A model for developing assertive outreach: meeting local needs

Although assertive outreach has undoubtedly been successful in delivering excellence in care, providing care that is sensitive to the services user's local needs has remained elusive. Keith Ford and Malcolm King propose a model that helps to overcome this

keywords

> patient centred care

> community care

> mental health: services

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to a double-blind review.

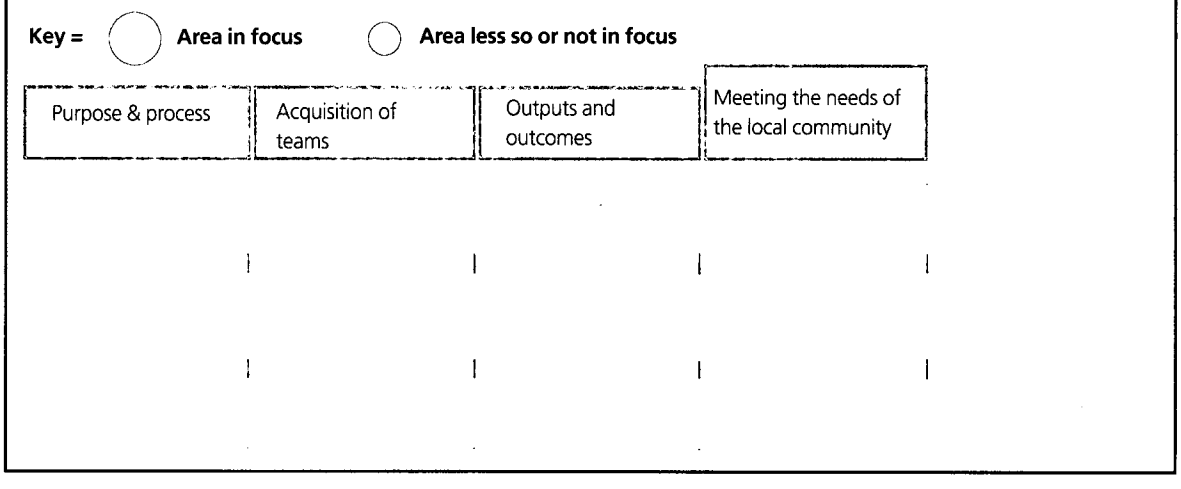
Assertive outreach teams in the UK began to surface in the mid-1990s, with more teams setting up nationally around the year 2000. Although the teams generally followed the model from the United States by Stein and Test (1980), differing degrees of compliance were observed (Clement *et al* 2002). Efforts have been made to develop the model to meet the needs of the UK but there are some aspects that require further development. Model fidelity has been contested fiercely since the inception of assertive outreach in the UK; 'pure fidelity' being viewed as a 'gold standard' for this service. However, fidelity to an US model, that until recent years had not branched out much further than the states of Wisconsin and Michigan (where it originated), does not necessarily suit the needs of service users in the UK. It has been said that, 'If assertive outreach is to prove its worth, it must be able to sustain the rigours of time, and not sway with passing trends that will move us further away from the core components of effective assertive outreach delivery' (Ford and McClelland 2002). In spite of this, the need to be sensitive to local need is key if assertive outreach is to be effective. The Department of Health (DH) (2001) had acknowledged this in the *Mental Health Policy Implementation Guide*. Indeed, chapter eight tackles the issue of 'tailoring services to local needs'. While this may be seen by many as reassuring, the reality was that it was rather incongruous due to other guidelines set for the development of teams.

After adopting the main components of the Assertive Community Treatment (ACT) model from the US we are now stamping our own mark on this model of care delivery for people with severe and enduring mental illness. Assertive outreach remains one of the most widely researched mental health service models (Hambridge and Rosen 1994, Meuser *et al* 1998). Yet results do not always show it as being as effective in the UK (Ford and Ryan 1997, PRiSM Psychosis Study 1998). This may be partly due to the UK having an established community mental health service prior to the arrival of assertive outreach, and that the idea that the ACT model is not as easy to translate to the UK context as originally envisaged. This could be due to many reasons, including: culture, resources, staff configuration, bureaucracy and demographics.

In recent years, assertive outreach has become one of the items high on the agenda for the DH, NHS trusts and primary care trusts (PCTs) to gain recognition as delivering excellence in care. This is not in dispute because if assertive outreach is delivered in a way that is focused around service users and their local area and needs, then it can go a long way to delivering excellent care.

Since the introduction of the National Service Framework for mental health (NSF) (DH 1999) the profile of assertive outreach has been relatively high. The NSF set a 'National Milestone' stipulating that all health authorities should have assertive outreach by April 2002. Following on, the *Mental Health Policy Implementation Guide* (MHPIG) (DH 2001) set out key components for assertive outreach. This guidance has been interpreted differently by some and this has served to complicate matters for teams setting up. The confusion that ensued was whether the MHPIG was 'guidance' or a directive, so some NHS trusts set up teams that met the MHPIG but fell short of making the service sensitive to local needs. Teams setting up in this way may appear to be rewarded by

Fig. 1. Areas of focus in assertive outreach



achieving the targets set by the DH (2001).

Despite these differences it has served to keep assertive outreach topical and has fuelled many useful debates around this issue. The concern now may be that as the development of new teams such as Crisis Resolution and Home Treatment and Early Intervention in Psychosis evolve, and become the primary focus for service provision, assertive outreach may lose some of the impetus that has developed over the last five years. The development of assertive outreach services sensitive to local need may again be overlooked by some.

The specific areas of focus in assertive outreach (Figure 1) in the past have centred on the development of a workable model (purpose and process) and the acquisition of teams. Presently the focus is still on the acquisition of teams, attempting to meet the anticipated demand for this service, and outputs and outcomes.

The need to measure the effectiveness and model fidelity of assertive outreach has seen the introduction of many tools and outcome measures. Some of which have been effective and some have been developed to satisfy PCTs, commissioners and Strategic Health Authorities. As highlighted in diagram 1, the focus for the future should lie in all the areas already mentioned but also strongly encompass meeting the needs of the local community. This will encourage the social inclusion agenda, which has been adopted by the DH as a major issue, and promote a higher degree of normalising for the client group. This can be achieved by utilising mainstream activities and by integrating service users back into the community, or enabling service users to maintain existing social networks.

How we achieve the improvement in service provision by making assertive outreach sensitive to local need has been the difficult issue. With many other issues being tackled, teams have been distracted by requests to provide and collate statistics on a myriad of areas such as contacts made, bed occupancy, admission rates, and new referrals. To accompany this is the expectation that each team completes and updates the Health of the Nation Outcome Scale (HoNOS), that has become part of the national dataset. The MHPIG, as mentioned, had a chapter addressing 'Tailoring services to local needs'. They recommended that certain changes take place in the organisational and care culture to achieve the modernisation agenda (see Table 1).

The changes recommended in the DH Policy Implementation Guide (Mental Health) refers to the whole of mental health services and not explicitly to assertive outreach. Therefore the agenda is immense. Within assertive outreach we are dealing with a specifically designated client group and as a consequence should be able to make some headway (although this has been more problematic than initially envisaged).

Some of the reasons for the difficulties in making assertive outreach sensitive to the needs of any given locality may be because mental health services, as a whole, are: a) not sensitive to local needs; and b) not operating in a 'joined-up' fashion. A whole systems approach would certainly prove beneficial for the delivery of mental health services at all levels. This approach would also be conducive for other 'functional teams' such as crisis resolution and home treatment and early intervention in psychosis services.

Table 1. Changes recommended

- Increased partnerships and reduced hierarchy
- Increased choice and autonomy for service user and carers
- Increased transparency – both for service planning and clinical care
- Increased value on evidence based services
- Increased focus on outcomes, as opposed to inputs and outputs
- Increase integrated and mainstream services, and reduced specialisation and service insularity
- Increased value on information systems
- Increased attention to supporting the workforce, both clinical and management
- Increased value placed on non-professional and volunteer staff
- Increased opportunities for involvement of staff groups in major re-developments
- Increased meaningful service user and carer involvement and inclusion in service planning

(DH 2001)

Table 2. Requirements to enable teams to be sensitive to local needs

- Integrated approaches to service delivery adopting a 'whole systems approach'
- Understanding of local agencies and potential contacts
- Good relationships and open communication with all stakeholders
- Leadership qualities in team members
- Service user involvement in setting up and on-going development of the team
- Carer involvement
- Regular training and updates for all team members
- Good retention of staff

Integrating health and social services

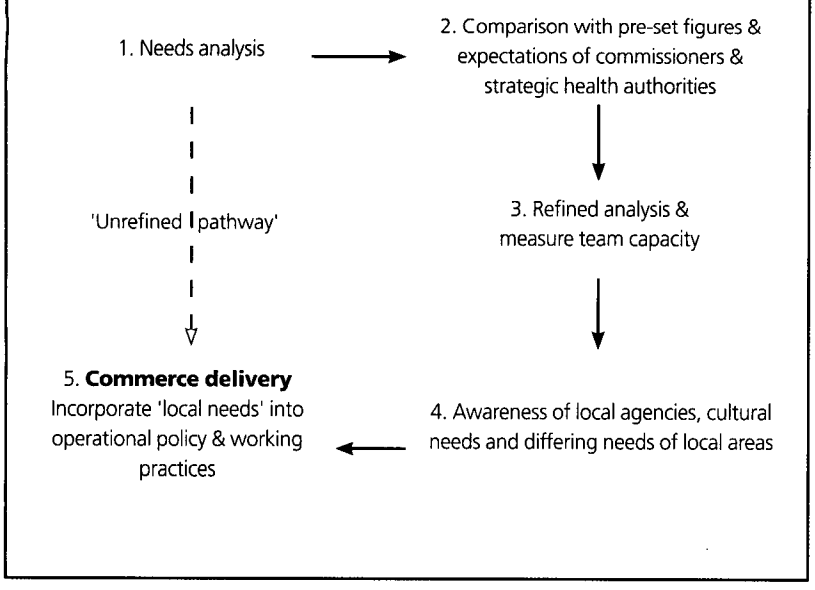
Integration between health and social services is essential for improved service delivery. While some areas have implemented this, in most areas this remains only superficially achieved. Achieving compatibility with written records and information technology devices remains insurmountable in some areas. Yet at the interface with service users integration has been working well to a large degree. Out-of-hours payments, contracted hours of employment, different line-management and outside clinical supervisors can be some of the problems faced by multidiscipline teams. However many teams have overcome these issues to offer true multidisciplined approaches to care.

Table 2 identifies some requirements necessary to enable an assertive outreach team to be sensitive to local needs and while this list is not exhaustive it would certainly assist in bridging the gap of unmet need.

Although 'meeting the needs' of the client group is seen as paramount, often it is viewed as having some negative connotations. The negativity in this often misused cliché stems from the practitioner viewing 'needs' rather than the 'strengths' of the individual in question. While needs are important, if they are the only focus they can draw the package of care to being more medicalised and restrictive in nature. Being able to operate a strengths approach in assertive outreach can work well (Ryan and Morgan 2004), and can be empowering for both the service user and practitioner. When attempting to address the issues around the integration of service users into the community we have to be mindful that: 'Local services are not necessarily geared up to work with service users with the range of risk and of assertive outreach clients' (Ryan and Morgan 2004). Barriers and difficulties will exist and differ in some locations when it comes to the integration of service users into the community and especially when using mainstream activity.

Figure 2 shows a model that may go some way to understanding how to set up an assertive outreach service that will prove to be sensitive to local need.

Fig. 2. A model for setting up assertive outreach services that are sensitive to local need



1. Needs analysis: When commissioning new services a needs analysis is required to gain an understanding of whether the service is really required. Traditionally for assertive outreach this has meant counting known service users who fit the referral or acceptance criteria for the team. Following this needs analysis the service is usually set up soon after and becomes operational (seen in Figure 2 as the 'un-refined pathway').

2. Comparison with pre-set figures and expectation of commissioners and Strategic Health Authorities etc: The people commissioning the assertive outreach service will have been aware of the national perspective and will know what the predicted number of service users should be for that geographical area. This may not correspond with the original needs analysis performed by the team manager or project manager. Differences here can occur due to the national distribution of figures. These numbers of expected clients who are going to require assertive outreach nationally is only a 'mean' average. When assessing need the DH states: 'Needs assessment will always pose a compromise between comprehensiveness and practicality' (DH 2001). The DH adds, '...there are difficulties in estimating the absolute level of need in the population' (DH 2001). The consequences of getting this figure wrong can have a huge impact on other mental health services, especially as functional teams are rarely set up with a clean slate and huge resources.

Table 3. Skills required for delivering assertive outreach

Experience:	Good background in community care provision Good background in mental health care Adequate maturity – to allow good life experience
Ability:	Good communicator Good team member – shares skills Adaptable – to take on 'new' role and practical tasks Able to use 'self' as a resource
Character:	Genuine, reliable and enthusiastic Low expressed emotion High tolerance for chaos
Attitude:	Employ a humanistic approach Realistic goals and level of attainment for client group Positive attitude

(Ford 2001)

3. Refined analysis and measure team capacity: Following on, the analyses gathered needs to be refined and a compromise reached with regard to the number of clients the team is expected to take on. Also, this needs to be measured in respect of the team capacity. The ratio of client to practitioner initially was 15:1. This has subsequently been reduced to 12:1, with an understanding that in more rural areas this will be reduced to somewhere nearer 6 or 8:1. The capacity of the team should not be stretched too far otherwise it affects the other components of assertive outreach. The need of the team to respond to service users experiencing relapse or increases in complex problems and often chaotic situations needs to be a built-in component if assertive outreach is to be successful.

4. Awareness of local agencies, cultural needs and differing needs of local areas: All assertive outreach teams should have an understanding of these issues, but they should be responded to more often and acknowledged to a greater degree. If there is a misinterpretation of what the local community holds for service users then there will be a lack of understanding as to why service users may fail and spend longer receiving mental health services. This goes across the grain of the purpose of any mental health service. Cultural needs are, perhaps, more topical to date but issues still need to be addressed so that seamless transitions may be encountered for service users. Experts in different aspects, such as cultural, religious and gender issues would enhance team effectiveness. The training needs of the team may also be identified to gain a greater understanding for both service users and team members. Without this understanding and ability to integrate service users into community living there is a feeling of setting up people to fail, once more!

5. Commence delivery: It is at this point that delivery can truly be considered. Without considering the previous components there is a danger that services will prove less effective. Cultural and other issues raised that come under the 'local needs' banner should be written into policies and procedures, wherever possible, so that there is continuity and a consistency in practice. So that this may be disseminated into other teams.

Developing assertive outreach services to be sensitive to local needs remains an ongoing and difficult task that requires skills and expertise from team members.

Stein and Santos (1998) placed a huge emphasis on team cohesion. 'The ACT team is the heart of the ACT program. One cannot overemphasize the importance of operating as a real team rather than as a group of individuals calling themselves a team' (Stein and Santos 1998). Recruiting appropriately skilled staff and developing existing staff is important to the ongoing success of assertive outreach, as highlighted in Table 3.

Conclusion

While the issue of developing teams to meet local needs has been somewhat superficial in the past it must now be placed higher on the agenda and action needs to be taken

to implement this. Assertive outreach teams that deliver services sensitive to local needs are key to the 'whole systems' approach in mental health.

A structured approach and a comprehensive understanding of service delivery is required. There is a need to demonstrate a commitment towards developing a team culture that remains sensitive to the local needs of the service users. The issues highlighted are not exclusive or stand-alone and tie in with other issues such as social inclusion, cultural needs and engagement for service users.

The model proposed aims to support the delivery of assertive outreach that is sensitive to local needs. While all teams and geographical areas vary greatly, the model is aimed at providing a broad overview to raise the profile of meeting local needs for the service users of assertive outreach. This cannot be successful without the commitment and support of all stakeholders, including those that commission services and service users themselves ■

Keith Ford MSc, BSc(Hons), DipN, RMN, practice development and training officer, Sainsbury Centre for Mental Health;

Malcolm King, BA(Hons), ASW, programme lead, Sainsbury Centre for Mental Health

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An evaluation of the Gloucester assertive community treatment team extended working service

Nathan Gregory and Nicola Hovey report on a study conducted in an innovative service

The National Service Framework for mental health (Department of Health (DH) 1999) reported that community mental health services should be available 24-hours-a-day for service users. Subsequently, *The NHS Plan* (DH 2000) called for the development of crisis resolution/home treatment teams to provide prompt and effective interventions 24 hours a day, seven days a week to care for people in the least restrictive environment possible. The *Mental Health Policy Implementation Guide* (2001) further specified that assertive community treatment (ACT) teams should deliver a multidisciplinary community-based treatment, rehabilitation and support service seven days a week from 8am until 8pm for the seriously mentally ill.

To examine the evidence base for extended working, a search of electronic databases including Medline, CINAHL, British Nursing Index, Embase, Medline and Psychinfo, and a hand search of key journals and reference lists was undertaken using the terms: '24 hours services', 'weekend working', 'out of hours', 'extended working', 'Assertive Community Treatment/Outreach teams' and 'Crisis Resolution / Home Treatment teams'. Although there were a selection of papers reporting these services within Crisis Resolution/Home Treatment teams, there appeared to be no studies within ACT.

The available literature indicates that the effectiveness of the full range of 24-hour services has not been systematically evaluated (Centre for Reviews and Dissemination 2001), although a systematic review of home treatment teams identified little support for 24-hour services (Burns *et al* 2001). Within ACT, there appears to be a lack of published evidence reporting on the availability of 8am to 8pm services, possibly because government policy indicates that this provision should be based on sound evidence and local needs (Chisholm and Ford 2004, Clement *et al* 2002, DH 2001). Therefore, this study aims to evaluate the level of intervention provided by the Gloucester City ACT team during its extended working service following the first 6 months of operation.

Subjects and methods

Setting

The study was carried out in Gloucester City in services provided through Gloucestershire Partnership NHS Trust.

Nathan Gregory MSc, BSc, Gloucester assertive community treatment team leader, specialist practitioner in community mental health care, RMN, Gloucestershire Partnership NHS Trust;

Nicola Hovey, clinical audit manager, Gloucestershire Partnership NHS Trust