Outreach, Engagement and Recovery

Working with a Mental Health Service for Homeless People in South London

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- A description of the service and its history
- Components of outreach
- Our “Care Pathway”
- What the team does
- Relationship with voluntary sector

Some UK – Specific Definitions

- **Health Trust** – the basic organisational unit of the NHS in England and Wales. It can be an individual hospital or community service but is usually more like a consortium of services.

- **Primary Care Trust** – the local commissioning body for health services

- **Voluntary Sector** - charity/NGO/not for profit businesses/social firms, eg St Mungo's, Thamesreach

- **Care Pathway** – the series of individual encounters, services and interventions that an individual may go through as a consequence of a health problem

Blackfriars Salvation Army Hostel 1985

Blackfriars Salvation Army Hostel 1985

Thamesreach 1st Stage Housing Project 2000

London Outreach "System"

Pre-1999:

- No central direction or organisation
- Hostels run by Department of Social Security and voluntary sector
- Hostel and street population mainly indigeonous white people with schizophrenia or alcohol problems
- Voluntary sector free-for-all
- Innovation, but ….
  - Much duplication of services, especially in street outreach
  - Little coordination between agencies competing for funds

London Outreach "System"

- 1995 DSS hostels leased to voluntary sector homelessness agencies
- 1999 "Rough Sleepers Unit" established by government
  - All London "homelessness" funding centralised to this unit
  - Street services strictly sectorised – one team per area.
  - Voluntary sector agencies (NGOs) invited to bid to provide street outreach services
- SPOT Teams
  - Work over 24 hours
  - Client has to be seen sleeping twice in the same location
  - Direct access hostel for around 6 weeks
  - Appropriate move-on

START Team Purpose

An NHS mental health service for people who have:

- Severe and enduring mental disorders
- Are homeless, or have a history of relapses into homelessness
- Are unable or unwilling to engage with local mainstream mental health services

Where are we?

Who do we see?

- M:F 5:1
- 70% white
- Mean age 34
- Increasing numbers of:
  - Refugees
  - Asylum seekers
  - Mobile EU citizens with psychotic illnesses

Diagnostic groups

- Schizophrenia
- Alcohol / substance abuse (as a co-diagnosis)
- PTSD / Adjustment Disorders
- Bipolar disorder
- Depression
- Personality disorders

Components of Outreach Provision I

Outreach Level

- Primary: Setting up an independent day centre/hostel/street outreach team
- Secondary: Working through existing hostels, day centres and outreach teams
- Tertiary: Setting up a specialist clinic within existing health services

Components of Outreach Provision II

Temporal Arrangements

- Regular informal visits
- Appointment system – through voluntary sector staff
- Drop in “clinic”

Components of Outreach Provision III

Site of Service

- Single / Multiple
- Static / Mobile
- Health service
- Social service
- Voluntary sector
- Street

Type of Service

Clinical provision (Specialist/GP)

Liaison/facilitative

Educational

Gateway vs Alternative

Team/single worker

Educational

START

- Specialist mental health team
  - 14 Multi-disciplinary staff + senior psychiatrist
    - Nurses, SWs, OTs & now a psychologist
  - Open referral system
  - Multiple sites (mainly in voluntary sector)
  - Appointment system + some sessions
- Training unit linked to clinical team
- Linked with housing organisation – Thamesreach

Three 12 – 20-bedded first-stage projects

Thamesreach 1st Stage Housing Project 2000

START Team - Organisational Context

Legal System
Home Office

Benefits
System

Local Authorities

Housing
Social Services

Voluntary Sector

NGOs
Hostels, day centres,
street outreach teams

NHS Health Services

GPs, clinics, hospitals,
rehabilitation facilities

START Team

Thames
reach

MH Assertive
Outreach
Teams

Clients

Primary Care Team

Interventions - Engagement

"The most critical ingredient in providing such help is....the establishment and maintenance of a trusting and meaningful relationship between outreach worker and client a continuous relationship model." (Gary A. Morse et al., Community Mental Health Journal Vol.32, no3, June 1996. p.261-274)

"Homeless people seem to engage better with people that with systems" (Sean Spence, the Psychiatrist. 2009)

Interventions - Engagement

Engagement in hostels/day centres/on streets

- Establishment of trust/rapport
    - Regularity
    - Reliability
    - Attending to clients priorities
    - Practical assistance – housing, benefits
    - Balance between being too assertive or too passive
    - Focussing as much on the impact of your intervention as on symptoms
    - Accepting your client's timetable for "opening up"

Engagement and Assessment

Assessment is informal and less traditional, performed within the process of engagement:

Careful observation

Multiple, perhaps quite brief, meetings

Establishment of collateral and historical information

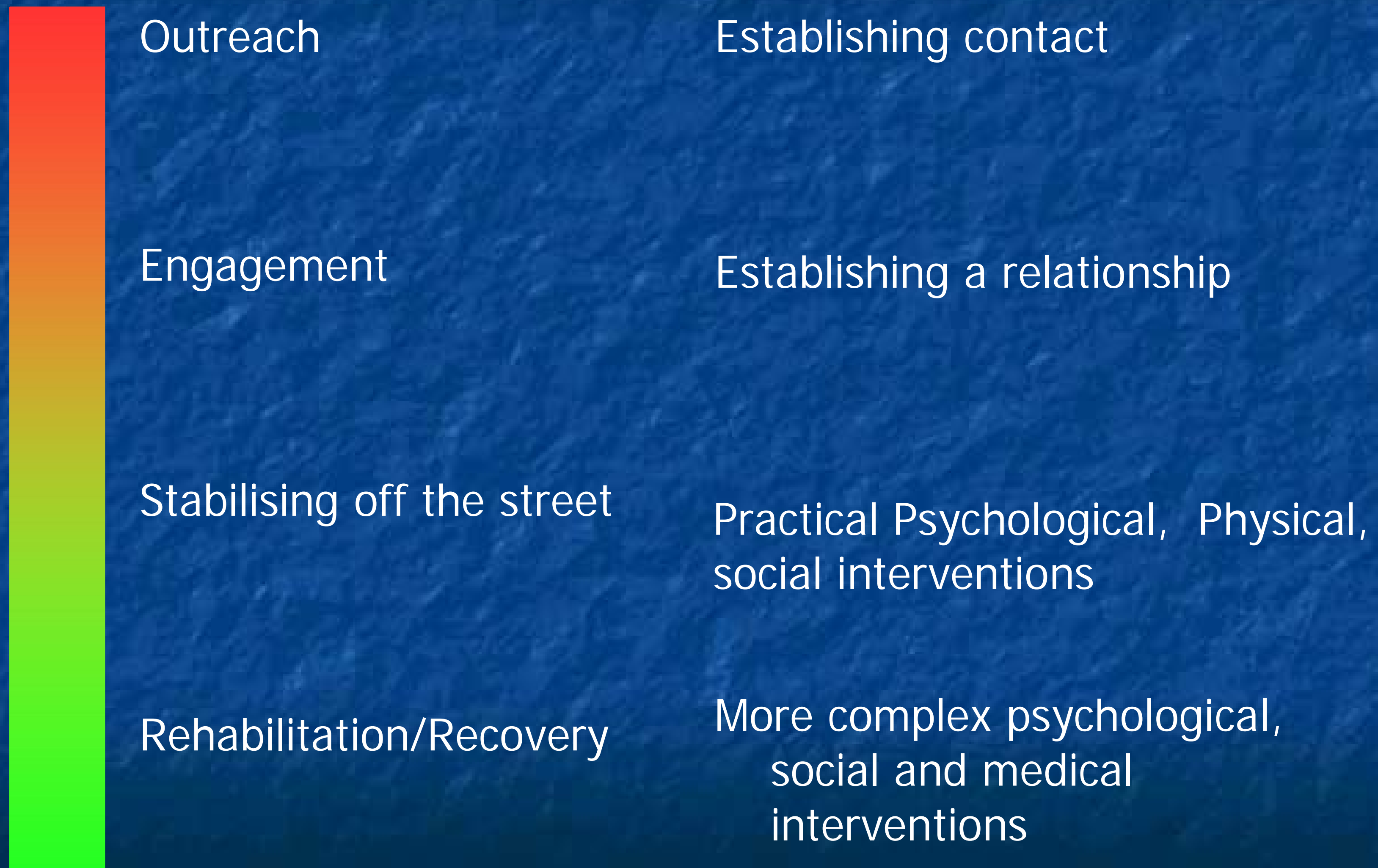
Informal conversations

More direct questioning after building a relationship

Interventions

- Formal psychotherapeutic interventions (CBT, solution-focussed techniques, motivational interviewing)
- Pharmacotherapy
- (Rehabilitation activities / work training)

START Care Pathway – 4 Stages of the “Continuous Relationship Model”

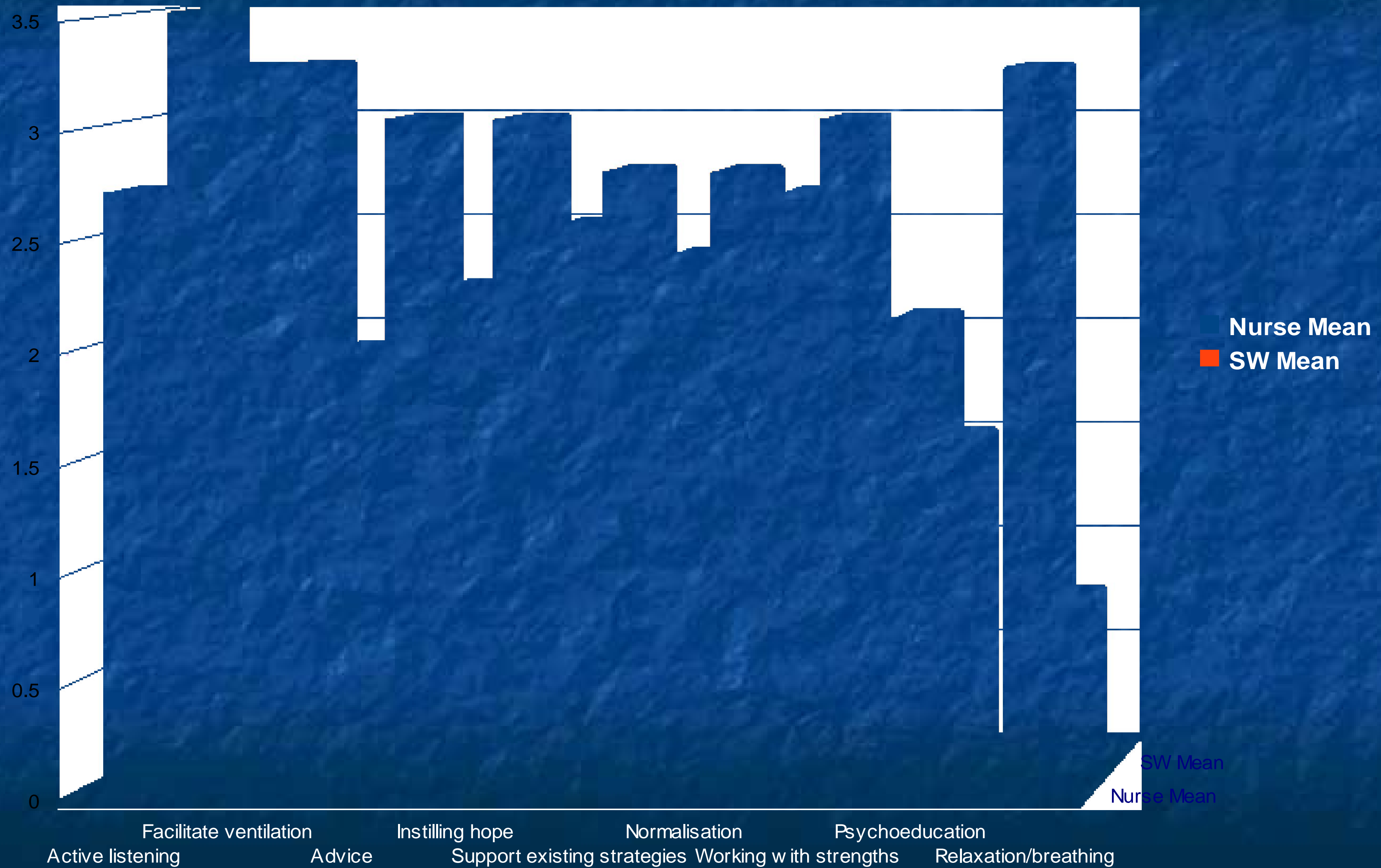


But – apart from the assessment of symptoms -

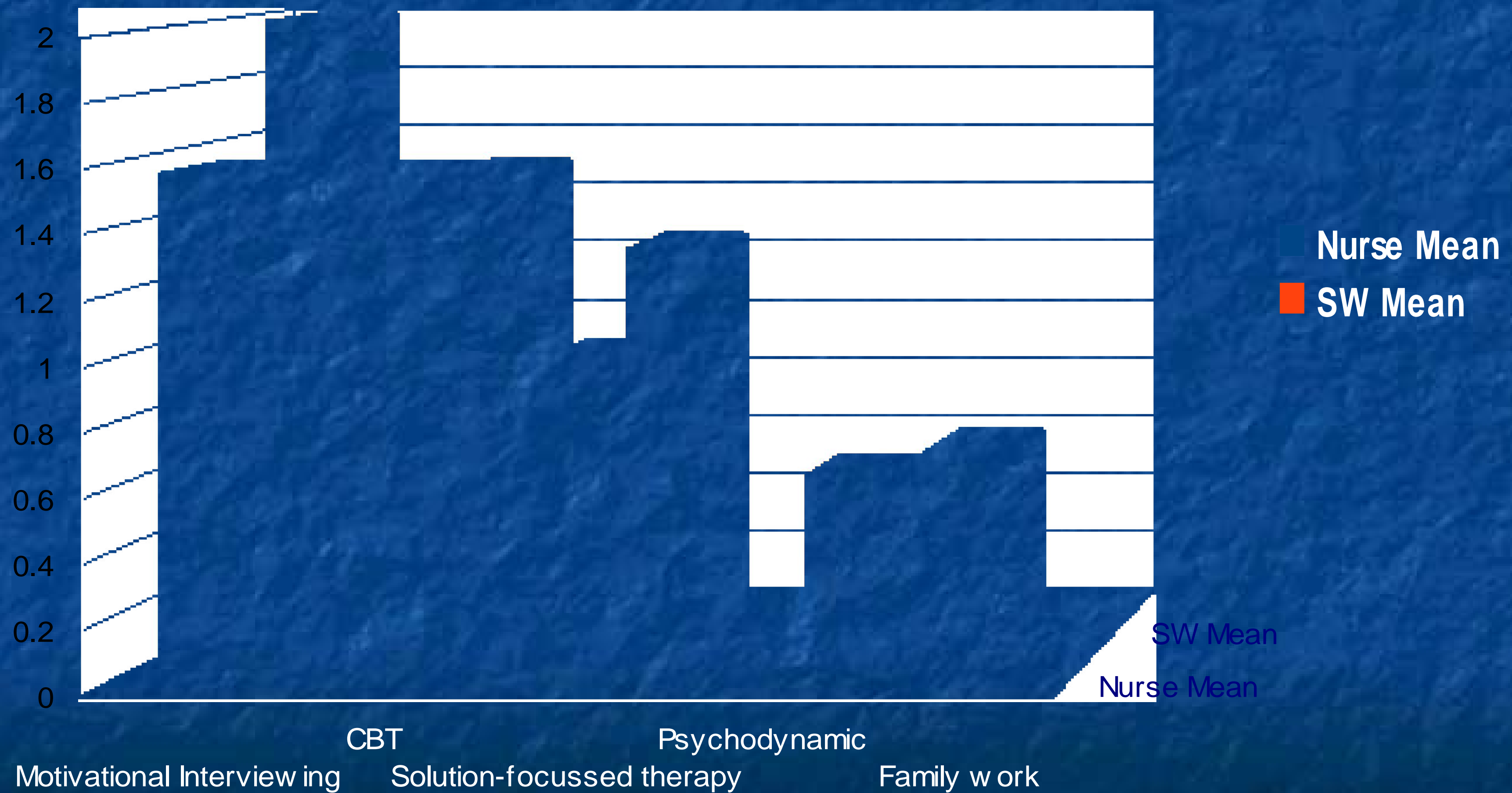
What value do we add as mental health workers?

Presumably it's psychological ….

START "Supportive" skills



START "Therapeutic" Skills



“Supportive Psychotherapy”

- “The term … has many different meanings ….”
- ….. is difficult to define”
- …… is what every good psychotherapist should be doing anyway …..
- “Good clinical care”

Supportive Psychotherapy I

- Active listening:
  - Acceptance
  - Encouragement to express emotional material (ventilation)
- Explanation/education – to boost self-confidence:
  - To increase the client's understanding of their situation
  - Identification of personal strengths
  - Appropriate reassurance
- Guidance - giving advice usually with reference to a specific problem, such as:
  - When to seek help
  - Where to get it from
  - How to ask appropriately

Supportive Psychotherapy II

- Encouragement
  - Statements of optimism
  - Reinforcement of clients achievements
  - Reinforcement of any +ve statements by client
- Developing coping strategies, working with defences
- Changing the environment (eg EE/Family work)
- Practical assistance – accompanying
- Sessions of variable length according to what the client can tolerate

Candidates for SP

- Poor adherence to treatment
- Erratic engagement with services
- Unable to take the responsibility for/initiative in addressing problems
- Poor tolerance of stress
- Limited number of rigid coping strategies
- Stuck in a sick role
- Lack of a specific problem focus

Meaden & Van Marle (2008) When the going gets tougher APT 14:42-49

Aims of SP

- Establish & maintain therapeutic alliance
- Holding and containing (both client and team)
- Promote stability
- Encourage maturation of psychological defences with a better adaptation to reality
- Recognition and containment of transference reactions

Effective SP Depends on:

- Therapist attitude
  - Not expecting unrealistic/quick results
  - Able to tolerate distress in the client
  - Able to tolerate working with a less formal model of psychological intervention
  - Able to identify transference issues/splitting when they arise
  - Unflappability
- Team attitude
  - Not expecting unrealistic/quick results
  - Able to resist organisational demands for “throughput”
  - Willing to acknowledge itself as a “container” for the client
  - Psychological expertise “in house”
  - Willing to spread the load eg joint key working/whole team app.

Outreach

Engagement

Supportive psychotherapy

“Helpful talking”

But is this all really necessary?

‘ Those clients who have been engaged, whose trust has been won, and who have been ‘linked’ to existing service providers…after all that effort has been expanded, slip into their interstices of a system all to willing to see them disappear’

Hopper et al (1990) in Morse (1996)

Fin

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Outreach in England/Wales

- Withdrawal of government from direct provision
- Increased government activity as a purchaser and standard-setter for services has achieved concrete results
- The results of current devolution are unclear
- The burgeoning voluntary sector
- "Outreach" incorporated into general mental health care

Problems

- Liaison with voluntary sector
- Liaison with wards and CMHTs
- Lack of clinical psychology input
- Poor infrastructure for physical health
- New patterns of morbidity
- Lack of opportunities for work/occupation

Costs

START Team

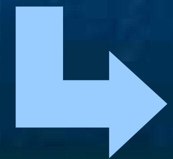
- Funding from central government
- Administered by local PCT (commissioning agency)
- £ 500,000 per year for clinical service
- £ 100,000 per year for training unit

Thamesreach Hostels

- £500,000 per hostel per year, mainly funded from housing benefit payments

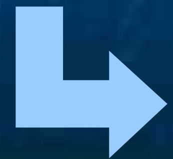
Organisational Working

- Acknowledgement of voluntary sector's contribution
- Service level agreements (SLAs)
- Mutual involvement in interviewing/recruitment
- Annual reviews
- Joint training programme for day centre and hostel workers
- Joint planning
- Joint purchasing



First Stage Housing - Overview

- 3 buildings with 12 small flats each
- Additional 8 bedsits in 1 project
- Sited in residential streets within 1 mile of river
- Admissions from START and street outreach teams



First Stage Housing – Staffing

- Housing workers employed by Thamesreach
- 2-3 staff on-site 08.00 to 20.00
- Staff member on-call overnight
- Meals provided at 1 project
- Keyworking system
- Some on-site activities