Assertive Outreach in England – Personal Reflections on the Evidence Base and Evolution from a Career on the Frontline

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Abstract

Assertive Outreach, also known as Assertive Community Treatment, is a service model of psychiatric care that has followed a complex course in the United Kingdom. This article aims to chart its evolution in England from the perspective of a frontline clinician. It highlights the societal drivers and evidence base that led to its introduction, factors leading to its subsequent demise and finally its potential future direction. It is hoped that this perspective might inform the use of this model in other countries for patient populations who stand to benefit.

On the 3rd of July 2025 the UK Government published it's NHS 10 Year Plan for England (1). Entitled "Fit for the Future", it set out its vision for the next decade of state healthcare. Broadly speaking it focussed on three areas: moving the location of care from hospitals to the community, increasing digitalisation of healthcare and moving from treatment of illness to preventative measures. It described the role of community mental health teams and on page 35 of the 168-page document this line appeared, "We will improve assertive outreach care and treatment to ensure 100% national coverage in the next decade, with a focus on narrowing mental health inequalities".

Having worked as an Assertive Outreach psychiatrist for over 20 years I am sorry to say that during the course of my career this clinical model which once enjoyed national coverage in England is unheard of in two thirds of the country. With this renewed interest however, I have been approached many times by colleagues eager to hear more. Assertive Outreach is nothing new. As a model it evolved during the early 1970s in Madison, Wisconsin as Assertive Community Treatment (ACT) in response to the deinstitutionalisation movement in the US and Stein and Test's landmark study was published in 1980 (2). It arose from the observation that many people discharged from psychiatric hospitals had very poor outcomes with homelessness, readmission or offending behaviour resulting from inadequate community support. The study which showed benefits in reduced hospital use and better housing stability spread rapidly across the US before its implementation in Canada and Australia. Assertive Community Treatment (ACT) developed in parallel to other models including Crisis Resolution Services, to provide short-term intensive support for people experiencing a

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mental health crisis and more traditional outpatient care. The emergence of ACT acknowledged the need for more continuous, intensive, holistic and coordinated care for those with severe mental illness.

Whilst there had already been some interest in ACT in the UK, a tragic catalyst in 1992 significantly boosted its uptake. At around 3pm on Thursday the 17th of December 1992, a man named Christopher Clunis fatally stabbed a stranger Jonathan Zito on a platform at Finsbury Park Station in London. The subsequent independent inquiry, the so-called Ritchie Report (3) highlighted a systemic failure of mental healthcare for those with severe mental illness who were poorly engaged with services, a lack of robust risk management, poor coordination of care between hospitals and the community, inadequate provision of resources and poor communication of clinical information. Its effects were tangible, with increased investment in mental healthcare, statutory strengthening of treatment plans and aftercare, and the introduction of additional mental health legislation as a safeguard for those too unwell to recognise the need for treatment.

As part of this Inquiry, models of care to support this patient group were explored and there was an obvious frontrunner. Assertive Community Treatment is one of the most extensively evaluated mental health interventions showing good evidence for its efficacy. And whilst the focus of the Inquiry was violence risk the model promised much wider benefits. For example, Bond et al. found that ACT was effective at reducing psychiatric admissions, improving housing stability, reducing symptom severity and improving quality of life (4). The authors concluded that fidelity to the model was crucial. This led to a national rollout of Assertive Outreach Teams and by 2004 there were over 250 Assertive Outreach Teams in England.

A key outcome attached to this implementation was an expected reduction in the days spent in hospital by patients, but this was not found in a number of UK studies, most notably the 2006 REACT study (6). This study did not find a difference in inpatient bed use or other clinical outcomes, but it did find that those receiving Assertive Outreach were better engaged, less likely to lose contact with services and more likely to be satisfied with their support. Various explanations for this difference between the UK and other countries have been suggested including lower fidelity to the model (including working hours, staffing levels, dedicated team psychiatrist, substance use and vocational specialists), the level of "in vivo" contact (home visits), greater similarity between Assertive Outreach and "treatment as usual" (standard Community Mental Health Teams) and the variation in hospital admission thresholds in different countries. In the UK, particularly in inner city areas like London where the REACT study was undertaken, admission thresholds are high, so interventions intended to reduce admissions or length of hospital stay are less likely to be effective. It is also reasonable to question whether the findings of the REACT study generalise to other areas in the UK or whether the findings would be replicated if repeated today. In my area of Leeds, West Yorkshire we have consistently demonstrated significant bed day reductions but, possibly to the wider detriment of the uptake of this clinical

model, our local data is unpublished. Whatever the reasons for this difference in the published outcomes, in a climate of austerity, there followed significant cuts in the provision of Assertive Outreach to the current position where in England there is now only 32% coverage and a significant variation in the fidelity of the remaining teams.

So, why the renewed interest in Assertive Outreach? Very sadly, the catalyst bears a striking resemblance to that which triggered the original national rollout. Valdo Calocane is a name that has sadly become familiar to most people in England. A young man originally hailing from Guinea-Bissau, he moved as a child with his family to Madeira and then Lisbon before settling in the UK. His school life was uneventful, and he graduated as a mechanical engineer from Nottingham University. But it was whilst studying for his degree that he started to become unwell. He had a variety of psychotic symptoms, all with a theme of persecution, but he didn't recognise that he was unwell and as a consequence he didn't take his medication or engage with community mental health services. He was detained for treatment in hospital four times. His behaviour which included threats and assaults towards neighbours and housemates led to police involvement but no intervention. On Monday the 13th of June 2022, Calocane fatally stabbed three people before stealing the van of his third victim and deliberately driving it into a further three people. He was examined by multiple forensic psychiatrists and found to have a diagnosis of Paranoid Schizophrenia which contributed directly to his offences. At trial he was convicted of manslaughter and detained indefinitely to a secure hospital. The subsequent review (6) revealed that there had been multiple failings and missed opportunities in his care and it was this that led to the renewed interest in Assertive Outreach.

The case of Valdo Calocane shifted the focus of the debate about the provision of healthcare for those with serious mental illness. Prior to the events in Nottingham ACT services had been significantly scaled back, possibly contributed to by concerns about cost-effectiveness. What the Calocane case highlighted however was the risk of serious violence that may tragically arise from providing inadequate care to a small proportion of people suffering from severe mental illness. The subject of violence risk is fraught with misinformation, fear and stigma and one that is largely still avoided, even in a culture of increasing mental health awareness. The reality is that there is evidence to support the role of treatment in the mitigation against serious violence. In appropriate cases, consistent treatment of those with serious mental illness with antipsychotic medication and also mood stabilisers can reduce violent crime, and the use of depot medication can be appropriate when compliance is a concern (7). Fazel and his colleagues, in their umbrella review of 22 meta-analyses examined the risk factors for interpersonal violence, including in mental illness. The meta-analyses included multiple countries, but data was mostly drawn from high income countries in North America and Western Europe. The main areas for effective intervention were treatment adherence, substance use treatment, and protective social factors including housing stability (8).

In my work as an Assertive Outreach Psychiatrist, I manage serious risks, including risks of violence, on a daily basis but the way in which that is achieved is not primarily by restriction. It is instead through a process of engagement and the forging of therapeutic alliances over extended periods. To understand what this means it is important to have knowledge of the ethos and the practicalities of the approach.

"Assertive Outreach is a flexible and creative client-centred approach to engaging service users in a practical delivery of a wide range of services to meet complex health and social needs and wants. It is a strategy that requires the service providers to take an active role, working with service users, to secure resources and choices in treatment, rehabilitation, psychosocial support, functional and practical help, and advocacy…in equal priorities" (9).

What this entails is a holistic approach, in which efforts are made by the team to meet the person's needs and not broker these out or signpost the person. It requires assertiveness and active engagement and an attitude of sticking with the person through difficult times. In order to be able to deliver this, Assertive Outreach Teams are configured differently to other community teams. We work, in line with the evidence base, with people who have severe mental illness and function using a team approach in which all members of the team know the person. This is achieved by direct contact and frequent clinical meetings, so all are updated on the person's progress. We work extended hours and maintain small caseloads which reflects the frequency, intensity and complexity of the work. It also means that when crises do occur, they are managed by the team. We are community based and mostly see people away from clinical sites. We offer a skilled and qualified workforce (allowing all aspects of treatment to be coordinated by the team) as well as having specialist input (vocational and substance use workers, the latter often employing a harm reduction approach). We offer continuity and aren't time-limited and, importantly, we have a "no drop-out" policy.

In the case of Valdo Calocane it is impossible to say with certainty that tragedy could have been prevented. The Independent Homicide Review into his care and treatment (10) highlighted a number of failings and generated both local and national recommendations which represent improvements in general care. It is hard to argue against the need for skilled practitioners, good quality, accessible information, working collaboratively with individuals, robust risk management and the involvement of a person's loved ones in their care. But there has always been a group of patients who are too unwell to acknowledge that they need treatment or support and who consequently find it very difficult to engage with services. Calocane avoided services, he didn't accept treatment in the community and ultimately this led to devastating consequences. The onus was on him to seek help which was wholly unrealistic. It was also noted that a statutory framework which might have ensured treatment (a Community Treatment Order) was not used despite him having been eligible for this earlier during the course of his illness. In the end he was discharged from psychiatric services due to his disengagement, and this happened despite

concerns from those around him including his family.

He needed a different approach, and it is people like him who provide the raison d'être for Assertive Outreach. He would have met the criteria for the service and more assertive efforts would have been made to see him and ensure treatment. His reviews would have been active and in his home rather than a clinical setting. His case would have been reviewed frequently by a team who knew him well and his social networks including his family would have been included in his care. His risks would have been regularly assessed, and he would have been offered support during crises outside of usual working hours. Most importantly the service would have been available to him for as long as he needed it and the no drop out approach, time-unlimited approach would have meant that he would not have been discharged for poor engagement.

There is a wealth of evidence for the effectiveness of high-fidelity Assertive Outreach, and it is my view that he would have benefitted. As a frontline clinician it is not the data in studies nor the management of serious risk which interests and motivates me, but instead the privilege of playing a small part in the recovery of the people our team supports. Witnessing, first-hand, the journey from a toxic cycle of repeated detentions in hospital to a fulfilling life of connection in the community is something truly precious.

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