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Reaching and supporting Londoners with severe
mental health problems

EXECUTIVE SUMMARY

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The Sainsbury Centre for Mental Health is a registered charity, working to improve the quality of life for people with severe mental health problems. It aims to influence national policy and encourage good practice in mental health services, through a coordinated programme of research, training and development. The Centre is affiliated to King's College London.

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Executive summary

The team has brought me a better understanding of mental illness and I feel able to deal with it. Before I ignored it and I wasn't able to deal with it, and I didn't want to accept help.

Lambeth client

The background

The care of people with severe and long-term mental health problems who do not want to use, or 'engage' with, services presents a major challenge. They may not get the treatment they need. They often have additional problems with money, housing, employment, education and training. Some also have problems of substance misuse. As a result, they may experience social exclusion. People from some black and minority ethnic communities are fearful of mental health services and may be more excluded. Assertive outreach services have been shown to be effective in helping people with these problems.

Assertive outreach is a way of organising intensive, user-centred community mental health care and support for people with severe problems who will not readily engage with services. Assertive outreach has become a central plank of mental health policy. After brief references in the *National Service Framework for Mental Health*, interest in and commitment to developing the approach increased. Assertive outreach was named as a key component of community mental health policy in the *NHS Plan* and its importance was emphasised in *The Mental Health Policy Implementation Guide*.

The Working Together in London programme was set up by the King's Fund, the Sainsbury Centre for Mental Health and the Department of Health to establish assertive outreach teams and develop new ways of working that can bring about the social inclusion of people with severe and long-term mental health problems, by helping them to find housing, work and a social network.

The teams

The programme supported the setting up of three pilot teams – the Antenna service in Haringey, the Islington Assertive Outreach Team and Lambeth Early Onset – that would use the assertive outreach approach to help this difficult-to-reach client group.

The teams in this study also formed partnerships with other organisations within and outside the mental health field, so that the benefits might be felt not just by the programme's clients but also by anyone with mental health problems locally.

Antenna, Haringey

The Antenna assertive outreach team in north London provides a culturally sensitive service to young people from African and Caribbean communities, with staff recruited from the communities. The service offers support and advice to families and other carers. It works beyond the boundaries of mental health services to help young people with serious mental health problems to achieve a better quality of life.

Islington Assertive Outreach Team

The Islington team, also in north London, works with an older group of clients who have experienced serious problems over a long period. Working with dual diagnosis is a particular feature of the team's work and links are being forged with the wide variety of ethnic minority communities living in the area.

Lambeth Early Onset

Lambeth Early Onset (LEO), in south London, provides services to a younger group of clients who have already experienced the onset of severe mental health problems. The team works to reduce the trauma of contact with mental health services and, by working closely with education and employment, aims to promote recovery. User and carer groups are a particular feature of the team's work.

The effectiveness of the teams was assessed by researchers from the Sainsbury Centre for Mental Health and the Centre for the Economics of Mental Health. The researchers asked a range of local stakeholders for their views on the programme.

Service users of the three teams were also asked for their views on the assertive outreach services.

Findings

Tackling social exclusion

On many occasions, service users were able to give examples of how they had been helped with housing, employment, education, leisure, religion, benefits and with their family relationships. These are all areas that are central to social inclusion. Users said that they felt better, not just in terms of their mental health, but also about their lives in general.

Developing sustainable partnerships

The review shows that new partnerships are needed if services working with people who experience serious and long-term problems are to be able to help them gain a better

quality of life. However, these partnerships are not easy to forge and sustain. Mental health services have to prioritise development of new partnerships if they are to make a lasting difference for service users.

Integrating new services

New services cannot be introduced without significant impact on existing services. Failure to deal with the potential impact of new developments may mean that new services struggle to work in the most effective way. Assertive outreach services deal with a very specific group of users but must be integrated with other community health and in-patient services.

Implementing key success factors

The Government has determined that there should be 220 teams by April 2003; therefore many localities are currently developing their assertive outreach services. The review shows that there are key factors for success in developing these new services: multi-disciplinary teams are needed, working with a team-based approach but specialist inputs are also needed. A balance between the medical and social approaches is needed, and all teams must respond to cultural diversity.

The recommendations

The report concludes with recommendations for policy-makers and service providers on the following themes:



Promoting the social inclusion of people with mental health problems

Standard 1 of the NSF concerns mental health promotion and combating discrimination; it has provided an important impetus to tackling exclusion, but it is still limited in scope:

- Developing partnerships with local agencies outside the mental health field must be specified as part of the mainstream work of mental health services.
- Commissioners should give priority to developing and sustaining partnerships with housing agencies, welfare benefits service and advice agencies and education and training providers.
- Partnership working must be properly resourced and there should be a dedicated community development worker in each assertive outreach team.

Working in partnership with the community

Community support can make the work of mental health services more acceptable:

- Mental health services need to engage with community groups and offer them support – information, training and joint working – as well as grant aid; this is particularly important for people from black and ethnic minority communities.
- Mental health problems are particularly common in deprived communities, and therefore mental health agencies will often be operating in the same neighbourhoods as urban regeneration programmes and neighbourhood development schemes. Mental health services need to participate in the planning and implementation of these schemes, both to advance the interests of people with known mental health problems and to promote new ways of thinking about mental health in the community.
- Spirituality and religious observance are known to be very important to many people with severe mental health problems. Mental health services should therefore aim to form partnerships with faith communities, which may have their own support systems for people with such problems.

Establishing and maintaining assertive outreach teams

Plans to set up new teams should be realistic if the considerable investment they represent is not to be lost by failure at a later stage.

Trusts should:

- allocate time and resources for recruitment and team training
- provide development support for both new and existing teams
- recruit from a range of disciplines initially, but re-balance skills and experience within the team as it works towards meeting the needs of its target group.

Assertive outreach teams:

- must be able to offer a full range of bio-psycho-social interventions if clients are to engage with services, receive high-quality and up-to-date treatment and improve their quality of life
- may need additional specialist resources (such as in dual diagnosis) to complement, rather than replace, the work of other team members
- should work to prescribed standards, but can adapt their approach to conform to local cultural norms
- should have a clear understanding about the balance between the medical and the social approaches and about team organisation if their staff are to achieve sustainable working arrangements.

Achieving a more integrated system of mental health services

Assertive outreach teams should give early priority to forming working relationships with existing mental health services (including in-patient teams), with other new teams (such as

crisis resolution) and with primary care. They should aim to develop an approach that will, over time, reduce reliance on expensive in-patient beds for crisis admissions and for lengthy hospital stays:

- A local communications programme is needed early on to advise on the functions and potential of any new teams – assertive outreach, crisis resolution or early intervention – and on how their work will relate to existing services.
- Arrangements for referral and for the acceptance of clients must be agreed with existing services: in particular, the speed and nature of the referral process.
- Assertive outreach teams must monitor the use of in-patient beds by their clients and plan to change the nature of these admissions over time.
- The possible effects of research intervention need be assessed at the beginning of a programme and explained within the mental health system. Monitoring systems should identify unintended effects so that these can be tackled.
- In order to maximise referrals from primary care, assertive outreach teams will need to explain to primary care trusts what their role, functions and potential are.

The following real-life case studies have been written by the assertive outreach project teams. The names of the clients have been changed.



CASE STUDY: KHADIJA

Khadija is a young Somalian woman who lives at home with her family. She came to England ten years ago and had difficulties learning English. Shy and timid at school, Khadija left with no formal qualifications. She remained shy and isolated, rarely leaving her home. She didn't want to wash or keep her room clean and she ate very little.

Khadija was referred to mental health services and admitted to hospital under the Mental Health Act, but her family found it difficult to accept that she had a mental health problem. During her hospital stay, Khadija began to communicate with people. She was interested by occupational therapy and was willing to take medication. But, when she went home Khadija's condition gradually worsened again. She refused to take medication or to agree to any treatment.

The assertive outreach team became involved to help Khadija change her behaviour by getting her out into the community and developing a care plan for longer-term development. Staff took her out for short walks and then to local shops and eventually to the cinema. The aim was to help her develop confidence to make informed choices, and to be able to return to education. The team arranged for home tuition and later helped Khadija enrol on a college course.

With intense support from the team's family co-ordinator and from the team psychiatrist, the family has seen the value of medication in helping Khadija to achieve her goals. This has helped her to carry on studying and she now looks after herself better, and keeps her room at home reasonably clean and tidy.

The team will continue to be involved with Khadija to support her in attending her course, and in being a part of the community, as well as maintaining her medication to improve her mental health and her involvement in activities outside the home.



CASE STUDY: DAVID

David is 20 years old, single and lives with his family. At 17 he had his first contact with mental health services. Following an interview with a counsellor, he was formally assessed and found to have psychotic symptoms. After an informal overnight admission to a local acute hospital ward, he and his family decided he should go home. Soon afterwards, David was seen by a local community mental health team, but he rarely attended appointments, and didn't take – or even collect – his prescription for anti-psychotic medication. About seven months after this first admission, his mother took him back to the team because his behaviour had deteriorated and was increasingly difficult for the family to manage.

This led to David's second hospital admission – this time under the Mental Health Act – lasting five months. The assertive outreach team became involved and plans were made to discharge him from hospital, using the Care Programme Approach. David and his family were seen weekly by the team, who discussed his problems, the recent admission, and how things could move forward for him.

David wanted to work. He got a job but struggled to cope. The long hours meant that he was often tired and he started to take his tablets intermittently. After two months he was relapsing. Although David denied any problems, his family reported early signs of relapsing. These signs had been identified earlier with David and his family, and a plan had been agreed to manage them. David continued to deny his problems but team visits and discussions were increased to provide support for him and his family.

As problems became more pronounced, there was increasing tension in the family home, with arguments and damage to property. The team started to visit every day to offer support and to ensure that David was following his prescription. The relapse lasted about three months but admission to hospital was avoided.

David slowly recovered, and efforts were made to help him find work or training and to find independent accommodation. He completed a pre-employment training course, and was interviewed successfully for supported housing. He has now recovered fully from his relapse and hasn't had to go into hospital.

The team's approach shows how the assertive outreach approach was extremely effective. The team offered a seven-day-a-week service, combined with assertive outreach interventions, using a psychosocial model: helping David to explore and gain employment and training, and housing. They worked with family support and with David to help him understand his illness, and to learn skills to cope with it. The work that the team did to gain his trust, and help him through his relapse, was essential to this positive outcome.