Psychology in assertive outreach

Rachel Cooper, Kate Gendle, Cheryl Mould and Claire Ackroyd describe their work

When you think of a mental health worker, what image comes to mind? As a group of psychology staff working in an Assertive Outreach Team (AOT) we challenge the stereotype of the traditional therapist, and often find ourselves coming to work in our jeans and meeting clients in local cafes in order to make psychological therapies less threatening.

We primarily work with clients who suffer severe and enduring mental health difficulties (often psychosis), who find it hard to engage with traditional mental health services and have experienced frequent hospital admissions. Some AOT clients are also homeless or have a dual diagnosis with substance misuse or personality disorder.

Outreach community treatment originated in the USA (Stein & Test, 1980). The Sainsbury Centre for Mental Health (1998) recommended the development of AOTs, and the National Service Framework for Mental Health outlined the role (Department of Health, 1999). Much has been written about this way of working, its adaptation to the British health system and its effectiveness (Hemming et al., 1999; Marks et al., 1994; Priebe et al., 2004).

Such research has suggested that for AOT to be effective, there are several critical factors. These include defined duties and expectations of staff, and small case loads (Hemming et al., 1999). The small caseload allows for an intense approach, where clients can be seen daily if necessary. AOTs also use a team approach, which means that all of the members of the team have an awareness of all of the clients. The Sainsbury Centre for Mental Health (1998) also suggests that there are fundamental interventions for an AOT to be involved in: medication management, crisis intervention, family interventions and psychological therapies. When the above structure and interventions are adhered to, AOT is shown to decrease hospital admission (Hambridge & Rosen, 1994).

Cheryl Mould, Kate Gendle, Claire Ackroyd and Rachel Cooper

Perhaps the main role for psychology within an AOT is promoting stable engagement: actually getting the client to take part. It can be difficult to apply traditional therapies if the client is inconsistent in their attendance, or less motivated than other groups to think about the work between sessions. Therefore therapy needs to be carried out in a creative way, with the therapist mindful of these difficulties.

This variable nature of the work that needs to be carried out, ranging from generic work to promote engagement to the complex nature of the client's particular needs, can lead to problems with role confusion for psychologists working in AOT (Cupitt, 2001; Yates, 2004). We hope that our article serves to illustrate the role of the psychologist in assertive outreach, and to show the reader that it is a fascinating and valued approach within the health service.

Our work

Our Severe Mental Illness Psychology Service (SMI) was set up in early 2005 in the Humber Mental Health Teaching Trust. SMI covers two AOTs, one urban and one rural. The rural team is split into four subteams. Along with two consultant clinical psychologists, there is a clinical psychologist, a cognitive-behavioural therapist and a trainee psychology associate in SMI. The specialty also offers placements to clinical psychology trainees.

Prior to the development of SMI, psychology input to AOT was very limited. SMI reflects a modern way of organising psychological services within the NHS, in line with National Institute for Clinical Excellence guidelines (e.g. recommending the use of psychosocial methods such as CBT and family interventions in the treatment of schizophrenia). Of course, other professions in AOTs have often received a level of psychological training and naturally they wish to use these skills in the workplace. We are not here to make their input redundant. But it may be that in times of stress, non-psychology staff often

references

Cupitt, C. (2001). Developing psychology posts in assertive outreach. *Clinical Psychology, 5*, 48–50.

Cupitt, C. & Meddings, S. (2006). *Clinical psychologists and assertive outreach*. Leicester: British Psychological Society.

Department of Health. (1999). *National Service Framework for Mental Health*. London: Department of Health.

Hambridge, J.A. & Rosen, A. (1994). Assertive community treatment for the seriously mentally ill in suburban Sydney. *Australian and New Zealand Journal of Psychiatry, 28*, 438–445.

Hemming, M., Morgan, S. & O'Halloran, P. (1999). Assertive outreach: Implications for the development of the model in the UK. *Journal of Mental Health, 8*, 141–147.

Marks, I.M., Connolly, J., Muijen, M. et al. (1994). Home-based versus hospital-based care for people with serious mental illness. *British Journal of Psychiatry, 165*, 179–194.

Priebe, S., Fakhoury, W., White, I. et al. (2004). Characteristics of teams, staff and patients: Associations with outcomes of patients in assertive outreach. *British Journal of Psychiatry, 185*, 306–311.

Sainsbury Centre for Mental Health (1998). *Keys to engagement: Review of care for people with severe mental illness who are hard to engage with services*. London: Author.

Stein, L.I. & Test, M.A. (1980). Alternative to mental hospital treatment. *Archives of General Psychiatry, 37*, 392–397.

Yates, K. (2004). The experiences of clinical psychologists in assertive outreach. *Clinical Psychology, 33*, 8–11.

revert to biomedical conceptualisations (Yates, 2004): we can play an invaluable role in supporting them to maximise their skills.

In working alongside other AOT staff, we can deliver comprehensive multidisciplinary assessments and risk assessments, offer a range of interventions (family, substance misuse, CBT, relapse prevention), and work with clients in their chosen location. Then there is indirect clinical work, away from the client. This includes client formulations (describing a person's presenting problems and their theory in order to make explanatory inferences about causes and maintaining factors that can inform interventions); offering team and individual supervision; and being an active team member through attending time out days and service development meetings. Since medication management is beyond the scope of our training we have not become specifically involved with these issues, but we have shown psychological work with clients to be useful in promoting insight and the need for concordance with their medication regime.

By surveying the AOT staff we found out that they perceive formulation skills to be the area where psychology can be most helpful, enabling the team to expand their understanding of the client and incorporate psychological ways of working into care plans. For this reason we have introduced formulation meetings, during which staff discuss a client to develop a better understanding of their presentation. This in turn seems to enhance empathy towards them.

Risk assessment is also an important part of our role. In AOT, risk is increased because we commit to seeing the clients in their chosen environment – often difficult circumstances. Risk assessments can include the level of client distress and its impact on their behaviour, the environment that the client is in and the changeable nature of a client's presentation. It can seem that a lot of time is spent in daily discussion about risks, but with the complex casework of the teams this discussion and reflection is critical. It reduces risk to a level acceptable to all team members, balancing the needs of the service with the needs of the client.

Support to families and carers is also offered by SMI. This has been readily accepted, and we have given talks about our service to the local Rethink carers' group. As an invaluable support system for the client, AOT will welcome carer work wherever possible. In fact they often offer a service to family groups where more than one member has severe and enduring mental health problems. Carers are offered an assessment in their own right by the AOT, thus acknowledging the stress that they are often under. SMI staff have also helped the AOTs to access formal family therapy where appropriate.

Challenges and solutions

Sometimes in AOT it is easy to feel that we are not doing 'real' psychology (Yates 2004) as there is a demand for the psychologist to carry out generic work as well as specialist. Having the opportunity to discuss these issues with our SMI peers through specialty meetings has left us feeling stronger as a staff group. It has enabled us to go back to our AOTs feeling more confident in our roles, including a certain amount of generic work. We also share our skills and discuss literature in these meetings. This maximises the skill mix of the psychology team, and enables us to draw on our differing experience and training. With the complexity of the client group, this support and sense of identity is invaluable.

> "Perhaps the main role for psychology within an AOT is promoting stable engagement... getting the client to take part"

One potential disadvantage of the model of working we use is that all members of SMI work in the AOTs part-time. This can reduce flexibility, and impact on engagement with a chaotic client. We were also concerned about this issue in relation to having trainee psychologists in the AOT – perhaps trainees on a six-month placement would not be with the team long enough to allow for the client's engagement difficulties? However, we have organised our service to minimise the impact of these issues by allocating a named staff member to each of the teams, whilst consulting each other if there are particular skills we can share, and also ensuring that the minimum length of placement with the teams is one year.

Summary

Many aspects of our work we have identified here closely relate to the role of psychology in the model of assertive outreach as described by Cupitt and Meddings (2006). This is reassuring, after spending time wondering if this relatively new service was meeting its aims. Thankfully, the AOTs also perceive psychology services to be of value, especially in developing a deeper understanding of the client's presentation. Our fortunate skill mix has allowed us to share skills and work across teams, responding to local needs.

In terms of development of the service we are enjoying a period of consolidation with a stable staff group and developing a consistent presence in the teams. We are also working hard to further develop our relationships with the AOTs, meeting periodically with team leaders and staff to discuss the way forward so that we can offer a valuable service, responsive to any changes in need.

As a staff team, we find it a rewarding challenge to come out from behind our desks, and we hope that this article will help some readers to consider this area of clinical work. We close with an acknowledgement that not all AOT's have input from psychology, despite Cupitt's (2001) suggestion that the inclusion of a psychology post in an AOT should be given high priority. These vulnerable clients are missing valuable input.

Rachel Cooper, *CBT Therapist;* **Dr Kate Gendle**, *Consultant Clinical Psychologist;* **Cheryl Mould**, *Trainee Psychology Associate; and* **Dr Claire Ackroyd**, *Clinical Psychologist, The Psychology Department, College House, Willerby Hill, Beverley Road, Willerby HU10 6XB*
Kate.Gendle@humber.nhs.uk

Calling all practitioners

Practitioners make up the bulk of the readership of *The Psychologist*, but we receive few submissions from them. As a membership publication we rely on your contributions, and our authors report that writing for us is a very positive and productive experience. We'd like to use the redesign of *The Psychologist* as an opportunity to ask all practitioners to take a fresh look at the publication.

Why not give it a go?

Formats include articles, debates, interviews, 'personal space' pieces, and the 'working lives' format. Put simply, we are looking for topics and style that will both engage and inform our wide-ranging audience. It's a great way to reach 45,000 psychologists from all corners of the discipline and to highlight important developments in practice.

To discuss ideas or to submit your article, e-mail the Editor, Dr Jon Sutton, on jonsut@bps.org.uk