Clinical Psychologists and Assertive Outreach

Briefing Paper No. 21

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Note
The terms ‘client’ and ‘service user’ are both commonly used by psychologists working in assertive outreach. This paper generally opt for ‘service user’ when discussing people in the context of services, and ‘client’ when talking about work done that requires someone’s active engagement with us, for example in therapy or care planning.

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Executive summary

Introduction
This document is an update of a 2006 Division of Clinical Psychology Briefing Paper on the same topic and is aimed at clinical psychologists, managers and commissioners. It focuses primarily on practice within England and Wales but the principles would apply across all four home nations.

It provides an overview of the service model in terms of underlying principles, available models and the evidence base. This will assist in local decision making about the most effective way of providing such a service.

It identifies roles and functions of clinical psychologists and makes recommendations for psychology staffing.

What is assertive outreach?
Assertive outreach is an outreach service, based on a recovery approach, for adults with severe and persistent mental health problems associated with a high level of disability, a history of high use of inpatient or intensive home based care, difficulty in maintaining lasting and consenting contact with services; and multiple and complex needs. The assertive outreach client group generally fall into the psychosis clusters 16 (dual diagnosis) and 17 (psychosis and affective disorder difficult to engage) (CPPP, 2012).

It is helpful to think of assertive outreach not as a team, service or a collection of specific staff, but rather as a function. To provide this function, different models are used in the UK and these are described in the document. Although designated teams were recommended in the past, and are supported by the most evidence, current national mental health policy does not favour one over another (DoH, 2011).

Function of assertive outreach
Assertive outreach aims to improve the quality of life of service users and their carers, friends and families, prevent social exclusion, assist people in managing and coping with their difficulties, promote informed choice about medication, manage risk and reduce hospital admissions. It achieves this by sustained and persistent efforts, by reaching out to people in their homes, workplaces, cafes or elsewhere, and by reaching into hospitals where necessary.

The benefits of assertive outreach
Research has shown that people receiving assertive outreach are more likely to remain in contact with services, less likely to be admitted to hospital, experience shorter admissions and show improvements in accommodation status, employment and satisfaction with services. It is thus a cost effective intervention.
The impact of not providing assertive outreach

Ceasing to provide any form of assertive outreach carries a number of risks, not least that of recreating the very problems that were identified by Keys to Engagement (SCMH, 1998) and led to the inclusion of assertive outreach teams as a key element of the 1999 National Service Framework. If the needs of this vulnerable group are not proactively met in the community, they will simply manifest in other ways such as through acute admissions, homelessness and the criminal justice system.

DCP recommendations

1. The DCP recommends that mental health services should include provision for assertive outreach and the document outlines options to achieve this.
2. The DCP recommends a ratio of one whole time equivalent (1.0wte) Band 8A or above clinical psychologist for a team caseload of 90 clients to meet need. Where designated teams do not exist, it may be possible to provide the assertive outreach function in other ways, but whatever model is used there should be a psychology post with an assertive outreach specialism.
Introduction

This briefing paper is intended for use by clinical psychologists, service managers and commissioners of services within mental health.

The aims are to:

1. assist in local decision making about the implementation of assertive outreach through providing an overview of service principles and models;
2. identify the positive outcomes for service users from assertive outreach and also the risks and impact of not having such a function within mental health services;
3. outline the roles and function of clinical psychologists in assertive outreach services; and
4. provide clear guidance about how clinical psychology in assertive outreach should be structured, taking into account, as far as possible, recent health service initiatives.

This paper updates the earlier Faculty of Psychosis and Complex Mental Health Briefing Paper, Clinical Psychologists and Assertive Outreach (BPS, 2006). It primarily focuses on England and Wales but the principles would apply across the four home nations.

Section 1: What is assertive outreach?

Assertive outreach aims to improve the quality of life of service users, their families and carers, prevent social exclusion, assist people in managing and coping with their difficulties, promote informed choice about medication, manage risk and reduce hospital admissions (Hemming et al., 1999; O’Halloran, 1999; SCMH/CMHSD, 1999; Davidson, 1999; Burns & Firn, 2002; Ryan & Morgan, 2004). It aims to do so by sustained and persistent efforts, working with people in situ: by reaching out to people in their homes, workplaces, cafes or elsewhere, and by reaching into hospitals where necessary.

There has been some confusion about the term ‘assertive’, which has sometimes been understood to mean aggressive, and to imply a coercive medical approach. In fact UK teams have tended to emphasise the need to work with users of services in partnership, to improve a wide range of aspects of their lives. Most of these services were designed for people needing enhanced care and at risk of losing contact with mental health services, but some have assumed more specialised functions.

1.1 Key features and policy context

Assertive outreach originated in the United States where it is now more often referred to as assertive community treatment (Stein & Test, 1980; Allness & Knoedler, 2003). In the early 2000s a network of assertive outreach teams (AOTs) was set up across England in response to the National Service Framework (NSF) for Mental Health (DoH, 1999) and subsequent NHS plan (2000). Since political devolution in 1999, Scotland, Wales and Northern Ireland have developed different systems of governance and different policies, and none have seen the same level of investment in assertive outreach services. Both Scotland and Northern Ireland previously had assertive outreach teams for adults, but there are now none in Northern Ireland and few in Scotland. A significant number of teams were...
established in Wales as a result of *Designed for Life* (Welsh Assembly Government, 2005) and Strategic and Financial Framework Target 21 in 2007/8 (National Public Health Service for Wales, 2007), which continue. In England and Scotland current policy does not promote assertive outreach (DoH, 2011; Scottish Government, 2012) although there remain significant numbers of teams in England.

*The Mental Health Policy Implementation Guide* (DoH, 2001) sought to define the model of assertive outreach recommended by the NSF. It identified the following:

**Key features:**

- **assessment** – comprehensive, multi-disciplinary, standardised, culturally competent;
- **team approach** – all team members involved with all clients, providing continuity by close team working;
- **age, culture and gender sensitivity** – gender and culture culturally competent service provision, including access to interpreters and translation services;
- **regular multi-disciplinary user focused reviews** – brief daily meetings, full weekly meetings and six monthly Care Programming Approach (CPA) reviews;
- **small caseloads** – ideally 1:10 ratio per whole time equivalent care co-ordinator;
- **frequent contact and extended hours** – 8am to 8pm, seven days a week;
- **inpatient and respite care** – maintaining contact through in-reach and liaison; and
- **discharge and transfer** – indefinite care from the team whilst of benefit and until recovery is made. All relevant parties involved in discharge planning with the potential of rapid re-referral if required.

**Additionally, services should:**

- work in clients’ own environments as much as possible;
- work with clients’ expressed as well as their assessed needs; and
- involve service users as closely as possible in the processes of assessment, review and discharge.

**Assertive outreach services are for adults with:**

- a psychiatric diagnosis of severe and persistent mental health problems associated with a high level of disability;
- a history of high use of inpatient or intensive home based care;
- difficulty in maintaining lasting and consenting contact with services; and
- multiple and complex needs, e.g. a history of violence or persistent offending, significant self-harm or neglect; poor response to previous treatment; problems related to drug and alcohol misuse (dual diagnosis); experiences of detention under the Mental Health Act (1983) on at least one occasion in the past two years; unstable accommodation or homelessness.
In the context of the more recent Mental Health Clustering Tool (MHCT), the assertive outreach client group generally fall into the psychosis clusters 16 (dual diagnosis) and 17 (psychosis and affective disorder difficult to engage) (CPPP, 2012).

Many assertive outreach teams were developed with recovery oriented practice and social inclusion central to their function. This is now supported by policy (e.g. DoH, 2011) which emphasises the importance of a recovery-orientated approach in mental health services. Recovery oriented practice now provides an over-arching framework for assertive outreach work.

The introduction of Community Treatment Orders (CTOs) in England in 2008 under the revised Mental Health Act (1983) has provided the legislative framework whereby people can be compelled to adhere to treatment while living in the community, and for many this has meant medication delivered as a depot injection. Many teams have therefore experienced increased tension between their overarching priority to engage people in collaborative relationships and the need to consider use of CTOs. Such a tension between collaboration and control is not new to the assertive outreach model, but it has been brought into sharper focus by the introduction of CTOs. Less coercive approaches have included incentivising service users for taking medication (often depot medication), but these too are not free from ethical tensions (e.g. Staring et al., 2010).

The Equality Act (2010) has made a significant impact on all public services and has a special relevance in assertive outreach since services tend to include a high proportion of people who have experienced discrimination (Wharne & Williams, 2011). All services now have a duty to ensure that people are not discriminated against due to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. In many areas this has led to teams working with people beyond the age of 65.

1.2 Is it effective?

Assertive outreach has been shown to be effective when the key features are adhered to and when conducted by designated teams. It has demonstrated increased engagement of the target population, decreased hospital admissions and length of stay, increased appropriate accommodation and improved functioning (e.g. Hambridge & Rosen, 1994). Compared with standard community care, the Cochrane Review found people receiving assertive outreach were more likely to remain in contact with services, less likely to be admitted to hospital, experienced shorter hospital admissions and showed improvements in accommodation status, employment and satisfaction with services (Marshall & Lockwood, 1998). More intensive support also facilitates improved social networks (Becker et al., 1998), and greater quality of life (Taylor et al., 1998). Some service users find it a more meaningful or acceptable approach than traditional services (Beeforth et al., 1994; Graley-Wetherall & Morgan, 2001; Hayward et al., 2004).

Nevertheless, findings are not unequivocal, particularly in relation to reducing disability (Thornicroft et al., 1998; Wykes et al., 1998). Some UK evaluations have shown disappointing results (e.g. UK700 Group, 2000; Killaspy et al., 2006), which early researchers attributed to low fidelity to the original model (e.g. Marshall & Creed, 2000). However, some teams with high fidelity have also shown disappointing outcomes (Fiander et al., 2003). There is now some evidence to suggest that this finding may be explained by
improvements in the comparison services (i.e. community mental health teams together with crisis resolution and home treatment teams) which have led to the situation where rates of hospital admission in the UK are already so low that teams are unable to show the dramatic improvements achieved by the early teams (Burns et al., 2007). Burns et al.'s findings lend some support to this hypothesis, since they found that those studies which showed high rates of hospitalisation at baseline were more likely to find a reduction in hospital care than those where the threshold for admission was already high. In the UK it may therefore not be appropriate to measure the effectiveness of assertive outreach by simply relying on numbers of admissions or days in hospital. An over-reliance on hospitalisation data as an outcome may not only be misleading, it may also neglect more positive and meaningful outcomes for service users.

By contrast, whenever the quality of teams is evaluated by measuring user satisfaction or engagement rate, the research findings are consistently positive for assertive outreach teams (e.g. Killaspy et al., 2006). As a result there is now interest in focussing more research on recovery processes and outcomes within assertive outreach services.

There is now a wide variety of assertive outreach services in the UK (Hovell, L, 2004; Ghosh & Killaspy, 2010) and few, if any, conform to the model originally advocated by the Mental Health Policy Implementation Guide (DoH, 2001). A survey of London teams (Wright et al., 2003) found that there were broadly speaking two kinds of team philosophy, one based on the principles of social inclusion and the other allied more closely to a medical model of treatment. They are likely to reach different groups of people and have differing effectiveness, but these factors are as yet poorly understood.

Recently researchers have tried to look more closely at the original model to identify which features are key to effectiveness. Burns et al. (2007) have conducted a meta-analysis which suggests that fidelity to the structure and organisation aspect of the assertive community treatment model (community based, manager with case load, full clinical responsibility, meeting daily, shared caseload, time unlimited service, extended hours) were related to decreased hospital use. Interestingly there is now significant overlap in some of these key features between AOTs and CMHTs (e.g. integrated health and social care, community based, manager with caseload, full clinical responsibility, in vivo work). A separate study by (Wright et al., 2004) concluded that the critical factors for reducing hospitalisation were an integration of health and social care, together with home visiting. However, in their observational study Brugha et al. (2012) found that they could detect no effect on admission rates attributable to joint management, or indeed of other team characteristics. They identified the provision of specialised psychological interventions as a key process variable, but note that few teams are resourced to deliver them.
Section 2: Service models

It is helpful to think of assertive outreach not as a team, service or a collection of specific staff, but rather as a function. Different models are used in the UK to provide this function, and although designated teams were recommended in the past, current national mental health policy does not favour one over another (DoH, 2011). Whilst it used to be considered appropriate to offer assertive outreach on an indefinite basis, there is a growing expectation that clients will move on, with the majority able to move on to services offering a lower level of support. However, most local audits reveal the existence of a significant group of assertive outreach clients who continue to need this service in the longer term.

Examples of current models:

- Designated assertive outreach teams
- Hybrid teams
- FACT (flexible assertive community treatment)
- Integrated assertive outreach function
- Ceasing to provide assertive outreach.

2.1 Designated assertive outreach teams

This was the model proposed in the Mental Health Policy Implementation Guide (DoH, 2001). Designated assertive outreach teams are generally thought to be best placed to meet the needs of the clients they serve and are able to follow the key features of the model closely. They are most practical in inner city areas, which tend to have relatively large numbers of people whom traditional services have not been able to engage, in a relatively small geographical area. Whilst the Mental Health Policy Implementation Guide (DoH, 2001) recommends that they be based in statutory services, there is some evidence that voluntary sector teams are more able to reach people who are most alienated by mainstream services (Wright et al., 2003). However, locating such a team within an NHS Trust has the advantage of facilitating a single point of access to many different services.

Designated assertive outreach teams are multi-professional, including psychologists as core members. Such teams show highest fidelity to the evidence base, and have been most successful in engaging the target client group discussed above and in delivering psychological interventions (Brugha, 2012). They have been the predominant model in the UK, accounting for 84 per cent of the 233 teams in existence at the time of the National Assertive Outreach Study of Service Organisation in 2003 (Hovell, 2004), but are also the most expensive, resulting in many recent closures. It is thought that the number of designated teams has halved in recent years with many Trusts now looking to provide the assertive outreach function in other ways.

One major area of challenge has been how to deliver a service in rural areas. This is not a unique challenge for assertive outreach: the challenge of delivering health and social care in rural areas compared to urban ones is a noted phenomenon (McCann et al., 2005). In some areas with low population density, a number of smaller designated teams have been used in place of one large team. These are not necessarily able to provide the full range of key features, and this may restrict access to psychological therapies, but they have been shown to be effective in reaching people who are often extremely isolated (e.g. Repper et al., 2003).
2.2 Hybrid teams
In areas of moderate morbidity and population it might be advantageous to combine the function of assertive outreach with another team. Common associations are with psychosocial rehabilitation, early intervention, community forensic and recovery teams. For this to work, both services need to have a focus on people with severe mental health problems combined with experience of working with people who are difficult to engage. Of the 233 teams in existence at the time of the National Assertive Outreach Study of Service Organisation, 30 per cent of assertive outreach teams had previously been community rehabilitation teams (Hovell, 2004), suggesting a successful merging of function for these teams. More recently, several assertive outreach teams have either merged with community forensic teams or taken over this function. There needs to be a careful process of mapping separate service functions to preserve individual functions effectively so that distinct functions can be preserved and shared functions combined. It is also important to focus on preserving similar levels of access and intensity of service provision within hybridised services.

An example of a service function mapping exercise below shows the distinct and shared functions of the four NSF recommended community mental health teams.

<table>
<thead>
<tr>
<th></th>
<th>CMHT</th>
<th>EIP</th>
<th>AOT</th>
<th>CRHT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary function</strong></td>
<td>Active community treatment</td>
<td>Early detection &amp; reducing duration of</td>
<td>Engagement, reducing admissions &amp; relapse</td>
<td>Crisis resolution &amp; gatekeeping</td>
</tr>
<tr>
<td></td>
<td>Relapse prevention</td>
<td>untreated psychosis</td>
<td>prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relapse prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Care delivery</strong></td>
<td>Coordination &amp; signposting</td>
<td>Emphasis on PSI family interventions (FI)</td>
<td>Emphasis on meeting complex/high need,</td>
<td>Emphasis on resolving problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relapse prevention</td>
<td>including FI and social inclusion</td>
<td>reinforcing coping skills, accessing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low dose atypical antipsychotics</td>
<td></td>
<td>resources</td>
</tr>
<tr>
<td><strong>Type of care</strong></td>
<td>Low intensity</td>
<td>High intensity</td>
<td>High Intensity</td>
<td>High intensity</td>
</tr>
<tr>
<td></td>
<td>Structured (time limited &amp; long term)</td>
<td>Structured</td>
<td>Flexible</td>
<td>Flexible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Time limited</td>
<td>Long term</td>
<td>Brief</td>
</tr>
<tr>
<td><strong>Location of contacts</strong></td>
<td>Outpatient clinic appointments</td>
<td>Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crisis response</strong></td>
<td>Refer to CRHT</td>
<td>Manages the majority of own crises</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Team organisation</strong></td>
<td>Individual case management</td>
<td>Team approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>Reactive</td>
<td>Follow up</td>
<td>Assertive Monitoring</td>
<td></td>
</tr>
</tbody>
</table>

2.3 Flexible assertive community treatment (FACT)
The FACT model originates from the Netherlands and as such is a genuinely European variant on the original ACT model. Although designated teams do exist in the Netherlands, mostly in urban areas, about 70 per cent of teams providing services to people with psychosis are FACT teams. These combine functions that, in the UK context,
would be provided by a variety of services, including assertive outreach, crisis resolution, recovery and rehabilitation. The variety of need is met by providing two distinct levels of service within a single team: one which is high intensity, following the classic assertive outreach shared caseload approach, the other offering low intensity, which is more like individual case management. Clients move easily between these levels depending on need, but the staff group remains the same, ensuring continuity of care (Van Veldhuizen, 2007; Van Veldhuizen & Bahler, 2013).

The FACT model, as described by its originators, requires a high level of investment and this has been the main obstacle to its implementation in the UK. However, some services are using elements of FACT in redesigning their services, and promising evidence is starting to emerge from early implementers. Firn et al. (2012) report on the amalgamation of two dedicated assertive outreach teams into six CMHT adopting the FACT principles of judicious use of two levels of care, whole team working, and daily coordination and allocation of AO care for patients in periods of higher need. They demonstrated significant efficacy in reducing bed days, less use of crisis response and home treatment and improved clinical and cost effectiveness despite fewer contacts and poorer engagement. They concluded that FACT allows access to periods of assertive outreach equivalent care for a wider CMHT population according to current need rather than historical team allocation. However, their study is observational and not controlled, making it difficult to rule out other interpretations of the results, such as a ward closure being responsible for reduced bed days. Another service redesign evaluation study in Southern Health NHS Trust showed that adopting FACT principles in teams did not dilute the assertive outreach function compared to the previous dedicated assertive outreach provision and it improved care pathways for assertive outreach service users. Qualitative data showed that the FACT model was considered advantageous for patient care (Rathod et al., in preparation).

The early evidence for FACT suggest that it may allow the assertive outreach approach to be retained in places where designated teams have been lost; however, the population receiving assertive outreach changes with the FACT model and this needs further research. Clinical psychologists are very much part of the FACT model as used in the Netherlands. However, their role is predominantly in the lower intensity function of the service, rather than the high intensity, ‘assertive outreach’ function. This may have implications for the ability of psychologists in FACT teams to reach the most disabled clients.

2.4 Integrated assertive outreach function

In some areas assertive outreach workers have been integrated into other teams, often with a view to reducing cost. They may continue to be part of a ‘hub and spoke’ model whereby they meet with each other at ‘the assertive outreach hub’ for training and supervision, but work day-to-day in separate locations (‘the spokes’), which might be generic CMHTs. A strength of this way of working is that it can promote adherence to the model by bringing assertive outreach staff together regularly; it also allows for localised service delivery and strong links with local community resources.

However, this model compromises on a number of key features of the evidence based model. Workers can become easily overwhelmed, particularly at times of high service demand, when the host culture and organisation may not support enough team working. A team approach has been found not only to be a very important feature of effective
service provision, but also a source of job satisfaction for staff undertaking challenging et al., 1999; Billings et al., 2003) and in some circumstances facilitating higher levels of therapeutic risk taking. Services providing an assertive outreach function using this approach rarely employ a specialist clinical psychologist and consequently there may not be adequate access to appropriately skilled psychological interventions. Individual assertive outreach workers could find themselves expected to provide a broad range of specialist functions, without quality training or supervision. Access to psychology would probably depend upon the skills and availability of a CMHT psychologist who may well have more stringent referral and attendance criteria and lack the time to travel or participate in engagement interventions.

In some areas former assertive outreach team psychologists have managed to maintain the assertive outreach specialism even after integration into CMHTs. It can be quite a challenge for the psychologist to understand how to relate to a function rather than a team or service. Part of this process involves clarifying distinct assertive outreach psychology functions above and beyond colleagues in more generic roles, especially in:

- Conducting psychological approaches in the client’s own environment.
- A greater emphasis on understanding (formulating) and resolving engagement issues, building client centred therapeutic alliances and resolving ambivalence about change.
- A more flexible approach to the delivery of evidence-based psychological interventions, including formulation based treatment planning; placing a greater emphasis on psychological principles rather than protocols; coordinating delivery via a team approach.
- More flexible criteria for psychological interventions for service users with complex needs, challenging service led criteria for service provision and discharge.
- Prioritising functioning and quality of life over symptom remission; a greater emphasis on living with symptoms and working with strengths.
- Supporting an effective team approach to delivering psychologically informed care plans.

In situations where there is no shared interest in delivering the assertive outreach function, individual assertive outreach workers are likely to experience conflicts in service models, typically pressures to discharge those service users who do not attend appointments regularly, inter-colleague envy relating to smaller caseloads, and criticism for making routine appointments when there is currently no clear treatment plan. At times of staff shortage within the CMHT (particularly at times of sickness, annual leave and staff turnover), individual assertive outreach staff may struggle to avoid becoming involved in more generic team functions such as assessments and duty, thus detracting from their ability to deliver their more specialist function. There is evidence that teams are more effective and have more satisfied staff when they have a clearer, less broad remit (BPS, 2007).

There are clear dangers with this approach. If a distinctive culture of assertive outreach is not maintained within the service, staff are unlikely to have enough time to do the proactive engagement work that some people need. This has been a complaint in Northern Ireland where designated assertive outreach teams have been closed.
2.5 Ceasing to provide assertive outreach

In some areas assertive outreach teams have closed and the assertive outreach function has not been provided in another form. Ceasing to provide any form of assertive outreach in this way carries a number of risks, not least that of re-creating the very problems that were identified by Keys to Engagement (SCMH, 1998) and led to the inclusion of assertive outreach teams as a key element of the NSF (DoH, 1999). Although to the authors’ knowledge there has been no recent research in the UK about the effects of ceasing to provide assertive outreach, anecdotally it appears that outcomes for service users vary. People who have received substantial assertive outreach already may be willing and able to move on to use other services. However, their experiences with other services may not be as satisfactory and there is evidence that it is likely to be more coercive (Killaspy et al., 2006; Davidson & Campbell, 2007). Those whose engagement remains difficult are more likely to be lost to mental health services. This latter group are likely to be extremely vulnerable people and if their needs are not proactively met in the community they will simply manifest in other ways, such as through acute admissions, homelessness and the criminal justice system. Keys to engagement argued that the costs of Assertive Outreach Teams are very reasonable in comparison with these alternatives.

Any area which does cease to provide assertive outreach should be encouraged to commission research which follows up the outcomes for people who used to receive assertive outreach or could have received assertive outreach.
Section 3: Interventions

The Mental Health Policy Implementation Guide (DoH, 2001) suggests that the following multi-disciplinary interventions should be available from within assertive outreach teams:

- Assertive engagement – persistent and creative, focusing on strengths and interests
- Daily living skills – practical and hands on help from within the team as well as skills training to increase independence and access local community resources.
- Social systems – social inclusion, maintaining and expanding social networks
- Education and employment – helping people to find and maintain employment, accessing local courses and relevant services
- Family/carers – carers assessments, psycho-education and family therapy
- Cognitive behavioural therapy – range of techniques available from within the team.
- Treatment of co-morbidities – substance misuse, anxiety, depression, suicide and self-harm.
- Relapse prevention – individualised early warning signs, shared relapse plans, ecological work to improve the environment.
- Crisis intervention – intensive support, access to least restrictive option in crisis.
- Medication – home delivery, side effect monitoring.
- Physical health – GP liaison, healthy lifestyle advice and health screening.

Evidently such interventions require the different skills of a whole range of professional and other groups, but psychologists are particularly well placed to ensure many of these interventions are carried out effectively. When clients disengage from mainstream services it is often because they have not experienced those services as useful. Users and staff may have different understandings about what getting better and recovery mean (Meddings & Perkins, 2002). It is obviously crucial that services provide what service users have been asking for, such as information, choice of treatments, decent housing, work, and help with finances (Shepherd et al., 1995; Read, 1996). Services also have to focus on peoples’ strengths as well as their difficulties (Ryan & Morgan, 2004). It is important to plan and deliver this effectively, with attention to rebuilding the relationships which underpin all interventions. As well as helping to achieve some of these outcomes, when psychologists participate in such generic work it offers a means for them to gain access to a client group who have rarely received specialist psychological help in the past. Psychologists have found that they can then introduce clients to psychological approaches, for example through using problem solving techniques, which engages them in a style of work that may lead to a more specific psychological intervention in the future. In this way, providing sufficient psychology time within assertive outreach to allow for some generic working offers a means to increase access to psychological therapies.

Psychologists can make a unique contribution to formulating engagement difficulties, which enables the team as a whole to work more effectively (Whomsley, 2010). For example, attachment theory and recovery style may help to explain why people may have experienced general difficulties with relationships in their lives and how this has extended to services (Tait et al., 2003; Cupitt, 2004a, 2010a). Psychologists are often able to form collaborative relationships with service users who have rejected mental health services because of past experiences of exclusively pharmacological interventions for their mental
health problems, often whilst subject to compulsion. Many have disengaged because they do not share the belief they have a mental illness and wish to avoid any treatment, particularly compulsory treatment. Interestingly, people who do not believe they have mental health problems tend to construe getting better in similar ways to those who do believe they have mental health problems, including seeing improved mental state as important (Meddings & Perkins 2002). People in this situation have rarely received any psychological help and are often happy to meet with a psychologist (Cupitt, 2001). If this approach constructively validates a person’s own account of their experience, it can lead to a new relationship with services, in which they feel more involved and in control of decisions about their care (Gillespie & Meaden, 2010). It may further lead to involvement in critiquing and changing the wider mental health service. In this way psychologists can make a significant contribution to assertive outreach services, helping to develop a culture of recovery-orientated practice.
Section 4: Team composition and functioning

Team members bring three sets of attributes to their work: the core functions of their profession, specialised training in specific interventions, and different life experiences and social backgrounds (Watts & Bennett, 1983). A multidisciplinary mix of staff with appropriate expertise is essential to ensure the possibility of a well-resourced and representative service. *The Mental Health Policy Implementation Guide* (DoH, 2001) recommends that an average team covering a population of 250,000 has eight whole-time equivalent care co-ordinators, made up of community psychiatric nurses, approved social workers, occupational therapists and a psychologist. The team also requires support workers, a dedicated psychiatrist and administrative support. Ideally there should be an appropriate mix of gender, sexuality and ethnicity, and staff would need to be low in ‘expressed emotion’ (Leff & Vaughn, 1981). In addition, some teams employ other specialist staff such as dual registered nurses, dual diagnosis workers and vocational specialists. Vocational rehabilitation is a key feature of the Assertive Community Treatment Association model in the US (ACTA, 2004) and has also been used in the Early Treatment and Home-Based Outreach Service (ETHOS) at South West London St George’s NHS Trust with good results (Rinaldi et al., 2004). Some teams, notably TULIP, have successfully used generic outreach workers to help clients gain access to other services. Staff with lived experience of mental health problems can make a particularly useful contribution, increasing engagement with the team, vocational and community services; being valued as role models; advocating for service users; and challenging other staff to examine their attitudes (Craig et al; 2004; Doherty et al., 2004; see also South West London and St George’s NHS Trust). Ideally, new teams should be supported by whole team training in assertive outreach, which can be provided by a number of national organisations or organised locally and tailored to local needs. Most teams also find it helpful to spend time learning about one another’s life experiences and interests, because of the impact this can have on engagement with clients.

Care co-ordinators should have low caseloads, ideally about 10–12 clients; specialised staff, including psychologists, normally provide a service across the whole team’s caseload as needs are identified. To be able to provide specialist psychological interventions, a psychologist should carry no more than half a caseload of clients for care co-ordination. In practice most psychologists do not engage in care coordination, either because they work part-time with the team or out of a need to focus on specialist psychological interventions; however, they do make a contribution to care coordination through care planning and formulation. Increasingly teams are seeing the value of preserving psychology time to provide psychological therapies so that they can meet NICE guidelines (e.g. NICE, 2009) and this view is supported by research (Brugha et al., 2012). However, all such arrangements need to be flexible over time, to allow the team as a whole to respond to crises and periods when the work becomes more demanding. Whilst many psychologists welcome the opportunity to be care co-ordinators when they judge that their knowledge and skills as a psychologist brings a specific benefit to the task, for those working part-time it may just not be feasible. Many psychologists have described difficulty participating in the generic work of care co-ordination whilst at the same time trying to conduct individual psychological therapy (Pipon-Young et al., 2010). When care coordination is appropriate,
allocation of cases should be done in consultation with the psychologist concerned, with specific attention to the ways in which it may affect their therapy work.

Some teams have made extensive use of staff other than psychologists who are trained in psychosocial interventions such as family interventions, behavioural activation, relapse prevention and coping strategy enhancement. Some services have developed competency frameworks which identify different levels of psychological intervention, specifying what training and supervision is needed to offer each (e.g. SLAM, Sussex Partnership Trust). This may increase access to psychological therapies such that all clients can be offered some form of intervention according to their need. Psychologists tend to work at the higher competency levels on the basis of their doctorate level training which crosses many client groups and different models of intervention. They may supervise those offering psycho-social interventions at lower levels who, whilst valuable members of a multi-disciplinary team, should therefore be seen as complementing rather than replacing the psychologist’s role in the team.

Different models of team working exist within assertive outreach teams. The literature suggests there should be a team approach, but does not define this (e.g. *The Mental Health Policy Implementation Guide*, DoH, 2001). The original US model advocated that every client of the team knows and works with every staff member (Stein & Test, 1980). This was a feature of the early UK assertive outreach teams in the independent sector such as TULIP (Navarro, 1998) and IMPACT (Cupitt, 1999). When used appropriately, it can have significant advantages, particularly in providing emotional containment for staff and service users (Cupitt, 2010b). Some statutory teams continue to use this whole team approach, others use less integrated, more traditional care co-ordination; whilst others have adopted a mixed model, in which care co-ordinators are the primary point of contact, taking responsibility for the overall care plan and paperwork, supported by the involvement of a cluster of three or four other staff (Steer & Onyett, 2011). In deciding which approach to use, consideration should be made of the overall team caseload size, as the more integrated team approaches tend to only function well in smaller teams. The delivery of specialist psychological work is possible within both approaches but they can lead to different roles for a psychologist and this needs careful consideration. Where a more integrated model of team working is used, psychologists can struggle to maintain their professional identify and so this may need to be supported by regular contact with other psychologists outside the team.

To be effective assertive outreach teams need to develop good relationships with other teams, the wider organisation and relevant community resources. When difficult local inter-team relationships become an issue, psychologists have often taken the lead in developing a systemic understanding of these tensions. The psychologist may then be able to help teams to develop active mechanisms to improve the situation, such as ‘warm networking’ (Steer & Onyett, 2011).
Section 5: The role of clinical psychologists

There are five identified aspects of the clinical psychology role: direct clinical work, indirect clinical work/work with the whole team, research and evaluation, training and supervision, and service development.

5.1 Direct clinical work

Many people who are referred to assertive outreach teams have long histories of mental health problems that have been poorly understood. Consequently, psychologists can play an important role by conducting in-depth assessments to determine the nature and extent of the person’s difficulties. The timing of such an assessment needs to pay respect to issues of engagement and be carried out in an imaginative and flexibly way, to maximise its value (Meaden, 2010). There may also at times be a need for more specific assessment, for example of mental capacity or risk.

Psychological interventions have been shown to be effective with people with a variety of severe mental health problems. Interventions can help people cope with psychotic experiences such as voices and distressing beliefs; help people understand their difficulties in their life context and learn to cope more effectively; enable people to give up self-defeating behaviours such as drug and alcohol use, self-harm and attempted suicide; enable informed choice about treatment and other aspects of their lives; facilitate relatives’ understanding and improve relationships through family interventions; develop strategies to identify early warning signs and prevent crises, and help with the social disability caused by severe mental health problems (Cupitt, 2010a). These are most likely to be offered individually, or to families but some teams are able to engage clients in group work.

For people with a diagnosis of schizophrenia, who generally make up the majority of assertive outreach clients, there is particularly good evidence for the efficacy of cognitive behaviour therapy (e.g. Kuipers et. al., 1997), family therapy (Burbach, 1996; Pilling et al., 2002) and employment (Rinaldi et al., 2004; Warner, 2000; Social Exclusion Unit, 2004), each reducing relapse rates by about 30 per cent (equivalent to the effect size attributed to Clozapine in Kane et al., 1988). The National Institute for Health and Clinical Excellence schizophrenia guideline suggests that all people with schizophrenia should be offered cognitive behavioural therapy (CBT) if they continue to experience psychotic symptoms, family work if they live with, or are in close contact with family members, and art therapies for negative symptoms (NICE, 2009). However, many people with this diagnosis do yet have access to such therapies (Schizophrenia Commission, 2012).

Considerable flexibility of approach is required to work successfully with people who have rejected conventional mental health services and most psychologists working in assertive outreach find that they need to adapt the recommended interventions to make them accessible to their clients, such as by doing therapeutic work in more informal settings (Cupitt, 2010b; Griffiths et al., 2011). These kinds of adaptations have not yet been rigorously evaluated, but in practice are often essential to engage clients. In addition psychologists may draw on a variety of therapeutic approaches including CBT (e.g. Morrison, 2001; Garety et al., 2001; Chadwick, 2006), acceptance and commitment therapy (Bach & Hayes, 2002), cognitive remediation therapy (Cupitt, 2004b), motivational
interviewing (Miller & Rollnick, 2002) ‘hearing voices’ (Romme & Eschir, 2000), cognitive analytic therapy (Ryle & Kerr, 2002), dialectical behaviour therapy (Linehan, 1993), humanistic (Doubt, 1996), narrative (White & Epston, 1990), systemic (Burbach & Stanbridge, 1998; Seikkula & Arnlil, 2006; Meddings, Gordon & Owen, 2010), recovery (Anthony, 1993; Turner-Crowson & Wallcraft, 2002), rehabilitation (Perkins & Repper, 1996; Watts & Bennett, 1991), existential (Hulme, 1999; Spinelli, 2001), spiritual (Clarke, 2010) and psychodynamic (Navarro, 1998; Gillham & Meaden, 2010) models. They may also facilitate group interventions, such as Hearing Voices Groups, recovery groups and use other alternative approaches (Meddings, Shaw & Diamond, 2010).

As Lambert (1992) points out, the therapeutic relationship and factors outside therapy are likely to be more significant factors in therapeutic change than the specific model of therapy used. The ability to offer a range of therapeutic approaches is also important in engaging clients who may feel that their treatment options have been restricted in the past. The National Study of Assertive Outreach found that although 80 per cent of teams said they could offer some psychological interventions, only 20 per cent could offer a wide range of psychological therapies (Wright, 2005). Brugha et al. (2012) found that the number of clients actually receiving interventions remains small, often as a result of limited psychology resources. Clearly there is still a long way to go before clients of assertive outreach teams have the access to psychological therapies that they need.

One important feature of assertive outreach teams is that they allow for very close multidisciplinary working. Psychologists often find themselves jointly planning psychological interventions with other staff with training in psychosocial interventions. These interventions may then be carried out jointly by a number of staff, either working as co-therapists or by following a structured care plan. To ensure such plans work well, teams usually use an integrated electronic clinical record system, which ideally is accessible remotely. Such close multidisciplinary working, which values each discipline’s contribution, can enable an assertive outreach team to provide the kind of consistent and reliable support necessary for people to overcome very long standing difficulties (Cupitt, 1999; Cupitt, 2010b).

In the early stages of development of a newly formed team or service, most psychologists find that there is limited scope for specific psychological interventions because of the poor engagement of service users. During this phase, a psychologist’s direct work is likely to be focussed on understanding and resolving engagement difficulties. As engagement increases and the team matures, the psychologist is likely to want to preserve more of their time for specific therapeutic work. The support of line managers and supervisors in negotiating this change of emphasis is vital.

Assertive outreach work requires psychologists to make creative adaptations to psychological work in order to engage with their clients. As a consequence, assertive outreach psychologists need to be flexible and creative with professional boundaries in their clinical work (Gray & Johanson, 2010). For example, the process of engagement and assessment often takes much longer than suggested by treatment manuals, and may take place in a wide range of settings. Although a clinic setting generally offers an environment which feels separate, safe and free from distractions, and is consequently the preferred setting for psychological therapy, most psychologists in assertive outreach teams see clients
It may also be necessary to consider and formulate the engagement of relatives. Many assertive outreach clients describe experiences of surviving alone, disconnected from family as well as services (Lukeman, 2003). Families may have felt blamed for their relative’s difficulties, they may have felt traumatised by previous experiences with their relative or mental health services, or they may have ongoing concerns about risk. The process of exploring and rebuilding these relationships takes time, and some relatives do not want to engage with services at all. For some, family work may simply involve the provision of information and practical support; for others psycho-education and further support from the team is welcome; and for a minority, formal systemic family therapy is appropriate. It is generally appropriate to provide such support in peoples’ homes, but the approach needs to be flexible and centred around the particular family’s needs (Meddings, Shaw & Diamond, 2010).

In common with psychologists working in rehabilitation and other longer-term settings, assertive outreach psychologists tend to offer more self-disclosure. Perkins and Dilks (1992) provide an excellent discussion of this issue in the context of working with people with severe social disabilities, suggesting that 'some self-disclosure, real two-way interaction and sharing, is essential in forming an effective relationship with someone who has few, if any, other close relationships'. Nevertheless, professional boundaries protect both the client and the therapist so on-going discussion of such issues is important, both within the team and in supervision with other psychologists (Gray & Johanson, 2010). Such reflection should involve consideration of the client’s psychological formulation, the intended therapeutic benefit and the risks involved. These discussions should be documented.

Since November 2008, when the Mental Health Act amendments came into force, psychologists have faced an added dimension to their work in that their clients may be subject to a community treatment order (CTO). Local audits suggest that about 10 per cent of assertive outreach clients at any one time may be on such an order (Cupitt & Ingliss, 2010), which requires the individual to adhere to specific conditions. The effects of CTOs are as yet unknown, but the numbers of people subject to them continues to rise (NHS Information Centre, 2012). In the absence of evidence, current advice is that psychologists should assume that interventions will have greater efficacy if offered as a choice, and should psychological interventions be included in the conditions of a CTO without consultation, psychologists should decline to provide them (BPS, 2009). Current MHA legislation allows psychologists to take on the role of Approved Mental Health Professional or Approved Clinician, but to the authors’ knowledge no psychologist working within assertive outreach services have yet taken on this role.

It is possible that access to psychological therapies will expand in England under the Increasing Access to Psychological Therapies for Severe Mental Illness (IAPT for SMI) initiative (IAPT, 2012). At the time of writing it is unclear how psychological therapies within secondary care will be affected by this initiative, but clearly psychologists who are embedded in assertive outreach services are better placed to ensure access to psychological therapies...
therapies than when a referral to specialist services is required (Mankiewicz & Turner, 2012). To demonstrate this, it is important that records of offers and actual psychological therapies are kept and regularly audited. Care will be needed when implementing IAPT for SMI in assertive outreach services to ensure that people who do not find it easy to engage with traditional services are not disadvantaged by requirements to complete packages of outcome measures.

5.2 Indirect clinical work/Working with the whole team
The majority of psychology posts in assertive outreach are part-time, limiting the amount of direct clinical work that they can contribute. In addition, the team approach offers great potential for psychologists to do indirect work, for example in facilitating team formulations of clients’ difficulties (Whomsley, 2010). This is especially important for a client group which has long-standing and complex needs, which conventional mental health services may have not been able to understand to the client’s satisfaction. Psychologists are a crucial part of the CPA process involving comprehensive systematic care planning, which involves service users as fully as possible. For psychologists to offer full input to these processes with all team clients, they need to be fully integrated into the team structure and have sufficient time with the team to have some face-to-face contact with each client (e.g. Cupitt, 1999). Psychologists also have a role in consultancy with individual team members and the team as a whole, for example in psychological understanding and management of challenging behaviour; being proactive in reducing violence or risk; developing team policies, and helping the team reflect on their work. They may also be able to support the team to reduce staff stress and burn out (Gray & Mulligan, 2010).

5.3 Research and evaluation
In the context of assertive outreach, where clients are generally receiving multiple interventions in parallel, it can be very difficult to isolate and measure the impact of any one intervention. For this reason most psychologists working in assertive outreach have focussed on team-based outcome measurement. Most of the research has used symptoms-based measures, which are problematic for various reasons, including their insensitivity to the kinds of changes that are most likely to occur, and their failure to capture the service user perspective. There is a growing consensus that outcomes measures which focus on engagement (see Gilliespie & Meaden, 2010) and social recovery (e.g. Neil et al., 2009) are the most relevant.

Whilst assertive outreach has been widely evaluated in the US, the UK model is still developing and research is ongoing. It is a feature of assertive outreach that services need to be tailored to the local situation and these adaptations need evaluating. Psychologists might be involved in researching broad models of assertive outreach as well as specific aspects of assertive outreach, such as the engagement process (Hall et al., 2001) and the adaptations required of existing therapies for this client group (e.g. Tait et al., 2003). Evidence-based practice, audit and evaluation are essential to service development and psychologists are one of the few professions whose basic training includes research methods to doctorate level. It has been suggested that following the NSF recommendation, too many teams just got on with their work assuming that it was effective without collecting data to prove its effectiveness, thus failing to establish the ongoing need for their existence. Clinical psychologists should take a lead in rectifying the urgent need for more research
and evaluation.

5.4 Training and supervision
Many services providing assertive outreach have a high demand for training and supervision. Clinical psychologists can make a major contribution to team induction and ongoing training needs. Psychologists may also take a role organising team supervision and reflective practice, including provision of specialist psychological supervision to other team members such as those trained in psycho-social interventions. Good team supervision is important to enable clinicians to keep working effectively and safely with such a challenging client group and clinical psychologists are well placed to deliver this. The close team working that is part of the assertive outreach function offers great opportunities for training by co-working and shadowing, which can contribute to all staff gaining basic therapy skills.

5.5 Service development
Psychologists have an important role in service development, in line with New Ways of Working (BPS, 2007). This overlaps with their role in supporting teams with clinical governance: striving to improve quality and clinical outcomes. This includes some of the areas already mentioned such as research and evaluation, training and supervision, which are key to ensuring high quality care. Service development includes policy development and implementation of national guidelines, such as NICE guidelines for schizophrenia (NICE, 2009) and bipolar disorder (NICE, 2006). It can also involve the auditing of team practice against Trust standards (e.g. quality of relapse plans) and national standards (e.g. NICE guidelines). At a service level, psychologists can be involved in ensuring that teams maintain fidelity to the assertive outreach model and thinking about how teams move forward. Psychologists have a particularly important role in developing appropriate and enduring systems of working which are more psychosocial than conventional services. In the pan-London assertive outreach study a significant proportion of teams identified themselves as following a social inclusion rather than medical treatment model (Wright et al., 2003). Clearly teams wishing to use psychosocial models of assertive outreach benefit from the presence of a psychologist to develop effective working practices.

Given the recent national trend towards the integration of assertive outreach into more generic services, psychologists can play an important part in helping to consider how best to provide an appropriate service to this client group in the future. The initial challenge for clinical psychologists is to ‘find a seat at the table’ of service reconfigurations so that they can help inform decision making, with a particular eye to various forms of evidence, be they scientific, historical or stakeholder contributions. Secondly, clinical psychologists have a potential role in evaluating the impact of any new service model. Thirdly, there is a role in developing new approaches/ways of working, gathering evidence for their effectiveness and disseminating this evidence through publication. Fourthly, psychologists are well placed to help determine which component variables of any new model have the largest effects on a range of valued outcomes.

Large, rapid and radical service reconfigurations contain the potential for cracks to appear in provision. If these demands are not promptly resolved they can potentially swamp and even temporarily paralyse a service or get lost as an unmet need, which may surface later as a much more challenging problem. Consequently service reconfiguration needs to be
approached with a great deal of care and planning, and involve service users, carers and the local community. Research into local needs and demands, in the light of existing models and service provision, is essential. Efforts should be made to reduce any disruption to the care received, particularly for clients of assertive outreach services, whose engagement with services is likely to remain fragile. Some service users will require a great deal of support through what they perceive as a loss or abandonment by services, others may be ambivalent about such changes, and some may even be pleased. A good knowledge and understanding of each individual client, without prejudging their likely reaction, in the context of a strong working alliance are important to support them through a process of change.

At times of radical change it is equally important to support and protect the staff working in the service. Staff are a critical resource in any service, particularly one where the primary objective is in relationship building. While clinical psychologists are not themselves immune from such stresses, there may be a need to shift the balance of their work at such times towards supporting colleagues, listening to their concerns, validating their reactions and counselling them through the process of change. Clinical psychologists going through such changes also need support themselves, and to consider how they can maintain specialist knowledge and skills in a new environment.

Whenever services are reconfigured there is always the risk that evidence-based practice is replaced by new and untried service models that look good on paper, but which lack supporting evidence. When this happens there is still an opportunity to develop services based on the idea of practice based evidence (Ryan & Morgan, 2004). This requires a culture of reflexivity whereby novel approaches are implemented, evaluated and reconfigured, through a continual evolving and learning process. When services are redesigned without any reference to evidence, there is a risk of encountering the same problems that led to the development of the NSF in the first place, including leaving the assertive outreach population without adequate support.
Section 6: Service user and carer involvement

To be effective at engaging their clients, assertive outreach services need to be especially good at understanding the perspective of those who use their services (Wharne et al., 2011). Clients and carers should be encouraged to participate actively in identifying their own needs and wishes from the earliest point of contact with the team. Many psychologists have played an important role in involving service users, their caring families and friends in the development of assertive outreach teams, for example by devising methods to elicit user feedback on the service and supporting individuals to become user and carer representatives at a strategic level in their organisations.

When working with a client group which is generally very alienated by mental health services, the initial stages of user involvement can be a challenge. One of the most successful models has been to organise a user forum with a social focus (e.g. Birmingham AO User Forums). Other teams have employed user consultants within their team, used focus groups, service user and carer advisory groups, questionnaires to elicit feedback (e.g. Birmingham AOTs), tools such as CUES (Lelliott et al., 2001), or encouraged individuals to become user reps (e.g. Peterborough AOT), with varying degrees of success.

In addition, many teams have sought ways to involve their clients in both the running of the assertive outreach team and the wider health service. Increasingly peer workers are employed within assertive outreach services to give voice to the service user experience and provide peer support. The assertive outreach team in Portland, Oregon USA (the Community Survival Program) was entirely user staffed and user run (Perkins, 1993; Nikkel et al., 1992). This work extends the notion of engagement to mean full and active engagement with the whole system of mental health service delivery. The ultimate aim should be to work towards involving users and their carers in all aspects of assertive outreach: in their own lives and care plans, in selecting and training staff, setting up self-help groups, writing information leaflets, working as paid staff and volunteers, research and audit, managing services, setting priorities and developing the service (Meddings, Collins & Simmonds, 2002).
Section 7: Specific employment considerations

The work of a clinical psychologist in assertive outreach is influenced by the model of service delivery, team composition and grading of the post. Clinical psychologists are best placed to perform the above roles within a designated team.

7.1 Gradings
A grading of Highly Specialised Clinical Psychologist (Band 8a) or above is needed under the Agenda for Change framework (DoH, 2004) to provide the complex clinical assessments and interventions, work with high risk in a community setting and carry out the consultative and service development work described above. At this level, it is also possible to have trainee clinical psychologists on placement with the team. However, many teams have recruited newly qualified Specialist Clinical Psychologists (band 7), who have completed a training placement in assertive outreach. Appointing such a junior psychologist is only appropriate where there is already a more senior assertive outreach psychologist employed nearby in the same Trust and when the team is well established. Some teams have appointed assistant psychologists, who have contributed a great deal to the work of the team and gained good clinical experience. However, the Division of Clinical Psychologists (DCP) strongly advises against the appointment of assistant psychologists in services without a clinical psychologist (DCP, 2003).

7.2 Full- or part-time
The Mental Health Policy Implementation Guide (DoH, 2001) states that all assertive outreach teams should have a psychologist whose main responsibilities lie within the team. Ideally teams would employ a whole-time psychologist since this provides the greatest opportunity for the psychologist to become a full member of the team. The recommendation is for a ratio of 1 WTE psychologist for a team caseload of 90 clients to meet need. In practice, however, the majority of psychology posts are part-time within a team, as part of a split post (Yates, 2004). This can work well provided the psychologist has sufficient time to become involved in all aspects of the team’s work, or there is more than one psychologist attached to the team. In practice this means a minimum of three days a week for a team caseload of 90 clients. Many teams have never had sufficient psychology resources to meet the needs of their clients and this has been identified as reducing the effectiveness of the team as a whole (Brugha, 2012). The reasons for this are likely to be varied, including lack of resources, difficulties in recruiting and a lack of awareness of the contribution psychologists can make to the work of the team. There is an urgent need to develop and recruit to these posts, especially in Wales where few posts exist.

7.3 Working hours
Whilst some assertive outreach services operate extended hours, usually 8am to 8pm, seven days a week, the vast majority of clinical psychologists work broadly traditional hours (Yates, 2004). The team is likely to gain most from their psychologist if there is flexibility for the psychologist to work the hours required to perform their function. This may mean working occasional evenings, for example, to meet families or run groups, but is unlikely to involve
shift working which can make it difficult to conduct regular therapy sessions. It should be borne in mind that there is evidence that out-of-hours working reduces a team’s capacity to provide specialised interventions (Brugha et al., 2010).

7.4 Supervision

It is essential that psychologists of all grades have access to appropriate supervision (DCP, 2003), strong links to their local psychology colleagues and access to the support of a consultant psychologist who has expertise and understanding of the speciality area. Many psychologists have had difficulty accessing support and supervision locally from other psychologists with experience of assertive outreach. In a speciality that can present many challenges, this can lead to a feeling of professional isolation and dissatisfaction, leading to difficulties with retention. In such situations the Network of Psychologists in Assertive Outreach may be able to facilitate access to support and supervision.
Section 8: Conclusions: the future for clinical psychology in assertive outreach

Since the previous briefing paper in 2006 there has been a significant shift in context, both broadly with the implementation of New Ways of Working, and more specifically in the delivery of assertive outreach after the end of the NSF. Recent financial pressures on NHS resources have also led to a wish for limited resources to be used more innovatively rather than more intensively (so called ‘smarter ways of working’). This appears to be leading to a greater diversity of service models, increasing integration of the assertive outreach function into more generic services and a shift towards prioritising specialist aspects of psychology roles. Given the wealth of evidence supporting the model of designated assertive outreach teams and the recognised need to provide dedicated psychology time for this population, such trends are concerning.

Whatever the form in which assertive outreach services continue, it is vital that they demonstrate their effectiveness, both clinically and as a part of the wider network of care. This is likely to mean adopting routine outcome measurement, regular caseload reviews and auditing referral and discharge rates. An effective assertive outreach service continues to offer a valuable contribution to a health system which will have to prioritise those with highest need as resources reduce (Cogan et al., 2012). Services with a designated clinical psychology post are more likely to be clinically effective and be able to demonstrate their effectiveness, giving them more chance of survival in an increasingly outcomes-driven system. There therefore remains an urgent need to develop and recruit to psychology posts in assertive outreach nationally.

Where service redesign is occurring, clinical psychologists are well placed to help, given their professional training in problem formulation, evidence-based decision making, problem solving and innovation. This is underlined in a recent BPS response to the NHS Chief Executive Innovation Review:

‘The training of practitioner psychologists equips them as innovators … the challenge is assessed, data collected, a hypothesis or formulation arrived at which points to possible solutions, and data collected on the effects of applying the solution. The results are then used to inform service development and innovation. This rigorous approach encourages both creative thinking and methodical testing of new ideas…

‘Where service changes are made to accommodate cost pressure, psychologists are often well placed to lead the innovation essential to continue to provide effective and acceptable services in the new conditions…’

(BPS, 2011)

Finally, it is essential to emphasise that assertive outreach is neither a team, nor a service nor a collection of specific staff, but a function. Assertive outreach is an opportunity to provide intensive support in situ for people disabled by serious mental health problems and has been shown to be an effective means to rebuild relationships following engagement difficulties. Clinical psychologists should play a major role in assertive outreach and its development. Through identifying the effective elements of assertive outreach, and by developing, delivering, and evaluating innovative approaches, clinical
psychology can be a driving force in assertive outreach’s future development. Given the
resources challenge that the NHS faces, clinical psychologists are arguably in a strong
position to assess this challenge, collect meaningful data, derive a hypothesis or
formulation which points to possible solutions and then evaluate the effectiveness of these
solutions. These principles and skills are no less useful when faced with a challenge to a
service than they are when faced with a challenge to a service user.
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