

Active Outreach

An independent service user evaluation of a model of assertive outreach practice

Roberta Graley-Wetherell (Advocacy Really Works)

Steve Morgan (The Sainsbury Centre for Mental Health)

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134-138 Borough High Street

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SE1 1LB

Tel: 020 7827 8300

Fax: 020 7403 9482

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Definition

Assertive (Active) Outreach is a flexible and creative team-based approach to working with the complex needs and wishes of a clearly defined group of people. This group is frequently referred to as experiencing severe and enduring mental health problems, and as being hard-to-engage or resistant to services. They have generally been inadequately served in the mainstream development of community and inpatient mental health services.

Why an independent service user evaluation?

The recent emergence in the UK of assertive outreach as a major component of mental health service delivery is largely attributable to the combination of major policy review and a focus on evidence-based practice. *Keys to Engagement* (The Sainsbury Centre for Mental Health, 1998) strongly advocated this approach for people experiencing severe and enduring mental health problems. The National Service Framework for Mental Health (DoH, 1999) and NHS Plan (DoH, 2000) translated this review into a major government initiative – the establishment of 50 new teams (a total of 220 teams) in England by 2003, which will provide services for some 20,000 people.

These ambitious targets reflect the message that assertive outreach is one of the most widely researched mental health models, with a strong evidence-base for its effectiveness. The messages from international research can be found in Mueser *et al.*, 1998; McGrew and Bond, 1995; Teague *et al.*, 1998; and are also summarised in the UK article (Hemming *et al.*, 1999).

In the UK, however, the enthusiasm for this approach has been met with some conflicting research evidence (PRiSM Psychosis Study, 1998; UK 700 Group, 1999; Marshall *et al.*, 1999; and Sashidharan *et al.*, 1999). Galvin (2000) has produced a succinct critical appraisal of all of the national and international studies mentioned above.

Most of the significant research addresses quantitative measures relating to:

- hospital bed use
- caseload sizes
- symptom management
- medication compliance
- housing stability
- service costs.

Qualitative data, particularly client satisfaction, is included but rarely accurately reported in sufficient depth. Beeforth *et al.* (1994) published one of the few independent service user evaluations of a model of care; in this instance, a model of case management in the UK.

The aim of this publication is to show the importance of gaining service users' views on the innovative local practices that they receive. It should establish one, albeit atypical example, of how service user involvement can be more widely implemented through direct consultation. It is not to be used as a rigid prescription of how to implement assertive outreach, as the Active Outreach Team at Julian Housing in Norwich is only a reflection of the local ideas and resources within one organisation.

The translation of good ideas into routine practice takes more than just the dissemination of the message. The current vogue for evidence-based practice offers an important challenge, for all practitioners to adopt a life-long learning

approach that continually questions whether 'what you are doing is what you should be doing'. The danger with large population-based studies is that they only offer evidence broadly about large populations. The individual service and service user may not easily fit into the research picture. Furthermore, reports of research studies rarely if ever give sufficient detail of the exact approach being implemented, how it adapted evidence and local circumstances together, and ultimately how it may be replicated in other areas (Galvin, 2000).

The Sainsbury Centre for Mental Health (2000) outlines its current vision of adapting 'local focus and national impact'. This argues for helping the local service to grasp the big picture, through dissemination of the evidence, whilst also using good local experience to inform the successful implementation of ideas. "Mental health is complex, and simple questions such as 'does this model work?' are inadequate. Instead, the challenge is to understand how a model works, for whom, and in what circumstances." (p.3). The moving on, beyond the 'what' and the 'why' to the 'how', is essentially a model of 'practice-based evidence' (Morgan, 2000). This is a complementary message to that contained in the research on evidence-based practice. It recognises some of the inevitable barriers to implementing the essential components of the research.

The Active Outreach Team

The team was established in a voluntary sector service (Julian Housing Support) in Norwich in August 1995, with a remit to support people in sustaining their own tenancies, through flexible and appropriately intensive levels of support. This was an attempt to develop an assertive outreach model of practice three years before the publication of *Keys to Engagement* (The Sainsbury Centre for Mental Health, 1998).

Team composition

- Part-time team manager (with other managerial responsibilities in the organisation).
- Five outreach workers (mixed nursing, social work and community housing support worker backgrounds).

Team development and team-working

The beliefs and personalities of the people who make up the team will inevitably shape the model of care. The team attended a Sainsbury Centre for Mental Health (SCMH) two-year practitioner course in Effective Community Care for People with Serious Mental Illness (20 days during 1997-1998), and also received some support and supervision from the SCMH lead trainer and other external sources.

The team currently works with 53 service users (see Appendix 2). They follow a 'co-working model' where each service user has at least two, but up to five

workers in contact, depending on what works best for the individual person at any point in time.

Primary responsibility for overseeing the individual package of care and support offered by the team is managed by outreach workers on an approximately one-to-ten allocation. This is very much in line with the recommendations from research.

The team operates a flexible structure around the hours of 8.30 am – 6.30 pm. They cover seven days a week, but because of the small size of the team only one person will be on duty at weekends. This lone worker will primarily offer social visits, but in the case of risks and crises can call for back-up from Oak House staff (the housing assessment unit part of the Julian Housing organisation).

A duty system, known as ‘front-line afternoons’, is managed on a rota basis by the team. This involves one member of staff being office-bound each afternoon, to deal with any service user visits or telephone calls to the office. It can also be a time for catching up on paperwork.

Whenever possible, the team targets its resources on those people who are not in touch with the services that should be meeting their needs. The age range is 16-65, but they will continue to work with clients who reach the age of 65, if no other suitable services can be found. Primary diagnoses of alcohol and substance misuse, learning difficulties, and personality disorder are excluded. However, a secondary diagnosis of any of these would be accepted.

The core client group are those who demonstrate a high level of vulnerability and isolation, and are managed chaotically in the community. They are generally people who are not receiving the services that would help to reduce this vulnerability, diminish the chaos, and improve quality of life.

A further component of good practice is a ‘no close’ policy. Once a client has been accepted for long-term support, the team will maintain their involvement for as long as is necessary.

Assessment procedures

Attempts to implement existing comprehensive assessment tools, and more specific tools, such as life skills profile, mental state examination and strengths assessment have proved unsuccessful. These tools have been found to describe the person in a narrow and standardised way, and do not offer a sufficient flavour of the individual as a person with needs and wishes. As an approach, formalised assessment also militates against the process of engagement. The team’s preferred approach is to apply a skilled method of assessment using a conversational and relaxed approach, working at the service user’s own pace. Only issues of crisis and risk will alter this pace. The team uses a revised version of a risk assessment and management tool.

The Active Outreach Team aim to develop their own ‘Day-to-Day’ assessment tool. This comprehensive format is largely based on the ‘Avon Measure for Mental Health’, but also draws on aspects of other formal assessment tools.

Interventions

Assertive outreach is primarily about gaining the trust of people who choose either not to become actively involved with, or to actively resist, mental health services. These are not easy conditions within which to replicate research findings. The Active Outreach Team recognises this dilemma by focusing their energy and attention on ‘engagement’.

Creative approaches to engaging individuals have included:

- a focus on pets (e.g. talking about service user pets, walking the dog, on-going correspondence with the office dog, caring for a parakeet, taking animals to the vet, visiting rescue centres);
- talking about art;
- washing up and cleaning, with the service user;
- painting and decorating;
- use of the office washing machine;
- use of the office shower;
- attending horse racing and football matches;
- giving Italian lessons;
- donations of food;
- facials and washing hair;
- forming a rock band (due to cut a CD). This is linked to the local community and is not solely a mental health venture;
- going to church;
- accessing community resources.

The first questions asked by the team, when considering interventions, are “How are we going to reduce this person’s vulnerability in the community?” and “What are their priorities?” With these in mind, the most frequent activities do not necessarily come directly from the research literature but tend to be much more practical in nature:

- relationship-building, through the type of examples offered above;
- checking housing and social security entitlements;
- improving the home environment (if the service user agrees);
- advocacy, for meeting their needs within statutory sector agencies;

- physical health checks;
- medication management;
- shopping;
- accessing community resources;
- working with families or more often significant others (problem solving, education, informal counselling, support to manage stress, resource networks, and advocating needs to other agencies).

The team possesses a solid base of professional expertise drawn from the diverse backgrounds of its members. They are all skilled at monitoring the mental health of their clients and its impact on day-to-day functioning. A key aspect of their work is in recognising the early warning signs of relapse which frequently manifest through changes in behaviour before psychiatric symptoms emerge. These are currently documented in the daily notes but the team plans to develop a more standardised and accessible format for the sharing of information.

A high priority is given to linking with other services. This takes the form of working closely with the service user and the inpatient team, if an admission to hospital is deemed necessary. This sustains the team’s working relationship with the service user and with workers in the inpatient unit. Onward referral and joint working, with drug and alcohol services, have been effective ways of tackling the complex issues presented by dual diagnosis. Fortnightly supervision from a psychologist, around the management of psychosis and CBT interventions, is a further example of how the team responds to service user needs, but also seeks to integrate its own highly skilled work with the expertise of others.

Interviews

The remaining sections of the report present the results from the independent service user interviews with:

- individual service users
- a service user group discussion
- a carer/family
- the staff members of the Active Outreach Team.

Roberta Graley-Wetherell conducted the interviews during the week commencing Monday 9th July 2001. The qualitative content of the interviews is enhanced by Roberta's descriptions of the process and by pertinent quotes from the interviews.

Introduction

The questionnaire used for the research on the Active Outreach Team at Julian Housing is based on a previous method used for researching case management projects, published by the Sainsbury Centre for Mental Health (Beeforth *et al.*, 1994). The questionnaire is designed to assess what impact the team has had on the quality of life for the service user.

Most research is quantitative, examining the cost effectiveness of services or the reductions in hospital admission rates. This is valuable information, but not what service users define as their priority. For example, service users do not like being treated in hospital; however, if the admission is planned and kept to

a minimum length of time, it then becomes far more acceptable to them. Most research looks at the number of admissions and considers a reduction to be a favourable outcome. Service users consider the process to be the most important factor; therefore, three short planned admissions in a twelve month period is considered to be much better than one longer admission under section. Service users also suggest that information and choice are the most important factors when considering the quality of a service. We developed the questionnaire to reflect these priorities. Our aim was to record users' experiences, both positive and negative, and to compare experiences of using the Active Outreach Team to that of using traditional services.

The questionnaire covers the following areas: input into care plan, access to services, advice and support, quality of life, service continuity and satisfaction with services. The interviewees were also given a chance to add anything else that they considered important (see Appendix I for a copy of the questionnaire).

The interviews

- total number of interviewees – 14
- 11 male and 3 female
- age range from 22 to 60.

I began each interview with a short explanation of the evaluation, and also informed the respondents that I too had had personal experience of using psychiatric services. I felt it was very important to share this with the interviewees. The empathy between service users is very important, and there is often a shared trust which is not present between psychiatric service users and other members of society.

I explained what the process would be and that I would be taking notes. I asked the respondents for permission to use quotes and assured them that they would not be identified. The first question was “What is the name of your support worker from Julian Housing?”, to establish that the user fully understood which service I was referring to, as some people were receiving a number of other services.

Most of the interviews were conducted in the service user's own home, with just three being held at the team's office. The carers' interview was also held at their home. The group interview was held at the office. I was introduced to each service user by their project worker, but all the interviews were conducted without the worker being present, so that the service user could talk as freely as they wished.

Input into service/care plan

Many service users complain that traditional services do not encourage them to be involved in their own care plan, or to be the one who determines what the priorities are. Thus, the care plan was the first area that we discussed, to establish if the service is succeeding in its stated aim of being 'user led'. I started by asking how the team's workers determined what was required from them – did they ask the service user what it was that they needed help with? Several of the service users stated that their first contact was when they were still in hospital and needed help with accommodation, so this was an obvious priority. The other major area that the interviewees identified as a priority was finance.

“I had to move very quickly, I was being evicted that day, so they really knew what I needed, but they got me a place to go straight away and helped me move in that day.”

Not all of the interviewees were inpatients during the initial contact. Some were referred because of their reluctance to engage with services, and because of their isolation. Much positive feedback was given about the pace of engagement. Some of the service users who in the past had felt that they had lost control of what happened to them, and that they were being pushed or coerced into doing things they did not really want to do, now felt that they were much more 'in charge'.

“They asked what I needed, just let me talk, I wasn't keen at first but they went at my pace, they waited to see what it was that I needed.”

“I am offered all sorts of things, swimming or shopping etc., then I decide what I need, sometimes it's just tea and a chat, sometimes it's more if I need it. I want to do more but my medication makes it hard for me, they understand that.”

The next question in this area was “Who decides what you will talk about when you meet your Active Outreach worker?”

Although only three interviewees replied that they set the agenda for discussion, they did all say that they felt comfortable about discussing issues that were important to them and did not feel forced to talk about things if they didn't want to. They all liked the fact that it was much more informal than most meetings with professionals.

“We just chat – if I have an important issue then I just tell them.”

“If there is something concrete they have to raise they just say it, but they are gentle with me and go at my pace.”

“They ask how I am, I tell them. I ask questions and things, I usually lead it.”

“We just natter about what's happening, unless something important has occurred.”

I asked if they could set extra meetings, and what happened if they did request one? They all stated that they could request a meeting, but very few had put it to the test. However, they were all confident that they would get a positive response. Some of them had asked for emergency meetings which had been positively responded to. They understood that it might take a little time for someone to call around, but an advantage of having more than one worker allocated to them usually meant that one of the workers could respond fairly quickly. A couple of the service users also stated they were happy to sort things out over the phone, and this could diffuse situations that might otherwise escalate into a crisis.

“Never tried to arrange extra meetings but I would just ring if I needed one.”

“I have and they have always turned up.”

“I sometimes have very bad nightmares and I phone them the next morning just to unload.”

The amount of contact that each service user had with their worker varied and was dependent on needs. For some they had started out seeing the team a couple of times a week at least, but were now only seeing them once every two weeks. The team are happy to increase contact as and when necessary. I asked the service users if they were happy with the amount of contact they had with the team.

Most of the service users were happy with the amount of contact they had, but some stated they would have liked a little more. However, they generally understood that resources for the team were limited and that priorities had to be made. One service user felt that the service was not as good as when he had first had contact with them. This was because they were unable to take him to the supermarket on the outskirts of town due to the time commitment involved. Some of the service users would like more weekend contact and

evening contact, but that of course, is dependent on resources. Although the organisation acknowledges that an extended service would be beneficial for the service users, they would need additional funding to provide the extra hours. None of the interviewees felt that they had too much contact, even though some admitted that they did not always keep their appointments, and one service user felt that he might be taking up too much of their time.

“I worry they give me too much of their time, but they always say it’s no problem.”

“I see them once a week which is just right at the moment.”

“I would like a bit more.”

“They are sometimes late, but the meetings are quite long which is good.”

“I would like to see them in the evenings or at weekends, as that is when I get most lonely, I have things to do during the day.”

I then asked if service users had set any goals or targets with their workers. I was quite surprised that most of them said they had not. However, when talking at greater depth it emerged that they may not have formally discussed language such as ‘targets’ and ‘goals’, but there was a kind of understanding about what they were working to achieve. This often took the shape of maintaining their tenancy, staying out of hospital or remembering to take their medication. For some it was about shopping, or going out of the house with support, and hopefully building up to the stage where they could do these everyday tasks alone.

“No I don’t have any goals, but I do have my own flat and furniture now.”

“I would eventually like to come off all medication, I hate having blood tests.”

“I would like to lose weight, and so I want to go swimming, but it’s hard getting motivated because of my medication.”

“To get my flat back – I have done that – now I just need to keep it.”

I also wanted to determine how much choice the interviewees felt that they had, so I asked what happens if they want to try something new or if they decide that they don’t want to do something which the worker suggests they should do. Generally the service users felt quite confident in saying no, and felt that they would not be pushed into doing anything they didn’t want to do. They thought the worker may try to persuade them, but certainly not pressure them.

“Never been a conflict or disagreement.”

“They just accept it’s my choice.”

“It’s my choice, they wouldn’t mind or take it personally.”

“They persuaded me to go into hospital, but I would have been sectioned if they hadn’t, so it was okay.”

When I talked about trying out new things they all said that they would have support and help in this, and no one said they would be discouraged or prevented from trying out something new.

“They would help me to do it.”

“I get full support both mentally and physically.”

“It might depend on what I want to do!”

Generally, I think that the service users I interviewed felt that they had a good deal of input into their care plan, that they felt happy to give honest feedback on the service without any fear of repercussions, and they felt well informed. Most importantly they felt that things were going at their own pace, they were not being *pushed along*, but supported and that they had CHOICE.

Access to services

Although this is an evaluation of the Active Outreach Team, I felt it was important to see what access to services in general each client had. I asked if they were receiving all the services that they felt they needed. Most of the interviewees felt that they were but some wanted more. This ranged from psychology input through to seeing a community psychiatric nurse on a regular basis. One client felt that “he didn’t need any of it really but was willing to comply”.

“I am now (getting the services that I need), but I wasn’t a few years ago. I get a care assistant and other things. Julian Housing is really good – much better than the medical services.”

“No, not really. I get community services but that’s just an injection, and I see a psychiatrist every three months. The Julian Housing workers take me to see him, I suppose it helps a little bit.”

“Julian Housing is great compared to statutory services.”

“I would like an analysis of my illness, I would like to see my notes and I would like psychology input.”

“I think so, but I am still a bit lonely, although I do voluntary work two days a week.”

I asked if there were some services that they would rather not be receiving. Very few of the interviewees said that there were. Taking into consideration that many of this client group have been defined as hard to engage and/or non-compliant, you might assume that they would rather not have services at all. It seems that delivering the ‘appropriate’ services for this group is the most important factor to ensure engagement. The main complaint was about medication, with many service users expressing a desire to be medication free. One or two suggested that they only complied with the injections because they

would be sectioned if they didn’t.

“I don’t need the nurse and injections, but I feel I have to really, if I don’t they might put me on a worse drug or even in hospital – I just don’t want the side effects anymore.”

“I think it might be necessary to see all of them (psychiatrist every three months, CPN giving fortnightly injections and weekly visits from Julian Housing), but I look forward to getting well so I don’t need to see them. At the moment I am stable but maybe that’s because I do see them.”

“I just want to get off my medication.”

“Yes the Police – they should never be involved in mental health, they treat mental health patients really bad. I also hate hospital, admission wards are just not therapeutic.”

Almost all of the interviewees said the team ensured they received services that they needed. Several of the service users said that they would have problems attending hospital appointments if the workers didn’t take them. There were also a couple of interviewees who said that in the past they had problems with remembering to take their medication and fetching it, but the team members brought their medication for them. Some of the interviewees said that they found it particularly useful that they had someone who would deal with the council or housing association for them, and could sort out their finances.

Many of them reported a large increase in benefit payments since being with the team. This had indeed improved their quality of life, and a couple of the service users said they could do much more in their social life now their finances were improved. This reduced their sense of isolation and had led to improvements in their mental health.

“I just couldn’t do it myself, they take me to my physio and other things.”

“They helped me with my DLA and my Council Tax.”

“They did until they had to reduce my shopping trips.”

“They help to keep me out of hospital, it’s having contact with normal people.”

I asked all of the interviewees what, if anything, was different about the Active Outreach Team. The service users **all** felt that the team delivered a service that was different to other services they received, or had received in the past. A large majority of them said that it was about attitude, they felt they are treated with more respect, that they are listened to and that they are given more time to express what their problems are. Some of them said that the workers are like friends, but that they understood that there are boundaries and it is their job. However, they certainly felt much more comfortable with the friendly approach, and they expressed a willingness to engage with this model of working. Some of the interviewees said that in the past they had not really wanted to have people coming to their home, but that now they looked forward to visits from the Active Outreach Team.

“They treat me as a person not a number.”

“They are like friends, if I don’t keep in touch they send little notes and cards. I get trapped in my environment but they stop me from being alienated. They are not intrusive; they talk about everyday problems not just mental health. They also help with the practical stuff like washing etc. and when I almost lost all my possessions they tried to stop that happening.”

“In London I was just discharged and left by myself, but I get much more support here.”

“They are professionally different, they do normal things.”

“Hospitals treat you like you are not normal, I feel like I am looked down on. Julian Housing treat you as a person should be treated, they make a conscious effort to do that. I feel like I do when I am with my friends.”

“They give me help, but they do it with dignity, I don’t feel patronised.”

Advice and support

This series of questions looked at the different types of support the service users might need if they were distressed generally, or had problems with benefits or finance, housing or medication. Most said they would contact their Active Outreach worker if they were in distress. Some said they would talk to friends or family, but when asked which mental health worker they would contact, a majority said the worker from the Active Outreach Team. This was a similar response for housing issues and benefits, although some mentioned the specialist benefits worker attached to Julian Housing. One or two felt confident enough to contact their housing association or the council direct.

It was interesting that a majority of those interviewed said they would not contact the team about medication, as they were not seen to be ‘medical’, even though most of the service users knew that some of the team were qualified psychiatric nurses. The interviewees in the main said they would contact their CPN or their GP if they had medication problems, and some said that their psychiatrist would be the first port of call.

“I would contact my CPN, Julian Housing deals with all the other problems but my CPN deals with my medication.”

“If I was very upset I might contact my friend up the road, or even my CPN, but more likely I would contact Julian Housing.”

I went on to ask if they could talk to their Active Outreach worker about anything, and if there was any subject that they wouldn't want to talk about. Most of them said they could talk about anything and would be happy to talk about things they certainly would not share with other professionals, in particular their psychiatrist. One or two said there were certain things that they would not talk about; these were usually around relationships, especially sexual relationships.

“If I was really ill, I might not want to share things with them.”

“I wouldn't talk about my sex life – if I had one!”

“Maybe not about my drinking, I don't think that's anything to do with them.”

“I feel comfortable to talk about anything with them, that's what they're there for.”

Quality of life

The service users I interviewed had been in contact with the wider organisation for periods of up to ten years, and the shortest period of contact was one year. All but one of the service users felt that their quality of life had improved in some way since having regular contact with the Active Outreach Team. I used a checklist to see if their quality of life had improved in particular areas. This list was based on what service users around the UK have defined as being important to them, rather than looking at medication compliance and number of admissions. The checklist was as follows:

- living situation
- relationships with family
- relationships with other people

- use of leisure time and/or keeping occupied
- physical and mental health
- personal safety
- religious or spiritual needs.

There had been improvements in various areas of people's lives, but nobody reported improvement in all parts of their lives. The greatest improvement had been in their living situation – many interviewees had previously experienced problems with their tenancies, or had been in supported accommodation. Most were now living in their own flats, and were coping quite well with support from the Active Outreach Team. Relationships with family varied from having no contact through to improved relationships. One person had finally managed to break away from a very dominating and controlling family, and to live in his own flat with minimum contact with his family. This had given him more confidence and a better social life.

“They got me much better benefits, and helped me get my own flat.”

“They supported me through the death of my husband and I now have some contact with my family which I didn't before.”

The team had also helped to find voluntary work for service users who had previously been quite isolated. Others were part of a social group who went bowling, swimming or on trips to various places.

The team also arranged various outings for individual service users. One person in particular had just spent several days at a religious retreat, and had enjoyed it so much that she was very keen to go again. Another very popular pastime is the rock group, the local community finances this, and one of the team is also the bass player!

“I have my music and the rock group, we also go bowling – in fact life gets better and better!”

“I enjoy my voluntary work, it keeps me occupied and not so lonely.”

Some service users had quite complicated physical problems, which in the past had been neglected. These had improved with support from the team; they are happy to transport service users to hospital appointments for physiotherapy and other physical treatments. The team also went with service users to mental health outpatient appointments that in the past would have probably been missed. The team collect prescriptions from the doctors, and then pick up the medication from the chemists. They will ensure that the service user understands how the medication should be taken, and supply medication boxes with each dose clearly marked. This enables medication adherence to be more easily monitored. If the service users have religious or spiritual needs these are also supported, often by encouraging contact with local church groups.

“I am much more stable in my head, not all over the place like I used to be.”

Some of the service users also reported that they feel safer since the contact with the Active Outreach Team, that they had better relationships with neighbours, and did not feel as paranoid as they used to.

“I feel safer now, I didn’t used to, I was so paranoid I was like Yosser Hughes.”

“I do feel safer whilst they are around, they sorted out things with my neighbours for me.”

It appeared that another major task for the Active Outreach Team was shopping. Many of the service users in the past had suffered from severe self-neglect, and seldom went out. The team will support service users by taking them to supermarkets, and assisting with shopping, slowly withdrawing the

amount of support they give. They will start by helping with all aspects, from writing the shopping list to paying the cashier, slowly encouraging the service user to do each process alone. This has now reached the stage where some service users are just being given a lift to the shop and back, the person doing the rest themselves.

The team helps to boost the service user’s confidence and encourages them to do things for themselves, identifying their strengths and then building on them. Some of the service users were recently involved in interviewing for a new member of the team; this not only built confidence, but also made the users feel much more involved in the process as an active part of the service.

“It really was a good experience being part of the interview panel, it made me feel really good.”

“I saw them in hospital and they got me a flat. I have had the tenancy for ten years now, they have kept me out of hospital and they have built on my strengths.”

Continuity

Many service users do not like having to change workers, it is very important for them to build a trusting relationship with the key workers in their care provision. Change can provoke extreme anxiety, and for some service users can also exacerbate their mental distress. I asked the service users if they had had the same workers all of the time, and if not why this was. Most of the interviewees had at some point had a change in workers, but they all said that this was not too problematic because they all have a minimum of two workers at any one time. They also liked having more than one worker, because it means that if at any time one is sick or on leave, they can still see someone that they know and who knows their situation.

All of the changes were simply because the worker had left the team. I asked if anyone had requested a change in worker, but no one had felt the need to.

The service users said that the workers have different skills, and this can be an advantage – one worker may be good at sorting out benefits or housing, whilst they may feel more comfortable talking about family relationships with another. Only one person said that he disliked one of his previous workers, but he had not requested a change of worker because the other one was good. He also said that on reflection it could have been that his relationship with the new worker was so good that it made him feel that his relationship with his previous worker was worse than it really was.

“Three other workers I had just moved on to other jobs, but they all left at different times so I always had someone that I knew.”

“I feel that I can talk to ‘X’ easier than I do to ‘Y’ but they are both very good.”

The overall impression is that the service users had no problems with having two or more support workers, and that they do in fact prefer this method of working.

Satisfaction with the service

I asked the users what they liked and disliked about the Active Outreach Team. There was very little that the service users disliked, except one or two did say that they would like to have a ‘little bit’ more contact or visits at the weekend or in the evenings.

Although there is no out-of-hours service as such, the service users did say that they could leave a message on the answer phone, and the team did respond quickly. Some did not like the answer phone, but they accepted that there are limited resources. One service user said that she didn’t always know

which worker was going to be calling, and would like to know in advance who to expect.

“It’s all good but sometimes there is no one there when I ring.”

“Not enough visits and I would like to see them at weekends.”

Most of the service users said they really liked the service, they felt that it was good at providing practical help, and that they were treated with respect. Many of the interviewees commented on the fact that the workers did not put them under pressure, and worked at a pace that was comfortable for them. Other positive comments included that the workers were easy to get along with and were very friendly, that they spent time with clients, and didn’t just go in and out in five minutes like the nurse.

“They seem to know how to handle me, they are not patronising or intrusive, they help without me knowing I am getting help.”

“They have helped me with my correspondence and forms, also with my language difficulties.”

“They believe what I tell them, they really listen and don’t dismiss what I say.”

“They were the only visitors that I had when I was in hospital.”

Catch all

I also included a catch all question at the end, so that the interviewees could tell me about anything that they felt they had missed. I have included most of the comments in the main part of this report, however this final comment perhaps sums up how most of the service users felt.

“I trust them to point out things which might be going wrong, advise me about anything, they make my life more relaxed and much easier, I do totally trust them.”

Group discussion

The final meeting with service users was a large group discussion, where all of the users had been invited to an open forum. This was an informal meeting to discuss their experiences of the Active Outreach Team in a shared environment, with lunch provided. Fourteen service users attended the meeting (only six of these had been volunteers for the individual interviews). A very lively discussion ensued between many service users who had not met each other before this event. They quickly shared their views and opinions, about how different the service is compared to statutory services, and they all felt that it is far better at meeting their needs. When I raised the question of medication, they came to the conclusion that they didn't consider the service to be a 'medical model'. This is probably the reason why they don't generally go to the team with medication problems, but some might ask for support in raising these issues with their GP or psychiatrist.

The group also said that many of them had received an increase in their benefits payments after the Active Outreach Team had intervened. They all felt that this gave a real boost to their quality of life. Many had also been in debt, some had just put the demands and threatening letters in a drawer or the bin because they couldn't face the anxiety and worry. They now faced these problems with the support of the Active Outreach workers and had cleared their debts or in some cases had them wiped out. One person had a water bill for £1,200 wiped out; he said that he could not have paid it, and was afraid that the bailiffs might have come in if the team had not sorted the problem out.

The group also felt that the practical help they received was invaluable, none of them knew of any other service that provides this type of help. They liked the fact that they had someone to go with them to hospital appointments, and the shopping trips were also very popular. The social aspect was also very much appreciated. Many said that before their contact with the organisation they would not have been able to attend a meeting like the one they were now sitting in.

Some of the service users did not realise that the team did so many different things. This provoked a discussion about how they met individual needs, and all of the service users thought that the variety was the key. Some people needed practical support to sort out accommodation, or bills and money issues; others were just very socially isolated. They all thought it was excellent that one organisation could address all of these problems. It meant that if your needs were complex then you didn't have to go to several different agencies.

All of the feedback was positive; the only complaint was that people would like more of it, especially at weekends and in the evenings. Another idea was that a Julian Housing User Group might be useful. Some of the service users had already been involved in staff interviewing and some felt that a user meeting once a month or so might be a good idea.

“I had a social worker for most of my life but they just didn't help, they were more like police, they patronised me. Julian Housing really works for people.”

“They went with me to the dentist for an extraction, to the hospital when I had stomach problems, and I went on a river trip with them, which was great!”

Interview with carers

I interviewed the parents of one service user, as the Active Outreach Team sometimes works with carers and provides family support. I used the same format for this interview. The parents were very open about their problems and the difficulties they had experienced with mental health services. In the past they had felt very excluded from their son's care and did not understand his illness. However, they felt the team had provided them with much more information, and they now understood about their sons 'voices', which had eased some of their anxiety.

They were very pleased that their son had more of a social life, and had been bowling and to football matches with the social group. He would not leave the house at all before, but he is happy to go out with the Active Outreach workers. They also felt that they personally get a lot more support, and are very comfortable with the workers allocated to the family. They said that they are not rushed, that the meetings they have are quite long, and that it gave them a chance to raise all their issues without feeling under pressure. They said that the team had helped them with benefit issues and other practical needs. They also stated that the team were generally very supportive, and had really made a positive difference to family life. Their son is 38 years old and has been ill since he was 17, but the family feels that there has been a real improvement in recent years since they have had support from the team.

“They are very supportive, brilliant, explained to us what happens when our son hears voices etc. The CPN and doctors do not explain things to us. Our son also now gets DLA which has really helped.”



Interviews with Active Outreach Workers

I interviewed each of the team members and the service manager. These were fairly informal discussions exploring the following questions:

- How different is this to other ways of working?
- Are the pressures greater or lesser compared to working in other services?
- Does this service give you greater rewards/job satisfaction?
- Do you feel that your clients have a better quality of life?
- How do you set and keep boundaries?
- Do you feel supported by the rest of the team?
- Does it help to share clients?

All five of the outreach workers agreed that this is a very different way of working from their previous experiences, particularly in contrast with working in statutory sector services. They enjoyed the freedom and creativity that doesn't always fit easily within the structures of other parts of the system. They also felt there was a much greater degree of autonomy, the management structure is quite hands off, but they still feel totally supported. The manager had her finger on the pulse, whilst still allowing the team the freedom to work in their own ways. Some of the team felt that just having more time to work on a one-to-one basis was far more therapeutic, and allowing time for engagement also helped to enhance the therapeutic relationship. Seeing the service users for longer periods allowed them to identify and build on people's strengths, not just problem solve all of the time.



The pressures were not felt to be any lesser or greater, just different and much more tolerable. They would appreciate more time for practical office-based work, like answering telephone enquiries and making calls to other agencies, rather than being out on so many visits. Limited caseloads and the sharing of clients helped to ease the pressure. The team also receives a lot of supervision. A psychologist conducts some of these sessions and they find this particularly useful. Reflective practice and peer support helps when a staff member feels frustrated at the unfulfilled potential of some clients. Generally, the team was very happy with the way the pressure is handled and the whole organisation promotes a mentally healthy workplace.

Co-working means that each worker carries a caseload of around twenty but as there are five workers sharing fifty clients it works out to an average of ten, which is within the recommended number for this type of working. It also means that when a client is in distress or having some sort of crisis that demands a greater input, it can be shared which again reduces stress levels.

All members of the team said that they felt supported by each other and by the Julian Housing organisation. They liked the fact that if they had a stressful visit they could just have a 'download over a cup of coffee' with a co-worker. They also felt it was important that all members of the team were committed to this way of working. They supported and encouraged each other in finding fresh and creative ways of engaging with clients and meeting complex needs.

They all recognised that setting boundaries when working this way can be difficult, especially as they get to know clients very well. They spend a lot of time over long periods (sometimes several years) with clients, and although both parties (workers and service users) accept that it is not a real friendship, there is a large element of befriending to the work. It is important that they are always open and honest with the client, and make it clear that their role is one of 'worker'. The team acknowledged that this is sometimes difficult, and

boundaries do get blurred, but they try to work in a structured way. They all felt it was important to come across to the client as a person, and said that it helped to be able to share some of their personal information, for example to talk about their holidays or pets.

All members of the team said that they felt their work contributed to a better quality of life for the service users, and although the improvement can sometimes be painfully slow, in the long run this way of working is very rewarding. The service users set the pace and this means that the worker needs patience!

The team would certainly benefit from a community integration worker, who could take over the organising of social activities. The team would also like better access to psychology and clinical services. They sometimes find it difficult to access statutory sector services, such as inpatient beds, because they are based in the voluntary sector. However, their relationship with the statutory sector is getting better. Many of the statutory services that they have worked with do treat them as co-professionals and respect the work they do.

“Clients definitely have a better quality of life, the access to the dentist and doctors for one, they just wouldn't go if there was no one to go with them, or even just doing the shopping.”

“I am allowed to be creative, I have more freedom and autonomy, I also have support from Julian Housing to work this way and this allows me to do the job.”

“I am totally supported by the rest of the team, we are all included. In a sub-conscious way we do keep an eye on each other, make sure that we are all o.k.”

*“We try to work **with** clients, a holistic approach geared to their agenda and at their pace.”*

Service user questionnaire

The aim of this questionnaire is to determine if clients' lives have changed in any way since being supported by Julian Housing Active Outreach Team. An independent user interviewer will conduct all interviews. As well as one-to-one interviews there will also be an opportunity to attend a group discussion.

All clients will have a short explanation of the project before the interview commences; they will also be informed that the interviewer has personal experience of using mental health services.

1. What is the name of your support worker from Julian Housing? (This is to establish that they understand which service we are talking about. We will explain that we are not checking up on the worker, and anything they say will be confidential and no one will be identified in the report.)

2. Input into service/care plan

How did..... (insert worker's name) go about finding out what you wanted from them?

Did they ask you what you wanted them to help you with?

When you meet, who decides what you will talk about?

Can you ask for a meeting if you want one? What happens if you do?

Are you happy with the contact you have with Julian Housing?

Have you set any goals/targets aims with (...)? How were they set?

If you want to do something new how does (...) usually react?

If you don't want to do something how does (...) usually react?

3. Access to services

Are you receiving the type of mental health services that you feel you need?

(You may need to give examples of services.)

Are there some services that you would rather not have?

Does (...) help to make sure that you get the services that you want?

How is Julian Housing different to other services you have received?

4. Advice and support

Who would you contact if you were very upset? (If an unpaid carer or friend is mentioned then ask which worker they would contact).

Who would you contact if you had a problem with your benefits or finances?

Who would you contact if you had problems with your housing?

Who would you contact if you had problems with your medication?

Do you feel that you can talk to (...) about these types of problems?

Do you feel that you can talk to (...) about any problems?

Is there anything you wouldn't want to talk to (...) about?

5. Quality of life

How long have you been in contact with Julian Housing?

Has the support that you have received from them had an effect on your life?

Check list:

- living situation
- relationships with family
- relationships with other people
- use of leisure time
- keeping occupied
- physical and mental health
- personal safety (How safe do you feel?)
- religious or spiritual needs.

6. Continuity

Have you had the same support worker since you first joined Julian Housing?

If not – what happened?

Have you wanted to change your worker? If yes – did you (tell me about it)?

7. Satisfaction with the service

What do you like about Julian Housing?

What do you dislike about Julian Housing?

8. Catch all

Is there anything else you would like to tell me about Julian Housing?

Current client profile

(from McCrudden, 2000)

Total Team Caseload – 53

Gender

Male – 38

Female – 15

Age Range

16-25 – 3

26-35 – 8

36-45 – 19

46-55 – 16

56-65 – 6

65+ – 1

Diagnoses

Schizophrenia – 28

Dual diagnosis (mental health & substance misuse) – 8

Schizo-affective disorder – 6

Bi-polar disorders – 5

Severe depression – 2

Obsessive compulsive disorder – 2

Borderline personality disorder – 2

All 53 demonstrate a high level of vulnerability and/or risk in the community.

Client needs assessment

The number of service users with the team who need, or have needed, interventions in the following areas:

Individual, flexible home based support – 46

Help with financial welfare matters – 44

Daytime support and social opportunities – 36

Comprehensive medication review – 30

Complete physical and dental check – 29

Access to respite accommodation, as an alternative to admission – 18

Spiritual, cultural and religious support – 17

Access to employment and further education opportunities – 16

Carer support and education – 15

Specialist interventions e.g. CBT, relationship/family therapy – 15

Specialist supported accommodation – 10

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