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CHAPTER 3 ASSERTIVE OUTREACH MENTAL HEALTH TEAM INTRODUCTION

The Assertive Outreach Mental Health Team was established to improve the service offered to those in the community with identified long-term serious mental health problems, including schizophrenia, bi-polar disorder and psychosis. In particular, the outreach approach is intended to extend the service to people who, for whatever reason, do not use the more traditional services that are delivered in health and care organisations.

The Assertive Outreach Mental Health Team was the first to be established in the area and started eighteen months ago when the team leader was appointed. The government set the National Service Framework for Mental Health Care and a Policy Implementation Guide which provided criteria for the composition of the team. While there is flexibility to adapt the team to local need, the guidance is prescriptive about essential personnel. These include a consultant psychiatrist, a certain number of nurses and social workers per population, a psychologist, community psychiatric nurses, an occupational therapist and support workers. It is a fully multidisciplinary and interprofessional team.

The government policy states that all patients with a mental health problem should have a care plan approach. Most teams work with individual clients and patients on a one-to-one basis, each qualified professional having a personal case load. This team is different in that although it uses care co-ordination it does so through a team approach. The theory is that all the people in the team will have working knowledge and a day-to-day relationship with each client.

The team was initially jointly funded by the National Health Service Trust, the Social Services Department and the Drug Action Team. These management structures have now merged with one direct manager and one source of funding.

How the team works

The team works from nine to five Monday to Friday but also, due to locality needs and constraints on numbers, the team members work flexibly to cover evenings and weekends. The team operates in deprived areas and tries to address social inclusion because people with mental health problems are often isolated and less likely to go out and have a social life. For example, on Bonfire Night team members went with clients and patients to a local pub for a meal and then held a party to help to enmesh participants into the local community. The team differs from other teams in the informality of its approach, trying to work on people's strengths to increase their independence and coping skills. Each qualified member of staff is expected to have approximately ten clients. Every morning staff have a risk and allocation meeting, mentioning every patient by name.

The vision describes the aspiration for this new service approach but different ways of working are necessary in order to achieve these outcomes.

Working as a team

The difference between this team and others you compare it with is that this one works as a team. The government policy is that all patients with a mental health problem should have a care plan approach. Other services work with one qualified professional with a case load. So if the

professional is off sick, someone else in the team will have to open their case files and read them. In our team we do still use care co-ordination, but it's a team approach. The theory is that all the people in the team will have a working knowledge and a day-to-day relationship with the client. This team put considerable emphasis on bringing their various strengths to bear on meeting the needs of their clients.

Meeting clients' needs

The team works together well because we're all passionate and we're all client orientated. We're all looking for what clients need. From the lowest-paid support worker or student up to the highest-paid consultant, we've all got a voice, we've all got a say in this person's care. We can all see things from a different perspective and we are all client focused. We've all got strengths in certain areas and we've all got weaknesses in certain areas so we all compensate for each other and we all look after each other. Although this way of working together brings benefits that the team value, people sometimes feel that their professional contribution is less visible than in traditional services.

Staying safe as a team

Historically there's been a quick burn out because of demands made on staff. For example, we had somebody referred to us because they can't be managed on the ward. It's taking seven or eight staff to control this person on the ward. What good is it sending them home and asking us to visit them as lone workers or pairs? What good could two people do in one person's home when they're struggling with seven or eight people on the ward? We did have to take a team decision. Although we're all passionate about it and we like the job and do want to be here, it is just a job and we all want to go home safe. The degree of risk faced by the team demands that the team members have considerable trust in each other.

Trust in the team

The foundation of trust was built by the people who were here at the beginning and that has sort of rubbed off on the people who've come since. With the type of clients we are dealing with you have to trust the people you are working with and you have to trust their opinion, regardless of your role or qualification. The support workers are often viewed as the unqualified staff, but in lots of situations their opinion is often the most important because they have the most day-to-day contact with someone. Therefore, I would trust their opinion implicitly, not over anyone else's, but due to the amount of contact they would have with someone. So, I think trust is a very big part because you've got to feel that you can say what you want without being made to feel inferior or inexperienced or that your opinion isn't valued. As a new team, it was inevitable that their practice as a team would be shaped, to some extent, by their experience. Sometimes useful learning came from making mistakes.