

'Strengths' Assertive Outreach: A Review of Seven Practice Development Programmes

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Abstract

Assertive outreach is based on extensive international research and has been promoted in the UK in 1999 as a key area of the *National Service Framework for Mental Health*. Its primary aim is to provide a specialist service for people disengaged from traditional approaches of mental health services, but very little attention has been paid to how such services can be developed. Practice Based Evidence, a practice development consultancy, has engaged seven assertive outreach teams to focus on development first, and follow-up evaluation of the impact of reflective practice on team functioning. This has prompted a number of strengths-based recommendations for changing the way we think about developing services before we engage in research and evaluation.

Key words

Developing strengths, developing teams, positive change through practice development

History, evolution and evidence of effectiveness can all be traced through the emergence and development of a name. In the case of assertive outreach, many think they know what it is about, with phrases such as 'complex needs', 'high risk' and 'hard-to-engage' frequently being associated with it. However, over the last 30 years the term has seen a number of changing uses, describing a process, a method of delivering interventions and, finally, attached to the name of specific teams.

The term 'assertive' appears within one of the earliest models of case management emerging in the US during the 1970s and 1980s. The Program of Assertive Community Treatment (PACT model) developed in Wisconsin out of the first attempts to provide 'total community living' as an alternative to hospital admissions (Stein & Test, 1980). The earliest use of the term 'assertive outreach' appears to emerge in the Threshold Bridge project in Chicago in 1985. It is used more as a description of a method of working, reflecting the need to assertively outreach to street homeless populations to deliver services in a flexible way (Witheridge & Dincin, 1985). As a method of service delivery it is becoming more widely acknowledged through the effectiveness research literature during the 1990s (Bond *et al*, 1995).

Meanwhile, in the UK the term emerges out of the semantic debates around case and care management in the early 1990s to become recognised as a fundamental type of team delivering a specialist service within a new national policy (Sainsbury Centre for Mental Health, 1998; Department of Health, 1999; Ford *et al*, 2001); yet not without its critics (Thornicroft, 1998; Weaver *et al*, 2003).

The Strengths Model was one of many US case management developments, uniquely prioritising working with personal strengths, and initiated in Kansas University from 1982. Its rationale, implementation and research outcomes have been fully described (Rapp, 1998). Further research has identified it to be comparable in outcomes to the PACT model (Barry *et al*, 2003). In the UK it has developed as an approach to practice without specific research attention (Ryan & Morgan, 2004); and it has been the method of choice in implementing a programme of practice development for a number of assertive outreach team (and other) projects (Morgan, 2004a).

Failing assertive outreach

Failing in one context is the lack of achievement of what a service is intended to deliver, and I am sure assertive outreach is not without its examples of

failure to deliver. However, my concern here is how and why assertive outreach appears to be failed by those who could be doing more to help it succeed. We have the international research evidence base (see above), the national policy initiative in place, training programmes available... so in what ways are assertive outreach teams being failed?

- Failed by the narrow focus attributed through the 'target culture'.
- Failed by the conflicting vision in central government 'policy', where notions of service-user involvement sit alongside revisions to legislation to implement compulsory community treatment against overwhelming informed opinion from service users and providers alike.
- Failed by the priority given to academic research, placed above that of developing the real potential of teams.
- Failed by the inability of training to achieve much more than deliver the message, then leaving teams alone to struggle to make sense of it in practice.
- Failed by piecemeal decision-making of local service management, responding more to external policy directives than to the support needs of their own teams delivering the service.

Targets provide us with a guide, but it is arguable what they contribute to achieving good quality teams that respond to the real complex needs and personal wishes of service users. When the target becomes the primary objective we risk developing mediocre or failing services through increased pressures on staff to achieve a narrower agenda; decreased motivation and increased burnout can result as much needed creativity is stifled. In effect, target-based assertive outreach teams, without a deeper consideration of their ethical dilemmas and practice development needs, will become community mental health teams by another name, not the different services that are required.

We are told the original target of 220 assertive outreach teams has been surpassed. Is this a success? Are we monitoring 'effectiveness by numbers' or are we seriously interested in making a difference to people's lives? Unpublished findings of national research reported to the National Assertive Outreach Forum conference in 2004 indicated that UK services were failing to replicate findings of US assertive community treatment (ACT model) teams, and referred to the Pan-London Assertive Outreach study's use of 17 study variables from research and literature. Interestingly, the explanations for possible failures in replication made no reference to the wider

'systems' failure to focus on properly developing the 233 assertive outreach services in the first instance. Rather than focusing solely on the numbers of teams and whether or not they achieved specific research variables, surely we should initially help teams to better understand, interpret and implement these research indicators within the local practice conditions and resources they have to contend with. Perhaps the 'chattering classes of mental health' are too busy with their own agendas to help resolve the gritty struggles of direct service delivery.

Adherence to the 'cult of numbers' does not necessarily stack up correctly: 1:10 or 12 or 15 (depending on the research you read), an intensity of contact of up to three times per week for many, and the travelling distances of most semi-rural and rural services is an equation that requires careful scrutiny in how to make the numbers work, before jumping to conclusions that services are ineffective for not meeting the targets. Severe pressures are placed on staff in many assertive outreach teams to meet directives that appear statistically unworkable. Other expectations around working across shift patterns totally ignore the need to deliver flexible services in response to genuine needs. Working nine to nine across two shifts does not necessarily produce flexible services; it can produce severe pressures at peak times of need, with comparatively high staffing at lower times of need. Commissioners and senior managers need to visit the workplace to appreciate real practice issues before making some of the sweeping two-dimensional demands of central policy and research.

The emphasis of assertive outreach should be to develop teams that think and do things differently: 'teams with attitude' (Onyett, 2003). The challenge is to explore new ways of going about the business of delivering creativity and flexibility in response to the real needs articulated by the individual service user. We need to support people directly in their struggle to implement good service user-focused practice; to identify and work with people's strengths as an engagement tool and personal motivator; to help people take the inevitable risks that come with supporting people to make positive gains in their lives.

The research we know, the messages we know; we pay far less attention to developing high quality service delivery. The passion that I experience in many staff when I visit the workplace of assertive outreach teams reflects what is so different and exciting about what they are doing; it cannot be generated by, or in, a research scale. It does not happen through training alone: it is a process, not an event. We need the resources to connect with and

develop flexible and creative practice, with ownership by those who deliver and receive it. Practice development offers the shift of thinking away from the short-term fixes towards ideas that may help to sustain long-term effectiveness.

The *National Service Framework for Mental Health* (NSF) (Department of Health (DH), 1999) and *The NHS Plan* (DH, 2000) provided a fitting fanfare for the potential of assertive outreach, but lamentably failed to offer the depth of ideas to support its implementation adequately. As the ten-year plan reaches its closing stages, some local mental health services are contemplating, or already implementing, changes in their services with the potential for assertive outreach to be diluted. Isolated outreach workers will struggle to attain the supportive structures needed to offset the danger of burn-out; and outreach functions within the broader demands placed on a community mental health or recovery team did not work before assertive outreach was heralded, and there is no evidence to suggest it will deliver the different type of service needed by the service user group now. Assertive outreach faces the prospect of a failure of implementation rather than a failure of the concept of assertive outreach itself. Surely the post-NSF period should be about developing and sustaining good ideas, not about changing to meet ill-thought-out targets and further service reconfigurations.

Developing a strengths approach

Strengths-based practice (Morgan, 2004b) presents a challenge to the inherently negative focus of attention adopted by the traditional problems-oriented approach most usually advocated in mental health services. It does not ignore the fact that the main reason people present to services in the first place is the experience of problems; but it does highlight the limitation of an entire preoccupation with a person's failings to the detriment of identifying, appreciating and using what they can do. Problems are by definition failings and deficits, and offer little sense of hope when focused on in isolation. By contrast, a strengths approach recognises the reasons why a person is in contact with services, but demands at least equal attention to the recognition that everyone has talents, abilities, interests, achievements, capabilities, wants, dreams and wishes. By focusing on these we may support people to develop their own real personal resources and resourcefulness, open up opportunities, inspire confidence and instil a sense of hope. If we truly want to develop an individual's potential we must resist our natural tendencies to focus on the things

they are less able to change, or they see as less of a personal priority. A strengths approach offers a genuine basis for tackling so much of what mental health services struggle to deliver on a daily basis:

- engagement of trusting working relationships
- empowering people to take a lead in their own package of care
- working collaboratively on a mutually agreed agenda for change
- tapping into personal sources of motivation
- sustaining gains through learning and growing through change.

A strengths approach is, above all else, a specific method of working with and resolving the problems undoubtedly experienced by a person presenting to mental health services. It provides materials with which to tackle the blank canvas that often accompanies the detailed outline of problems.

A focus on practice development

The Practice Based Evidence consultancy has engaged opportunities with seven assertive outreach teams in England to implement an approach to practice development that focuses on team-working and adopting a specific strengths approach to its model of practice. The participating projects are shown in **Table 1**.

Through adopting this approach to practice development, the Practice Based Evidence initiatives have achieved some success in applying the qualities of creativity and flexibility to a number of traditional areas of service delivery:

- particular attention has been focused on capturing the true meaning of the care programme approach, in relation to applying its fundamental principles in ways that can genuinely place many service users in an influential position for shaping the care and support they receive
- new thinking about how levels of service can be gradually reduced in ways that help people 'move on' from assertive outreach with confidence in greater levels of self-sufficiency. The stepping down to lesser levels of intensity by different teams works for a few, but is sloppy thinking in many cases
- the concept of a whole team approach can be developed from the early stages of initiating an assertive outreach team; and the sub-dividing of a service into geographical components can help to maintain this way of team-working as team

caseloads increase; but this is not the only structure adopted by teams for implementing effective team-working.

In developing a strengths approach to assertive outreach, a number of initial hypotheses were identified and then examined in depth through working alongside people in their workplace, rather than the traditional mode of training through a workshop. These are shown in **Table 2**.

The rationale underpinning a strengths approach led to the development of a 13- item tool to help capture some measurement of how practice development and team functioning can influence positive changes in team practice. The tool should also act as a prompt to areas of good practice, so the items are designed to be a sufficiently comprehensive reflection of ethical issues, care process, team functioning and an underpinning knowledge base. Yet this also needs to be a manageable tool (ie fitting one side of paper) if it is to engage practitioners' interest and be used. The 13 items for shaping this approach to practice development are:

Ethical practice

1. Service users are fully involved in determining the priorities for the working relationship.
2. As a team, we regularly examine and review the impact of values and principles on our practice.

Care process

3. Time for creative approaches to engagement is a priority.
4. Our assessment of needs includes the identification of service user strengths.
5. We identify and manage the appropriate opportunities for positive risk-taking in practice.
6. Our working practice draws on a broad range of practical and research-based approaches.

Team working

7. We are clear about our purpose as an assertive outreach team.
8. We have a clearly agreed model of team-working (within team).
9. We have effective systems of support and supervision.

Table 1 Participating projects

Assertive Outreach Team (North) Northants	Practice Based Evidence commenced in January 2001, supporting the development of the established pilot project for the county in Kettering. Extended in July 2001 to the newly emerging development in Wellingborough, and in May 2003 to remaining areas of the north of the county: Corby and E Northants. Intensive support ended December 2006
Haringey HOST Assertive Outreach Teams	Practice Based Evidence commenced in July 2003 with a three-day training programme. Practice development commenced one day/month from January 2004. Continuing as bi-monthly contact supporting the implementation of the team development plan across 2006
Cambridge Assertive Outreach Team	Practice Based Evidence commenced in September 2004 with a three-day training programme. Practice development support commencing one day/month from January 2005. Input to this project ceased after December 2005
West Suffolk & Thetford Assertive Outreach Team	Practice Based Evidence commenced in January 2005 with a three-day training programme. Practice development support commencing one day/month from April 2005. Continuing as bi-monthly contact from February to December 2006
East Suffolk Assertive Outreach Team	A three-day Practice Based Evidence training programme was delivered in May 2005, with a programme of monthly practice development from January to December 2006
Ipswich Outreach Team	Initially set up in 1999 with Steve Morgan facilitating a detailed training programme through his former position in the Sainsbury Centre for Mental Health. A Practice Based Evidence bi-monthly practice development programme was facilitated from February to December 2006
North Birmingham Locality Assertive Outreach Team	A well established assertive outreach team since 1998. A Practice Based Evidence programme commenced with two days of training in March and April 2006, followed by monthly 'practice development' input from April 2006 to March 2007, with a team development day to finish the programme in November 2007

10. We have clear processes of decision-making in the team.
11. We link effectively with other parts of the mental health system (including primary care).

Knowledge in practice

12. We make full use of the diverse knowledge, skill and experience within the team.
13. We access appropriate expertise from outside the team.

The method of practice development focused on processes of team reflection, engaging practitioners to evaluate changes in team practice, providing useful feedback about their global functioning, as well as indicators to priorities they may choose to focus specific attention on. When amalgamating all seven teams' results, a total of 74 practitioners completed the first point of evaluation; 72 completed the tool at the second point; and 59 practitioners provided a third response. Two of the teams did not reach a third point of evaluation because the length of the practice development contracts did not permit sufficient time.

Summary of findings

The overall mean scores amalgamated across the teams show an upward trend from 3.42 > 3.77 >

3.80 (out of a total of 5) at the three points of evaluation. This indicates that a focus on practice development encourages practitioners to spend more time reflecting on and developing their practice as an on-going function of their work, with positive results. **Table 3** identifies the items in rank order by the overall percentage opinion shifts between the first and third points of evaluation by the practitioners within the teams.

In relation to the hypotheses established earlier, the overall results indicate the value that this approach to practice development, through processes of team reflection, can offer to teams. Staff are generally motivated by opportunities to set their own agenda for positive changes in practice, and do target specific areas that training workshops rarely have a lasting impact on. Values and principles can be effectively considered, in a practical rather than theoretical sense, through reflective discussions based around some of the ethical dilemmas drawn out in the experiences of working with service users. Most notably are the tensions between a person's right to refuse a service and the need for a team to offer different experiences of service delivery before a person can then exercise that right as a genuinely informed choice.

Working with a service user's expressed priorities is specifically highlighted through the process of a

Table 2 Hypotheses in developing a strengths approach to assertive outreach

- **Training sessions raise awareness, but practice development can have a real influence on changing practice.** It is only by working *with* staff that you can fully appreciate their motivations, capabilities, desires and achievements, and use these strengths to make positive changes in practice
- **The impact of our values and principles is not routinely reflected on by individuals or teams.** To develop a coherent strengths approach to practice requires people frequently to examine their deeper feelings and think about the work they do, why they are doing it and who they are doing it for. Our values shape every decision we make, and a set of principles gives much-needed structure to the way we work
- **Working with strengths will help us to become more focused on the service user's priorities.** Service-user involvement, empowerment and capacity to make decisions should be a real experience, not just a convenient mantra for services to use as a smokescreen for more coercive practice
- **Assertive outreach teams claim to operate a team approach, but the actual models of team-working are not consistent.** We need to clarify in what ways a team approach is practised, and for what benefits (ie what are the strengths of this way of working?); otherwise these teams become more of the same with lower caseloads
- **Positive risk-taking is happening in practice for a range of reasons, but we remain unclear about its mechanics.** Practice development offers the potential to increase confidence for being more explicit about why and how this concept happens, and to be clear about what gives us strength to help promote its place within the realms of good practice
- **Training and accessing literature and research equips people with knowledge, but it is the systems within and between teams that need more attention to detail.** Levels of individual and collective knowledge are generally not too difficult to develop; true strength across services depends on how we access and use this knowledge

Table 3 Items in rank order

Item	Item description	Rank order by % opinion shift
6.	Practical and research approaches	11.8%
2.	Impact of values and principles	11.6%
5.	Positive risk-taking	11.0%
13.	Access outside expertise	10.8%
1.	Service user priorities	10.2%
7.	Purpose of AO team	7.4%
12.	Diversity of knowledge/skill in team	7.2%
4.	Identify strengths	5.8%
3.	Creative engagement	5.8%
11.	Links to other parts of system	4.4%
8.	Model of team-working	3.4%
10.	Clear decision-making	2.8%
9.	Support and supervision	0.4%

strengths approach. Indeed, one of the essential outcomes of the approach is to enable teams to have a positive impact through refocusing attention onto the things that service users want to achieve for themselves, without losing sight of the need to manage risks and crises that will also emerge. One of the important messages through practice development is to encourage practitioners to see the learning opportunities that can emerge, through the process of a crisis, about identifying and working with strengths. Regarding issues of risk, positive risk-taking emerges as one of the items where practitioners and teams gain in confidence as a direct result of having opportunities for detailed team reflection in order to agree on challenging decisions.

Strengths-based recommendations

1. Overall, the practice development approach advocated through these initiatives requires a shift in priorities away from centralised workshops to a stronger emphasis on teams taking responsibility for their own facilitated team-based reflective practice. It requires more effective use to be made of the training resources and priorities within organisations.
2. A strengths approach can more clearly articulate the unique roles assertive outreach teams play within a comprehensive local mental health system, as well as articulating how they go about delivering recovery-based principles in practice.
3. A closer examination needs to be undertaken by teams of how they go about identifying and working with strengths. Paying lip-service to a number of positive statements about a service user is not working with strengths.

4. Greater attention to active practice-based discussions within teams helps them to raise their awareness of the impact that values and principles have on their decision-making and daily practice.
5. The concept of positive risk-taking is nothing new; it is always happening in practice, but rarely reflected on and articulated in a confident way. The reality of taking constructive risks for positive outcomes is essentially based within an appreciation of strengths (of the service user, their informal supports, the individual practitioners, and the wider network of formal supports). By applying strengths-based practice, development practitioners in assertive outreach teams can lead by example in why and how they undertake this challenging area of their work.
6. Knowledge can be imparted economically through written literature and research, and use of training events. However, the strength to apply the knowledge and skill within the limitations of local resources requires specific attention to the strengths of the systems developed within teams. *In vivo* practice development enables far more active attention to be paid to these systems than external training events. The greater challenge not yet met is to look at the strength of systems across teams and agencies.

When the spotlight dims

Following previous experiences of inpatient units and community mental health teams we have a tendency from national policy downwards to compartmentalise services into their isolated units. Attention is heaped on one specific area for a period, then the spotlight moves on to the next flavour of the month. This can

leave the previous service devoid of attention at best, or left to be manipulated and distorted by local service commissioning/management in a vacuum, with no real understanding of what they are changing, or what they are changing it into. The focus on targets as the sole driver of services also has a significant role to play in the ability of management to distort priorities, and subsequently undermine the implementation of good ideas.

Will assertive outreach now join the aforementioned services that have had their time, and now need to fight to be heard? Or is this the time, post NSF, when we seriously get to grips with what a truly holistic local mental health system looks like, with all of its effective and intermeshed component parts adequately defined and supported? Before we further criticise assertive outreach for not achieving goals that were not that explicit, and may have changed over time, we should be looking at what was actually provided in the equation regarding the balance of active practice development and the attention given to researching outcomes.

I assume that what appears to underpin UK assertive outreach service development seems to be that teams are set up on the flimsiest of training resources, expected to somehow assimilate the messages from prestigious international research studies, and apply these messages to the locally available systems and resources. They are then randomly subject to outcomes-focused research scrutiny, in relatively short timescales, and generally criticised for not having at least matched the results of the international research. They are further criticised for not having saved money in very short timescales, irrespective of whether they will be able to make these savings over the medium to longer term. The mantra of 'fidelity to the model' is tripped out in rigid fashion, with no consideration of local differences in resources and systems – when we should really be talking about 'fidelity to core components', which can actually be applied in flexible ways.

Good practice can be developed, implemented and supported, if the political will and priority is there. Applying research methods after attention to implementation is likely to bring about very different results. The approach is more resource intensive but demonstrates positive shifts in perceptions of practice across the board, as well as being able to target specific areas of practice and provide a motivator for staff. Short-term economics does not necessarily result in economic effectiveness. There can be realistic long-term positive outcomes for service users through targeted assertive outreach services; but flexibility and creativity around the core components of effectiveness need to be key ingredients in the mix, not 'fidelity to a fixed model'. Assertive outreach has the ability to meet most of the

research outcomes it is currently criticised for, given the appropriate support and long-term measure of success.

Assertive outreach is a very specific function for entirely different service-user needs, which is why it can not be replicated or successfully delivered through a community mental health team model, unrealistic numbers set as targets, or unrealistic outcomes for many of the specific service users as the measure of success. If we ignore these messages at this stage we will surely have to reinvent this approach to assertive outreach further down the line (with a different name). The strengths approach to practice development is equally applicable to all other parts of the wider mental health system; and in a bold step could be a way of genuinely developing integrated whole systems. Where will the vision and inclination come from?

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