

**ANTENNA
OUTREACH
SERVICE**

**OPERATIONAL
POLICY**

APRIL 2004

1. Organisational Details

Name of organisation

Antenna Outreach Service

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1.1 Health & Safety

Antenna Outreach is compliant with the Health and Safety Act 1974. The policy covers compliance with associated acts and regulations such as the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1985 and the Code of Practice on In-service Inspection and Testing of Electrical Equipment 1994.

Other policies aimed at ensuring health and safety include:

- Fire Prevention and Safety
- Lifting and Handling
- Procedure to Follow in Even of an Accident
- Smoking
- Incident Reporting Policy Violence and Aggression - Prevention and Management
- Food Hygiene

Mechanisms for ensuring compliance include Announced and Unannounced Quality Audits, Announced and Unannounced Health and Safety Inspections.

1.2 Employment Practices and Race Relations

Antenna Outreach has a fully developed Equal Opportunities framework governed

by its Equal Opportunities Policy, which sets out the team's commitment to Equal Opportunities in respect of employment and service provision through compliance with:

- Sex Discrimination Act 1975
- Race Relations Act 1976
- Disability Discrimination Act

In addition to the Equal Opportunities Policy, Antenna Outreach employs the following policies and procedures:

- Recruitment and Selection Policy
- Management of Staff: Induction, Supervision and Appraisal Process
- Complaints Policy
- Code of Practice for Employees

2. Nature of Service

Introduction

Antenna Outreach Service offers a professional service for Black African and Black Afro-Caribbean young people ages between 16-25 years, suffers the effects of mental illness. Implicit in its service delivery are the ethical principles which staff are bound and responsibilities to maintain.

Antenna's Assertive Outreach Service provides a flexible and creative client-centred approach to reaching those most disengaged from society and services. It will provide service users with reliable long-term, intensive support to meet their complex health and social needs and wishes in order to sustain community living and enable users to take up active roles as citizens.

2.1 Service Structure

Antenna Outreach proposes a model of multi-disciplinary intensive assertive outreach provided by a multi-skilled team of workers, which will provided integrated health and associated social care. The team is community based and has direct links with a range of local services including, primary health care, housing provision, training and employment services.

2.2 Service Operation

The Service will operate seven days per week, 365 days per year.

The team will offer a range of support and interventions.

- Assertive Outreach
- Intensive community support
- Trusting and supporting relationships
- Practical assistance and problem solving

- Symptom management including self-management
- Family work and support for carers
- Life skills training
- Education and information about medication and side effects, to promote compliance
- Daily medication administration where needed
- Enabling access to occupation, training, leisure and services
- Out of hours on-call support

Evidence based practice

The service is focused on forms of support, which have been demonstrated to be effective and are valued by service user and carers, such as frequent contact, warm and positive relationships and practical assistance with problems of everyday life.

2.3 Staff Composition

The team will consist of a mix of qualified and experienced staff from a range of disciplines including psychiatry, social work and mental health nursing. There will be a range of knowledge and expertise within the team so that individual team members can act as resources for the team as a whole.

The proposed staffing structure is based on providing service for 52 service users, seven days per week.

The proposed staffing model is as follows:

- Project Manager
- Team Leader
- Psychiatrist
- Assertive Outreach Workers
- Admin Worker
- Medical Secretary
- O T

- Dual Diagnosis Worker
- Social Worker

2.4 Knowledge and understanding of service area and key issues

A number of key issues will need to be explored and addressed by the service.

Targeting the service

A clear focus will need to be maintained on the target client group and the agreed referral criteria.

Caseload management

Caseloads will need to be maintained at the optimum level if the desired outcomes are to be achieved. Evidence from established services suggest that care should be taken to build up caseloads gradually in the first instance as the team develops confidence and expertise.

Evidence based practice

We need to know which interventions work and which are most highly valued by service users and carers.

“The content of care must include evidence based psychosocial interventions but service users needs and priorities must be a guiding principle” (Geoff Shepherd, Journal of Mental Health 1998).

Team approach/case management

The benefits of the team approach are considerable in terms of shared ownership and flexibility but we still need to be able to foster a sense of professional accountability and to ensure high standards of individual case management.

Team communication

There is a need to ensure effective day-to-day communication systems. Mechanisms such as daily handovers, use of white boards, team meetings and group supervision will be very important in achieving this. Staff will be issued with mobile telephones to ensure contact and facilitate speedy notification of changes in visits etc.

2.5 Engaging and keeping contact with people who are difficult to engage

The target client group will be characterised by being difficult to engage with more traditional mental health services. Some of the reasons for this may be:

- Suspicious about mental health services.
- Had previous negative experiences of mental health services.
- More traditional mental services have not had the skills or resources to sustain engagement with the client group.
- Service users have not perceived services as helpful or able to meet their individual needs.
- The negative symptoms experienced by people with severe mental health needs have meant that they are unable to engage with services or articulate their needs.
- Chaotic lifestyles or involvement with the criminal justice system has meant that access to such services has been limited or that service users have slipped through the net.
- Experienced distressing side effects of medication.
- Felt coerced or dis-empowered by previous treatment or been subject to a section of the mental health act.
- **Engagement** - Recognising that for many service users the establishment of a trusting and therapeutic relationship will take time and that the consistency and reliability of the service will be key to sustaining this relationship.
- **Practical support** - Much of the work with the service users will be of a practical nature, and will be such things as assistance with domestic tasks, shopping, welfare benefits and housing advice and support.
- **Intensive contact** - Service users will require a high level of contact due to the nature of their complex needs. There is a need for flexibility in order to take up opportunities to establish contact with a service user.
- **Range of expertise** - The Assertive Outreach Team will have a range of skills and experience.

2.6 Participation

Participation is a vital antidote to social exclusion and must be a key feature of the

Assertive Outreach service. The participation of both service users and relatives can be facilitated in many ways and the service needs to develop a variety of opportunities for people to put forward their views. Examples include:

- **Care planning** - The full participation of service users in care planning based on a model of building on individual strengths and working towards personal aspirations would facilitate and enhance engagement with the service and both build and sustain relationships where previously people may have mistrusted services or due to the illness and lifestyle were not able to link in to more traditional models of service delivery.
- **CPA reviews** - For service users and carers to have a meaningful input and full participation in the CPA process and to feel that their views are being listened to, respected and incorporated into any CPA plan again to facilitate engagement.
- **Medication** - For many service users medication non-compliance is a major cause of deterioration in mental health status leading to admission to hospital. To increase compliance, the sharing of information in this area is likely to assist in compliance.
- **Therapeutic engagement** - Through working with people over a prolonged period of time and in establishing and sustaining a relationship with service users, individual work could be done with service users and carers to enable them to gain in some insight and understanding of the illness.
- **Service user evaluation** - We would ensure that service users were instrumental in service development through systematically eliciting feedback, consulting with service users and carers throughout the development of the service and on an ongoing basis and through the involvement of service users in staff training.

3. Clinical Definitions

3.1 Philosophy/Mission Statement

Working Together with the individual, family and community to effect change.

The Outreach work has three central components to its core work as described below:

Aims:

1. **Early intervention**
2. **Prevention**
3. **Sustaining young people in the community**

Objectives:

- To deliver a service that reflects both the mental health and aspirational needs of the client and primary carers.
- To raise the level of awareness in the black community regarding mental health care in the community.
- To develop an outreach service to the client, family and community that operates within a culturally sensitive framework.
- To enhance the quality and level of integration of the outreach service with mainstream care agencies in Haringey.

3.2 Quality Assurance Group

The Quality Assurance Group

The QA group is a team forum where all staff in the Haringey Outreach Service Team can participate in determining service development and the monitoring of current departmental practices.

Objective

To ensure that the Outreach Teams provides a high quality treatment and service planning for the client group it has been commissioned to provide for within Haringey and Edmonton.

3.3 The Clinical Review Group Protocols

Purpose

The aim of the clinical review group is to provide a forum for all staff to discuss ongoing problematic clients, with a view to their ongoing management, progress and potential discharge.

Resources

- Active client list available
- To be held (to begin with) every month

- The Clinical Review Group will be minuted
- To be chaired by Team Leaders
- The chair will ask for a volunteer to discuss a client (please see agenda).

Structure

- To provide peer clinical discussion
- The voluntary team member (for that particular week) will discuss a client of their choice highlighting problems, difficulties or progress they wish to share with the team.
- This group can be used to inform team of positive clinical outcomes.
- Follow ups to provide brief update of active clients, as requested by the Chair.
- It is expected that all team members will take it in turns to present a case for discussion.

3.4 Slow Intake Model

The Aim of the Assertive Outreach Service:

The principle aim of the Assertive Outreach Team is to engage those clients who have demonstrated a reluctance to use mainstream services and who because of their non-engagement with existing support services are considered to be at risk of breaking down or hospitalisation. In practice this often means clients who regularly miss fixed appointments, or who have a history of non-compliance with medication, excessive use of recreational drugs or alcohol, due to their chaotic lifestyle have been identified as being at risk to themselves or others.

The origins of (Pact) programmes in community treatment came from the highly successful (TCL) Training in Community Living Programme developed during the 1970s in Madison, Wisconsin (Marx et al, 1973). The architects of the programme Arnold Marx, Leonard Stein, and Mary Anne Test recognised contemporaneous community treatments did little more than maintain the chronically disabled patient in a “tenuous community adjustment on the brink of re-hospitalisation” (Stein and Test, 1980). Marx, Stein and Test argued the needs of patients should not be confined to just the treatment of their illness. An effective community treatment programme should address the material needs of the clients such

as food, clothing, shelter and the coping skills required to enable the client to sustain themselves in the wider community (Kent and Burns, 1966).

Another key observation concerned the expectation that the socially disabled patient would come to the clinician was replaced with the expectation that the clinician would be assertive in delivering care and go to the patient (Kent and Burns, 1966).

Engaging the client

The Assertive Outreach Service will be unique in its approach to its target client group of 16-25 year old black African and African Caribbean clients by virtue of the fact the whole operational and clinical team will be drawn from the above cultural background. In essence this should enhance the level of sensitivity and understanding of the psychological, socio-economic and cultural needs of the targets client group.

“If we consider the core task of engagement is to build and foster a positive attitude on the part of the patient to both the key worker and treatment” (Kent and Burns 1966), we can then begin to conceptualise the importance of the Assertive Outreach Workers using their own individual and cultural experiences to inform their direct practice with the client.

The Team Approach

One of the major planning tools the Assertive Outreach Service will be using to draw on the individual and collective experiences of the clinical work is known as the Team Approach Model. This may be described as all the workers acting together, thinking together in decision making and sharing responsibilities towards clients (Navarro, T 1995). The team will also receive fortnightly clinical supervision as part of the ongoing commitment to working reflectively with the clients. In conclusion the three guiding principles for using this approach are:

- Improved continuity
- The benefits of “two heads being better than one”
- Reduced stress for workers (Gauntlett ‘Ford’ Muijen 1997).

4. Pathways

4.1 Referral Guide

1. Fill out initial referral form
2. Label three plastic sheets
 - Initial referral form
 - Admin document
 - Clinical diary (each with client’s name)
3. Place in referral folder in alphabetical order
4. Put name on client audit board
5. Send out Action Sheet
6. Send out information to client
 - Antenna leaflet
 - Antenna fact file
 - Antenna 24-hour helpline
7. Send out information to parents
 - Information on Antenna
 - Letter from Maxine
8. Information to be sent out to Organisation who do not have Antenna information
9. Discuss at new referrals or earliest meeting space
10. Make necessary calls to gather information
11. Book first visit
12. Visit client in pairs for six visits, one with Consultant and one social assessment whilst in the community.
“Order is essential for the universe”

4.2 Inactive Pathways

Antenna Inactive Guideline

Introduction

Inactive clients are those clients, which the Outreach Services are not regularly visiting, but who are still included in Antenna’s no close policy.

When a client becomes inactive either by a unilateral choice on the part of the client or by an agreement between the client and the Outreach Services. The client should be assured that the services are available should it be required in the future. The services are:

- Outreach support both practical and emotional.
- Medical information required for Court, benefits, etc.
- Access to 24-hour helpline number

- Access to counselling by a member of the team.
- Family support.

If the client decides that they do not want the support or simply withdraws, the Outreach Service makes an assessment, which will determine the level of risk. The assessment includes the responsible medical officer's assessment of the client's mental state.

If three planned visits with the RMO are unsuccessful the team will make the client inactive.

Inactive Plan

The inactive plan consists of:

- Inactive standard letter
- Inactive information form
- Inactive contact form
- Risk Assessment form.

Inactive Form

- The inactive form should be completed as part of CPA on all clients made inactive by Antenna.
- The forms should have details of the client, which is required to monitor and review its effectiveness.
- The inactive plan forms, if unable to be completed as part of the CPA, should be done as part of Assessment Review Meeting.

Inactive Letter

Inactive letter should be sent to all agencies including parent/carers that are involved with the client.

Inactive Contact Sheet

The contact sheets records information and action of other agencies contacting Antenna about the client.

Risk Assessment

An important aspect of the assessment of risk is to state and determine the risk to self and others and the client's level of vulnerability, especially with regard to their mental illness.

The risk assessment should consider the level of alternative care that is available.

- The risk assessment will follow the guidelines on risk assessment and management by Barnet, Enfield and Haringey Health Care Trust.
- Antenna Outreach Service recognise the views of parents/carers in relationship to risk may differ to that of the service. The Quality Development Unit London states 'people with schizophrenia, particularly young people who are unemployed and have more serious recurring illness causes a lifetime risk of suicide 10%.
- Antenna recognise positive risk taking has possible benefits as well as harm as such. When assessing risk there may be tendencies to focus on harmful outcome, which may produce an unbalanced risk assessment.
- Antenna Outreach Service recognise that young people may pose some of these risk.
 - Drug abuse/misuse
 - Criminal offences
 - Delinquent behaviour
 - Risk due to influence of peer group
 - Social/physical abuse exploration
 - Family conflicts
 - Homelessness
 - Social exclusion/isolation

Reactivated Clients

Antenna recognises from time to time clients who have been made inactive will return to the service either on their own volition or concerns expressed by agencies involved or parents/carers.

Antenna model of apparatus is the fidelity to Act Model of Assertive Outreach, which states that Outreach Services should operate a no close policy.

Assessment

The initial assessment with the client should state why Outreach Service is required. In order for the client to receive the service, consideration should be given to:

- Any changes in mental state
- Service actively i.e. full caseload, waiting list.
- Parents/carers assessment of what has changed.
- Information from other organisation or agencies

The above information should be gathered either:

- Via telephone, letter, facsimile or e-mail.
- A planned face-to-face assessment.

The planned assessment should be carried out by any member of the Outreach Team as a joint visit either with colleagues or other agencies, parents/carers.

Discussion with the team at the first available space is required in order to give a quick response as to whether the client will receive service or not.

Formation for reactivation

If client is in crisis when reactivated refer to ERC.

- I Telephone GP/carer/Social Worker/other to be completed in 48 hours.
- II Organise scheduled appointment to visit client if required after contacting the above agencies.
- III Initial visit to be joint with RMO/Consultant within one week.
- IV Second visit to be conducted in the community with client.
- V Discussion with Team in morning handover on Tuesday or Thursday to configuration future working plans with client.
- VI If activated, client to be placed on board for scheduled visit and client to be informed (this is only the case if Antenna is not working to full capacity)
- VII When Antenna caseload is full, or after assessment, it is not feasible for Antenna to work with client. Client to be referred to appropriate alternative agency.
- VIII Assessment summary and risk assessment to be forwarded to alternative agencies.

5. Care Programme Approach (CPA) and Care Management

Keyworker

The statutory keyworker under CPA will be a member of the Assertive Outreach Team. It is not anticipated that the keyworker will have responsibility for care management budgets or brokerage with other service providers.

The team approach adopted by this model of service will mean that the CPA keyworker will have a pivotal role in the co-ordination of care, specific interventions and support for service users, and for the regular reviewing of the care plan on a multi-disciplinary team basis.

It is anticipated that all professionally qualified members of the Assertive Outreach Team will take on the CPA keyworker role with the unqualified members of the team having co-working responsibilities.

Care Plan

Because of the anticipated needs of the client group the care plan will be complex and multifaceted, requiring interventions from several members of the team. The care plan assessment documentation will be developed jointly with the partner agency, however, it is anticipated that the core areas will be as follows:

- Psychiatric/mental state
- Risk
- Substance use
- Physical health status
- Daily living/life skills
- Housing/accommodation
- Welfare benefits/finances
- Family/carers
- Social networks/relationships
- Employment/occupation
- Spiritual/religious
- Cultural
- Sexuality
- Legal status

The development of the CPA documentation and assessment tools will be based on the 'strengths' model which aims to focus on identifying individuals strengths, realistic goals and personal service user aspirations, rather than on deficits and problems. The aim of this approach is to facilitate the engagement process and build and sustain positive relationships with the team.

CPA Reviews

As all clients will be on enhanced CPA reviews will be held every three months as a minimum. CPA reviews will be on a multi-disciplinary basis with full service user and carer participation.