Appropriate referral to assertive outreach teams

Assertive outreach teams offer a means of engaging clients who used to fall through the net. But the model is designed for a particular client group and, say Lucy Toynbee and Danny Allen, there are significant problems associated with using the team as a 'catch-all' service for difficult-to-manage clients

When the government made the decision to set up assertive outreach teams (AOTs) nationwide, the decision was based on a well-established evidence base (Stein and Test 1980). Because of the challenges posed by AOT clients who have a history of non-engagement with mainstream services, AOTs often attract some of the most experienced staff. This means that they will be adept at dealing with most problems presented by mental health clients.

At the same time, generic community mental health teams (CMHTs) can become stripped of these same staff as their more difficult-to-manage clients are transferred to other specialist teams. The consequence of this is twofold: a deskilling of the team and the development of a risk-averse culture where risk is seen as something for 'specialists' to manage.

It can be very tempting for CMHTs to refer to AOTs clients who, frankly, should be managed 'in-house' or in other settings that do not exist locally, such as community forensic teams. While this might, superficially, seem to help the larger organisation, the evidence base for AOTs being able to add value to the care of this client group is lacking (Burns 2004). Worse still, deviating from a recognised model may have detrimental effects on the nominated client, other clients in the team, the team itself and the larger organisation.

Non-engagement as a concept

The concept of non–engagement lies at the heart of the AOT model. However, in our experience there is widespread misunderstanding in mental health services about what 'non-engagement' means. Along with non-engagement, the other primary criterion for acceptance into an AOT is the existence of a severe and enduring mental illness (SEMI).

Although this might seem straightforward, a lot of detective work is sometimes required to determine if the client has a SEMI and if he or she is hard to engage. AOTs screen for several secondary factors to assist in establishing the existence of a SEMI, a process that also requires help from mental health services. It is possible, for example, that a person could have a SEMI and be non-engaging with mental health teams but be faring well and not be in need of any external support.

These secondary factors commonly include dual diagnosis, a history of self-neglect, repeated hospital admissions, a chaotic lifestyle and housing problems. Referring agents often misconstrue these criteria; they see the secondary list as having equal weight as the primary, thus thinking that AOTs specialise in working with difficult-to-manage clients. However, the training AOT staff receive and the special skills they develop focus on developing a good therapeutic relationship with clients with a primary diagnosis of SEMI who have not engaged with the CMHT at all. This is defined as non-engagement in the face of concerted efforts from CMHT staff over a period of between six months and a year and, significantly, does not include clients who periodically disengage when relapsing. Such clients are the 'bread and butter' of CMHT work as it is a characteristic of people with a SEMI to believe that they do not have a mental health disorder and so do not to want to have any contact with a service that is for mentally ill people.

The therapeutic relationship that AOT staff are so good at developing with previously non-engaged clients is a powerful determinant of how well a client will do (Priebe and Gruyters 1993). The ability to develop this depends on other aspects of the AOT model, such as relatively small caseloads and offering a seamless service. Clearly this sort of service has the potential to benefit a wider range of clients but, significantly, not alongside AOT clients, for reasons explained below.

How assertive outreach teams work

A core component of AOT work is the whole-team approach whereby all members will visit every client over time. Given that it is only through a trusting relationship that therapeutic work can be done, the AOT accepts that this can take a long time to build up. In the case of appropriate referrals, clients do not have any form of meaningful relationship with the CMHT, and, despite having been ostensibly under its care, the chances are that these clients would not even know the name of their care co-ordinator and would not want anything to do with mental health services. In such cases, the client has nothing to lose by the transition to AOT – there is nothing of any value between the client and the CMHT staff who have been trying to get involved.

When people are accepted by an AOT they experience neither any sense of loss nor of rejection. It is from this position that the AOT starts a process of forming a therapeutic relationship from scratch. While transition between teams is known normally to be a time of high risk – for example, increased suicide rates when clients move from inpatient to outpatient care (Crawford 2004) – the person who is referred appropriately to an AOT is not likely to have any such increased risk when the slow process of building a relationship starts.

Mismatches in expectations

In our experience, many mental health staff not only misunderstand the concept of engagement, but are also ignorant of how AOTs work with people and how this model may affect clients. If an AOT accepts clients who are (even only partially) engaging with their CMHT, no matter how many secondary risk factors there are, we are contributing to the removal of a support network to which the client has become accustomed. It may appear to staff trying to work with such clients that the relationship is not therapeutic

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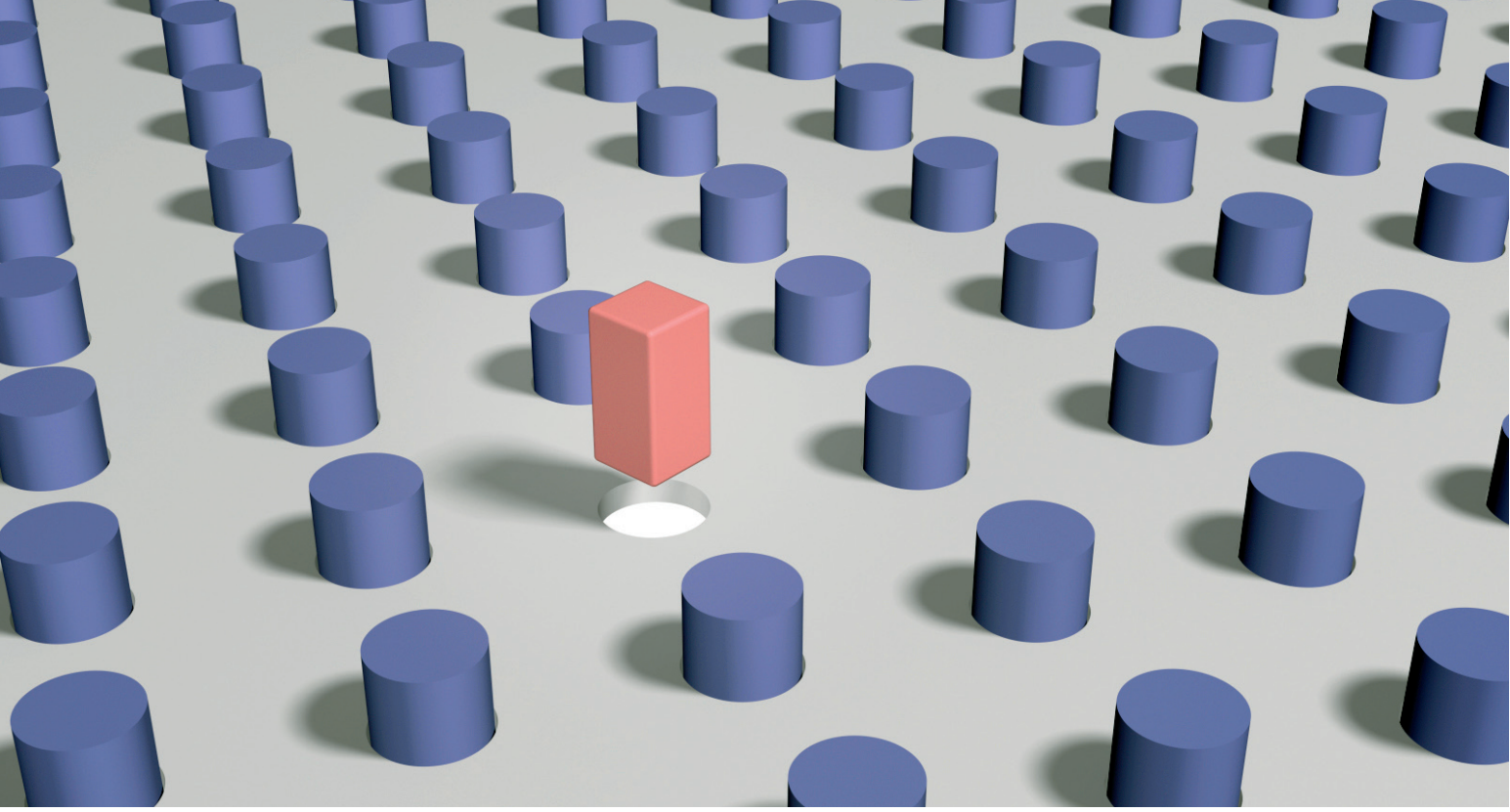

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and that there is no sense of any progress being made.

However, it is likely that the client is not only dependent on the small CMHT care team with which he or she is involved, but does in fact have a therapeutic relationship with the team, however flawed this might seem to the professionals involved.

It may, therefore, be difficult for clients to make the change from having two or three familiar faces coming to see them to as many as eight or nine unfamiliar AOT professionals. For these clients the impact of the transition to an AOT from a CMHT may be quite negative, with all the risk and detriment that this might entail.

Our view is that referring to AOTs severely mentally ill clients, who are (even only partially) engaging with the CMHT on the grounds that the clients are simply deemed chaotic (Burns 2004), high risk and hard to manage, is analogous to referring a pregnant woman with a high risk of miscarriage to an oncologist to treat her severe morning sickness and pain from Braxton Hicks contractions on the grounds that oncologists are particularly skilful at treating people with severe nausea and pain. Both miss the point about the primary skill-base of the practitioners referred to.

Maintaining the model

We have found that there is a commonly held myth that an AOTs' capacity to work more intensively with clients means that they are best placed to manage 'at-risk' clients. Many staff believe that, even if a client does not meet the criteria for acceptance by an AOT, our therapeutic approach is effective with any mentally ill client.

One consequence of this widespread belief is that senior managers, keen to resolve conflicts between referring CMHTs and AOTs, can find it tempting to override the autonomy of AOTs. We believe that, as well as challenging the beliefs that underlie this approach, the mere act of undermining team autonomy can have detrimental effects, which have the capacity to reverberate through the organisation.

Accepting inappropriate clients fills up our caseload which in turns prevents us taking on appropriate clients with whom we have the real expertise to work, and for whom we can achieve a very positive impact on their quality of life.

Working with inappropriate clients is demoralising for a team that has been specially trained and equipped to work with people with severe and enduring mental health problems and complex needs, and who are unwilling or unable to engage with existing mental health services (Libberton 2000).

From our own long experience of working in CMHTs, we know that there are many people with secondary risk factors and management problems who do not meet AOT criteria. Once we accept one client others will be referred. Not only will AOTs feel under pressure to accept them but in the process CMHT staff run a real risk of becoming deskilled.

AOT staff need to feel that their special expertise is being heeded. The original assessor, and in fact the whole team, is deskilled if they are not the arbiters of whether to accept or decline clients on the basis of the AOT model.

These issues affect the quality of the team's work so there is an indirect adverse effect on all the clients managed by the team.

If a client is engaging with staff from the CMHT, albeit only partially, he or she is likely to experience a sense of loss or rejection when transferred to an AOT, with all the attendant risks of morbidity and mortality.

Conclusions

It is vital that AOT and CMHT staff have a good shared understanding of what is meant by the term 'engagement' through a process of information and education, and that inappropriate referrals are not accepted, however superficially tempting this may seem. To do so can be damaging to the individual, the whole client group and staff teams.

AOTs should be judged on what they are established to achieve with this very difficult client group, and this should be agreed by stakeholders. The Department of Health has rightly made clear that any change in emphasis to simply increase a team's number of clients by taking on people who are not suitable for AOTs should be avoided (Care Services Improvement Partnership 2005) ■

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