Norfolk and Waveney NHS
Mental Health Partnership
NHS Trust

THE NORWICH ASSERTIVE OUTREACH SERVICES

The Norwich Assertive Outreach Service consists of the City Outreach Team [NWMHP Trust], located in the Statutory Sector, and the Active Outreach Team [Julian Housing Support] located in the Voluntary Sector. The remit of both teams is to work with those clients who have complex needs, and who, for whatever reason, find it difficult to remain in contact with mental health services.

Both AOS Teams are among the longest running in the UK. Initially AO was seen as a potentially lifelong service for its client group, however in the past eight years, with the development of recovery focussed services and approaches, the goalposts have changed. Discharge is now an option and a challenge for both assertive outreach services and their clients.

Partnership working

Each team has their own distinct philosophy and operational procedures, guided by Assertive Outreach principles. They have their own management and recording structures, supervision, and offer different approaches to the delivery of an Assertive Outreach service. This diversity offers choice to clients and creative options for the delivery of a service, which has similar aims. Each team offers a creative, team based approach, with the aim of providing a service that will reduce a client's level of vulnerability, increase their control over their life, and work towards recovery for that individual.

Both teams have collaborated closely in the past and continue to do so, by sharing training and supervision and the development of the AOEIU [Assertive Outreach & Early Intervention Umbrella]. Building on this collaboration, in order to provide an effective Assertive Outreach service for the Norwich City Locality, and to improve choice for this client group, all referrals for both teams will be assessed jointly.

Indicators for considering a client's need for Assertive Outreach

This service is for people aged between 18-65yrs registered with a GP practice in the Norwich City Primary Care Trust [COT] or Norwich Locality [JHAOT] who:

- Have a severe and enduring mental illness, with multiple and complex needs which require a coordinated input, but who have found it difficult to engage with services in the past.

The person will demonstrate at least **one** of the following indicators:

- Significant risk to self
- Significant risk of self-neglect
- Significant risk to others, based on recent history and current mental state

The person will also demonstrate at least **eight** of the following indicators:

- High use of inpatient admission
- Requires intensive input and monitoring [e.g. more than weekly visits]
- Finds it difficult to engage with services; or services with them
- Poor medication concordance
- Generally poor or unstable motivation
- Difficulty in forming relationships
- Regularly uses alcohol and/or illicit substances, which have a detrimental affect on their living skills
- Previous contact with the Criminal Justice System
- Poor family or social support
- Housing difficulties
- Unstable work or education history

This service is **NOT** for people who:

- Have a primary organic mental disorder
- Have a primary diagnosis of a personality disorder
- Have a primary alcohol or illicit substance use difficulty

Please note Julian Housing do not work with people who are in supported accommodation, unless it is part of a clearly defined period prior to their move on to independent accommodation.

It is important that Assertive Outreach Teams and referrers are clear about the eligibility criteria. A common cause of confusion appears to be the reference to clients as 'difficult to engage' or 'difficult behaviour to manage'. A helpful interpretation of 'difficult to engage' [Cornwall AO Team] defines the clients as: Those who have difficulty in engaging meaningfully with existing mental health services, who could be characterised by:

- Individuals feeling discriminated against and stigmatised by existing services
- An active refusal to engage
- Consistent problems with maintaining contact with existing services
- Existing services may have been unable to identify and engage an individual

The Referral Process

If a client meets the above indicators, following discussion with the current care team, **both a comprehensive letter stating the need for Assertive Outreach including what has already been attempted, or the Joint**

Norwich Assertive Outreach Service Referral Form, and copies of all current CPA documentation including risk assessments should be completed and sent to either the COT or JHAOT Team Manager.

The monthly City Locality Assertive Outreach Service referral meeting is held at 11.30hrs on each 4th Thursday of the month in room B19 at 80SS, whereby all referrals will be discussed. If the referral indicates an assessment is appropriate, it will be prioritised, according to the need and level of vulnerability of the current referrals, and the capacity of both teams. It would be helpful if the referrer could participate in the referral meeting to help aid the decision making process.

The initial assessment will be jointly undertaken by a member from each team, [COT & JHAOT], as far as is possible. This is to enable a decision as to which team can best meet the client's current needs.

This assessment should be completed by the next referral meeting, at which the outcome will be discussed. There may be several options, it may be proposed that a set period of joint working with the referring care team may be undertaken by one of the AO teams, or, that it had been identified that one of the teams should continue the assessment process. There may be an assessment period of up to three months, during which time case responsibility remains with the referring team. The Assertive Outreach Service Team may make appropriate interventions to facilitate engagement; and will work jointly with the existing team during this period.

Once a decision is made about the appropriateness, or otherwise, of the client for the AO Service a CPA/S117 **must** be convened and formally allocated to the new team. If the COT accepts the client, at this point care coordination will be handed over to the identified COT worker.
Please note that if the client is accepted by the JHAOT, currently the care coordinator remains unchanged. Also if the client is currently an inpatient, the COT cannot take over as care coordinator until the discharge CPA/S117.

Discharge from the Assertive Outreach Service

Assertive Outreach is not a time-limited service. It may take several years to establish a positive and helpful engagement with a client, even before working towards greater stability and the individual's goals.
In line with Assertive Outreach principles and a recovery-focussed approach, as good practice, both teams operate a policy of "positive graduated disengagement". This recognises that they are working with people who have either lost, or never had the opportunity to establish their trust in mental health services. Their previous experiences of a period of contact with services followed by discharge to situations of coping without support, has led them to the disengagement that has warranted their referral for Assertive Outreach. Clients are supported to take control of the process of disengagement by

developing parallel engagement in other valued relationships in their lives. Wherever possible, real connections are established in the person's social network, and longer-term crisis and contingency plans put into place. When considering discharge from the AO service, the teams will refer the client back to the appropriate service e.g. the CMHT or GP. In both cases the team will jointly work with the new service and the client to facilitate a supported handover. It is interesting to note that the initial research into discharge from AO services indicates that if the level of support is not provided, as is in place at point of discharge, then all benefits of AO are lost within two years. Both teams have a policy of informal contact with the client, if needed; following discharge to ensure 'disengagement' does not reoccur. When discharged from the COT, for a period of six months, the team can be approached to advise, joint work with the new team, or re-engage with the client should a serious problem occur.
Demand and capacity is an ongoing issue for all mental health services. In Assertive Outreach the 'throughput' is, by nature, slow, and the team has an identified maximum capacity. Nationally, the discharge of AO clients is a major problem, and no area has yet managed to successfully solve this dilemma. Originally it was considered to be a long-term [up to lifetime] service for clients, however, over the past 8 years the debate has continued, and it is now suggested that although a small proportion of clients may require this service for life, the majority of clients will at some point, be able to move on [Lambert, J; Burgess, D. 2003 unpublished]. Burns, T; and Firn, M. [2002] report that their team experiences around a 10% turnover of caseload per year, and for individual clients it represents a potential time with the team of ten years. However they acknowledge that experience is restricted by the lifetime of current teams in operation.