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Assertive Outreach Team and Caseload Survey

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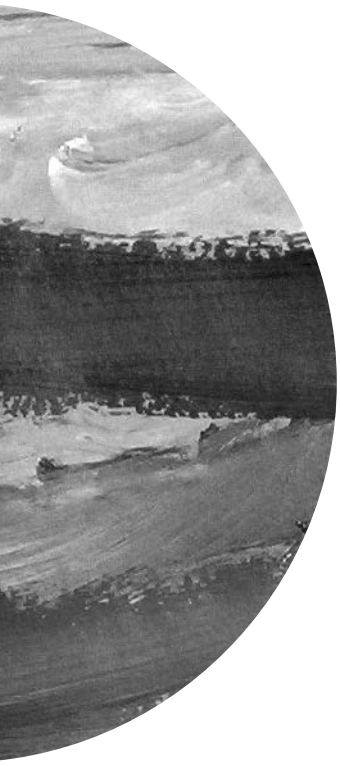
Abstract

The UK Department of Health requires the provision of Assertive Outreach (AO) for adults with severe mental health problems, high use of hospital, difficulty maintaining contact with services and complex or multiple needs (Department of Health, 2001). AO is a mental health service taken to service users, through which staff with low caseloads deliver practical support, care co-ordination and advocacy. Its approach is holistic, with an intensive focus on needs. This survey, commissioned by a consortium of 12 mental health and primary care trusts in the north east of England, examined in detail the caseloads of all 28 dedicated AO teams in those trusts. The aims were: to describe the organisation and operation of these relatively new teams, and to describe the demographics, diagnoses, service use, medication, risk factors and social problems of the study cohort. It was found that, as intended, AO teams are treating people with complex and severe mental health needs. However there appears to be considerable variation between trusts with respect to risk factors, severity of mental health problems and global functioning of those service users in contact with AO teams.

Keywords: Assertive Outreach, Community Mental Health, Dartmouth Assertive Community Treatment Scale (DACTS), Global Assessment Scale (GAS),Health of the Nation Outcome Scale (HoNOS), Matching Resources to Care (MARC).



Introduction

Since its widespread implementation in the USA, AO has been positively evaluated (Bond et al., 1995; Stein & Santos, 1998; Marshall & Lockwood, 1998). Overall, when compared to 'standard' community mental health care, AO has been found to reduce hospital use, increase housing stability and promote satisfaction amongst people with severe mental health problems who have had repeated hospitalisations. The Policy Implementation Guide (Department of Health, 2001) required all mental health services in England to have implemented Assertive Outreach (AO) by April 2003. By March 2005, an estimated 263 teams were registered, employing 2,543 staff.

A consortium of providers and researchers in the former Northern & Yorkshire health region met in October 2000, to explore common needs for information concerning the development of AO in the region. These centred on knowing more about the operation of teams and their caseloads. The study design, developed in consultation with practitioners and researchers at the universities of York, Hull, Newcastle and Durham, included the study of the teams reported here, which was undertaken by researchers at the University of Durham.

The original research consortium was convened by the Northern Centre for Mental Health. The consortium's geographical spread corresponded to the former Northern and Yorkshire region. The period of the course of the study saw the reconfiguration of health regions, the introduction of Primary Care Teams, and the amalgamation of several mental health trusts. The effect was that the make up of the consortium changed through the course of the study. The geographical area increased to include the Northern Region, including Trent and all of Yorkshire. The total population covered by the participating trusts is approximately 3.835 million people. Three trusts with responsibility for AO teams were PCTs, the remainder were secondary care Trusts.

All participating Trusts contributed funding to the enterprise, and ethical approval was granted by the Multi-Site Research Ethics Committee, with the proviso that team leaders were responsible for the completion and collation of questionnaires before passing them on to the researcher.

Method

Sample

Data was collected in 2002-03 on 836 of the 956 people on the teams' caseloads at the time of the study, an overall response rate of 87%. This high rate gives us confidence that the data reflects what is happening in AO in the trusts studied.

According to the policy guidance, there should be 90 AO places per 0.25 million, which amounts to about 1380 places in the region. At the time of the study, therefore, on average, AO teams were operating at 69% of their intended capacity.

Table 1 shows the number of responses made by each trust to the caseload survey, and the proportion of service users that each trust contributed to the overall total. For reasons of confidentiality each Trust was assigned an identification (ID) number.

Table 1. Number of Respondents by Trust

TRUST ID	Number of service users	Per cent of service users in study
1	97	11.6
2	64	7.7
3	88	10.5
4	40	4.8
5	66	7.9
6	54	6.5
7	31	3.7
8	80	8.8
9	171	20.5
10	21	2.5
11	100	12.0
12	24	2.9
Total	836	100

Instruments

Qualitative interviews were conducted with team leaders or their equivalent representatives to explore their experience of providing AO. The topic guide for these interviews covered issues of staff structure, models of working, training, caseload structure and user and carer involvement.

Further information about the teams and their operation was collected using the Dartmouth Assertive Community Treatment Scale (DACTS: Teague et al, 1998), the Team Organisation Questionnaire (TOQ: Wright et al, 2003) and the International Classification of Mental Health Care (ICMHC: de Jong, 1996).

The DACTS measures adherence to 28 indicators of fidelity to an American model of Assertive Outreach. It has been adapted for application in the UK (known as the DUK) with the addition of three questions exploring: the clinical activity of the team leader; the presence of a vocational specialist; and the presence of a substance misuse specialist within the team. The DACTS/DUK has three dimensions; human resources,

organisational boundaries and the nature of services. Within these dimensions each of the indicators is rated on a 1-5 scale, the higher the score the higher the fidelity to the ideal model of AO.

The TOQ is a semi structured questionnaire designed for the purpose of studying AO, with questions on team staffing, caseload, relationships to providers in local health and social care provisions, policies and protocols.

The ICMHC has been designed by the World Health Organisation to permit comparison of mental health services in relation to ten dimensions of care given and expertise provided.

A survey of team caseloads was undertaken using the following standardised measures: Matching Resources to Care (MARC: Huxley et al, 2000), Health of the Nation Outcome Scales (HoNOS: Wing et al, 1996) and Global Assessment Scale (GAS: Endicott et al, 1976). The MARC generates a summary score of severity and risk, called the M3. This contains a number of items that relate directly to service use history and risk factors, and so are directly comparable to the Policy Implementation Guide eligibility criteria for AO. HoNOS is a similar but briefer measure which is widely used in mental health services, and GAS gives a single measure of functioning levels for people with severe mental health problems.

Results

Team leader interviews

Presented here are the main themes drawn from semi-structured interviews with each of the 28 team leaders (or other team representative) in the study.

Programme implementation

Team leaders described a lack of clarity over client inclusion criteria, particularly when the teams were first set up. Initially, it seemed that potential Assertive Outreach service users had been identified primarily because meeting their needs posed challenges to existing community based services. However managers indicated that this situation had improved over the course of time, and that their inclusion criteria had been clarified.

'Initially, the Assertive Outreach service was seen by CMHTs as a relief – as a place to offload all the difficult and really ill people.'

'We had a lot of pressure in the early days to take people who were [diagnosed as having a] borderline personality disorder … they were taken then but not now.'

Reactions from other mental health services to the setting up of AO teams were said to be mixed. Most managers considered that there had been a lack of understanding of the role of Assertive Outreach services, and concern about the potential impact of AO teams on other parts of the mental health services:

'One consultant was quite negative about Assertive Outreach at first. He was anti us because we took two members of staff from the CMHT in one area and he saw no replacement.'

However, this manager claimed that views were now much more favourable, largely because the AO service had produced evident benefits:

'We reduced the bed occupancy for revolving doors clients over two years. CMHTs are now saying that they don't have to chase people all over the place and their turnover of clients is more rapid.'

The team managers' satisfaction regarding partnership working with other agencies was on the whole quite high. The presence of dedicated liaison officers and mutual support systems had helped in building positive working relationships:

'We have good relationships with Housing which are helped by having a liaison officer in same office as us.'

'The police have a good liaison officer who is non-uniformed and does a lot of work with mental health clients and joint visits.'

One service expressed concern over the purpose of inpatient care:

'… there is the expectation that the purpose of our service is solely to keep people out of hospital, in fact it may be about people needing to go into hospital in a peaceful structured way while in crisis.'

Even so, sometimes the ward was powerless to retain patients:
'What's the point of inpatient care if they are not under a Section and they can't stop them just leaving after a couple of hours of being admitted?'

Team development

Team managers expressed some concerns about development within the teams:

'It's difficult to deliver a service and develop it at the same time.'

'Not enough formal recording of work takes place. We need more IT support as we have a manual record keeping system so we can't even get basic data back. We need access to all informal/formal assessments and forensic history plus significant events.'

Some team leaders saw Assertive Outreach as quite straightforward and therefore not requiring specialist training, but others disagreed:

'It would be helpful to have [training] in communication skills, engagement, specific skills, drugs and attitude.'

A number of comments reflected the piecemeal implementation of the AO service, with difficulties recruiting and retaining staff. For instance, four services reported not having a team manager. One of the indicators of fidelity to the Assertive Outreach model is that the supervisor of front line clinical staff provides direct services to clients at least 50% of their time. Where there was no permanent team leader, this aim was not met:

'The main problem here is the manager left 18 months ago. We have just had stopgaps since then, but no one dedicated to the Assertive Outreach way of working and the team. A number of different managers from various parts of the service have worked here but none carried an Assertive Outreach caseload.'

There was a mixed response to the role of the consultant psychiatrist within the team. Much appeared to depend on the individual characteristics of the consultant(s) involved in the service and their willingness to work with an Assertive Outreach team approach:

'We have 0.5 of a consultant psychiatrist. It does not work that well, as he was press-ganged into it. All service users are with him and he does go to the team's weekly meeting and Mental Health Act assessments. We don't bring him into the Assertive Outreach model. We ring him only if medication needs to be reviewed or we require his input to an assessment.'

The advantages of having the right consultant within the team were stressed by the majority of the team managers:

'Some of our consultants will go out and do visits. They (service users) would never see a psychiatrist if they did not do home visits.'

'We have a laid back registrar whose knows medication is not the whole story. He is one of the team - not distant like some. He will do home visits and sits in the office with other staff.'

Managers also commented about the professional practice differences between team members:

'Having an Approved Social Worker in the team is a mixed blessing. It's a benefit in terms of completing admissions but it may affect possible future engagements.'

'CPN training means they get more stuck into the work . . . this is more appropriate to Assertive Outreach work. The social worker does more care coordination involving other staff and services - working less directly with [the user]. Nurses tend not to grab the service users into the service but take the service to them so they are more likely to be engaged for longer.'

Models of working

Assertive Outreach styles of working were achieved in a number of key areas. Specifically, managers referred to befriending and a consistent process of engagement:

'If someone phones up at 4pm, no matter who answers there will be a consistent response. Many service users have already burned bridges with services. We can rebuild them, giving them the possibility of, say, a tenancy.'

'Everyone in the service should have an Assertive Outreach type of working, not just the top 2%. There is nothing special about Assertive Outreach; no magic, just low caseloads and a way of engaging with people in a creative way. It's about team working and people skills.'

The recovery model of mental illness was the most frequently discussed approach:

'A few years ago it was a very medical model. In the last 4 years we have moved to a newer contact and more collaborative ways of working as we value the personal experience of clients.'

'We are trying to challenge the medical model through training and looking at the NICE guidelines on psychiatry, looking at the language of 'optimism' and 'recovery' which need to be reflected in the use of anti psychotic medication. It's vital not to overmedicate people in early interventions and therefore lose engagement.'

Overall, about two thirds of AO teams' work appeared to be done in suburban settings, but in some teams up to 85% was rural, while in others up to 100% was urban-based.

'There are massive travel time and issues of transportation. I can deal with travel claims of £1000 a month. In terms of service users' accessibility you can't just drop in and provide a flexible system, we have to plan more. We tend to do block 3 hour visits rather than a series of 3 one hour visits. [Monitoring a user's] compliance with medication is harder with an 80 mile round trip.'

User involvement

Few services had any formal arrangements for involving users in the planning and delivery of services, although most claimed that, at an individual level, users were involved in collaborative care planning. Two services employed staff specifically because of their experience as service users. The role of one of these user development workers was explained as follows:

'In clinical meetings she helps us with engagement [of potential service users]. She challenges power bias. She assists in the evaluation of service. She will do advocacy work.'

The manager emphasised her position within the team:

'She has equal status [with the professionals] ... She has her own telephone line and admin support.'

Other services utilised service users' experiences in different ways:

'A group of ten Assertive Outreach service users meet every month and they evaluate our service and try to improve it.'

'Service users link into the service and they share office space here with us. They also come to CPA audits and we consult them about satisfaction. We have a SU on placement with the college doing healthcare.'

Team operation and organisation: DACTS and TOQ

Overall, AO teams in the north east had high fidelity with respect to 14 of the 28 indicators, and low fidelity with respect to only eight. During the summer of 2001, the Pan London Assertive Outreach Study (PLAO) surveyed 24 AO teams in the city using the DACTS, among other instruments (Wright et al 2003). Our team data can therefore be compared to the PLAO findings.

The indicators for which the AO teams in the north east scored high or low are shown in Tables 2 and 3 respectively. The tables compare the mean scores for the AO north east teams in the study to the published scores for PLAO teams. Where no score was published for the PLAO team, it can be assumed that their fidelity to that indicator was rated as 'medium', i.e., between 3 and 3.9. Indicators of high fidelity are given in brackets.

Table 2. DACTS Indicators: Areas of High Fidelity (mean >= 4)

Indicator	North East AO teams		PLAO where published
	Range	Mean (St Dev)	Mean
Nurse on staff (at least 2 FTE nurses per 100 client programme).	5-5	5.00 (0.00)	
Intake rate low (admissions accepted at a low rate to maintain a stable service environment).	5-5	5.00 (0.00)	4.90
Small caseload (client to clinical staff ratio of 10:1).	4-5	4.96 (0.19)	4.70
Intensity of service (high amount of face-to-face time, reflecting severity of clients' needs).	4-5	4.93 (0.27)	
Time-unlimited services (programme remains the point of contact for all clients indefinitely).	4-5	4.93 (0.27)	4.40
No dropout policy (programme engages and retains clients at a mutually satisfactory level).	4-5	4.93 (0.27)	4.40
In-vivo services (contacts and assessments made in community settings, rather than in office).	4-5	4.89 (0.51)	4.40
Explicit intake criteria (measurable criteria to screen out inappropriate referrals).	3-5	4.80 (0.51)	4.40
Responsibility for hospital admissions (95% or more of admissions are initiated through team).	4-5	4.78 (0.42)	
Assertive engagement mechanisms used (using outreach, and legal mechanisms if appropriate).	2-5	4.70 (0.82)	4.50
Responsibility for discharge planning (at least 95% of hospital discharges are planned jointly with the programme).	3-5	4.70 (0.54)	
Full responsibility for treatment services (team provides integrated, tailored services, rather than referring clients to different service providers).	3-5	4.30 (0.72)	4.20
Team approach (the team shares responsibility for each client).	2-5	4.26 (1.10)	
Work with informal support system (programme provides support and skills for support network such as family, landlord, shelter staff, employer).	2-5	4.07 (0.96)	

Table 3. DACTS Indicators: Areas of Low Fidelity (mean < 3)

Indicator	North East AO teams		PLAO where published
	Range	Mean (St Dev)	Mean
Clinically active team leader (supervisor of front line clinical staff also provides direct services).	1-5	2.96 (1.85)	
Individual substance abuse treatment (at least one team member provides substance abuse treatment for clients with substance use disorders).	1-5	2.81 (1.42)	2.70
Permanent psychiatrist on staff (at least one full-time psychiatrist per 100 clients is assigned to work with the programme).	1-5	2.48 (1.87)	2.90
Responsibility for crisis services (programme provides 24-coverage).	1-5	1.67 (1.47)	1.9
Substance abuse specialist on staff (at least two staff members on the team with at least one year of training or clinical experience in substance abuse treatment, per 100-client programme).	1-5	1.52 (1.28)	2.20
Role of users in treatment team (consumers are included as staff on case management teams, to attune the teams to consumer perspectives).	1-3	1.22 (0.58)	1.70
Employment specialist on staff (at least two staff members with at least one year of training or experience in vocational rehabilitation and support, per 100 client programme).	1-1	1.00 (0.00)	1.80
Dual disorder treatment groups (programme uses group modalities as a treatment strategy for people with substance use disorders).	1-1	1.00 (0.00)	1.10

Three of the 'low fidelity' areas relate to services for AO users with substance misuse problems, which were not widely available at the time of the survey. There is also little evidence of teams having a specialist worker who can help users obtain employment. In the USA, employment specialists play an important role in AO teams, and this is one aspect of the work for which there is strong research evidence of benefits (Bond et al, 2001). Later, we report that very few AO users were in any kind of employment, suggesting that this is a matter for concern in service development. AO teams were not generally responsible for crisis services in the north east, possibly because of the recent development of crisis resolution teams. The average rating for having a permanent psychiatrist on the team was low, and somewhat lower than the PLAO findings. The north east teams were at a slightly earlier stage of their development compared to the London teams, and had a lower average caseload.

Indicators where teams showed medium fidelity, scoring 3-3.9, are listed below. The definition of high fidelity for each indicator is given in brackets.

- Staff Capacity (programme operates at 95% or more of full staffing).
- Programme Meetings (team meets frequently to plan and review services for each client).
- Continuity of staffing (programme maintains the same staffing over time).
- Programme size (team is of sufficient size to consistently provide necessary staffing diversity and coverage).
- Dual disorders model (programme uses a stage-wise treatment model that is non-confrontational, follows behavioural principles, considers interactions between mental illness and substance abuse, and has gradual expectations of abstinence).
- Frequency of contact (clients receive as high a number of face-to-face service contacts as needed; frequent contacts are associated with improved client outcomes).

The PLAO teams also scored medium for four of these six indicators; however for staff capacity, they were rated as high fidelity (4.1) and for frequency of contact, they were rated as low fidelity (2.7).

Analysis of the TOQ responses revealed that all of the north east teams were in the statutory sector, and had responsibility for the Care Programme Approach. Seven of London's 24 teams were in the voluntary sector, and six of those teams had no responsibility for the Care Programme Approach. However, five London teams had access to dedicated inpatient beds, which is the case for only 2 teams in the north east.

It is notable that fewer than half the AO teams in the north east provided a service at weekends, and the situation in London was similar. The ratio of full time to part time staff was higher for the north east.

The ICMHC scores indicate that engagement, care co-ordination and assessment were the focus of most of the north east AO teams' work, with medication, personal care and general health care being the least important objectives.

Caseload analysis

In this section, we explore differences between trusts in the composition of the AO caseloads. The number of service users for whom questionnaires were returned ranged from 21 and 24 in Trusts 10 and 12 respectively, to 171 in Trusts 10 and 12 respectively, to 171 in Trust 9. Table 4 summarises the service users' characteristics.

Table 4 – Caseload demographics, service use, risk factors and psychometric ratings

	Caseload average	Range across Trusts
	(percent unless stated)	
Gender		
Male	69	42-89
Age in years *(mean)*	38	36-43
Ethnicity		
Black and ethnic minority communities	10	3-27
Marital status		
Single	71	58-81
Accommodation		
Living alone	57	42-68
Homeless	4	0-14
Employment status		
Full or part time	1	0-8
Service use history, diagnosis and medication		
Age of onset *(mean)*	24	22-27
Compulsory admission within past 2 years	86	70-96
Ever inpatient for 6 months+	56	22-78
Number of psychiatric admissions in past 2 years *(mean)*	2	1.4-2.8
Currently subject to Section 117 of the MHA	62	31-88
Currently detained under Section 2 of the MHA	6	0-20
Currently detained under Section 3 the MHA	17	4-36
Psychotic illness	95	80-100
Personality disorder	27	10-59
Prescribed atypical antipsychotic	42	25-71
Co-morbidity, risk factors and moderate to severe social problems		
Problematic alcohol use	31	4-44
Problematic drug use	28	9-44
Suicide attempts	46	25-58
Physical aggression towards family	12	4-24
Physical aggression towards others	16	4-25
Contact with criminal justice service other than as a victim of crime	29	4-49
Level of cooperation with services rated as 'poor'	17	8-33
Rated 'seriously at risk of', or currently in, institutional care	26	10-39
Accommodation problems	51	38-67
Family relationship problems	72	54-87
Relationships with others problems	80	46-90
Personal care problems	54	40-81
Problems looking after the home	63	60-77
Problems with finance	54	38-68
Daily occupation (meaningful activities) problems	88	66-100

Demographics

Although the proportion of men varied between the trusts, only one had a larger proportion of women, and this was Trust 12 with which had a caseload of only 24; therefore the profile could change with the inclusion of relatively few people.

Sixty one percent of the total caseload was under 40 years of age, less than 5% were aged 60 or over. The mean age of the sample was 38, with Trusts 2, 5 and 11 having a caseload with the lowest mean age, 36, and Trust 10 the highest mean, 43 years.

The representation of Black and ethnic minority groups varied widely, with five trusts (2, 4, 8, 9 and 12) having less than 5%, and two trusts (5 and 6) with more than 25% minority ethnic clients.

The incidence of homelessness was low; some trusts told us that none of the service users on their caseloads were homeless, but generally the percentage ranged between two and six percent. Trust 10 recorded three people as homeless, 14% of their caseload of 21.

Only half of the trusts had anyone in full or part time employment on their caseload. This may be related to the availability of support into employment, which varies from place to place. One of the Assertive Outreach fidelity criteria is having an employment specialist on the team, and this element of the DACTS scored low.

Service use history, diagnosis and medication

People in this study had a low age of onset of mental health problems; the mean age of onset ranged between trusts from 22 to 27 years.

Across trusts, the maximum number of psychiatric admissions during the previous two years varied widely, from 4 to 18. The trust with the highest average of admissions was Trust 5, with a mean of 2.8. The vast majority of service users (86%) had experienced at least one compulsory admission, and with the exception of Trust 12's 70%, the proportion was similar for all trusts (81%-96%). Trust 12 also had the lowest proportion of service users who had experienced an inpatient period of more than 6 months; Trust 1 (n=91) was the next lowest with 42%. Trust 4 was the highest, with 31 of their 40 service users having experienced being hospitalised for a period of six months or more.

In the caseload as a whole, 23% were detained under either Section 2 or Section 3 of the 1983 Mental Health Act (MHA). For Trust 11, the proportion was 56%, but in Trust 12 it was only 4%. More than half of the AO caseload (62%) were subject to Section 117 of the MHA, making social services responsible for their aftercare, and 98% had an enhanced level Care Programme.

The vast majority of service users on the AO caseload were reported to have a psychotic illness (95%). All trusts except Trust 12 (80%) reported percentages of 90 and above. Forty two percent of the total caseload used atypical antipsychotic drugs; Trust 3 had the lowest recorded use, 25%, and Trust 10 the highest, 71%. Personality disorder was recorded for 26% of the total number of service users, ranging from 10% in Trust 10, to 59% in Trust 7. The overall level of severity is compared to community mental health team caseloads in Schneider et al. (in press).

Co-morbidity, risk factors and social problems

Overall, 31% of people in this study were judged to have 'problematic alcohol use'; this ranged from just one of Trust 12's 24 clients (4%) to 28 of Trust 2's 64 clients (44%). Less than 10% of Trust 10 and Trust 12's caseloads were judged to have problems with drug misuse, whereas the for Trusts 8 and 3 the proportions were 40% and 44% respectively.

Forty six percent of the total caseload had attempted suicide in the past; Trust 12 again had the lowest proportion, 25%, whereas Trusts 1, 3, 4, 9 and 11 ranged from 50 to 58%. Regarding current problem behaviour, 12% were recorded as showing physical aggression towards members of their family, ranging from 24% and 23% in Trusts 5 and 7 respectively, to 4% in Trust 12 and 6% in Trusts 9 and 2. Sixteen percent were rated as being aggressive towards others; Trusts 5, 7, 8 and 11 reported that more than 20% of their caseloads had problems in this area.

Twenty nine percent of the AO caseload has had contact with the criminal justice services other than as a victim of crime; Trust 12 reported the lowest proportion, 4%, and Trust 5 the highest, 49%.

Only 17% of the AO service users' level of cooperation with help offered was rated as 'poor', ranging from 8% in Trust 4, to 33% in Trust 10.

Twenty six percent of the AO service users were rated as being seriously at risk, or currently in, institutional care; Trusts 3 and 5 had considerably higher proportions, 39% and 36% respectively. Over half the total caseload (51%) was experiencing moderate or severe accommodation problems. Trusts 2 and 5 had substantially higher than average numbers of service users in these categories, 67% and 67% respectively.

Other social problems included: family relationships (72%), relationships with others (80%), personal care (54%), looking after the home (63%) and finance (54%), and daily occupation (88%).

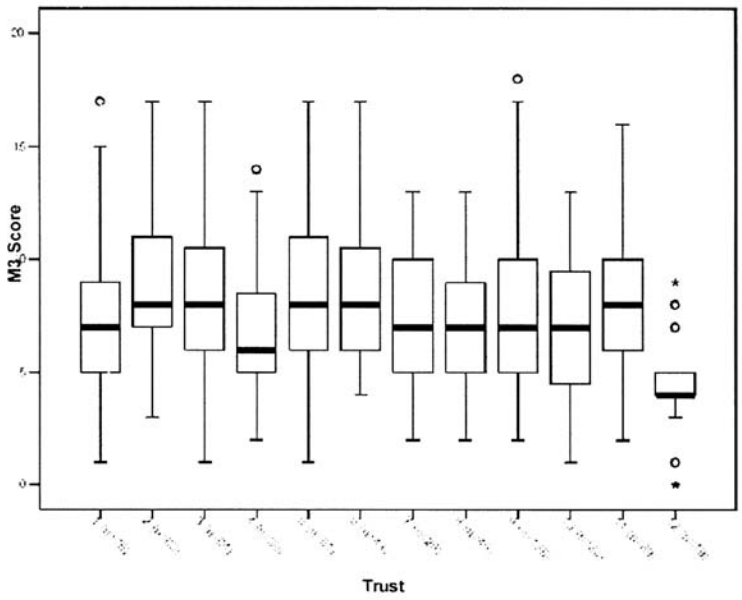
Summary Scores of severity

M3 scores

Higher M3 scores indicate more severe mental health problems. Trusts 2, 6, 5 and 3 had mean M3 scores at the higher end of the range (8.9, 8.5, 8.5 and 8.4 respectively). Trust 12's caseload had the lowest mean score (4.5), however the M3 score could only be calculated for 19 service users in this PCT.

Figure 1 summarises the range of M3 scores for the trusts. The median score is indicated by the line across the box; Trusts 2, 3, 5, 6 and 11 had the highest median score, 8. Trusts 7, 8, 9 and 10 had a median score of 7. Trusts 12 and 4 had the lowest median scores (4 and 6 respectively). Both were PCTs.

Figure 1. Boxplot of M3 scores

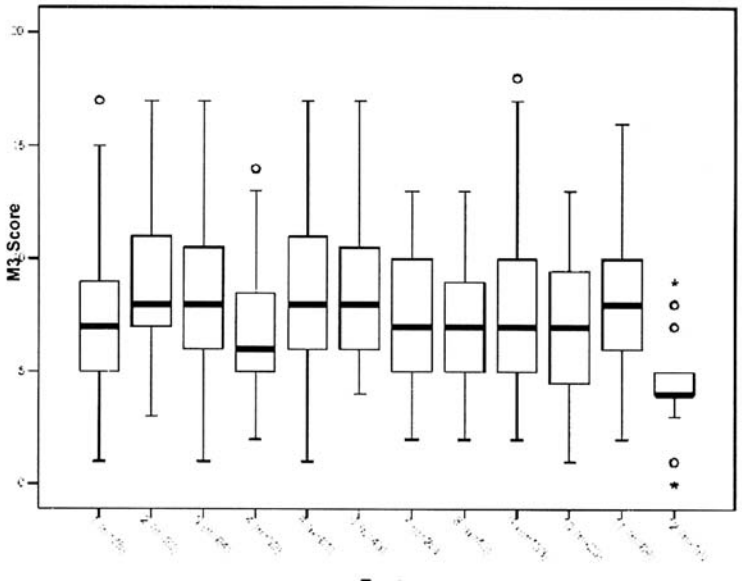


GAS scores

Lower GAS scores indicate more impaired mental health. Four trusts (1, 3, 9 and 11) reported having a service user on their caseload with a GAS score of zero. Six trusts rated at least one service user's GAS score as being 90 or above. Trusts 10 and 2 had the lowest mean GAS scores ($p < 0.05$), Trust 4 (a PCT) the highest ($p < 0.01$).

Figure 2 summarises the range of the GAS scores for each trust. Trust 10 had the lowest median score, with Trusts 2, 8 and 11 scoring a median of 50, and Trusts 3, 5, 6 and 9 scoring 51. The highest median scores were found in Trusts 4 and 12, with scores of 61 and 60 respectively. As noted previously, both were PCTs.

Figure 2. Boxplot of GAS scores

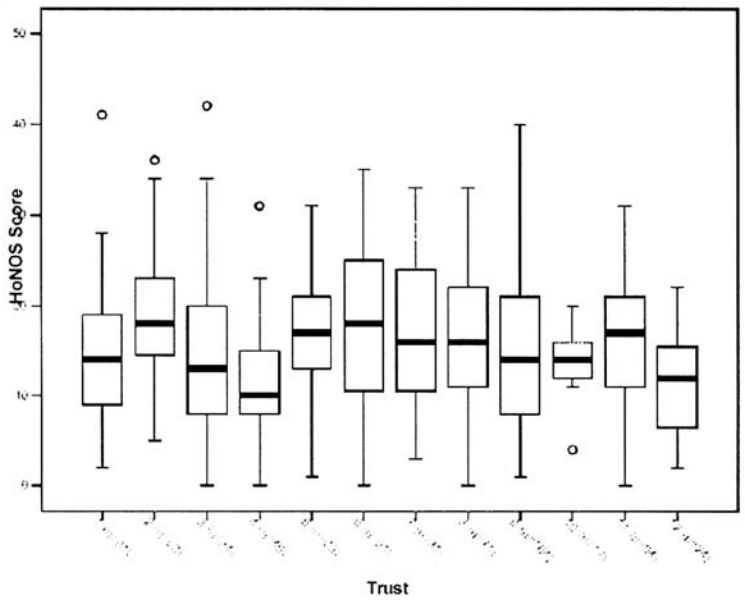


HoNOS

Higher HoNOS scores indicate more impaired health and social functioning. Trusts 2 and 5 had the highest mean HoNOS scores, 19 and 17 respectively. Trusts 12 and 4 had caseloads with lower mean HoNOS scores, 5 and 7 respectively.

Figure 3 summarises the HoNOS scores for the trusts. Trusts 2 and 6 had the highest median HoNOS scores (18). Trust 4 had the lowest median score (10).

Figure 3. Boxplot of HoNOS scores



Discussion

AO teams in the north east show high fidelity to the standards of AO with respect to 14 indicators, compared to PLAO's high fidelity rating for 9 indicators. However the north east teams were at a slightly earlier stage of their development compared to the London teams (around 7 months), and their caseloads were smaller, with about 8 clients for each care coordinator, as compared to 9 in London.

The Policy Implementation Guide (2001) states that the AO service is intended for adults with severe and persistent mental disorders, with a history of high hospital use, and multiple, complex needs. In the north east caseload, 95% of service users had a psychotic illness compared to 74% of service users in the PLAO survey (Priebe et al, 2003), and 86% had been compulsorily admitted in the previous two years compared to 56% in the PLAO survey. Almost a third of people in this study were judged to have 'problematic alcohol use', and nearly half of them had attempted suicide in the past. Yet low fidelity to the AO model was found in relation to treatment for dual diagnosis, having a full time psychiatrist in the team, and being responsible for crisis services. In all these respects, AO teams in the north east resembled the London AO teams (Wright et al, 2003). By comparison with generic community care for people with severe mental health problems, their needs and severity were high (Schneider et al., in press).

It has been reported that M3 scores for clients served by community health (CMH) teams in two districts were significantly lower than those of the north east AO service users ($p < 0.05$; Schneider et al., in press). The mean scores for all of the trusts except Trust 12 were 7 or above. The three trusts with the lowest scores were Trusts 12, 10 and 4, all run by Primary Care Trusts (PCTs).

For the GAS, the mean for six trusts was between 43 and 50, suggesting more serious symptoms or serious impairment of functioning; the other trusts' means were between 51 and 60, indicating moderate symptoms and difficulties. The highest mean scores were found in Trusts 12, 7 and 4, again, trusts run by PCTs.

The interviews with team managers suggest that implementing the service was not without difficulties in some areas. A lack of understanding of the role of AO services resulted in issues about which service users would be included. Furthermore, there were negative reactions from other mental health services as a result of staff being recruited from existing CMH teams, and because of the low caseloads of the AO teams. However, largely because of the evident benefits produced by the AO service, attitudes towards the teams are now more favourable.

Conclusion

These findings suggest implications for service development. Providers should be asking if their services compare with the benchmarks given here, as well as the DACTS. In particular, are they meeting the needs of clients with respect to employment, substance use and 24-hour attention?

The discrepancies found with regard to AO teams run by PCTs may warrant further investigation. These differences appear to indicate lower thresholds to admission to AO caseloads in PCTs, but they could be related to local referral practices. Moreover, the phenomenon may be transient, in which case differences would disappear as PCT-run AO teams attain their full operational capacity.

Further development in mental health services, including Early Intervention and Crisis Resolution/ Home Treatment teams and, in some areas, the dismantling of CMHTs, will impact on AO teams. So will selection of clients as teams reach their caseload complement, and learn which people they can work with effectively. This paper provides a baseline for future comparisons.

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