recommended for different conditions and when different psychotropic medications are taken.

Further Reading


Sports therapy and assertive outreach

Graham Balch

The goal of a Sports Therapist working in assertive outreach is to improve the health, quality of life and life expectancy of the service user. Fitness does not just affect physical health; it can have a positive effect on mental wellbeing and is especially helpful in treating depression. A survey carried out by Mind (2001) found that 83% of people with mental health problems looked to exercise to help lift their mood or to reduce stress. Two-thirds said exercise helped to relieve the symptoms of depression and more than half said it helped to reduce stress and anxiety. 60% of the respondents said that physical exercise helped to improve their motivation, 50% said it boosted their self-esteem and 24% said it improved their social skills.

Benefits from taking regular, moderate intensity exercise

- immediate improvement in mood
- deeper sleep
- improved fitness and strength
- improved co-ordination
- positive body image
- more confidence boosts
- aids relaxation
- encourages social inclusion and the practicing of transferable skills

Until recently the evidence for the effectiveness of exercise on mental health has been regarded as inadequate for this to be seen as an adjunctive treatment, although there is actually a large body of evidence that supports this view, for those with alcohol misuse, schizophrenia and clinical depression. The United Kingdom government has published guidance (Choosing Health: Making healthy choices easier, Department of Health 2004). Choosing Health and supporting the physical health needs of people with severe mental illness (Department of Health 2006), recommends the inclusion of a physical fitness element to treatment of service users with mental illness.

Although the benefits of including exercise into daily routine for the general population and those with mental health problems are now well established, it is not entirely agreed upon how these occur (see below).
Models explaining the value of exercise

Hyperthermic model

This model relates to the concept that an elevation in body temperature causes the hypothalamus to alter its regulation of certain functions such as muscle tension and increase slow wave sleep (deep sleep that benzodiazepines have been found to shorten).

Endorphin model

Euphoria induced by the release and subsequent binding of endogenous opioids, these being β-endorphins to receptor sites in the brain (Steinberg & Sykes 1985).

Self esteem and mastery

Self esteem increases from exercise have been found to be cyclical. As a person becomes fitter, healthier and perceives their physical looks to improve, they become increasingly focused on maintaining and advancing their gains. Mastery relates to the way that the person perceives their body to have changed due to exercise e.g. muscle tone and weight loss. The positive cues relayed by proprioceptors (movement sensors) around the body lead to a sense of achievement.

Distraction hypothesis

It has been observed that exercise can serve as a useful distraction or ‘time-out’ from stressful stimuli and feelings and that this can lead to improved psychological wellness. In this respect, service users may find exercise a useful strategy to help them focus on events other than their particular life circumstances (Bahrke & Morgan 1978).

Exercise and lifestyle counselling

Some people may not have the skills or knowledge that promotes regular exercise. Lifestyle counselling is a process that includes practical strategies to maintain exercise adhesion after the therapy has been delivered. Therapy follows the basics of cognitive–behavioural techniques (such as cognitive reappraisal and consciousness raising, goal setting, self-monitoring and finding social support) for promoting positive exercise attitudes, experiences and behaviour. There are a number of different types of exercise we can use to achieve the goals of improving quality of life and life expectancy, but the techniques employed vary depending on the individuals own motivation, their current mental status, their capacity to absorb and utilise information and their fortitude. This being true, the skill and art of any clinician is that of building trust and achieving the most effective and long lasting result from even the least likely of beginnings.

Working with people

When a sports therapist begins working with a service user, the following key elements should be included: engagement, assessment, motivation, goal setting, written treatment plan, monitoring, troubleshooting and outcomes. Each person is different and will have differing goals, levels of motivation and starting point fitness. Some will need the sports therapist to help them with motivation to leave their house, to get to the fitness venue, be with them constantly during the intervention and take them home, whereas others will have
little input other than the setting up of the treatment plan, initial interventions and regular monitoring.

Interventions

Choosing between group and individual interventions is dependant upon the service user’s ability and needs and also the resources of the team. Groups are an efficient way of working with a number of service users at the same time.

Sports therapy interventions

Walking is particularly beneficial to those clients with lower fitness levels. It can be started in a range of different environments, from quiet country locations to a busy town centre, at low or no cost. It is easily maintained after discharge and walking groups are great for developing a broader social life!

Badminton and Tennis is good for all ages and abilities, but it is best to match those of similar skill. It is generally low cost, uses community facilities, good for developing co-ordination skills, balance and also promotes mastery and good for interpersonal skills and teamwork.

Gym training is not for everyone, but it’s particularly popular amongst the younger service users. It can be adapted for all levels of fitness, particularly good for those who want to achieve higher levels of fitness or those who need firm boundaries. Gym training can be difficult at times for service users to maintain on a regular basis due to the unpredictable environment, but this is often a good way of observing how the person copes with stress.

Weight management / healthy eating groups provide service users with peer support and encouragement maximising the potential results. Nutritional education is particularly important as many service users have little understanding of food, or the skills in food budgeting, buying and preparation. Simple tools, such as portion size plates and handouts with healthy recipes, can empower service users to make small changes that, over time, add up to life changing improvements.

Individual interventions are often the most effective way to begin a service user’s treatment programme, with quality one to one attention. The levels of trust which are built up from successful early interventions enhance motivation and the likelihood of goal achievement. Service users who are socially anxious or those with complex individual presentations might remain on one to one programmes for a considerable time before being introduced to group environments.

Motivation and goal setting

These key elements are linked to the service users own desire, their need to change and also their self-belief. The skill of setting realistic goals and progressing at the service users pace is the key to a successful outcome, often a service user will give a goal that they think you want to hear. Goal setting with the service user is vital, in particular, differentiating the goals of the clinical team or family from that of the service users.
Measuring outcomes

These can be measured quantitatively or qualitatively, perhaps with a questionnaire or a survey, or simply by asking the service user “how do you feel?” Qualitative measures can be more difficult to assess and interpret but may generate rich data and suggest important new areas of enquiry. Quantitative outcomes are somewhat easier to collect. Weight loss or gain, longer distance or faster speed, smaller or larger clothing size and more powerful are simple measures that indicate how well a service user is progressing.

Everyone is different, one person may achieve as much in a day as another may in a month and, using Carl Roger’s theory of the person-centred therapy, all achievement should be acknowledged and celebrated.

Further Reading

Daley, J. (2002). Exercise therapy and mental health in clinical populations: is exercise therapy a worthwhile intervention? Advances in Psychiatric Treatment, 8, 262–270


Department of Health. (2006). Choosing Health: Supporting the physical health needs of people with severe mental illness. London: DoH


Working with service users who have a dual diagnosis of severe mental illness and substance misuse

John Chilton and Kevin Donaghue

What is dual diagnosis?

The rates of substance misuse within mentally ill population groups are high, with estimates for community mental health population groups of recent and current substance misuse in the range of 20-40% (Health Advisory Service 2001). These ‘dually diagnosed’ service users are at high risk for illness complications including positive / negative symptoms of psychosis, depression, suicide and sudden death, poorer adherence to treatment, more inpatient stays (Linzen et al 1994), violence (Cuffel et al 1994), disturbed behaviour and poorer overall prognosis (Hunt et al 2002).

The associated problems tend to result in dual diagnosis not only having heavy costs for the service users and services generally, but they also affect families and the wider society including social and judicial systems. Current Department of Health (DOH 2002) policy suggests that assertive outreach services may be well placed to develop and effectively support a dual diagnosis population group of service users who present with a whole panoply of complex needs. Drake et al (1998) has suggested that the traditional practice of treating dual disorders as separate conditions (a practice which tended to polarise and antagonise staff, and lead to service users falling out of services) has proven to be largely ineffective, regardless of the treatment.

What tends to be common to all effective intervention with dual diagnosis service users is a collaborative approach. One must try to work with the individual within a mutually agreed framework and try not to impose blanket solutions. This may mean, in some cases, initially having limited, realistic expectations and limited goals and tolerating a slow pace of change. It can be argued that this fits well with assertive outreach best practice.

Within assertive outreach service users in the United Kingdom, it is clear that the reasons for such high rates of dual diagnosis tend to be varied and complex. Figure 1 demonstrates the complex nature of the interactions between illness and substance use, showing how illness and other factors may serve to maintain a substance misuse problem (see Figure 1).
Figure 1. Model of maintenance of substance use in Schizophrenia (adapted from Blanchard et al 2000).

This model tends to be associated with a range of clinical typologies and needs to take account of feelings of stigmatisation and problems around social exclusion. One key factor mediating the link between mental illness and substance use is a limited range of alternative coping strategies: the use of maladaptive coping strategies has been associated with the development and maintenance of substance use (Wills and Hirky 1996). Additionally, poor problem solving tends to be evident in service users with co-morbid mental health problems and substance use (Carey and Carey 1990). A further predictor of continued use of substances is learned expectancies of the positive benefits of use. In service users these may include, for example mood enhancement, anxiety reduction, “time out” from problems, general feelings of well being, release from unpleasant self consciousness and performance enhancement through physiological effects on arousal or other mechanisms. Since these functions are learned through use in different situations, the salience and perceived value of particular functions will show variation across individuals (Wills & Hirky 1996). Unfortunately, the longer term consequences of substance use can be very adverse in the context of enduring mental illness as typically seen within assertive outreach services.

Increased problems may arise from external stressors such as interpersonal conflicts (e.g. high expressed emotion from relatives and service providers who disapprove of substance use and blame service users for making their situation worse), or financial and accommodation issues, i.e. poor housing stability (Osher et al 1994), as well as from the substance use having a negative impact in the service user’s internal state in the form of
unpleasant withdrawal symptoms, depressed mood, increased perceptual and cognitive anomalies, increased arousal and possibly psychotic symptoms. Thus a vicious ‘feed forward cycle’ of maintenance and escalating problems may develop, summarised in figure 1. A common example might be:

Case vignette - Gary’s unpleasant spiral of pain

Gary experiences persistent unpleasant voices. He drinks to drown them out, only to wake the next day feeling hungover and depressed. The depression feeds into the depressive and self derogating voice content and the voices become more persistent and distressing. Gary experiences financial problems as a result from the alcohol binges and he has arguments with his landlady about his drunken behaviour, increasing stress and thus both the need to drink leading to the exacerbation of his psychosis.

The model outlined (figure 1), would link these interrelated problems together and suggest treatment implications for the assertive outreach practitioner. Firstly it is important to accept, that from the service user’s perspective, there are benefits, as well as, challenges from the substance use and hence a decision to reduce substance use is only likely to take place when the challenges are perceived to outweigh the benefits. Hence the need for a motivational component (Miller and Rollnick 1991) to assertive outreach therapy. Secondly, there may be a relationship between the substance use and the service user’s related issues.

A clinician’s account

A clinician in an assertive outreach service describes these challenges as a means of working within a process which recognises the complex issues that the dually diagnosed service user may experience. He describes a potential pitfall of “spending all day banging on a door that is permanently shut, when the door right next to it is open”. The general aim of the intervention would therefore, be to facilitate the service user in making changes in areas of life identified as problematic. The intervention is structured to maximise the possibility that the service user will identify substance use as a challenge with the expectation of “walking through the opened door of change”. However, it is important for the clinician to be realistic and to understand:

- Not all service users will identify substance use as a problem, particularly in the early stages of engagement. The intervention is structured to facilitate such service users making links between the challenges important to them and their substance use, and hence the need to make changes in substance use if they are to make progress in the things that concern them.

- In acknowledging the particular challenges of this service user group, the probable links between substance use and illness symptoms are explored carefully and in detail. Since service users often link their substance use to attempts to reduce illness related problems, this is important not only for providing motivation for change in substance use, but in the overall evaluation process of assertive outreach care planning.
Case vignette - Tim’s voices

Tim’s voices were upsetting and distressing and he had tried many self management techniques to make them better. Eventually, after working with his assertive outreach Care Co-ordinator for many months, he was able to say; “I smoke cannabis to reduce them but in the long term it seems to make them worse, therefore, I need to rethink my cannabis use”.

Case vignette: Tom’s self efficacy

In Tom’s case it seemed his substance use was giving him social contact (from his point of view very important, although from a clinician perspective at least partly exploitative). It also seemed to bolster self esteem. In this case the following approaches were important:

- The intervention was sufficiently flexible to allow the assertive outreach therapist to work with other service user led problems when attempts to increase the service user’s motivation for change (identify substances as problematic) were not successful. In such cases it may be that the assertive outreach therapist offered help with the service user’s main concerns or they could risk disengagement. The assertive outreach therapist continued to encourage the service user to link the substance use to their concerns through motivational interviewing techniques.

- The over riding philosophy of the intervention is that the therapist’s goal is to help the service user reduce substance use but acknowledges that this can only be done when the service user shares that goal and takes responsibility for change. Hence the service user takes the lead in deciding the what, when and how of working on concerns which are important to them.

The details of the intervention will be determined by a shared formulation. The level of detail and complexity in the formulation will vary but the minimum formulation will focus on the development and maintenance of key lifestyle concerns or problems, thus leading to possible intervention strategies. In all cases this will attempt to bring together relationships between key concerns, symptoms, and substance use based on the model illustrated in figure 1.

However, the aim in all cases will be to work through all the key stages of the intervention, albeit at different rates and not always in the same order or with the same emphasis, until a treatment formulation is established.
Outline of treatment

Stages of therapy:

1. Engagement of the service user in talking about their concerns and life satisfactions
2. Identification of how substance use fits into the concerns and life satisfactions
3. Identification of how the mental illness fits into this picture
4. Share formulation of life concerns with the service user fitting together concerns / illness / substance use
5. Help motivate / consolidate motivation for the service user to reach an action stage of planned substance reduction
6. Review and modify formulation and from this identify and develop strategies for change.

The focus of work will depend on the service user’s stage of change readiness (Prochaska and Di Climente 1992) as regards substance use, as follows:

<table>
<thead>
<tr>
<th>Committed to change</th>
<th>Ambivalent or pre-contemplative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and develop strategies for substance reduction based on the shared formulation</td>
<td>Work on any aspect of the formulation acceptable to the service user and continue to use motivational interviewing strategies to highlight / link the substance use to the problem focus</td>
</tr>
</tbody>
</table>

In summary, assertive outreach is an important aspect of intensive case management and risk reduction targeting people with dual diagnosis in mental health services within the United Kingdom.

The model of care described, adopted alongside a policy of harm reduction techniques, can work well within assertive outreach services. However, the reality is often one of long term, challenging work with dual diagnosis service users and their respective families, in addition to engagement with a variety of other services.

An intensive case management approach within an assertive outreach multidisciplinary team can provide an optimal long term treatment setting for the dually diagnosed service user within assertive outreach services.
Further Reading


Supported accommodation and the assertive outreach service user: social approaches

Anne Jones and Rob Macpherson

As a strongly social model of treatment, and working with people who often experience great problems finding and maintaining appropriate housing for their needs, it can be argued that working with service users to obtain appropriately supportive accommodation is one of the most important aspects of assertive outreach work.

As with anyone, for an assertive outreach service user the location, quality of the environment and whole ethos of a place is crucial. When appropriate for an individual it can be pivotal to their ongoing recovery / rehabilitation.

So how does the right accommodation help?

- Provides stability
- Provides consistency
- Someone/team to care for all issues relating to daily life
- Properly managed it can help the individual to achieve personal freedom within a caring framework

Deinstitutionalisation and the development of supported accommodation for the mentally ill

The traditional asylum model of care was in decline from the mid 20th century, due to many factors including political initiatives and policy, advances in treatment of severe mental illness and awareness of the potential pitfalls of institutional models of care, following the writing of Goffman (1961) and others.

The background to our current system of supported accommodation in the United Kingdom relates to the programme of de-institutionalisation, which led to a closure of more than 100,000 NHS psychiatric beds between 1954 and 1996 (Lelliott 1996). It became apparent that despite new treatment approaches, not all people with severe mental illness could be discharged from hospital, resulting in the idea of the ‘new long stay patient’ (Mann and Cree 1986).

A specialised branch of rehabilitation psychiatry was developed to try to develop more acceptable and less institutional forms of support for those with chronic disability associated with their illness and a number of pioneering hostel units such as Douglas House in Manchester, 111 Denmark Hill at the Maudsley, London and Cranbury Terrace in Southampton, were developed. Many service users were rehabilitated into group homes and accommodation provided through social services lodgings schemes. It was recognised that over time, and with consistent, optimal treatment, mental health could stabilise and improve and living skills lost through illness could be regained. It was hoped that this would result in a move to more independent living.

Over the last 20 years there has been a continuation of hospital closures, associated with the development of new forms of accommodation including core and cluster (a complex of flats developed around a central support unit) and individual supported flat schemes. In the early 21st century, there is a complex mixed economy of private and charitable provision of supported accommodation, provision in each locality relating heavily to local historical
patterns of provision and the local activity of key ‘champions’ / enthusiasts, during the phase of deinstitutionalisation.

**Recent health and social policy in supported accommodation**

Care in the Community (Department of Health and Social Security 1981) moved the responsibility for managing residential care from Regional Health Authorities to Local Authorities, while the National Health Service and Community Care Act (1990) enabled and encouraged non-statutory agencies to operate residential facilities. The Supporting People initiative (DETR 2001) aimed to provide housing-related support services to vulnerable people, including those with mental illness, robustly funded and planned using a co-ordinated multi-agency approach. In more recent years, the development of NHS Partnership Trusts which incorporate health and elements of social services, has meant that some Trusts are now directly managing the budget for supported accommodation for the severely mentally ill, with a complex relationship to the commissioning role of the Primary Care Trust.

**Three pieces of research evidence showing the importance of accommodation for those with severe mental illness**

The three hospitals study, by Wing and Brown (1970) showed that environmental poverty (i.e., lack of stimulation, opportunities and a lot of time doing nothing) in a long stay hospital ward was strongly linked to negative symptoms in schizophrenia, and crucially that improvements in social environment led to better social networks and improved negative symptoms. This simple study powerfully demonstrated the impact of environment on mental health and reminds us that improvements in accommodation and support can radically change the outlook and experience of service users.

The TAPS hospital closure study by Leff (1977) and Leff and Trieman (2000) showed that a carefully planned hospital closure programme enabled nearly all ‘long stay patients’ to move from wards in Friern and Claybury hospitals in North London, to a range of supported accommodation with homely characteristics, which were much less restrictive than the hospital environment in the local area. There were very few adverse events and service users had improvements in negative symptoms, community skills, and improved quality of social networks. 5 years after the closure programme, most were still in stable community placements. This study showed that carefully planned rehabilitation led to wide benefits for service users, in particular regarding integration into the community.

The Nithsdale schizophrenia surveys (Kelly et al 1998) showed how community care has developed in a rural part of Scotland. Between 1981 and 1996 there was a development of supported accommodation which from nothing at the start, was ultimately providing support for 20% of non-in patients in the area, many of the staff working in accommodation services having only basic training in mental health.

The range of supported accommodation provided in a local area varies and often relates as much too historical patterns as to any local needs assessment. Guidance was provided in the National Service Framework for Mental Health (Department of Health 1999). For a guide to what should be available in each health locality, see the table below which was developed from Lelliott et al (1996).
The range of supported accommodation needed for people with severe mental illness in a typical locality

*Low secure, long stay and rehabilitation wards* - provided mostly in the NHS with increasing private low secure provision

*High / medium staffed hostels (24 hour nursed care units)* - provided in and outside the NHS. Staffing 8-20 per unit, typically 6-12 residents.

*Low staffed hostels (day cover only)* - staffing by unqualified staff mainly

*Supported lodgings / landlord run care homes* - often run through a social services scheme

*Group homes* - unstaffed, up to five residents. Popular in 1980s less so now. Usually social services-run, with visiting care staff.

*Core and cluster flats* - often run by charitable providers, such as Rethink or MIND.

*Individual care packages* - developed around an individual’s needs.

Case examples: interventions involving supported accommodation

**Vignette 1**

A man aged 45 years, with diagnosis of paranoid schizophrenia and learning difficulties had been living in a psychiatric hospital for over 20 years. Risks included a history of inappropriate and aggressive behaviour towards staff and female shop workers. Previous attempts to move from hospital to supported lodgings failed due to staff being unable to manage risks. He was placed in an individual care package in a one bedroom flat, provided by a private provider, with a small, discrete male staff group who worked for a period at the hospital with in patient nursing staff to learn how his care and risks were managed. Close, ongoing liaison with the hospital team continued and led to eventual discharge with hospital staff providing assistance and advice if needed.

It was thought that the individual would need respite care in hospital, due to the history of challenging behaviour and being institutionalised for so many years. However, he has been living in accommodation for the past 4 years without any hospital admissions. He appears to have responded to the greater autonomy and privacy in his new living arrangement by developing greater personal responsibility and by developing more positive relationships with mental health professionals.

This example highlights the importance of “joined up” working with the private provider at the beginning, before and during discharge planning. Safe discharge is more likely to occur with all staff working in partnership.
**Vignette 2**

A male service user, now 22 years, has since the age of 13 years experienced psychosis and had been using multiple illicit drugs. Violent behaviour and assaults led to him being evicted from supported accommodation. He moved to a council bed and breakfast where he was evicted and ended up in the homeless night shelter.

Due to serious physical assaults he was admitted to a low secure unit for 2 years and then moved to a 24 hour nursed care rehabilitation unit in community, where he spent a further 18 months. He now lives in stable, minimally supported accommodation, is not using illicit drugs and is completing a college course in catering.

This example highlights the need for appropriate services to work together, to allow a ‘stepped’ model of care, leading to greater independence and lower levels of support as the service user progresses through their recovery.
Further Reading


Lelliott, P. (1996). Meeting the accommodation needs of the most severely mentally ill. Journal of Interprofessional Care, 10, 241-247


Lelliott, P. (1996). Meeting the accommodation needs of the most severely mentally ill. Journal of Interprofessional Care, 10, 241-247


Mann, S. and Cree, W. (1976). ‘New long stay’ psychiatric patients; a national survey sample from fifteen mental hospitals in England and Wales. Psychological Medicine, 6, 603-616

Social inclusion in assertive outreach work

Jane Melton

People who use assertive outreach services are arguably amongst those in our communities who experience the highest level of social exclusion. By definition individuals eligible for the service are difficult to engage and tend to become withdrawn from mainstream society. If we are to ensure that being under the care of assertive outreach services does not itself lead to a set of socially exclusive interventions, we must establish both a stated mission and actual practice that is capable of embracing the principles of social inclusion, recovery and community participation (Department of Health 2007). We must be certain that all staff have a genuine belief in supporting social inclusion, are highly proficient in the required skills, and are supported within the organisation to make this happen. This includes setting intervention goals with people which reflect their human right to engage in everyday activities of their choice (Jackson 2008). We must not underestimate the skill, time, optimism and energy often required to achieve this.

People who experience severe and enduring mental illness can achieve engagement in everyday activities despite their illness (Kielhofner 2008, de las Heras et al 2003). We must embrace the fact that interventions which focus solely on symptom reduction and risk assessment are not enough (Repper and Perkins 2003) and acknowledge the fear that people have experienced through traditional service models (Gray 2008). We must understand that achievements gained through taking part in facilitated everyday activities can be equally important and have the advantage of assisting a person to gain personal fulfilment, belief in their ability and to activate their interest in the lived in world (Kielhofner 2008).

When considering socially inclusive principles to underpin practice in an assertive outreach service the following top ten points are offered as a guide for practitioners:

1. Identify the barriers that a person experiences in forming relationships and take positive action to engage with them.
2. Ensure that each person’s interests and obligations to recreation, education and vocation are understood, valued and progressed.
3. Create hopeful, re-motivating interventions by appropriately tailoring each activity based intervention into a positive experience for the person.
4. Build opportunities for a person to experience valued roles, routines and relationships within their environment.
5. Facilitate access to meaningful occupations within everyday communities rather than in clinic environments.
6. Celebrate each person’s skills and talents. Look for and reinforce the positive attributes that the person presents with.
7. Tackle discrimination through being ambassadors for socially inclusive practice and attitude. For example, take personal action to only relay positive and respectful accounts of working with people using assertive outreach services.
8. Form alliances with colleagues in partner organisations to ensure that people who use assertive outreach services have equal (and as required bespoke) opportunities to general health care, accommodation services, benefit agencies and job centres.
9. Foster hope by encouraging certainty about how interventions will support a persons long term ambitions.
10. Involve service users in shaping the interventions that are offered.
The experience of social inclusion is the right of every service user and can have a therapeutic effect. Every practitioner has a responsibility to take action towards this goal in their everyday work. No assertive outreach team practice is complete without broad consideration of the principles of social inclusion.

**Further Reading**


Setting goals and evaluation progress

Mike Blackburn

For people receiving treatment from mental health services the formulation and achievement of goals is central to the treatment plan. It could be argued that in the past goals were seen more in terms of containment and relapse prevention. There did not appear to be a real expectation on the part of either service providers or users that there should be initiatives which really focus on enhancing opportunities for users.

Developments in services and perhaps general improvements in standards of living across society have led clinicians to give greater consideration to helping service users, across a broader range of settings and lifestyle choices. The National Social Inclusion Programme has encouraged staff and service users to challenge negative and prejudiced attitudes about mental illness, and to enable people with mental health problems to fulfil their aspirations and to significantly improve their opportunities. Looking at work with service users who have a severe mental illness such as schizophrenia, the National Institute for Health and Clinical Excellence (NICE 2002) identified a number of domains, forming an assessment framework of key areas to work on:

NICE (2002) recommended assessment areas

- Degree of symptomatic recovery
- Stability and quality of living accommodation
- Degree and quality of social integration
- Degree of financial independence
- Experience and impact of treatment

Within assertive outreach teams there is prevailing awareness that service users are on a ‘journey’ in their lives and through mental health services. Key stages in the assertive outreach component of this journey are - assessment, engagement, treatment and recovery/discharge. Because of the nature of the client group, as identified earlier in the handbook, the stages of the journey are often prolonged. When working with individuals whose mental health needs are less complex one may anticipate having a range of treatment goals set soon after the initial assessment or meeting.

It is not uncommon for service users referred to assertive outreach teams to have very basic initial goals such as ensuring that they get their next giro and to be free to spend it on what they choose. At the heart of the interventions carried out in assertive outreach is the relationship between the service user and the team (most importantly, the care co coordinator). The reality is that discussions around goal setting only have any meaning once that relationship has been established.

Effective goal setting creates a framework within which the various components of a recovery plan can co exist and support each other.
Goal Setting

Starting to plan goals together with the service user is essential. Service users assessed as appropriate for an assertive approach usually have, for many reasons, difficulties engaging with services. They often bring with them feelings of mistrust about professionals, resentment and frustration, some of which may be well founded. The period of engagement is aimed at overcoming these obstacles.

Of crucial importance, interventions should be based upon a trusting, collaborative working relationship in which the person is seen as the expert in their care, with the expectation that they are central to all plans and decisions. This is not to say that the clients are always well engaged and concordant with medication before goals are discussed. Far from it. What we are hoping to achieve during the engagement period is to overcome some of the negative attitudes towards services and to establish a degree of trust. This is achieved by persistently demonstrating an understanding and appreciation of the situation that the service user may be facing, and looking at the strengths and challenges they face together.

Much work is done and time spent helping service users to establish some degree of stability in what may have been a chaotic world. Whilst clinicians may see this as “achieving goals”, the framework within which this is carried out is ideally open and non directive. An individual may be engaging with an assertive outreach team for months before there is even a mention of goals or objectives. Goals are like stars: we may never reach them but we can chart our course by them. It is within the period of engagement that the service user may be encouraged to start considering where their life may be going, along with their hopes and fears.

The Care Programme Approach (CPA) review

A useful and important forum for the discussion and development of goals is the CPA meeting. Present at the meeting there should be all those involved in the service user’s care provision, including accommodation support staff or carers, assuming the service user gives consent for this. Led by the care coordinator and service user, the review should systematically consider all those areas relevant to the service user and agree goals to help them enhance their quality of life. The reality, most often, is that these goals have been worked out over time between the service user and care coordinator or other team members.

Using the team to set goals

In setting goals, it is essential for the full resources of the team to be used. This means ensuring that the full range of professionals is involved in helping service users consider their health and social circumstances. Occupational therapists, social workers, nurses, doctors and support staff will all be able to enhance the process of setting goals with the service user.

There is a skill to enabling service users to consider opportunities beyond what they may have been used to considering. For example, for some of those coming to the assertive outreach service it has been many years since they have been out for a meal or been on holiday. Vocational and work opportunities may have never really been considered. A key is to be able to help the individual to start to look beyond what may have been a narrow and circumscribed set of opportunities and existence. The impact of achieving simple
goals may have a huge impact on other areas of an individual’s life. Small changes can lead to radical changes in attitude and lifestyle. There is a need for clinicians to be available, at times with little notice, to provide support and encouragement when sustaining small changes becomes difficult. Setting complicated or unachievable goals risks losing the commitment and interest of the service user, as well as demonstrating that the clinician does not really understand the complexity of their client’s problems.

The SMART guide to developing goals with a service user

Ensure goals are:

S – Specific
M – Measurable
A – Achievable
R – Realistic
T – Time orientated

There is a need to empower and enable service users to play an active part in identifying goals that are meaningful to them. If goals have simply been set by clinician’s service users will feel no ownership of them and they will be unlikely to participate in making them work.

Evaluation

Evaluation of progress ideally occurs at three different levels in assertive outreach work:

1. Informal evaluation as part of clinical overview and review

There are many opportunities for assessment and evaluation when working with service users in an assertive way. Firstly, there are some informal and simple ways to address change and consider this with the service user. There will of course be an initial referral and core assessment made by the referring team, against which progress may be measured or compared. For the majority of service users who have come to an assertive outreach team a basic evaluation of progress can be measured at a glance. Their lives have often been so totally chaotic that it is self evident that changes have occurred. In the first instance there is a need to evaluate such things as accommodation and financial issues. Is there stability and constancy where before there was frequently eviction, loss of accommodation, inactivity and debt? These issues can be helpfully fed back to service users and the CPA review is an ideal forum for this.

Daily living skills, accommodation, finances, drug and alcohol use, relationships, risk management, physical health and wellbeing, pastime vocational and work opportunities, mental state and medication issues will also need to be evaluated. As part of the evaluation process it is helpful to consider why changes may have occurred. Service users may have been offered the same opportunities many times before without success, so much can be learned as to what may have made a difference when there have been positive changes.

Clinicians should have an expectation that they may need to spend many hours working to address simple issues. They need to be ready for those times when goals they think have been achieved or resolved revert back to square one. An attitude of persistence and maintenance of hope, even in adversity, is important if we are to address entrenched
problems which have developed over many years. It is helpful to remind service users to understand that trends are more relevant than spot results – it is the pattern of change that is important.

Although working with service users is generally informal and does not have a systematic, team based method of evaluating outcome, there are some examples (Perkins and Fisher 1996, Macpherson et al 1999) of studies which have looked at deriving simple methods of outcome measurement in order to derive a meaningful measure of the achievement of goals set in clinical practice, or by service users. It can be seen that for clinicians or teams who wish to adopt such systems, there may be benefits at the level of the individual work, but also through the ability to reflect on the team’s effectiveness (by aggregating results across the team) and the ability to demonstrate to external sources (including commissioners of service) how a team is working.

2. Formal evaluation

There are also a range of tools that may be used to evaluate aspects of the health or social functioning of a service user. Such assessment tools may be used to evaluate the effectiveness of interventions in helping a service user achieve goals. In situations where an individual may find it difficult to express their experiences or how they feel these tools may be particularly helpful and may open a more meaningful dialogue in these areas. There are many assessment rating scales which may be of use in different ways:

The Liverpool University Neuroleptic Side effect Rating Scale (LUNSERS, Day et al 1995) is a rating scale that gives service users the opportunity not only to talk about their experience of the benefits and side effects of medication but also about their experience of psychotic symptoms. This can help when evaluating the impact of medication.

The Engagement Measure (EM, Hall et al 2001) is helpful for evaluating the client’s changing relationship with services. Ratings range from 0-50, with a cut-off of 35 indicating satisfactory engagement.

The Camberwell Assessment of Need Short Appraisal Schedule (CANSAS, Slade et al 1999) is an assessment measure best used by staff and service users, so that differences in perception of unmet needs (i.e., in financial circumstances, accommodation) can be identified. It is a simple, easy to use scale which enables assessment of the health and social needs of people with mental health problems across 22 domains. See further detail on this scale in the section on needs assessment.

The Health of the Nation Outcome Scales (HoNOS, Wing et al 1996) is a short, simple rating scale which gives a cross sectional overview of staff rated health and social functioning across 12 domains.

The KGV Scale (Kravieka, Goldberg & Vaughan 1977) is helpful for measuring the severity of those psychiatric symptoms that are most commonly experienced by people who have psychotic illnesses such as schizophrenia and bipolar affective disorder.

Formal measures help evaluate the effectiveness of interventions in a concrete way. They may also act as a shared framework, enabling us to show service users how over a period of months and years they are gradually turning their lives around in a more positive way.
3. Service evaluation

It is important to consider the work of the team as a whole. There are a number of descriptions of the work of teams in the literature, and it is clearly possible to look at this in different ways. Whether the team wishes to look at its fidelity against standardised markers, consider the impact of the team’s approach on the rate of admission or satisfaction among the service users, we would strongly advocate an approach which encourages reflection and review on the work of the team at this level. There may be opportunities to develop and share new ways of working. The lack of published research looking at how teams work effectively suggests a great need to develop more evidence in this area.

Macpherson et al (2008) have developed an example of a service evaluation looking at the impact (on service uptake and on engagement, health and social functioning), of working with service users in an assertive outreach approach, over the first year. Interested parties are welcome to contact this service (see contributors list for contact details), should they wish to share ideas, or consider joining this project.

Further Reading


Macpherson, R. et al. (2008). Service evaluation of assertive outreach teams; SEAT. 2gether NHS Foundation Trust publication


Assertive outreach and recovery

Keith Coupland and Nathan Gregory

The recovery model

Context

Recovery is a relatively recent development in mental health services. It is a concept that has been introduced primarily by people who have recovered from their mental health experiences. Now many people are talking about the word “recovery”. Recovery is what people experience themselves as they become empowered to manage their own lives in a way that allows them to achieve a fulfilling, meaningful life and a positive sense of contribution within their own communities (NIMHE 2005).

Recovery further emphasises the importance of hope in sustaining motivation and supporting expectations for service users to lead an individually fulfilled life (Shephard et al 2008). The concept of recovery has received international recognition, and in the United Kingdom is supported in various Department of Health polices which aim to promote self management of long term conditions and choice. These policies include the Expert patient (Department of Health 2001), Our Health, Our Care, Our say (Department of Health 2006a) and the commissioning Framework for Health and Well Being (Department of Health 2007a).

The professional role

The recovery approach requires staff to shift from people who are perceived as experts / authority to more of a personal coach / trainer. This relationship is based up the Rogerian principles of openness, trust and honesty. The professional aim is to provide the person with information, skills and resources to help them access the resources required for people to live their lives. Repper and Perkins (2003) term this as professionals “being on tap, not on top”. The central objective of this relationship is to ensure the service user has access to housing, employment, education and participation in mainstream community / leisure activities.

Definitions of recovery from mental illness

- Recovery from mental illness can mean being free of symptoms; being off all medications; being off all benefits; employed; living in your own place with your own family.

- However, many service users describe being free of all symptoms and medications as being less important than having control over their lives and adequate, friendly support when times are difficult.

- The concept of survivor and courageous struggler can seem more recognisable to service users in assertive outreach than ‘recovered’. Having said that, it can be a delight when, for example a service user working with an assertive outreach team for years, turned down an offer to help facilitate a group because she was now ‘working full-time, still on medication and still vulnerable to mental illness but too busy’. Yippee!
Key facts

- Recovery from MOST mental illness is the norm rather than the exception
- Who will recover and who will have ongoing problems is not clear
- Hope is the greatest psychological asset for those affected by mental illness
- Taking an active part in your own recovery is essential
- Many service users in secondary care will experience on-going problems

Key principles in promoting recovery

- Involving people with first-hand experience of recovery from mental illness, in planning and presentations to build and inspire a reservoir of hope
- Every person needs love; they may need someone to love; somewhere they love living and some work they love to do
- Actively involving service users and carers in recovery focussed ways of working is likely to foster hope, positive attitudes and change
- It should be acknowledged that recovery is a contested term, which some service users do not like or recognise, and a more helpful term might be ‘resilience’

JOINT POSITION PAPER 08: A Common purpose: Recovery in future mental health services
http://www.scie.org.uk/publications/positionpapers/pp08.asp

Recovery is possibly:
- A spontaneous and natural event
- An intended outcome of skilled intervention by professionals
- A personal journey of discovering resilience, despite ‘symptoms’ and ‘illness related problems’
- All of the above

JOINT POSITION PAPER 11: Whose recovery is it anyway? Some questions to ponder
http://www.scie.org.uk/publications/misc/recovery.asp

- Does ‘the system’ really value journeys as defined by users, or are they trying to create their own version to suit their needs?
- Are people being forced into recovery by services and is the recovery model being used to justify cuts in services?
- Is recovery just the current flavour?
- Where do pharmaceutical companies stand regarding the notion of recovery? What are their interests?
- Is the mental health system interpreting recovery in a way that keeps power in the system?
Some examples of recovery-focused practice

- Service users planning and delivering courses
- WRAP (Wellness Recovery Action Plans) adopted as part of Care Planning
- Recovery groups in inpatient and community settings

Further Reading


Recovery and discharge from assertive outreach

Alison Curson and Bronwen Williams

Discharge from the assertive outreach team

At some stage service users will be discharged from assertive outreach. This can be for a variety of reasons but mainly it is when they have made improvements that enable them to recover, live more independently and as a result they require a less intensive treatment approach. The following list may help to guide this:

- Minimum of 6 months stability of the service user’s recovery, with no crises or admission and ideally seeing an improvement in outcome measures (Engagement and CANSAS measures)
- A clear lack of progress over twelve months or longer of offering an assertive outreach approach to the service user
- No meaningful engagement achieved by the assertive outreach despite consistent attempts to engage over at least 6 months

Service users will usually be handed over to a community mental health team, recovery team or occasionally back to primary care. Service users may move area within the area and be transferred to the appropriate locality assertive outreach team or they may move out of county and an assertive outreach team in that locality will be found. Infrequently service users may completely disappear from services and in this case the clinicians should follow the local policy for ‘People who Drop Out of Services’.

When a service user is first accepted onto the caseload it is useful to have a discussion with them about the service user’s journey and explain at this point that they will only be on the caseload for as long as is therapeutically helpful for them. From the start of the journey their engagement and their met and unmet needs will be identified and planned for. This is in line with the spirit of hopefulness that assertive outreach workers and teams adopt.

Any discussion about handover needs to be broached in a careful manner and managed skilfully. For many moving to another team can be seen as a loss and can be a frightening time. Discharge from assertive outreach should be a gradual process and underpinned by good practice, following the CPA process and the Trust’s policy relating to planned transfer between teams.

Generally a minimum handover period of 3 to 6 months is usual. There will be discussion with the receiving team, usually by the care coordinator, consultant and team manager and identification of a receiving care coordinator. The introduction of the new care coordinator is often best done by scheduled joint visits by the team and the current care coordinator or other appropriate assertive outreach worker. A CPA should be planned and worked towards where a formal handover and new care plan can be drawn up.
<table>
<thead>
<tr>
<th>What can help a handover</th>
<th>What can hinder a handover</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Service user identifies they are ready to move</td>
<td>• Service user feels it is forced upon them</td>
</tr>
<tr>
<td>• That the move is service user driven</td>
<td>• It is service driven</td>
</tr>
<tr>
<td>• Slow, measured, managed approach</td>
<td>• The service user is not ready</td>
</tr>
<tr>
<td>• All parties are involved</td>
<td>• Hurried, rushed, unplanned approach</td>
</tr>
<tr>
<td>• Service user presents their own CPA if willing and able</td>
<td>• Others not consulted</td>
</tr>
<tr>
<td>• Seen as positive and affirming of how far they have progressed</td>
<td>• Seen as rejection and loss</td>
</tr>
<tr>
<td>• WRAP. Rainy day plans Early Warning signs work</td>
<td>• Risks become too high</td>
</tr>
<tr>
<td>• Stable accommodation</td>
<td>• assertive outreach approach has created dependence</td>
</tr>
<tr>
<td>• Good daily routine with activities and occupation</td>
<td>• Service user becomes unwell</td>
</tr>
<tr>
<td>• Reduction of support has already occurred over time in the assertive outreach team – often down to seeing one worker with less frequency</td>
<td>• Paperwork not up to date – e.g. core assessment</td>
</tr>
<tr>
<td>• Using the local protocol for transfer between teams</td>
<td>• Accommodation not stable</td>
</tr>
<tr>
<td>• Good rapport between teams</td>
<td>• Moving prescribing to another prescriber e.g. GP</td>
</tr>
<tr>
<td></td>
<td>• Details such as phone numbers are not handed over</td>
</tr>
<tr>
<td></td>
<td>• Physical health issues are not properly handed over</td>
</tr>
</tbody>
</table>
Part VI: The assertive outreach team approach

Teams and individual working styles in assertive outreach

Steve Onyett

Working as a team

Assertive outreach teams are teams, like any other. They need therefore to fulfil key features of effective team working in having:

- Clear and shared objectives- these often need to be negotiated with neighbouring teams.
- Members who work closely together to achieve the objectives of the team. This is particularly relevant to assertive outreach teams where service users present with complex needs that require the involvement of a range of individuals and agencies.
- Members who have different and clearly defined roles within the team. Team working is NOT about all being the same even where there is a large core component of people’s roles that everyone in the team undertakes.
- The right size, skill mix and number of members. The most effective teams have the minimum number of team members required to get the job done.
- Opportunities to review the performance of the team and how it could be improved.
- Support for innovation- both rhetorical and practical.
- Safety in participation- being able to contribute ideas with no fear of criticism or ridicule, even if the idea is a bit “half-baked”.
- Good processes for decision making, particularly who decides what and when? If every little decision needs to go through a team process then it can become clogged and sluggish, but at the same time everyone needs to make the best use of the collective knowledge, skills and experience within the team to inform decision making. This always requires crystal clear clarity about accountability (who you report to on what) and responsibility (the tasks that you can be held accountable for).
- Ambition- excellence is the expectation.
- Defended time out to review what it is trying to achieve, how it is going about it and what needs to change.
- A team identity, in that others can recognise it as a team.

The “team approach” in assertive outreach is a good example of effective team working mirroring the complexity of need presented by service users and their supports. In this model everybody in the team has some input and involvement with individual service users rather than working on a strict “key worker” or “care coordinator” model where only one team member links in with service users. However, there is a balance to be struck. There is some research to show that service users do not value the team approach where dogmatically applied. People will clearly get on better with some people than others and being able to recognise this and make best use of it in keeping people effectively engaged
is a key strength of any team. It is important to avoid situations where service users find themselves having to tell the same story to a series of visitors, especially where those visitors appear not to communicate with each other behind the scenes.

**Team leadership**

Team leaders have a particularly challenging and important role. They need to face into teams communicating messages from above, and face out representing the team in more senior forums. As people sitting on a boundary, who are seen to have authority they are often a place where people project a lot of their anger and dissatisfaction about the current state of play. They therefore need a lot of support and role clarity - including peer support from other team managers and particularly their own immediate line manager. The team’s senior medical consultant psychiatrist often shares a leadership role, perhaps with a more clinical focus. It is crucial that these two key individuals are clear about their own and their colleagues roles and supportive of each other, particularly where they work together to represent any issues to management.

Recent models for understanding leadership have moved away from heroic, “great man” approaches where people lead from the front to an approach that recognises that leadership is more dispersed and shaped by the task at hand. In essence you only really know when there has been or is good leadership when something good is seen to happen. Leadership is about the creation of environments in which people can be most effective (including service users and carers). It can only be judged by results and those results are the outcomes that are valued by service users, their supports, and other key stakeholders.

The “post heroic” leader places more emphasis on working through others, voicing the vision of the team and its underlying values. They show more faith in other people than they have in themselves - and they have a lot of faith in themselves! They demonstrate ambition, optimism, openness and personal humility and promote connectedness and inclusion. As Sir Gerry Robinson recently observed, “Management is not an exercise in bludgeoning people. It is about getting people on side, about making them feel important. The secret is to make them feel special, part of an organization that works, where they play their part”. Recent research with home treatment teams has shown that “showing genuine concern” for the person being line managed has the biggest impact on staff motivation. This is where a leader or manager shows interest in your needs and aspirations and how things feel for you.

**Inter team working and the team leader**

Another key role for the team leader (and often the team consultant) is as a “boundary spanner” between teams. Because of our natural human tendency to form groups by deriding others outside the group, relationships between teams are not always as good as they can be and there is a lot of reciprocal stereotyping (inpatient staff as medical model oppressors, assertive outreach staff as privileged and protected prima donnas for example). In this context it is ultimately the service user who has to navigate complex local systems that lose out. As the Mental Health Policy Implementation Guide (2005) points out, “communities will also have to take care that they do not think about service elements in isolation. All elements have to interact as a system, so that the service user experiences continuity during their pathway through care, with each element offering added value”.

Boundary spanners are people in organisations with a special role in developing relationships external to the team. In assertive outreach the role would often be taken on
by the team manager and he / her would have a dual identity in that they experience a positive sense of belonging both to the team and the wider organization or service. Research has shown that this dual identity is positively related to effective intergroup relations, and is most pronounced if boundary spanners have frequent out-group contact. Their sense of positive belonging (identification) with the organization or service appears to function as a buffer to the poor intergroup working described above by shifting the focus to a common superordinate group and objectives but without blurring group boundaries and identity.

Some of the practical implications are that managers can combat ineffective intergroup relations by enhancing identification with the organization. Measures include:

- Communication of organisational successes, values, and goals
- Rotation of individual boundary spanners
- Promotion into boundary positions of employees with dual identification
- Ensuring that intergroup working is on a group’s agenda, in order to combat “silo working”
- Intergroup social gatherings
- Frequent intergroup meetings

Invite your least favourite team to have a joint Christmas party with you!

**Case management – the role of the assertive outreach worker**

The role of the assertive outreach worker is one that differs in some elements from that of the care coordinator in other mental health teams. The philosophy of assertive outreach working is one of a shared case load / team approach which necessitates most staff knowing all the service users on the caseload of the team.

The contact with different team members will differ according to the individual service user’s needs and the frequency of visits. For example someone who is currently stable and having weekly visits may only be seen by their care coordinator and a nominated other. Someone who is requiring daily input with more acute complex needs will often see most members of the team.

Some new service users to the caseload will only be able to accept or tolerate one new person or professional approach, with the gradual introduction of other team members in a paced and measured way. If too many people are introduced rapidly the service user can become over-whelmed, stressed and may well disengage with the service. Often a great deal of thought will go into deciding who the best worker to get alongside the individual is and this will depend on their personal and professional skills and interests as well as their personality.

This means that teams need to know their strengths and weaknesses both as a group and as individuals. Whilst this can be a very rewarding way of working, the downside is that this level of openness about skills and personal attributes can feel quite daunting at times and requires a very open, flexible and reflective approach by the practitioner. A supportive
team is a must, both informally through the knowledge of each other and support that is given to formal structures, including team and individual clinical supervision.

The individual care coordinator will be responsible for managing the service user’s care throughout the CPA process but usually several other team members will be involved in this, bringing their particular disciplinary and individual skills to the care plan and to service delivery. The benefits of this way of working are that there is always support from colleagues who know and understand the service user, often as well as the care coordinator.

**Personal characteristics of staff suited to assertive outreach working**

The assertive outreach worker requires a peculiar set of personal characteristics which include long term optimism, continual hopefulness and abundant creativity to enable problem solving. Individuals need to be resourceful and able to turn their hand to anything with a ‘can do attitude’. Staff need to be able to cope with rejection and at times, down right abuse. Here the support of other team members is essential, as is a sense of humour!

<table>
<thead>
<tr>
<th>Individual characteristic</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘can do attitude’</td>
<td>Can I help with getting Joe to the GP – I have time to do that on Thursday</td>
</tr>
<tr>
<td>Long term optimism</td>
<td>This accommodation may have proved to be unhelpful for Joe but we are a step nearer to finding the right place for him</td>
</tr>
<tr>
<td>Eternal hopefulness</td>
<td>Looking over the past two years things have slowly improved for Joe. We can make other things better for him.</td>
</tr>
<tr>
<td>Coping with rejection</td>
<td>Joe doesn’t want to see me right now but perhaps Fred will be able to see him – he managed to help last time this happened</td>
</tr>
<tr>
<td>Supporting colleagues who are rejected</td>
<td>I’ll see Joe for you but tell me what you think would be most helpful for me to do and I will let you know how it goes and when they are ready to see you again</td>
</tr>
<tr>
<td>Sense of humour</td>
<td>“I wonder if Joe knows the one about the light bulbs and the OT?”</td>
</tr>
<tr>
<td>Team nurturing / looking after each other</td>
<td>“I’ve brought cakes!”</td>
</tr>
<tr>
<td>Flexibility</td>
<td>Joe hasn’t turned up so I can do my clinical manager recording!</td>
</tr>
</tbody>
</table>

Workers’ outside interests and skills are often used with great benefit in their assertive outreach work. For example interests and skills in football, swimming, cooking and home decorating can be put to good use for engaging service users and getting to work alongside them. Staff need to want and to enjoy working with an assertive outreach approach and to be able to develop trusting relationships with both their service users and their colleagues. The ability to be truly service user centred is essential to work with service user’s strengths and help them to achieve their aspirations over time.
If staff are not suited to this type of work they may be better suited to other types of teams where individual caseloads are held, or inpatient settings. Having your peers what can feel like constantly scrutinising your work can be off putting and difficult for some workers.

**Multidisciplinary roles**

Assertive outreach teams are usually comprised of a wide variety of disciplines including doctors, nurses, social workers, occupational therapists, unqualified staff and some teams will include specialists in dual diagnosis, housing workers and service users. Respect and understanding of each professional role is required and takes time and good communication to achieve. Understanding what different disciplines can bring is important. Generic work is expected of all – to a lesser or greater degree – and a task is often best performed by the person best placed to undertake it, as long as it is within their skill range.

Whilst each qualified core team worker is expected to care coordinate a number of service users, consideration needs to be given to ensure that the particular professional skills of each can be used, for example occupational therapists will need sufficient ring fenced time to undertake their specialist assessments and deliver planned interventions. Similarly team members with specialist skills and knowledge may need time set aside to deliver planned work such as family work, individual psychosocial work and non medical prescribing.

The team manager has an important role in monitoring the ability of the individual practitioner to deliver and practice their particular skills. The team manager also needs to support the individual professionals to ensure their continued disciplinary knowledge and skills – attendance at best practice forums, specific training and supervision from their professional lead.
### Case examples demonstrating differing roles of team members

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
</table>
| OT care coordinates service user with a bipolar illness, who dislikes anyone he sees as ‘authority’. Service user knows OT from past and sees OT able to give practical help. 
At start of assertive outreach involvement, team manager discussed the team with the service user and explained that this would be different from his previous experiences of mental health teams and that he would be seeing more people that he had in the past. 
Been with assertive outreach for 6 months. | OT has developed good engagement with the service user. Sees him once a week, would like it to be more but service user unable to tolerate this. 
OT delivers medication. This is overseen by CPN. Depending on the condition of the flat OT is able to assess mental state. If flat total tip service user is very unwell. If one room only is chaotic then early warning signs are appearing. 
Completes DLA and other benefits – team Social Worker would help when things get complicated. 
Gets budgeting back on track. 
Liaises with elderly relative. 
Encourage and support to take up old interests – yoga 
Sees hospital chaplain when he turns up at hospital – OT liaises with him. 
Just starting to join the walking group. 
Team manager working at a weekend found service user without money and was able to help – this impressed the service user! |
| CPN works with 30 year old man with psychosis who is geographically isolated. Risk of aggression when unwell. | Main contact with service user is once a week to transport to get weekly shopping. 
Now developed into going swimming before shopping. 
When he became unwell team visited once a day to deliver and monitor medication. 
Conversation whilst driving to and from shopping will give indication of mental state – if talks enthusiastically about what he is going to buy and cook all is well. If less enthusiastic or vague, less chatty and preoccupied these are early warning signs. 
Manages money well but if begins to struggle – sign that all is not well and team may have to help with emergency electricity etc. 
Care coordinator sees service user’s mother every two months for informal psychosocial work about illness and support. 
Care coordinator supports service user in applying for a bus pass which will enable more independence and to access community facilities further a field. |
<table>
<thead>
<tr>
<th>Case 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service user in 30’s with psychosis and opiate abuse problem. Problems of long term self neglect and concern for safety and health of pets.</td>
<td>Two cats – both eventually neutered and one re homed when service user could no longer cope. Service user given regular updates about how cat is doing.</td>
</tr>
<tr>
<td>CMHTs in the past had never managed to see him consistently.</td>
<td>OT assessment and help with clearing rubbish from flat.</td>
</tr>
<tr>
<td>Service user’s main diet is cereal.</td>
<td>OT starts cooking with service user and CPN makes occasional rock cakes.</td>
</tr>
<tr>
<td></td>
<td>Substance misuse service continues to be involved and prescribe methadone. Assertive outreach team ensure service user gets to these appointments.</td>
</tr>
<tr>
<td></td>
<td>Team support worker gets service user to GP appointments and ensured he had blood tests for Hep C which proved negative.</td>
</tr>
<tr>
<td></td>
<td>Team supported service user to get to all three appointments needed for Hep B inoculations. Support worker takes service user cycling</td>
</tr>
<tr>
<td></td>
<td>CPN reapplied for higher DLA.</td>
</tr>
<tr>
<td></td>
<td>Regular appointments with Psychiatrist to find right medication for psychosis for service user.</td>
</tr>
</tbody>
</table>
Team management

Bronwen Williams and Alison Curson

Whilst there is a clearly defined role for the team managers there is also a need for delegation and understanding of the management tasks by team members to enable the team to be self-sufficient and develop a sense of team ownership. Team managers can come from a variety of professional background: nursing, occupational therapy or social work. As the team manager in assertive outreach is generally required to have a small caseload of their own, the manager must be clinically credible, as well as having good management skills.

The role is often a fine balancing act between the management and clinical elements of the role. Both will demand the manager’s attention and time, sometimes with equal urgency which can make the role sometimes feel pressured. However, despite sometimes feeling torn in different directions the assertive outreach team manager role can be one of the most rewarding within adult mental health services.

Meeting with team workers regularly for case / workload management is imperative. This allows the team manager to have an understanding of the work that is being undertaken and also the balance and weighting of each worker’s caseload. For example, one caseload of eight service users may be quite different to another. This can be due to the stage that the service user is at with the team – from complex and chaotic requiring daily or even more frequent contact to weekly or less often contact with a service user who has been stable for sometime and preparing for a move to a less intensive approach such as a Recovery team.

The table below is from an idea by Steven Covey (1989) about how we use our time. We have used activities common to assertive outreach teams to complete the table. Covey suggests that as human beings time is often spent in the important / urgent quadrant but that we are better to use our time in the important non-urgent quadrant to be our most productive. We would suggest that when assertive outreach teams have problems such as low staffing / high sickness we can spend much of our time in the important / urgent quadrant. However as shown, being in this quadrant can lead to stress and burnout which, combined with the type of work we do and the complexity of the cases is a serious matter.

Work and time: an important balance (after Covey, 1989)
<table>
<thead>
<tr>
<th>Important and urgent</th>
<th>Important and not urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHA assessment</td>
<td>CPAs</td>
</tr>
<tr>
<td>Crisis</td>
<td>Routine outpatient’s appointments</td>
</tr>
<tr>
<td>Telephone calls</td>
<td>Planned interventions / visits</td>
</tr>
<tr>
<td>A&amp; E appointments</td>
<td>Sports activities</td>
</tr>
<tr>
<td>SU locked out of flat</td>
<td>Social activities</td>
</tr>
<tr>
<td>Missing medication</td>
<td>Writing notes</td>
</tr>
<tr>
<td>Unable to get benefits</td>
<td>Clinical manager</td>
</tr>
<tr>
<td>Clozapine bloods</td>
<td>Audits</td>
</tr>
<tr>
<td>Fire fighting</td>
<td>Emails</td>
</tr>
<tr>
<td>Deadlines</td>
<td>Social Circumstance reports</td>
</tr>
<tr>
<td>Complaints</td>
<td>Specialist assessment – OT, psychology, psychosocial</td>
</tr>
<tr>
<td></td>
<td>Cup of tea</td>
</tr>
<tr>
<td></td>
<td>Team away days</td>
</tr>
<tr>
<td></td>
<td>Team planning / reviewing</td>
</tr>
<tr>
<td></td>
<td>Workload management</td>
</tr>
<tr>
<td></td>
<td>Clinical supervision</td>
</tr>
<tr>
<td></td>
<td>Complaints</td>
</tr>
</tbody>
</table>

**STRESS & BURNOUT**

<table>
<thead>
<tr>
<th>Not important and urgent</th>
<th>Not important and not urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SU wants lift to collect his cheap tobacco</td>
<td>Trivia</td>
</tr>
<tr>
<td>Some reports / meetings</td>
<td>Time wasters</td>
</tr>
<tr>
<td>Interruptions</td>
<td>Unproductive activity</td>
</tr>
<tr>
<td>Other people’s gossip</td>
<td></td>
</tr>
<tr>
<td>Unprepared meetings</td>
<td></td>
</tr>
</tbody>
</table>

**OUT OF CONTROL, SHORT-TERM FOCUS AND FEEL VICTIMISED**

**VISION, PERSPECTIVE, CONTROL AND BALANCE**

**Not important and not urgent**

**IRRESPONSIBILITY AND DEPENDANCE ON OTHERS**

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**Further Reading**

Covey, S. (1989). *The seven habits of highly effective people - powerful lessons in personal change*. UK: Simon and Shuster UK Ltd
The role of the support and recovery worker

Karen Amesbury and Eileen Thackeray

Quote from a support worker:

‘Our aim is to boost service user confidence and to help them feel that they are important people. They know we don’t do this just because it’s a job. They know they are important to us’

The support worker has a distinct role within the team contributing to each aspect of the service user’s journey through assertive outreach. They need a range of skills and can take on a huge variety of roles as below. Arguably, the more informal and befriending approach they are often able to offer can make a real difference working with even the most difficult to engage service user.

Some key roles of the support worker

- reporting back to care coordinators
- giving hope when there does not seem to be any hope left, ‘being there’
- not allowing service users to feel small because you’re doing a simple task for them or with them – always promoting dignity and respect
- helping service users to do simple things like make a GP appointment. Knowing when to do it for a service user and when to promote independence
- giving telephone support
- financial assistance – helping with budgeting, making choices, banking, benefits making sure bills are paid on time – real problems can arise if we do not do this
- helping with house moves
- try to lower service user stress levels
- take service users on holidays – this takes lots of preparation – deciding which service users are able to go and get the right mix of service users. Deciding what levels of support will be needed on holiday
- promoting family ties and relationships
- promoting group activities ensuring that service users take as much responsibility for helping in the groups as possible- walking, gardening, badminton, shopping, cinema, meals, sports and theatre trips
- being aware of medication changes and how it may affect service users – helping with and encouraging concordance with medication. Knowing side effects and helping service users to cope with them
- keeping up to date with mandatory training
- keeping notes and clinical audit
- participating fully in the CPA process
- regular contact to ensure that none of the activities are undermining independence
- looking to move service users on not letting them become ‘stuck’ in the system
Skills used by support workers

Good communication skills

Be a good listener, know your limitations, be non-judgemental, be patient as building relationships takes time, knowing when to push / encourage and when to back off and give the service user’s space, accept that there may be some service users that you can not work with at all,

Be tactful especially when working with families and carers

It can be valuable to meet as a group of support workers, using reflective practice to enhance our role within the team.
Supervision and support for assertive outreach workers

Rachel Freeth

‘Successful teams rely on the skills and commitment of individual staff members’ (Burns and Firn 2002).

The effectiveness, morale and well-being of staff are key to providing what can often be highly demanding and challenging assertive outreach work. It should therefore be self-evident that one of the key tasks for assertive outreach teams (both at a team and individual level) is to consider what is needed to develop and maintain staff effectiveness, morale and well-being, and to minimise the risk of burn-out. Supervision can be a useful process for meeting a variety of these needs. In what follows some general issues concerning supervision will be explored, especially supervision within mental health settings and assertive outreach teams in particular. A particular form of group supervision (‘reflective practice’) will be described.

Supervision: some general points

There is no overarching definition of supervision, which is a term often used rather loosely. Rather, there are a variety of different descriptions which highlight a range of processes, goals, tasks (functions) and relationships (roles) within supervision. These differing perspectives and understandings are in part a reflection of differences between professions and their different roles, responsibilities and needs. Adding further to potential confusion is a variety of descriptive terms for specific activities that may fully or in part be subsumed under the umbrella term of supervision, terms such as ‘consultative support’, ‘educational supervision’, ‘caseload management’, ‘peer support’, and ‘clinical supervision’.

Because the term supervision will mean different things to different people, it is important to identify and describe as clearly as possible at the outset of any supervisory arrangement what it is we might want from supervision. Drawing on the supervision literature may be helpful here. Carroll (1996) identifies seven generic tasks of supervision which are as follows:

The tasks of supervision (Carroll 1996)

- To create a learning relationship
- To teach
- To consult
- To counsel
- To monitor professional and ethical issues
- To evaluate
- To monitor the administrative aspect of practice

Similarly, but more simply, Kadushin (1976) describes 3 broad functions of supervision which are: educational, supportive and managerial. The formative, restorative and normative functions described by Proctor (1988) roughly equate with Kadushin’s framework.

It is worth noting that managerial functions are often more an organisational need. It is understandable that when staff experience or perceive supervision as primarily a
management tool (e.g. with a focus on productivity), or when their performance and work is being scrutinised and monitored, they may be wary and resistant towards the supervisory process. In contrast, when the emphasis within supervision is to consider and attend to the educational and support needs of staff, it is more likely to be regarded as helpful.

Supervision for mental health professionals

Well organised, quality supervision has the potential to meet a range of needs for professionals working in mental health settings. Attempting to identify and describe at the outset what the specific goals and functions of supervision should be for that particular group or individual is very important. As well as considering educational, supportive and managerial functions, another framework that may be helpful is to consider those functions in which the focus is primarily on the service user, and those in which the focus is primarily on the staff member:

Focus on service user

- Focus in detail on specific clinical work, i.e. review clinical practice.
- Develop deeper understanding of service user’s needs and problems.
- Explore how to develop and maintain therapeutic effectiveness (which may involve exploring the nature of the ‘therapeutic relationship’).
- Review clinical work in the context of the organisation, i.e. considering how organisational factors and demands (e.g. constant change of structures and policies), interfaces with other teams and services, or the assertive outreach team culture influence our thinking and practice.

Focus on staff member

- Identify learning needs, i.e. areas in need of development either to improve competence (clinical skills and knowledge) or job satisfaction, and ideally both together.
- Explore the relational and emotional demands of working with people with mental health problems (e.g. reflect on the nature of our emotional engagement and capacity for empathy, or how to respond when we become important attachment figures to our service users).
- Reflect on our job satisfaction and morale and how this impacts on the quality of our work.
- Reflect on and monitor our own mental well-being, stress levels and risk of burnout, and consider the impact of our work on our health, and vice versa.
- Develop greater self-awareness, e.g. an opportunity to examine our attitudes, prejudices and behaviours, and the values and belief systems that inform them. This may also include the development of our own personal philosophy towards our work (e.g. how much do we believe in and aspire to ‘recovery’ values?), and how we manage differences of philosophy and values.

Many of the above do, of course, overlap and cannot be separated.
Supervision is often regarded as an opportunity to explore particular problems, challenges or difficulties. It may also be important to use supervision to celebrate things that go well, aspects of our work we enjoy and give us satisfaction, and to acknowledge achievements and successes.

**Supervision for assertive outreach work**

There are a number of particular characteristics of assertive outreach work that are worth highlighting because of their potential influence on the supervisory and support needs for staff. These include, with overlap:

- Complexity of the service user group (complexity of psychopathology and often complexity of social issues). This makes for particular intellectual as well as emotional demands.

- The particular challenges of developing and maintaining therapeutic relationships and engagement. This may be due to the nature of an individual's psychopathology (e.g. persecutory delusional beliefs) and / or more general personality characteristics such as emotional instabiltiy or antisocial traits). Similarly, the challenge of coping with rejection and hostility when this occurs.

- The intensity of assertive outreach work – working with fewer patients but more intensively.

- The unpredictability of assertive outreach work and needing to be highly flexible.

- Coping when people don't seem to 'get better' (due to any or a combination of illness, personality factors and social factors) which may lead to feelings of frustration and powerlessness within staff.

- Prevalence of risk issues.

Multi-disciplinary team working. Sharing caseloads within Assertive Outreach places a particularly high demand for effective team-working, potentially creates more opportunities for clashes of values or misunderstanding, as well as being difficult for some people having their practice more 'on show'. Need for clear team objectives and clarity around roles.

Assertive outreach work can be challenging and due to its long term nature does not suit all individuals. There is evidence that staff working in assertive outreach may be more resilient and have clearer roles and job satisfaction, than staff in community mental health teams (Billings et al 2003). However, for anyone working in a mental health field, it is important to be aware of the risks to one’s own health of problems such as burn-out, which has characteristics as described below:
Characteristics of burnout

Roberts (2000) identifies the following characteristics, the development of which may be slow and insidious:

- Emotional exhaustion
- Disillusionment
- Detachment
- Reduced energy
- Negative job attitudes
- Reduced care and concern for others

Team ‘reflective practice’

Reflective practice sessions are regular (often fortnightly) meetings for the entire team to meet for one hour to focus in depth on an individual clinical case. They are ideally facilitated by a colleague such as a clinical psychologist who invites (usually) the care co-ordinator of the service user to present a brief history and summary, and then to state as far as possible the particular issues or questions to address. For best results this initial introduction by the care co-ordinator should be planned and have specific questions to be addressed. It is also helpful for the team to know in advance who will be discussed so that other members of the team who are involved in the care of the service user can do some thinking in advance. The facilitator’s role is to hold the boundaries (e.g. of time), to help the group stay focussed on the relevant issues, as well as bring, where useful, their own observations or clinical insights to the issues discussed.

These sessions tend to take the form of clinical problem solving rather than a more personal exploration of feelings and values (these are generally more suited to individual or small group supervision arrangements). Indeed, the scope of these sessions is inevitably limited by the size of the group and the fact that not everyone will be equally engaged in the process, especially for those staff who don’t know the service user. In general though, these sessions can be helpful in deepening understanding, hearing the thoughts of others in the team (gaining a multi-disciplinary perspective) and in sharing struggles and responsibilities.

Other supportive activities

Supervision is only one, albeit a very important, form of support, and even if one is fortunate to have group as well as individual supervision, it will still be necessary to consider how other needs can be met if not met through supervision. Educational and support needs can be met through a variety of other processes, for example, away days, conferences, workshops, professional development groups, protected learning time, mentoring and informal networks of support.
Below is a list of other factors which can impact on the morale of the assertive outreach team:

**Organisational factors impacting on morale**

Manageable workloads

Bureaucratic demands

Adequate physical working environments

Administrative support

Effective leadership

**Conclusion**

Care and thought in setting up formal supervision, which will include paying attention to practical realities such as frequency and venue, expectations of all parties, whether individual or group, who to facilitate is usually repaid well. The worst kind of supervision is that which is imposed on unwilling participants in order to tick a box. The best kind is that which leads to the development of reflective practitioners who can use the process as one of ‘collaborative enquiry’ (Merry 2002) in the spirit of exploration and openness. It is worth remembering that ‘receiving support and feeling supported can make the difference between thriving and surviving in work that is often intensely personally demanding’ (Gilbert 2004).

**Further Reading**


Part VII: Assertive outreach and the ‘whole systems approach’

Assertive outreach as part of a wider health care system: interface with other teams

David Pugh

Assertive outreach is part of a wider health and social care system. Teams are mostly provided within a specific mental health system within NHS Mental Health Trusts, many of which are now joint health and social care organisations. ‘Systems Thinking’ is a framework that is based on the belief that all the parts of the system will act differently when the system relationships are removed and one part is looked at in isolation.

The only way to understand why a problem or element occurs is to understand that part in relation to the whole system (Capra 1996). To look at things as a system, involves an understanding of the system by looking at the linkages and interactions between all the parts.

An improvement or a problem in one part of the system can positively or adversely affect another. Also, parts are generally systems in themselves and are composed of other parts, just as systems are generally parts of other systems. Recognising the interdependence between groups of individuals, structures and processes enables an organisation or system to function.

The following diagram shows how an assertive outreach team may fit within the health and social care services of a primary care and secondary mental health care system. It demonstrates the pathway by which a service user may both enter and exit the services of the assertive outreach team.
Referrals within this model would be expected to come mainly from the community mental health team / recovery teams and inpatients / crisis teams, but also from forensic services, transfers from out of county services and other sources such as the early intervention service. Discharge from the service is likely to mostly be to recovery teams, with a small number of cases being transferred directly back to primary care.

Assertive outreach teams are generally part of working age adults ‘Directorate’ or ‘Service Unit’ within a Trust and there may also be a need to sometimes work with psychological therapies services, the eating disorders service, employment projects, day centres and if a specific service exists, the black mental health team. Assertive outreach teams also work with the Older People’s, Substance Misuse, Learning Disabilities and CAMHS Strategic Service Units.

External to the Trust assertive outreach works with primary health care services including GPs and health visitors / district nurses, carers mental health support workers, employment services, further education, community and adult care services, children and young people's services, the voluntary sector, criminal justice agencies including probation, police, courts and prison and the supporting people service (there are probably others!).

To be seen as effective by the commissioning services, assertive outreach will have a designated target of cases, defined by the Policy Implementation Guide and by extrapolation to consider local factors. This will mean matching ‘demand’ (i.e. referrals) to ‘capacity’ through ability to discharge to other parts of the system, in order to be able to take on new referrals. Discharge criteria are likely to be based on the following:

- Stable improvement in recovery over a 6 month period
- No improvement after 12 month engagement
- No engagement after 6 months assertive approach by assertive outreach team

There are often tensions in the system centring on the capacity and ability of some recovery teams and primary care teams to take transfers and discharges respectively from the assertive outreach team. "System Dynamics", a method for understanding complex systems, recognises that the many circular, interlocking, sometimes time-delayed relationships among its components are often just as important in determining its behaviour as the individual components themselves (Wikipedia Systems Theory 2008).

The assertive outreach team is one of the most important parts of the mental health system. External to the Trust, assertive outreach is also dependent on partner agencies to provide accommodation for what are sometimes very challenging individuals and education / training or employment opportunities.

In summary, to be 100% effective, assertive outreach is dependent on other parts of the mental health system and external agencies playing their part in meeting the needs of its users. This effective working can only be created through openness, good communication and the development of a common understanding of the role and function of all the teams that contribute to the process of Recovery and Social Inclusion for assertive outreach service users. Within mental health Trusts it can be very helpful to develop steering groups made up of team managers and lead professionals, to provide a mechanism where understanding of the specific team roles can be fostered, services reviewed and developed and tensions resolved. Locality ‘cabinets’, providing a forum to bring together all services in a geographical area, made up of all locality team managers and clinical
leads, can provide a local forum for the development of common understanding and resolution of system issues. To be an effective part of the whole system, it is essential that assertive outreach contributes positively and in a spirit of co-operation within all these forums.

**Further Reading**


Working with the assertive outreach service user in crisis: links with the crisis team

Trish Butler and Bronwen Williams

‘Crisis’ is best defined as an acute psychiatric crisis of such severity that without intensive intervention there will be further deterioration in an acute episode of illness, with the possibility of acute admission being required and the development of risks to the individual or others.

This work needs to be seen as collaboration between the assertive outreach team and Crisis Resolution and Home Treatment Team (CRHT). The CRHT team focuses on treating all those with severe mental illness who are in psychiatric crisis, in the least restrictive environment, offering an alternative to hospital admission. The assertive outreach team’s way of working replicates some of this, so assertive outreach teams may ask for assistance later than other teams might, and will typically be dealing with the crisis alongside colleagues in the CRHT team through the episode.

When an assertive outreach service user starts to show signs of relapse, which can often lead to hospital admission, this is the time to call CRHT in to do a joint assessment. Shared care between the assertive outreach and CRHT teams should enable the service user to offer a real alternative to admission, for the benefit of the service user and their carers.

This requires good working relations, excellent communication between all included and robust care planning which should include comprehensive work around early warning signs and the development of rainy day plans / wellness and recovery action plans (WRAP). When this works well it offers the service user a real opportunity for relapses to have a different outcome, hopefully having less impact on their lives, and improving social inclusion.

Interventions needed at times of crisis:

- Daily medication out of hours to support the assertive outreach team in their delivery of medication
- Effective risk planning and management
- Support to carers
- Mental state assessments
- Increased frequency of contact
- Joint visiting with assertive outreach team
- Work on early warning signs
- Problem solving
- Practical support
There are some areas of assertive outreach work which may be intensive and complex, but where CRHT involvement would not be appropriate:

- Support that is ongoing, where hospitalisation is not an option.
- Long term chronic work, not associated with acute mental state relapse.

**Admission to hospital**

In many services, the CRHT team 'gate keep' all acute psychiatric admissions, therefore all possible admissions must be considered for a joint assessment by assertive outreach team staff and CRHT team staff. The nature of assertive outreach working means that few crises are totally out of the blue, therefore the CRHT is likely to have been involved in discussions and a visit in the weeks or days proceeding the time when admission is required.

Despite an assertive outreach approach, the evidence suggests that admission to hospital remains an important part of the long term treatment and engagement work being carried out. The Pan London study of assertive outreach teams (Priebe et al, 2003) found that on average 52% of each team’s case load would be admitted each year, the majority being formal admissions. As has been discussed in part III of the handbook, the early evidence from United States studies suggesting that assertive outreach prevents admission has not been replicated in United Kingdom work, the latest study by Kilaspy (2007) finding little impact on admission rates from an intensive case management approach (although other important benefits from this form of service have been established).

It is important that admission is seen as a necessary, positive and therapeutic process for service users when community treatment options have been exhausted. As many service users working with assertive outreach teams are in very poor social circumstances, admission can be used as an opportunity to review progress and consider whether alternative support systems need to be put in place.

When the service user is in hospital it is important that the assertive outreach consultant and assertive outreach team continue to be responsible for the service user, providing continuity. In-reach into the hospital by the key worker is vital and should ideally be daily, assuming this fits with the clinical need and risk assessment. The CRHT team can continue to liaise and enable early discharge by supporting assertive outreach and helping to keep up frequency of contact, possibly facilitating early discharge.

**Further Reading**

Prioritising vocational training and employment in assertive outreach: righting the balance

Jo Denney, Judith Rimmel, Nicky Cape and John Pallister

Government guidance and directives around focussing services on those with severe mental health problems who do not engage with traditional provision (DoH 2000) has encouraged specialist workers in teams using an assertive outreach approach to re-evaluate the assumptions previously made around the employment aspirations and capabilities of those with psychosis.

Far from showing lack of interest or negative beliefs that the effects of mental illness preclude working, service users themselves frequently identify employment and educational goals as integral to recovery and realistically identify both social exclusion and low expectations of mental health workers as the actual barriers to engaging with vocation (Secker and Gelling 2006). Previously, funding within services has often been directed at setting up facilities which offered what is now regarded as "substitute" work (Ross 2007), characterised by its segregated setting, low (or absent) pay and a focus on diversion rather than self efficacy and recovery. In such settings there is sometimes a blurring of what is designed to be ‘therapeutic’ and what might be termed true vocational rehabilitation. This may make it more difficult for the service user to progress back into work if some needs at least are seemingly met.

The recognition that such traditional vocational provision often fails to meet the values and needs of assertive outreach service users is of particular relevance to assertive outreach team occupational therapy staff, who have traditionally assisted service users identify and engage with vocational opportunities. They have access to models, assessments and intervention skills designed to develop the individual’s ability to engage with all valued occupation including employment and education. There is certainly a strong movement within the profession nationally (see for example College of Occupational Therapists / National Social Inclusion Programme 2007) to update what can accurately be seen as vocation focused practice and ensure it is put on an equal footing with the development of practical skills and meaningful leisure activities in aiding all service users to achieve a balanced lifestyle.

At the same time the team approach of assertive outreach working and specific responsibility around fulfilling this remit as part of the social inclusion agenda, means that (more than ever) joint working within teams to identify opportunities, support access to employment and education and aid retention is encouraged, alongside facilitating the service user to access community vocational services when this becomes the appropriate pathway. It is therefore our contention that vocation is the business of everybody working in assertive outreach.
Some important research findings

In the past a variety of models have been used to try to help people with problems around meaningful daytime activity but there is a developing consensus that the Individual Placement and Support (IPS) model is more successful and cost effective (Catty et al 2007) than previous approaches. The principles of IPS are as follows (after Becker et al 1994):

The Individual Placement Support Model

- The aim is competition for open employment
- No selection criteria (other than a wish to work)
- Consumer preference drives the process- i.e., the job is fitted to the person
- Rapid job search and placement- ‘place then train’
- Close work between clinical teams and employment specialists
- Individualised, long term support with continuity
- Access to benefits counselling

IPS was found in a multi centre randomised controlled trial including a United Kingdom focus (Catty et al 2007), to lead to employment in 55% cases (twice as often as controls), and patients were not destabilised by the process (no increase in hospitalisation). It is not an answer for everybody, but timing is seen as crucial, with advice to start as early as possible and to work closely with independent sector providers. The perverse incentives which operate in the benefits system may be addressed by part time work and the use of permitted earnings (at this time in the United Kingdom, up to £86 per week)

What do we mean by vocation?

For the purposes of this chapter we have taken our lead from the College of Occupational Therapists / NSIP publication (2007) which defines work as “some kind of valued activity that uses skills and facilitates social inclusion”. On a practical level this most often means engagement in paid or voluntary employment, studying or participating in activity leading up to any of these activities.

Why focus on work to support health?

In order to address this question, you might ask yourself: what do you get out of work and having a major productive role in your life? Financial incentive - almost certainly; social opportunities; a structure to the day; contribution to society and the chance to develop and use specialist skills of interest to you? When you break it down like this it’s easy to see how work provides many of the elements that we value in life and keep us in good mental health. Despite this it has been a common response to mental ill health for people to give up working (by choice or due to lack of options) or be unable to (re)enter the workplace. Giving up work completely when living with mental illness does not promote recovery and in our experience can be highly detrimental to mental well being.
Why do people with severe mental illness stop work and can not get back into work: a local project

An exploration through a collaboration between staff in 2gether NHS Foundation Trust, Gloucester, England, working with the vocational taskforce with its membership of service users, practitioners, employment partners and carers) into why this happens identified the following:

- Financial disincentive (the “benefit trap”) whereby service users are better off financially not working or returning to work. This is further complicated by a confusing array of rules around what is permissible in terms of part time work and education without affecting benefit.
- Difficulty locating and accessing community resources for supporting voluntary work, educational and employment opportunities, particularly in the county’s extensive rural areas.
- “Cherry picking” by such services of those who appear most able rather than offering an inclusive service to anyone who would like to work or study.
- Assumptions from all quarters about inability or inadvisability of working or studying based on outdated medical models of psychosis.
- Lack of funding for training and retraining.

In summary, locally and nationally many service users want to return to work or study but face considerable barriers. There is a lack of opportunity and support and social exclusion and discrimination remains an inherent part of the service users’ and carers’ experience.

Moving the agenda forward for service users with serious mental health problems

The government has recently set out a commissioning framework designed to support the vocational needs of those “most disabled by their mental ill health” (NSIP / NIMHE / CSIP 2006). The document advocates some concepts very familiar to assertive outreach workers from the original guidance about best practice in assertive outreach working (Stein and Test 1980), for example the employment of vocational leads and employment specialists in every team. It also directs Trusts to set up multi-agency groups, such as the vocational forum mentioned previously to bridge the inter-agency gaps between employment, education and health.

‘Journey to Work’: a local project to support people with mental health problems back to work

Local agreement was reached between Jobcentre Plus and Occupational Therapists in the Gloucester assertive outreach team of the 2gether NHS Foundation NHS Trust to run a pilot course supporting people with severe and enduring mental health problems back to work with the goal of preparing for work, hence the title “Journey to Work”.

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The ground rules for course creation were as follows:

- It would be person centred
- Ability to work accepted as a given
- It would include work experience with local employers
- It would not affect benefits
- It would be run in a community setting (i.e. not in healthcare premises)
- Referrals could come from healthcare workers or Jobcentre Plus employees
- The assessment process would be non-medical and made reference to whether individuals wanted to return to work, whether they had approached the issue of vocational rehabilitation previously and whether they felt practically able to cope with a group setting. Symptom level did not feature as a factor in the assessment
- It was aimed at working aged adults 16-65
- Attendees would have a mental health problem being treated by primary or secondary care
- The role of the health professional was to provide expertise on how best to support people with severe and enduring mental health needs in ordinary employment settings

The aim was to provide a socially inclusive opportunity for individuals with mental health difficulties to experience / re-enter mainstream employment within their community. The programme ran for 90 minutes a week over 16 weeks. The teaching method tailored the skills advice to the needs of individuals and offered mentoring by either Jobcentre Plus or 2gether staff.

**Service user feedback:**

“The work experience was excellent”, “Support was always available”,

“Help with CV writing and interview preparation was excellent”.

**Employer feedback:**

Our trainee was “very friendly and punctual, a delight to have on board, enthusiastic with a thirst for knowledge and work”.

Of the eleven people who started the course, 80% completed it. One person is now in paid employment and other participants have continued in their work placement or have taken up other voluntary or permitted work. The hope is now to extend the programme to the other areas of the county (to ensure equitable service) and to explore how the programme integrates with the current implementation of the welfare reform measures (DWP 2002) around supporting people on Incapacity Benefit to take on or return to employment.

Another way in which public services are encouraged to enhance employment opportunities is to become “exemplary employers” themselves. A service user who completed the Journey to Work programme found paid employment via this route whilst resident in one of the Trust Recovery and Rehabilitation Homes. The home has adopted the Work Matters in-patient programme which ensures that vocational aspirations and
goals are always addressed during the assessment and settling in period, and this identified that either retaining previous work or finding new employment and training opportunities was very important to this resident’s recovery.

**John’s story:**

I left school and went to college gaining a BTec in computer studies. I did various jobs including retail agency work and waiting on tables. My main job however was at the age of 18 in a supermarket. During this period I became acutely ill twice and was hospitalised both times. Each episode lasted six weeks in total and I was diagnosed with paranoid schizophrenia. On both occasions I kept my job due to a return to work programme where I decreased hours and built them up gradually. I regained full time employment and in total stayed with the company for six years. However after failing to take my medication I became very unwell and ended up in hospital for a year. I was unable to keep my job and this was very stressful and things seemed bad for me.

However I pushed myself to get better and moved into a recovery unit which has helped build up skills for community life. In that time I had attended the Journey to Work programme described above which taught me skills in how to cope with working life. Through this I worked for BBC Radio Gloucestershire as a volunteer. Soon after I was offered a paid job part time four hours per week at the hospital as a hotel services assistant. I am learning all the time and am hoping to go back to college part time to study for a Higher National Diploma in computer studies. My outlook on life is very optimistic and I hope to achieve at least some or maybe all my goals.

**Further Reading**


Further Reading (cont)


Black and Minority Ethnic (BME) populations and assertive outreach

Jisu Nath and Usman Bhaimia

Members of the BME community may be disadvantaged concerning mental health care and the treatment of mental illness. There are many potential barriers to accessing treatment and care for serious mental illnesses (SMI) in minority ethnic populations. Also, rates of compulsory admission are generally higher for the BME group (Department of Health 2007).

The more intensive assertive outreach approach to treatment is likely to be helpful for many BME service users with SMI, just like their counterparts in the wider community at large. A recent census showed that the Black Caribbean, Black African and other Black and Minority Ethnic groups had consistently lower than average rates of referral for specialist mental health care via GPs and community mental health teams, but higher rates of referral via the criminal justice system (Count me in Census 2007). Socio-economic and other complex dynamic factors influence this variation. Creation of specialist Black Mental Health Teams in the NHS has been used to specifically target some of the issues, although it is not clear how they will function in the current organisation of the mental health services in the United Kingdom. It may be that the optimal means to address this issue will be for mental health workers with training in cultural issues and diversity to be embedded in mental health teams. Such roles are much appreciated and needed within the assertive outreach teams. Networking and support groups within services for BME service users are some of the other approaches. Good linkage with religious and community leaders from the BME population is essential for this to occur.

The Delivering Race Equality (DRE) in Mental Health programme of the United Kingdom Department of Health is a positive step which is aiming towards improvement in this area (Sandhu 2007). The programme not only includes Black and Asian communities, but also those from the Irish or Mediterranean origin and Eastern European migrants. The DRE programme aims to:

1. Support more appropriate and responsive services
2. Engage communities in the planning and development of services
3. Gather and provide information on people who use services

Focused Implementation Sites have already demonstrated that the implementation of DRE values can generate positive outcomes for BME service users and carers, and meet the needs of the diverse communities (NIMHE 2007).

The purpose of an assertive outreach (and treatment) model is to maintain regular and frequent contact with service users in order to monitor clinical condition so as to provide effective treatment and rehabilitation (Stein and Test 1980). Since access is an obvious issue for the BME community, this raises the very need for a culturally adaptive proactive approach with requisite skills for professionals working in these teams, particularly so for those with SMI.
Further Reading


Relationship with the criminal justice system

Dave Buckle

Mentally disordered offenders have special needs and it is in their interests as well as those of the general public, that these needs are taken into consideration. However, there are two objections to this approach, one from those who see efforts to divert people from the criminal justice system as a form of interference and ‘nannying’, which helps to support the perpetrators of crime than the victims. The other is that mentally disordered offenders often suffer a greater loss of liberty when given special consideration and hospital treatment, than they would by remaining within the criminal justice system. However, whilst an individual’s informed choice to remain within the criminal justice system should be respected, government policy is that no one with an acute severe mental illness should be in prison (Department of Health 2005).

These considerations can lead to an unhelpful, polarising ‘mad or bad’ debate and such debates can lead to conflict and disagreement within the care team. Nonetheless, one of the challenges for assertive outreach teams is to continue positive engagement with mentally disordered offenders in prison, or secure hospital, and to contribute to effective risk management planning when they return to the community.

Context

Assertive outreach team service users are more likely to be involved with the criminal justice system due to the complexity of their illness, diagnosis and risk profile. This is especially the case in the modern era, when services are designed to promote the integration of mentally disordered offenders into mainstream services on an equitable basis. Thus, avoiding the segregation and discrimination associated with specific forensic community teams (Vaughan and Badger 1995). This approach is welcomed by some staff as it offers staff the opportunity to work with mentally disordered offenders and, thus, enhance their knowledge and skills (Vaughan et al 2000).

Case Vignette

A young man with a diagnosis of schizophrenia had become more difficult to engage with, due to an increase in the use of recreational drugs. After verbal threats he sexually assaulted a care worker and was arrested. After his arrest a Mental Health Act (MHA), 1983, assessment involving members of the assertive outreach team concluded that he did not meet the criteria for detention. This required good communication with the criminal justice liaison officer to assess his mental state. The Offender Mental Health Care Pathway (Department of Health 2005) describes good practice at all stages from police custody to either release from prison or transfer to hospital.

The assertive outreach care coordinator attended the police cells to offer support, provide information and act as appropriate adult under the Police and Criminal Evidence Act 1984 (PACE). However, in most cases an appropriate adult will be provided through the National Appropriate Adult Network. Importantly, if there is any doubt about the persons' mental state or mental capacity, an ‘appropriate adult’ should be involved. It is difficult to conceive of a situation where an assertive outreach team service user should be interviewed without an ‘appropriate adult’ present. It is crucial that the service user understands their right to free legal advice. Moreover, if the appropriate adult feels the
service user is not making an informed choice and legal advice would be in their best interests they have the right to ask for a solicitor (PACE 1984). A useful source of information for anyone undertaking this role is the Home Office Guidance for Appropriate Adults (2008).

Whilst in police custody good exchange of information between all agencies involved and the family is essential. In this case, earlier threats had been made to the carer but were, arguably, not acted on decisively. As in many cases involving the criminal justice system the issue of breaching confidentiality arose and the ‘offence’ was ‘officially ignored’. The consequences of such a decision need to be carefully considered- noting that this was also found to be the case in the Inquiry into the death of social worker Isobel Schwarz (Report Committee of Inquiry 1988).

After being placed on remand, it was important to provide the prison in-reach team with the CPA plan, risk assessment for self-harm / suicide and discuss the possible need for special treatment due to his vulnerability as a sex offender. The Probation Service prepared pre-sentence reports and input from the assertive outreach team provided crucial information to help in considering community disposal options.

For three months the service user was monitored by the prison in-reach team and the CPA process was implemented in prison (as far as possible). Nonetheless, he experienced an acute relapse, was transferred to the prison health care centre but refused treatment and was subsequently had to be transferred to hospital for urgent treatment under section 47/49 on the recommendation of two medical practitioners. He remained in hospital and became a ‘notional S37’ patient when the restrictions under S49 were lifted and discharge was planned.

It was noteworthy in this case that where the court convicts a person for a sexual or violent offence or makes a finding of insanity or unfitness to plead and then makes a hospital order, with or without restrictions, the victim has a right to make representations in relation to the conditions of discharge, including at a Mental Health Review Tribunal (Explanatory Notes to Domestic Crime and Victims Act, 2004). Victim issues are often complex and, thus, require good communication with the Probation Service Victim Liaison Officer who will take the leading role in any victim contact as specialist knowledge is required in order to protect the rights of all parties. Thus, in this case prior to discharge referral to the multi-agency Public Protection group MAPPA formed an essential part of the risk management plan. Consideration of a Community Treatment Order with conditions of engagement and place of residence would now be good practice in such cases.

In conclusion, in the course of assertive outreach work, where service users offend and enter the prison system, one aspect of good practice is maintaining good contact with the service user in the criminal justice system. Attempts to maintain positive clinical engagement by in reach will include engaging in the CPA process and providing some tangible benefit whilst detained, often in the form of emotional support, practical assistance and problem solving. This all helps to build a trusting relationship. It is argued that this investment of time not only helps to meet the individual’s needs; it makes the complex task of risk management after discharge or release more effective.
Further Reading


Legal frameworks and the use of the Mental Health Act (2007) in assertive outreach work

Stephen Arnott and Steve Keech

Assertive outreach clinical work frequently involves consideration of medico-legal issues. These include admission under the Mental Health Act (MHA 2007), issues of consent, use of extended leave, and the new community treatment orders created by the 2007 amendment of the Mental Health Act. Arrest and interview by the police and fitness to drive are situations where specific clinical guidance applies.

Application of the Mental Health Act in practice

The assertive outreach service user will normally have an established diagnosis of serious mental illness, often psychotic illness, requiring long term treatment. Whenever possible it is preferable to treat informally with consent, and the principle of treatment of the least restrictive nature is always followed, but this is not always possible. A key aim of working with this group of users is to not simply to avoid hospital but to use admission to hospital in an appropriate, timely way, when this is necessary. In England and Wales the Mental Health Act (MHA 2007) provides the legal framework for treatment of a non-consenting service user. A fuller description of the Act and how it is applied is set out in the relevant reference guide and code of practice, both available on-line (see further reading).

The common legal basis for treatment of assertive outreach users in England and Wales (See relevant reference guide and code of practice for MHA 1983)

Section 3 Admission for treatment for up to 6 months initially.
Section 17 Extended leave in the community.
Section 17A Community Treatment Order up to 6 months initially.
Section 37 Hospital Orders imposed by the Court.
Section 41 Restrictions on discharge imposed by the Home Office.

Service users are commonly subject to treatment orders when they are taken onto the caseload of the assertive outreach team. An important initial aim of engagement is to stabilise the illness to a point where it is safe and practicable to remove the treatment order and continue to treat informally in the community. Initially the service user will often be sent on section 17 leave from hospital, but remain liable to be returned to hospital. This process of trial leave can run from days to many months.
The experience of Mark using section 17 leave whilst on a Treatment Order:

Mark is a man with a 12 year history of chronic psychosis associated with terrifying delusions of persecution.

When ill he became hostile and aggressive. He disengaged from services and treatment to the point that he was detained and admitted directly to the psychiatric intensive care unit on average once every year. Taken on by the assertive outreach team he was kept relatively well and out of hospital. He was encouraged to ask for and accept brief overnight stays when under stress and under his control, whilst on extended leave.

Initially wary and frightened of any return to hospital, he managed to cope with planned overnight stays with a lot of joint working between the assertive outreach and ward teams. He was allowed freedom to come and go during the admission as if he was not detained.

Use of brief respite where he was given more control over his stay allowed him to develop a greater sense of autonomy when he was showing warning signs of relapse. During the next 18 months he learnt to use occasional admission effectively, lost many of his fears around hospitalisation and his treatment order was lifted. The cycle of recurrent detention was broken.

Careful planning of section 17 leave can allow the service user to regain their place in the community, with a robust framework for their care. The conditions of leave can be designed to encourage compliance with treatment and allow regular supportive contact by the assertive outreach team so that all risks are minimised.

The new Mental Health Act (2007) has introduced a Community Treatment Order (CTO) under section 17A. Supervised Community Treatment (SCT) as it is known allows patients to be discharged from detention as an alternative to the use of extended S17 leave. The order is subject to mandatory conditions that require the user to make themselves available for medical review by the responsible clinician or second opinion doctor and allow other conditions of treatment to be set out. There is only limited experience available with its use as yet. Experience from other countries on CTOs has not as yet confirmed their utility.

Possible use of a Community Treatment Order S17A:

John had been on extended leave for a short period of time during an admission under section 3. He had been admitted due to refusal to continue treatment with depot antipsychotic medication and use of oral medication had always failed in the past. He responded well to depot medication, his symptoms and associated risks of neglect settled quickly. He coped with being at home and happily accepted support from the team, but he continued to make it clear that he would stop all medication if he was free to do so.

The Consultant Psychiatrist, the Responsible Clinician, agreed with the Approved
Mental Health Professional, a Social Worker to apply a Community Treatment Order. This ensured Johns’ concordance with necessary treatment, keeping him well and at home.

The role of the police

Service users on assertive outreach caseloads are sometimes arrested by the police. In England and Wales the Police have statutory powers of arrest under section 136 of the MHA (1983) to detain a mentally disordered person in a public place. The person is removed to a ‘place of safety’ historically a Police station but increasingly now a special unit attached to a psychiatric hospital. An assessment under the MHA is then co-ordinated by the Approved Social Worker (now termed Approved Mental Health Professional). People who are arrested for other reasons but known to suffer from mental disorder are regarded as especially vulnerable and the statutory regulations of the Police and Criminal Evidence Act (1984) require that they are only interviewed in the presence of an ‘appropriate adult’. It is good practice for a member of the assertive outreach team to immediately attend the custody suite when a user on the caseload is arrested. They will know the person well and can reassure and support them as well as screening them for any change or deterioration in their mental health. The assertive outreach team worker can fulfil the role of ‘appropriate adult’, or this function can be taken on by the duty social worker.

Definition of ‘the appropriate adult’

A relative, guardian, or other person responsible for care or custody.
Someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police.
Failing these, some other responsible adult over 18 who is not a police officer or employed by the police.

Roles of ‘the appropriate adult’

Advise the interviewee.
Observe that the interview is conducted properly and fairly.
Facilitate communication with the service user

Fitness to drive

Those of us who drive tend to take for granted the freedom and choice that being able to drive gives us. Service users may want to be allowed to drive and this may represent an important goal for their recovery.

It is important for professionals and these service users to understand the statutory regulations governing medical fitness to drive, as many service users may need to work over time towards conforming with the guidance, with support from the team.
Driving regulations as a tool to engagement:

Ryan, a service user in his 30’s, was making a good recovery from a long psychotic illness. In the past his relapses were linked to excessive alcohol use and occasional illicit substance misuse. His dream was to start riding his motorbike again, something that he has fond memories of from his happier teenage years. The team discussed the DVLA regulations that he must satisfy to regain his licence, carefully with him, and talked about how to support him to work towards complying with these.

Ryan was highly motivated to drive and he developed a strong motivation to work with the team on this, including an agreement to take his medication long term. He accepted the need for regular illicit drug testing and for his carers to keep a diary of any episodes of problem drinking to help the team psychiatrist support his application for a return of his driving licence in the long term. The arrangement was seen as a working alliance by both sides and following receipt of a letter from the psychiatrist confirming the positive progress and recommending that a license should be granted, the DVLA issued a 12 months license. Ryan was delighted and has developed a wide range of positive social activities thanks to the greater freedom driving has given him.

Further Reading

At a glance Guide to the current Medical Standards of Fitness to Drive, DVLA, Swansea: 2008. Available at: [http://www.dvla.gov.uk/medical.aspx]


Ministry Of Justice, Mental Health Unit Website available at: [http://www.mentalhealthunit.com/mhuguidance.html]
The importance of the non-statutory sector

Chez Milne

The national picture

Rethink is the leading national mental health membership and campaigning charity. It works to help everyone affected by severe mental illness recover a better quality of life. We help over 48,000 people each year through our services and support groups and by providing information on mental health problems. Our website receives over 300,000 hits every year.

Our aim is to make a practical and positive difference by providing hope and empowerment through effective services and support to all those who need us. We believe that people who experience severe mental illness are entitled to be treated with respect and as equal citizens. We actively campaign for change through greater awareness and understanding and we are dedicated to creating a world where prejudice and discrimination are eliminated.

We also work to support carers in the form of a variety of projects including carer’s groups and carers’ help lines.

An example of a local Rethink project

The One 2 One Support project provides housing related support to people aged 16-60 years in Gloucestershire who may be experiencing any mental health problems. We are funded by money from the Government through Supporting People. We take referrals from many agencies including: Social Services, GP’s and mental health professionals, probation, the homeless teams, and non-statutory drugs services. People can self-refer and carers and friends can also make referrals.

Service users often hear about us from leaflets in surgeries, advice centres, housing departments, or by word of mouth from other service users. They may continue to access a service from their GP or a specialist mental health professional. Support from the Gloucester One 2 One project ensures that each Service User has an individual recovery based action plan of care, which is reviewed every 3 months.

Housing related support accounts for 70% of the support time allocated e.g.; looking at appropriate housing needs, ensuring service users are claiming the benefits they are entitled to, reducing the risk of eviction, setting up payment plans for utility bills. Other support can account for up to 30% of the support time and may include; helping service users access meaningful use of time (training courses, voluntary work, leisure activities), advocacy support to attend GP/psychiatric appointments, emotional / listening support, sign-posting to other relevant agencies for further support e.g.; drug / alcohol services, alternative therapies (counselling, CBT, massage).

Other projects include different forms of supported housing such as core and cluster, advocacy projects and self harm phone helplines.
The advantages of the non-statutory sector

Many service users have commented that receiving a service from our services is less intimidating: floating support workers cannot section anyone, force people to take medication or receive treatments against their wishes. Some service users have said they feel “suspicious” of statutory services and feel that the One 2 One Service has a more “relaxed, accessible approach to their service provision”.

Rethink believes recovery is possible for everyone with enduring mental health problems. We are committed to working with service users, to promote a recovery approach, to support and provide information to enable service users to make informed choices, gain a sense of well being and move forward with increased self esteem, hope and independence.

Further information

For further information on Rethink Phone 0845 456 0455; Email info@rethink.org
www.rethink.org

Registered in England Number 1227970, Registered Charity Number 271028
Registered Office 89 Albert Embankment, London, SE1 7TP
Rethink is the operating name of National Schizophrenia Fellowship, a company limited by guarantee
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Homelessness and assertive outreach

Brian Jones

The size and nature of the homelessness problem

Statistics on Mental Health and Homelessness

- Mental health problems are up to eight times more common in the homeless population. (The Health of Single Homeless People, Centre for Housing Policy University of York, 1994)
- 9% of households accepted as unintentionally homeless and in priority need by local authorities in 2004 are in priority need due to mental illness (ODPM, 2005).
- Mental health problems are nearly four times as common among hostel residents as in the general population. At least one in five homeless people have severe mental health problems; these problems are likely to have played a significant part in the circumstances which have caused that person to become homeless (Crisis: Pressure Points 1999)
- Homelessness and housing problems increase a person's chances of physical and mental ill health. Homeless people are more likely to experience physical, mental and emotional problems than the general population.
- Many homeless people find it difficult to register with a GP. As being registered with a GP is often the first step towards getting support, homeless people often fall outside the system and get no help. This is particularly worrying as around 30-40 per cent of rough sleepers have mental health problems. Some have suggested that as many as 70 per cent of homeless people experience some form of mental health problem.
- When a scheme aimed at helping homeless people was introduced in Exeter, they found that referrals to psychiatric support facilities dropped by 76%.
- One in five people say that mental health problems were a reason for becoming homeless. One survey suggests that 94% of homeless men and 90% of homeless women developed mental health problems before they became homeless (MIND).
Case example: a local project

The project provides a night shelter for people who are homeless, a day centre and a group of dry houses for recovering addicts. When GEAR started in 1996, 60% of the people we dealt with had no access to a GP. Health needs of any kind were either ignored or dealt with at Accident and Emergency units. Our clinic, which is based in the day centre, exists to help individuals at the point of need.

From October 2007 to October 2008, 93 people were seen at our clinic that had mental or behavioural disorders of some sort. Of these 28 had mental or behavioural problems related to drug or alcohol abuse, 26 with problems not related to alcohol or drugs and 30 had mental or behavioural problems related to drugs or alcohol combined with some other mental health problem. It is not uncommon for some people to attend on a number of occasions and positive outcomes for these people are difficult to achieve for a variety of reasons.

Like a lot of night shelters and similar agencies there is a “dumping” syndrome and often it appears as if once a person is with us, he / she become our responsibility. Alone, GEAR does not have the resources to deal with the range of problems that we often face but we fundamentally believe that, together with others, at the point of need, we can make a difference.

The importance of working together

A 2006 report from the Mental Health Foundation and Centrepoint; ‘Making the Link between Mental Health and Youth Homelessness’, said that “increasing numbers of young homeless people with mental health problems are not getting adequate support because services rarely work together to provide the necessary help”. Social isolation is an important issue but unless services are provided at the point of need, they will stay isolated.

There is a need for a coordinated approach to dealing with the homelessness problem where it manifests itself, rather than existing as a group of disconnected services which do not communicate and wait for people to come forward. It is important to reach out to these service users who are among those in greatest need, working together across all the health and social care agencies, and always from a stand point of putting the service user first.
The National Forum for Assertive Outreach

Mike Firn

The National Forum for Assertive Outreach (NFAO) is a grassroots organisation established in 1998 at the time when the first English teams were being established. The Forum was set up initially to meet the need for mutual practitioner support and champion coordinated and faithful applications of the assertive outreach model. The Forum has elected regional representatives and elected officers who support the range of activities on a voluntary basis. Representation derives from free membership of those attending regional and national NFAO events. The constitution was recently updated in 2007 and maintains this democratic model.

As a practitioner focused organisation the NFAO aims to:-

- Increase knowledge and good practice in Assertive Outreach
- Disseminate good practice in Assertive Outreach at a Regional and National level
- Identify and promote quality services
- Develop the quality agenda in Assertive Outreach
- Represent the membership’s views at a Regional, National and International level

Each year annual objectives are agreed at the national conference and posted on the web site [http://www.nfao.org/Objectives/Objectives.html](http://www.nfao.org/Objectives/Objectives.html)

Recently these have reflected broadening the remit towards including improving access for service users and carers in NFAO activities and meetings, and increased policy and research activity with partners in government and research institutes / medical schools.

The annual report provides a useful up to date resume of both regional and national activity and an electronic version can be downloaded from the website: [http://www.nfao.org/Annual_Report/Annual_Report.html](http://www.nfao.org/Annual_Report/Annual_Report.html)

From the 250 or so assertive outreach teams 900 people attend regional events annually, and typically 250 attend a 2 day annual national conference. Some regional financial support derives from close links with the National Institute for Mental Health in England (NIMHE/CSIP). This has enabled, for example in London, NFAO to provide on site training and consultancy to individual teams. In all the regions queries come in to NFAO representatives and many of these have been translated into frequently asked questions responses on the web site: [http://www.nfao.org/FAQ/FAQ.html](http://www.nfao.org/FAQ/FAQ.html)

- What is the role of the voluntary sector in Assertive Outreach?
- Why is fidelity to the model important?
- What are the pro’s and con’s of the team approach?
- What are the criteria for discharge?
- What about Assertive Outreach in rural areas?
- What should an Assertive Outreach team take into account when considering skill mix?

More recently teams and NHS managers have consulted their NFAO regarding commissioning and fidelity concerns as all services, including assertive outreach, have been financially squeezed. On top of this research findings (Killaspy et al 2006, Glover et al 2006) have shown that the effect of assertive outreach on reducing hospitalisation has been disappointing. NFAO published a response (Firn 2007) demonstrating the benefit
and place for assertive outreach in modern mental health services, and has been working with the small number of services that have been threatened.

**Further Reading**


## Part VIII: Useful Websites

1. Health Care Commission  
   [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

2. National Forum for Assertive Outreach  
   [www.nfao.co.uk](http://www.nfao.co.uk)

3. Norfolk and Waveney Mental Health NHS Foundation Trust: Pharmacy Medicine Information  
   [www.nwmhp.nhs.uk/pharmacy](http://www.nwmhp.nhs.uk/pharmacy)

4. Drugs.com: Clozaril side effects  
   [www.drugs.com/sfx/clozaril-side-effects.html](http://www.drugs.com/sfx/clozaril-side-effects.html)

5. National Institute for Mental Health in England (NIMHE): Equalities – Race, Gender, Age  

6. Department of Health: Delivering Race Equality at a glance  

7. Home Office: Police  
   [www.police.homeoffice.gov.uk](http://www.police.homeoffice.gov.uk)

8. Department of Health  
   [www.dh.gov.uk](http://www.dh.gov.uk)

9. Rethink  
   [www.rethink.org](http://www.rethink.org)

10. Social Care Institute for Excellence: Position paper 8: A common purpose: Recovery in future mental health services  

11. Social Care Institute for Excellence: Whose recovery is it anyway?  
    [www.scie.org.uk/publications/misc/recovery.asp](http://www.scie.org.uk/publications/misc/recovery.asp)

12. Institute of Psychiatry: Camberwell Assessment of Need (CAN)  
    [www.iop.kcl.ac.uk/prism/can](http://www.iop.kcl.ac.uk/prism/can)

13. Crossroads: Caring for Carers  
    [www.carers.org.uk](http://www.carers.org.uk)

14. Sainsbury Centre for Mental Health  
    [www.scmh.org.uk](http://www.scmh.org.uk)

15. National Institute for Clinical Excellence  
    [www.nice.org.uk](http://www.nice.org.uk)

16. ²gether NHS Foundation Trust  
    [www.partnershiptrust.org.uk](http://www.partnershiptrust.org.uk)

17. National Institute for Mental Health  
    [www.nimhe.csip.org.uk](http://www.nimhe.csip.org.uk)
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AC</td>
<td>Approved Clinician</td>
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<tr>
<td>AMHP</td>
<td>Approved Mental Health Professional</td>
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<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
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<tr>
<td>CAN</td>
<td>Camberwell Assessment of Need</td>
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<tr>
<td>CANSAS</td>
<td>Camberwell Assessment Need Shortened Appraisal Schedule</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
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<tr>
<td>CTO</td>
<td>Community Treatment Order</td>
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<tr>
<td>DACTS</td>
<td>Dartmouth Assertive Community Treatment Scale</td>
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<td>DLA</td>
<td>Disability Living Allowance</td>
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<td>HoNOS</td>
<td>Health of Nation Outcome Score</td>
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<td>ICM</td>
<td>Intensive Case Management</td>
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<td>IPS</td>
<td>Individual Placement Support</td>
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<td>MAPPA</td>
<td>Multi-Agency Public Protection Arrangements</td>
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<td>MARMAP</td>
<td>Multi Agency Risk Management and Assessment Process</td>
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<tr>
<td>MCA</td>
<td>Mental Capacity Act 2005</td>
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<tr>
<td>MHA</td>
<td>Mental Health Act 2007</td>
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<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<tr>
<td>OT</td>
<td>Occupational Therapist</td>
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<tr>
<td>PACE</td>
<td>Police and Criminal Evidence Acts 1994</td>
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<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
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<tr>
<td>PSI</td>
<td>Psycho Social Intervention</td>
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<tr>
<td>RC</td>
<td>Responsible Clinician</td>
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<tr>
<td>SCT</td>
<td>Supervised Community Treatment</td>
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</tbody>
</table>
### Appendix: Assessment Scales

#### Camberwell Assessment Need Shortened Appraisal Schedule (CANSAS)

**User / Client Name:***

<table>
<thead>
<tr>
<th>Assessment Number</th>
<th>NEED RATING</th>
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<tbody>
<tr>
<td>1</td>
<td>0 = no problem</td>
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</table>

<table>
<thead>
<tr>
<th>Date of assessment</th>
<th>Initials of Assessor</th>
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</tbody>
</table>

1. Accommodation
   - What kind of place do you live in?
   - 0 = no problem
   - 1 = met need
   - 2 = unmet need
   - 9 = not known

2. Food
   - Do you get enough to eat?
   - 0 = no problem
   - 1 = met need
   - 2 = unmet need
   - 9 = not known

3. Looking after the home
   - Are you able to look after your home?
   - 0 = no problem
   - 1 = met need
   - 2 = unmet need
   - 9 = not known

4. Self Care
   - Do you have problems keeping clean and tidy?
   - 0 = no problem
   - 1 = met need
   - 2 = unmet need
   - 9 = not known

5. Daytime activities
   - How do you spend your day?
   - 0 = no problem
   - 1 = met need
   - 2 = unmet need
   - 9 = not known

6. Physical Health
   - How well do you feel physically?
   - 0 = no problem
   - 1 = met need
   - 2 = unmet need
   - 9 = not known

7. Psychotic Symptoms
   - Do you ever hear voices or have problems with your thoughts?
   - 0 = no problem
   - 1 = met need
   - 2 = unmet need
   - 9 = not known

8. Information on condition and treatment
   - Have you been given clear information about your medication?
   - 0 = no problem
   - 1 = met need
   - 2 = unmet need
   - 9 = not known

9. Psychological distress
   - Have you recently felt very sad or low?
   - 0 = no problem
   - 1 = met need
   - 2 = unmet need
   - 9 = not known

10. Safety to self
    - Do you ever have thoughts of harming yourself?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

11. Safety to others
    - Do you think you could be a danger to other people’s safety?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

12. Alcohol
    - Does drinking cause you any problems?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

13. Drugs
    - Do you take any drugs that aren’t prescribed?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

14. Company
    - Are you happy with your social life?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

15. Intimate relationships
    - Do you have a partner?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

16. Sexual expression
    - How is your sex life?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

17. Children
    - Do you have any children under 18?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

18. Basic education
    - Any difficulty in reading, writing or understanding English?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

19. Telephone
    - Do you know how to use a telephone?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

20. Transport
    - How do you find using the bus, tube or train?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

21. Money
    - How do you find budgeting your money?
    - 0 = no problem
    - 1 = met need
    - 2 = unmet need
    - 9 = not known

22. Benefits
    - Are you getting all the money you are entitled to?
    - A. MET NEEDS: count the number of ‘1’s in the column
      - 0 = no problem
      - 1 = met need
      - 2 = unmet need
      - 9 = not known
    - B. UNMET NEEDS: count the number of ‘2’s in the column
      - 0 = no problem
      - 1 = met need
      - 2 = unmet need
      - 9 = not known
    - C. TOTAL NUMBER OF NEEDS (add together A + B)
      - 0 = no problem
      - 1 = met need
      - 2 = unmet need
      - 9 = not known

Note: CANSAS is Copyright-protected. To obtain the adult CAN book (which allows free use of all versions of the CAN) please go to www.iop.kcl.ac.uk/prism/can
Engagement Measure (EM) (Hall et al 2001)

Engagement Measure

Date Rated: ...................................................
Client’s Name: ..............................................   Rater Name: ..............................................

Therapist length of involvement with client:

For each area please circle the number that best describes your client at the current time.

Terminology: ‘Treatment’ refers to the whole treatment package, not just medication. Therapist refers to the person most involved with the client on the unit and may not be the person’s care co-ordinator / key worker

---

**Area 1) Appointment keeping**
*(Include attendance of outpatient appointments and keeping other appointments, i.e. being at home when arranged)*

**a) Without Support:** (i.e. without key-worker bringing them)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Never keeps appointments</td>
<td>Rarely keeps appointments</td>
<td>Sometimes keeps appointments</td>
<td>Usually keeps appointments</td>
<td>Always keeps appointments</td>
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</table>

**b) With Support:** (i.e. named key worker bringing client to appointments)
(Note: Even if client attends without support, please rate what their attendance would be like with support)

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**Area 2) Client-Therapist Interaction**

**Quality of Relationship**
*(The extent to which the client relates well with the therapist, giving rise to a positive atmosphere during sessions)*

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<tbody>
<tr>
<td>Never relates well with therapist</td>
<td>Rarely relates well with therapist</td>
<td>Sometimes relates well with therapist</td>
<td>Usually relates well with therapist</td>
<td>Always relates well with therapist</td>
</tr>
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</table>
Area 3) Communication / Openness

(The extent to which client volunteers relevant personal material, is open in discussing feelings, problems and current situation)

a) Personal feelings (i.e. anger, depression, anxiety etc)

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<tbody>
<tr>
<td>1</td>
<td>Never discusses personal feelings</td>
<td>Rarely discusses personal feelings</td>
<td>Sometimes discusses personal feelings</td>
<td>Usually discusses personal feelings</td>
<td>Always discusses personal feelings</td>
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<tr>
<td>2</td>
<td>Never discusses personal problems</td>
<td>Rarely discusses personal problems</td>
<td>Sometimes discusses personal problems</td>
<td>Usually discusses personal problems</td>
<td>Always discusses personal problems</td>
</tr>
<tr>
<td>3</td>
<td>Never discusses symptoms</td>
<td>Rarely discusses symptoms</td>
<td>Sometimes discusses symptoms</td>
<td>Usually discusses symptoms</td>
<td>Always discusses symptoms</td>
</tr>
</tbody>
</table>

b) Personal problems (i.e. difficulties in current life situation)

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<td>Sometimes discusses personal feelings</td>
<td>Usually discusses personal feelings</td>
<td>Always discusses personal feelings</td>
</tr>
<tr>
<td>2</td>
<td>Never discusses personal problems</td>
<td>Rarely discusses personal problems</td>
<td>Sometimes discusses personal problems</td>
<td>Usually discusses personal problems</td>
<td>Always discusses personal problems</td>
</tr>
<tr>
<td>3</td>
<td>Never discusses symptoms</td>
<td>Rarely discusses symptoms</td>
<td>Sometimes discusses symptoms</td>
<td>Usually discusses symptoms</td>
<td>Always discusses symptoms</td>
</tr>
</tbody>
</table>

Area 4) Client's perceived usefulness of treatment

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Never perceives treatment as useful</td>
<td>Rarely perceives treatment as useful</td>
<td>Sometimes perceives treatment as useful</td>
<td>Usually perceives treatment as useful</td>
<td>Always perceives treatment as useful</td>
</tr>
</tbody>
</table>

Area 5) Collaboration with treatment

(The extent to which client agrees to proposed intervention, as stated in their care plan, and is involved in carrying it out i.e. keeping diaries, practising relapse drills etc.)

a) Agreement with treatment

<table>
<thead>
<tr>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Never agrees with proposed intervention</td>
<td>Rarely agrees with proposed intervention</td>
<td>Sometimes agrees with proposed intervention</td>
<td>Usually agrees with proposed intervention</td>
<td>Always agrees with proposed intervention</td>
</tr>
</tbody>
</table>

b) Involvement in treatment i.e. carries out ‘homework’ etc

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<tr>
<th></th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is never involved in proposed intervention</td>
<td>Is rarely involved in proposed intervention</td>
<td>Is sometimes involved in proposed intervention</td>
<td>Is usually involved in proposed intervention</td>
<td>Is always involved in proposed intervention</td>
</tr>
</tbody>
</table>
c) Active involvement in treatment

(Active involvement: Client clearly wants to involve themselves in the rehabilitation process)

<table>
<thead>
<tr>
<th></th>
<th>Is never actively involved in proposed intervention</th>
<th>Is rarely actively involved in proposed intervention</th>
<th>Is sometimes actively involved in proposed intervention</th>
<th>Is usually actively involved in proposed intervention</th>
<th>Is always actively involved in proposed intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Never complies with medication</td>
<td>Rarely complies with medication</td>
<td>Sometimes complies with medication</td>
<td>Usually complies with medication</td>
<td>Always complies with medication</td>
</tr>
</tbody>
</table>

Area 6) Compliance with medication

(Extent to which client agrees to take medication and will take it freely)

<table>
<thead>
<tr>
<th></th>
<th>Never complies with medication</th>
<th>Rarely complies with medication</th>
<th>Sometimes complies with medication</th>
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</table>

Summed ratings give a total engagement score. A score of 33 separates ‘Good’ from ‘Poor’ engagers. Scores of 33 indicate progressively good engagement, with scores below 33 indicating progressively poor levels of engagement.
<table>
<thead>
<tr>
<th>CRITERION</th>
<th>RATINGS / ANCHORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1 SMALL CASELOAD: client/provider ratio of 10:1.</td>
<td>50 clients/clinician or more. 35 - 49 21 - 34 11 - 20 10 clients/clinician or fewer</td>
</tr>
<tr>
<td>H2 TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.</td>
<td>Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period. 10 - 36%. 37 - 63%. 64 - 89%. 90% or more clients have face-to-face contact with &gt; 1 staff member in 2 weeks.</td>
</tr>
<tr>
<td>H3 PROGRAM MEETING: Program meets frequently to plan and review services for each client.</td>
<td>Program service planning for each client usually occurs once/month or less frequently. At least twice/month but less often than once/week. At least once/week but less often than twice/week. At least twice/week but less often than 4 times/week. Program meets at least 4 days/week and reviews each client each time, even if only briefly.</td>
</tr>
<tr>
<td>H4 PRACTICING TEAM LEADER: Supervisor of front line clinicians provides direct services.</td>
<td>Supervisor provides no services. Supervisor provides services on rare occasions as backup. Supervisor provides services routinely as backup, or less than 25% of the time. Supervisor normally provides services between 25% and 50% time. Supervisor provides services at least 50% time.</td>
</tr>
<tr>
<td>H5 CONTINUITY OF STAFFING: program maintains same staffing over time.</td>
<td>Greater than 80% turnover in 2 years. 60-80% turnover in 2 years. 40-59% turnover in 2 years. 20-39% turnover in 2 years. Less than 20% turnover in 2 years.</td>
</tr>
<tr>
<td>H6 STAFF CAPACITY: Program operates at full staffing</td>
<td>Program has operated at less than 50% of staffing in past 12 months. 50-64% 65-79% 80-94% Program has operated at 95% or more of full staffing in past 12 months.</td>
</tr>
<tr>
<td>H7 PSYCHIATRIST ON STAFF: there is at least one full-time psychiatrist per 100 clients assigned to work with the program.</td>
<td>Program for 100 clients has less than .10 FTE regular psychiatrist. .10-.39 FTE per 100 clients. .40-.69 FTE per 100 clients. At least one full-time psychiatrist is assigned directly to a 100-client program.</td>
</tr>
<tr>
<td>H8 # QUALIFIED NURSE ON STAFF: there are at least two full-time nurses assigned to work with a 100-client team.</td>
<td>Team for 100 clients has less than .20 FTE regular nurse. .20 - .79 FTE per 100 clients. .80 - 1.39 FTE per 100 clients. 1.40 - 1.99 FTE per 100 clients. Two full-time nurses or more are members of a 100-client team.</td>
</tr>
</tbody>
</table>
### Human Resources: Structure & Composition

#### Criterion Ratings / Anchors

<table>
<thead>
<tr>
<th>CRITERION</th>
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<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>ACTUAL NUMBER</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>H9 # Substance Abuse Specialist on Staff: A 100-client team includes at least two staff members with 1 year of training or 1 year clinical experience in substance abuse treatment</td>
<td>Team has less than .20 FTE S/A expertise per 100 clients</td>
<td>.20 - .79 FTE per 100 clients</td>
<td>.80 - 1.39 FTE per 100 clients</td>
<td>1.40 - 1.99 FTE per 100 clients</td>
<td>Two FTEs or more with 1 year S/A training or supervised S/A experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H10 # Vocational Specialist on Staff: The team includes at least one staff member with =1 year training/experience in vocational rehabilitation and support</td>
<td>Team has less than .10 FTE vocational expertise per 100 clients</td>
<td>.10 - .39 FTE per 100 clients</td>
<td>.40 - .69 FTE per 100 clients</td>
<td>.70 - .99 FTE per 100 clients</td>
<td>One FTEs or more with 1 year voc. rehab. training or supervised VR expertise</td>
<td></td>
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</tr>
<tr>
<td>H11 Team Size: Team is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage</td>
<td>Team has fewer than 2.5 FTE staff</td>
<td>2.5 - 4.9 FTE</td>
<td>5.0 - 7.4 FTE</td>
<td>7.5 - 9.9 FTE</td>
<td>Team has at least 10 FTE staff</td>
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</tbody>
</table>

# calculate pro rata for 100 clients

### Organizational Boundaries

#### Criterion Ratings / Anchors

<table>
<thead>
<tr>
<th>CRITERION</th>
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<th>(5)</th>
<th>ACTUAL NUMBER</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>O1 Explicit Intake Criteria: Team has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals</td>
<td>Team has no set criteria and takes all types of cases as determined outside the team</td>
<td>Team has a generally defined mission but the admission process is dominated by organisational convenience</td>
<td>The team makes an effort to seek and select a defined set of clients but accepts most referrals</td>
<td>Team typically actively seeks and screens referrals carefully but occasionally bows to organisational pressure</td>
<td>The team actively recruits a defined population and all cases comply with explicit admission criteria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O2 Intake Rate: Team takes clients in at a low rate to maintain a stable service environment</td>
<td>Highest monthly intake rate in the last 6 months = greater than 15 clients/month</td>
<td>13-15</td>
<td>10-12</td>
<td>7-9</td>
<td>Highest monthly intake rate in the last 6 months no greater than 6 clients/month</td>
<td></td>
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</tbody>
</table>
## ORGANIZATIONAL BOUNDARIES

### CRITERION / RATINGS / ANCHORS

<table>
<thead>
<tr>
<th>(1)</th>
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<th>(4)</th>
<th>(5)</th>
<th>ACTUAL NUMBER</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>O3 FULL RESPONSIBILITY FOR TREATMENT SERVICES: in addition to care co-ordination and psychiatric services, team directly provides counselling/psychotherapy, housing support, substance abuse treatment, employment, and rehabilitative services</td>
<td>Team provides no more than care co-ordination and psychiatric services</td>
<td>Team provides one of five additional services and refers externally for others</td>
<td>Team provides two of five additional services and refers externally for others</td>
<td>Team provides three or four of five additional services and refers externally for others</td>
<td>Team provides all five of these services to clients</td>
<td></td>
</tr>
<tr>
<td>O4 RESPONSIBILITY FOR CRISSES SERVICES: team has 24-hour responsibility for covering psychiatric crises</td>
<td>Team has no responsibility for handling crises 24 hours a day</td>
<td>Emergency service has team-generated protocol for team clients</td>
<td>Team is available by telephone, predominantly in consulting role</td>
<td>Team provides emergency services backup e.g. team is called, makes decision about need for direct team involvement</td>
<td>Team provides 24-hour coverage</td>
<td></td>
</tr>
<tr>
<td>O5 RESPONSIBILITY FOR HOSPITAL ADMISSIONS: team is involved in hospital admissions</td>
<td>Team has involvement in fewer than 5% decisions to hospitalise</td>
<td>5-34% of admissions are initiated through the team</td>
<td>35-64% of admissions are initiated through the team</td>
<td>65-94% of admissions are initiated through the team</td>
<td>95% or more admissions are initiated through the team</td>
<td></td>
</tr>
<tr>
<td>O6 RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: team is involved in planning for hospital discharges</td>
<td>Team has involvement in fewer than 5% of hospital discharges</td>
<td>5-34% of team client discharges are done in co-operation with the team</td>
<td>35-64% of team client discharges are done in co-operation with the team</td>
<td>65-94% of team client discharges are done in co-operation with the team</td>
<td>95% or more discharges are planned jointly with the team</td>
<td></td>
</tr>
<tr>
<td>O7 TIME-UNLIMITED SERVICES: team never closes cases but remains the point of contact for all clients as needed</td>
<td>More than 90% of clients are expected to be discharged within 1 year</td>
<td>From 38-90% of clients are expected to be discharged within 1 year</td>
<td>From 18-37% of clients are expected to be discharged within 1 year</td>
<td>From 5-17% of clients are expected to be discharged within 1 year</td>
<td>All clients are served on a time-unlimited basis, with fewer than 5% expected to graduate annually</td>
<td></td>
</tr>
</tbody>
</table>

* Follow guidelines for time restrictions
<table>
<thead>
<tr>
<th>CRITERION</th>
<th>RATINGS / ANCHORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1 IN-VIVO SERVICES: team works to monitor status, develop community living skills in vivo rather than in service sites</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Less than 20% time in community</td>
</tr>
<tr>
<td>S2* NO DROPOUT POLICY: team engages and retains clients at mutually satisfactory level</td>
<td>Less than 50% of the caseload is retained over a 12-month period</td>
</tr>
<tr>
<td>S3 ASSERTIVE ENGAGEMENT MECHANISMS: as part of assuring engagement, team uses street outreach, as well as legal mechanisms (e.g. representative payees, probation/parole, OP commitment) as indicated</td>
<td>Team passive in recruitment and re-engagement, almost never uses street outreach legal mechanisms</td>
</tr>
<tr>
<td>S4 INTENSITY OF SERVICE: high total amount of service time as needed</td>
<td>Average of less than 15 min/week or less per client</td>
</tr>
<tr>
<td>S5 FREQUENCY OF CONTACT: high number of service contacts as needed</td>
<td>Average of less than 1 contact/week or fewer per client</td>
</tr>
<tr>
<td>S6 WORK WITH SUPPORT SYSTEM: with or without client present, team provides support and skills for client's support network: family, landlords, employers</td>
<td>Less than .5 contact per month per client with support system</td>
</tr>
<tr>
<td>S7 INDIVIDUALISED SUSTANCE ABUSE TREATMENT: one or more members of the team provide direct treatment and substance abuse treatment for clients with substance use disorders</td>
<td>Clients with substance use disorders average fewer than 3 minutes / week in substance abuse treatment</td>
</tr>
</tbody>
</table>

* Follow guidelines for time restrictions
## CRITERION RATING / ANCHORS

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>RATINGS / ANCHORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MULTIDISCIPLINARY TEAM:</strong> team reflects all major mental health</td>
<td></td>
</tr>
<tr>
<td>professionals</td>
<td>Team members are from only one mental health discipline</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>INTEGRATED HEALTH AND SOCIAL CARE:</strong> team operates in a service that has a</td>
</tr>
<tr>
<td></td>
<td>fully integrated health and social care</td>
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<tr>
<td></td>
<td><strong>HOURS OF OPERATION:</strong> Team provides access to a mental health professional out of</td>
</tr>
<tr>
<td></td>
<td>normal office hours: 8:30am--5:30pm Mon-Fri</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td><strong>CLINICALLY ACTIVE TEAM LEADER:</strong> Team leader has active caseload</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>SUBSTANCE ABUSE SPECIALIST:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>VOCATIONAL SPECIALIST:</strong></td>
</tr>
</tbody>
</table>

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**DARTMOUTH UK (DUK) ITEMS**
Health of Nation Outcome Scale (HoNOS)  (Wing et al 1996)

HoNOS – SMI
Health of the Nation Outcome Scales
Note: HoNOS is copywrite protected as Health of the Nation Outcome Scales (HONOS) © Royal College of Psychiatrists 1996

Summary of rating instructions
1. Rate each scale in order from 1 to 12.
2. Do not include information rated in an earlier item
3. Rate the most severe problem that occurred during the period rated.
4. All scales follow the format

| 0 = | no problem |
| 1 = | minor problem requiring no action |
| 2 = | mild problem but definitely present |
| 3 = | moderately severe problem |
| 4 = | severe to very severe problem |

Rate 9 if not known or not applicable

1. Overactive, aggressive, disruptive behaviour.
Include such behaviour due to any cause, e.g. drugs, alcohol, dementia, psychosis, depression etc.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems of this kind during the period rated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Occasional irritability, quarrels, restlessness etc. but generally calm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Includes occasional aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked over activity or agitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Physically aggressive to others or animals (short of rating 4); persistently threatening manner; more serious over activity or destruction of property</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>At least one serious physical attack on others or on animals; destructive of property (e.g. fire-setting); persistent serious intimidation or obscene behaviour</td>
<td></td>
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</tbody>
</table>

2. Non-accidental self-injury
Do not include accidental self-injury (due e.g. to dementia or severe learning disability); the cognitive problem is rated at Scale 4 and the injury at Scale 5. Do not include illness or injury as a direct consequence of drug/alcohol use rated at Scale 3; (e.g. cirrhosis of the liver or injury resulting from drunk driving are rated at Scale 5)

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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Occasional or fleeting thoughts about ending it all but little risk; no self harm</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Minor risk during this period includes non-hazardous self harm e.g. wrist scratching</td>
<td></td>
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<tr>
<td>3</td>
<td>Moderate to serious risk of deliberate self-harm; includes preparatory acts e.g. collecting tablets</td>
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<tr>
<td>4</td>
<td>Serious suicidal attempt and/or serious deliberate self-injury during this period</td>
<td></td>
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</tbody>
</table>

3. Problem drinking or drug taking
Do not include aggressive/destructive behaviour due to alcohol or drug use, rated at Scale 1. Do not include physical illness or disability due to alcohol or drug use, rated at Scale 5.

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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Occasional over-indulgence but within social norm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Occasional loss of control of drinking or drug taking but not seriously addicted</td>
<td></td>
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<tr>
<td>3</td>
<td>Marked dependence on alcohol or drugs with frequent loss of control, drunk driving etc.</td>
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<tr>
<td>4</td>
<td>Incapacitated by alcohol/drug problems</td>
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</tbody>
</table>

4. Cognitive problems
Include problems of memory, orientation and understanding associated with any disorder: learning disability, dementia, schizophrenia etc. Do not include temporary problems (e.g. hangovers) resulting from drug/alcohol use rated at Scale 2.

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<td>No problems of this kind during the period rated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Minor problems with memory or understanding, e.g. forgets names occasionally</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>Mild but definite problems, e.g. has lost the way in a familiar place or failed to recognise a familiar person; sometimes mixed up about simple decisions</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Marked disorientation in time, place or person, bewildered by everyday events, speech is sometime incoherent</td>
<td></td>
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<tr>
<td>4</td>
<td>Severe disorientation, e.g. unable to recognise relatives, at risk of accidents, speech incomprehensible</td>
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</tbody>
</table>

Patient ID Number: …………..
Date rated: …………………….
Rater: …………………..
5. Physical illness or disability problems
Include illness or disability from any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning. Include side-effects from medication, effects of drug/alcohol use, physical disabilities resulting from accidents associated with cognitive problems, drunk-driving etc. Do not include mental or behavioural problems rated at Scale 4.

<table>
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</thead>
<tbody>
<tr>
<td>No significant health problem during this period rated</td>
<td>Temporary health problem during the period (e.g. cold, non-serious fall etc)</td>
<td>Physical health problem imposes mild restriction on mobility and activity</td>
<td>Moderate degree of restriction on activity due to physical health problem</td>
<td>Complete or severe incapacity due to physical health problem</td>
<td></td>
</tr>
</tbody>
</table>

6. Problems associated with hallucinations and delusions
Include hallucinations and delusions irrespective of diagnosis. Include odd and bizarre behaviour associated with hallucinations or delusions. Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions rated at Scale 1.

<table>
<thead>
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<th>2</th>
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<th>4</th>
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</tr>
</thead>
<tbody>
<tr>
<td>No evidence of hallucinations or delusions during the period rated</td>
<td>Somewhat odd or eccentric beliefs not in keeping with cultural norms</td>
<td>Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, i.e. clinically present but mild</td>
<td>Marked preoccupation with delusions or hallucination, causing much distress and/or manifested in obviously bizarre behaviour</td>
<td>Mental state and behaviour is seriously and adversely affected by delusions or hallucinations with severe impact on patient and/or others</td>
<td></td>
</tr>
</tbody>
</table>

7. Problems with depressed mood
Do not include over activity or agitation rated at Scale 1.
Do not include suicidal ideation or attempts rated at Scale 2.
Do not include delusions or hallucination rated at Scale 8.

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>No problems associated with depressed mood during the period rated</td>
<td>Gloomy or transient mood changes associated with life events</td>
<td>Mild, but definite depression and distress, e.g. feelings of guilt, sleep disturbance, loss of appetite, loss of self esteem</td>
<td>Depression with marked physical or mental slowing, inappropriate self-blame, preoccupied with feelings of guilt</td>
<td>Severe depression, retardation (stupor at the most severe), severe guilt or self-accusation</td>
<td></td>
</tr>
</tbody>
</table>

8. Other mental and behavioural problems
Rate only the most severe clinical problem not considered at Scales 1-7, e.g. anxiety, panics, phobias, obsessions, anorexia, bulimia, sleep problems, fatigue, persistent complaints about bodily symptoms with no known physical cause.
N.B Specify the type of problem by entering the appropriate letter: A – phobic; B – anxiety; C – obsessive compulsive; D – stress; E – dissociative; F- somatoform; G – eating; H – sleep; I - sexual

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</tr>
</thead>
<tbody>
<tr>
<td>No evidence of any of these problems during the period rated</td>
<td>Minor persistent problem or short-lived problem associated with life events</td>
<td>A problem is clinically present, but there are relatively symptoms-free intervals and patient/client has a degree of control, i.e. mild level</td>
<td>Constant preoccupation with problem. Occasional severe attack or distress with loss of control (e.g. has to avoid anxiety provoking situations altogether, call in a neighbour to help etc) i.e. moderately severe level of problem</td>
<td>Severe, persistent problem dominate most activities</td>
<td></td>
</tr>
</tbody>
</table>
### 9. Problems with relationships

*Rate the patient's most severe problem associated with active or passive withdrawal from social relationships and/or non-supportive, destructive or self-damaging relationships.*

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No significant problems during this period</td>
</tr>
<tr>
<td>1</td>
<td>Either transient or long-lasting minor problems but accepted by patient and others</td>
</tr>
<tr>
<td>2</td>
<td>Definite problems in making or sustaining supportive relationship: patient complains and/or problems are evident to others</td>
</tr>
<tr>
<td>3</td>
<td>Persisting major problems due to active or passive withdrawal from social relationships and/or to relationships that provide little or no comfort or support</td>
</tr>
<tr>
<td>4</td>
<td>Severe and distressing social isolation due to inability to communicate socially and/or withdrawal from social relationships</td>
</tr>
</tbody>
</table>

### 10. Problems with activities of daily living

*Rate the overall level of functioning in activities of daily living (ADL), e.g. problems with basic activities of self-care such as eating, washing, dressing, toilet; also complex skills such as budgeting, organising where to live, occupation and recreation, mobility and use of transport, shopping, self-development etc. Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning. Do not include lack of opportunities for exercising intact abilities and skills rated at Scales 11-12.*

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems during period rated: good ability to function in all areas</td>
</tr>
<tr>
<td>1</td>
<td>Minor problems only, e.g. untidy, disorganised</td>
</tr>
<tr>
<td>2</td>
<td>Self-care adequate, but major inability to perform one or more of complex skills (see above)</td>
</tr>
<tr>
<td>3</td>
<td>Major problems in one or more areas of self-care (eating, washing, dressing, toilet) as well as major inability to perform several complex skills</td>
</tr>
<tr>
<td>4</td>
<td>Severe disability or incapacity in all or nearly all areas of self-care and complex skills</td>
</tr>
</tbody>
</table>

### 11. Problems with living conditions

*Rate the most severe problem with the quality of living conditions and daily domestic routine. Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and a choice of opportunities to use skills and develop new ones? Do not rate the level of functional disability itself, rated at Scale 10.*

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible and supportive of self help</td>
</tr>
<tr>
<td>1</td>
<td>Accommodation is reasonably acceptable although there are minor or transient problems (e.g. not ideal location, not preferred option, doesn’t like the food etc)</td>
</tr>
<tr>
<td>2</td>
<td>Significant problems with one or more aspects of the accommodation and/or regime, e.g. restricted choice, staff or household have little understanding of how to limit disability to how to help develop new or intact skills</td>
</tr>
<tr>
<td>3</td>
<td>Distressing multiple problems with accommodations, e.g. some basic necessities absent, housing has minimal or no facilities to support patient</td>
</tr>
<tr>
<td>4</td>
<td>Accommodation in unacceptable, e.g. lack of basic necessities, patient is at risk of eviction or 'roofless' or living conditions are otherwise intolerable making patient’s problems worse</td>
</tr>
</tbody>
</table>

### 12. Problems with occupation and activities

*Rate the most severe problem with quality of daytime environment. Is it to help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, access to supportive facilities, e.g. staffing, equipment of day centres, workshops, social clubs etc. Do not rate the level of functional disability itself, rated at Scale 10.*

*N.B. Rate patient’s usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9.*

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient’s daytime environment is acceptable; helpful in keeping a disability rated at Scale 10 to the lowest level possible, and support of self help</td>
</tr>
<tr>
<td>1</td>
<td>Minor or temporary problems, e.g. late giro cheques; good facilities available but not always at desired times etc.</td>
</tr>
<tr>
<td>2</td>
<td>Limited choice of activities, e.g. there is a lack of reasonable tolerance (e.g. unfairly refused entry to public library or baths etc); or handicapped by lack of a permanent address; or insufficient care or professional support; or helpful day setting available but for very limited hours</td>
</tr>
<tr>
<td>3</td>
<td>Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills or add new ones; unskilled care difficult to access</td>
</tr>
<tr>
<td>4</td>
<td>Lack of any opportunity for daytime activities makes patient’s problems worse</td>
</tr>
</tbody>
</table>
Notice

The handbook is available as a PDF file on the ²gether NHS Foundation Trust website at www.2gether.nhs.uk in the Working Age Adults Publications and Assertive Outreach section.

It is also available on the National Forum for Assertive Outreach website at www.nfao.co.uk.

Disclaimer

The opinions expressed in this handbook are those of individual authors and do not necessarily represent the views of the ²gether NHS Foundation Trust.