

A service evaluation project to explore what  
defines positive outcomes and recovery in  
Bradford Integrated Outreach Team: a qualitative  
study with Bradford IOT staff

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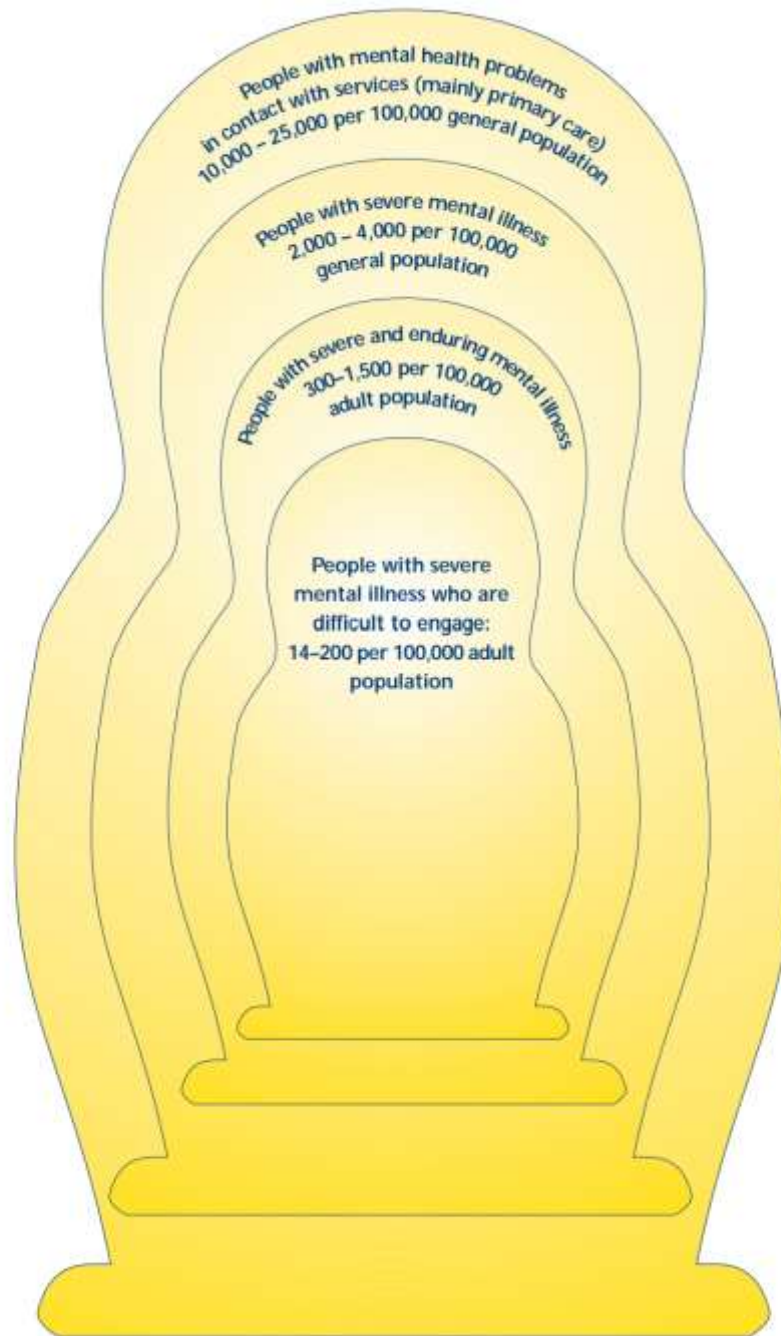
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## **1. Introduction**

### **1.1 Individuals with complex needs whom services struggle to engage**

Within the population of individuals who have a diagnosis of a severe and enduring mental health disorder, there is a small but significant group who have especially complex needs and whom traditional mental health services struggle to engage (Sainsbury's Centre, 1998; see Figure 1). These individuals are typically frequent users of health services, often require multiple hospital admissions, may not adhere or respond to treatment and generally have a poorer health status and lower life expectancy than others with a mental health condition (Hemming, Steve & O'Halloran, 1999; Public Health England, 2018). In 1998, it was estimated that this group was 15,000 people nationally and lived in deprived areas, usually inner cities (Sainsbury's Centre, 1998).



*Figure 1.* A representation of the prevalence of this client group within the population (Sainsbury Centre, 1998)

The needs and characteristics of this group are complex and wide-ranging. Individuals may engage in repeated offending or engage in risky behaviour; some may be homeless or

frequently change address; others may have substance use problems; many are socially isolated with poor social functioning and experience stigma and discrimination (Hemming, Steve & O'Halloran, 1999; Sainsbury's Centre, 1998). This group are typically unemployed and may not access their benefits; many will self-neglect and often have physical health problems which are not being appropriately managed (Sainsbury's Centre, 1998). Individuals typically will have a diagnosis of schizophrenia or a psychosis (Mingella, Gauntlett & Ford, 2002; Sainsbury's Centre, 1998), may experience hallucinations, voice-hearing or paranoid thoughts, often perceiving the world and others as threatening and unsafe (Hardy et al., 2005). Individuals who experience psychosis typically have experienced significant attachment trauma (Bentall et al., 2014; Shevlin et al., 2008). As a result, this group experience a combination of psychological, social and practical difficulties.

Moreover, many individuals will not agree with professionals' view of their difficulties and often will repeatedly decline help. This may be due to previous unhelpful or traumatic experiences of services coupled with a history of traumatic attachments, leading to a pattern of rejecting care (Sainsbury's Centre, 1998).

## **1.2 Offering an appropriate service**

What may be unique to this group is that many will require a mix of acute or emergency care, and rehabilitation and continuing care (Sainsbury's Centre, 1998). Their diverse needs require different service provision, making it a challenge for services to provide holistic, integrated and continuous care.

This group can pose a challenge for mainstream services and are sometimes referred to as "revolving door patients" due to repeated hospital admissions (Sainsbury's Centre, 1998). Additionally, individuals may require months of persistence to gradually build a relationship with services.

Substance use is common among individuals with severe and enduring mental health problems and the relationship between the two is complex (Department of Health, 2002; Public Health England, 2017). Where once it was debated whether individuals under mental health services should be referred elsewhere for specialist drug and alcohol support (Sainsburys Centre, 1998), it now a commonly held view that this support should be delivered as part of an integrated service model (Department of Health, 2002; NICE, 2016; Public Health England, 2017).

### **1.3 What is Assertive Outreach?**

A review of care for this client group suggested that the best service model to meet their diverse and complex needs was through Assertive Outreach Teams (AOTs; Sainsbury's Centre, 1998). These teams are based on the Assertive Community Teams (ACT) model from the United States (Stein & Test, 1980). Core characteristics of AOTs include a multidisciplinary team (MDT), low ratio of service-users to clinicians and a team approach to care (as opposed to allocation to one key worker; Hemming, Steve & O'Halloran, 1999; Wharne, 2005). Developing trusting relationships with service-users is of utmost importance (Hemming, Steve & O'Halloran, 1999; Priebe et al., 2005). Thus, for AOTs, engagement with the service should be perceived as a positive outcome in its own right, as well as the essential first step to providing ongoing care.

In 1999, the National Service Framework for Mental Health (Department of Health, 1999) aimed to set up AOTs nationally. This was based on evidence in a systematic review which suggested AOTs were a clinically effective approach to managing the care of individuals with severe and enduring mental health difficulties in the community and reduced costly hospital admissions (Marshall & Lockwood, 1998).

However, this systematic review later came under scrutiny as the majority of the studies were America-based which has a different mental health system than the UK (Burns, 2010; Mahmood, 2010). Moreover, later studies (e.g. Killaspy et al., 2006) in America and the UK failed to replicate the initial findings of Stein and Test (1980), although various arguments were put forward to explain this (Burns, 2010). Nevertheless, with the evidence-base for AOTs compromised coupled with financial constraints, many English AOTs were subjected to remodelling, decommissioning and integration into standard care (Firn & White, 2013).

#### **1.4 Alternatives to AOTs**

With many AOTs decommissioned, alternative service models were implemented in different parts of the country to meet the needs of this group. For example, one alternative model was integrating AO functions into standard community mental health teams (CMHTs; Firn & White, 2013).

Integrated care is a model for co-occurring mental health and alcohol/drug use needs which are attended to as part of an integrated offer of care (Public Health England, 2017). This does not necessarily refer to care delivery in the same location or by the same person; rather integrated care is delivered in and by mainstream services rather than specialist dual diagnosis teams.

#### **1.5 Measuring change and outcomes**

There is a pressure on services to demonstrate short-term outcomes to evidence they are providing a valuable and effective service (Sainsburys Centre, 1998). However, for services who support a client group with complex needs and a reluctance to engage, the aspiration for short-term improvement may be overly ambitious and impossible to achieve in some cases. This means services may be under pressure to reach unattainable outcomes, leaving services at threat of closure if they do not achieve commissioning objectives. With commissioning



decisions increasingly made on demonstrable clinical progress, it is essential for services to reflect on finding the right outcome measures (Macpherson et al., 2013).

However, it is difficult to measure outcomes of evidence-based practice and interventions in AOTs (Wharne, 2005). In its initial service proposal, it was suggested that success in AOTs could be measured in terms of achieving initial engagement and gaining acceptance of what may appear to be low-level interventions (Sainsbury's Centre, 1998). For a client group who disengage with services, valuing engagement as an outcome is essential (Priebe et al., 2005).

Various service-user outcomes measures have been used to evaluate AOTs in research, including the Life Skills Profile, Participation Continuum and Camberwell Assessment of Need Short Appraisal Scale (CANSAS; Phelan et al., 1995). For further information see Macpherson and colleagues (2013) and Wharne (2005). However, it has been argued that traditional outcome measures, which have been developed by clinicians and academics, have limited usefulness for service-users for what reflects a 'good' outcome (Rose et al., 2011). In fact, a lack of appropriate standardised outcome measures is often cited for a lack of routine use in mental health services (Slade, 1999). Furthermore, many factors influence outcomes in mental health services. For example, the aim of an intervention may be to slow decline or maintain functioning, meaning outcome measures do not improve despite excellent clinical care (Slade, 2005). Nevertheless, there remains a rationale and a pressure to demonstrate clinical outcomes at a service user, team/service and national level (Slade, 1999).

Finally, different stakeholders within the system may have different ideas of what may be a good outcome (Slade, 2005). Practitioners and providers may value outcomes reflecting social and clinical functioning, while service commissioners may value reduced hospital use and reduced cost (Mingella, Gauntlett & Ford, 2002). Service-users often have diverse or conflicting goals, hoping to remain out of hospital, stay off their medication, or to continue

drug use (Chorlton & Smith, 2016; Sainsbury's Centre, 1998). In sum, these factors make evidencing change in this service-user group difficult.

## **2. Commissioning & Project Aims**

### **2.1 The service**

Bradford Integrated Outreach Team (IOT) is a specialist adult mental health service under Bradford District Care Foundation Trust (BDCFT) in Bradford, West Yorkshire which serves the populations of Bradford, Airedale, Wharfedale and Craven. They provide a range of services including social interventions, drug and alcohol treatment, medication and talking therapies. The purpose of the service is to engage and stabilise individuals so that they can access traditional community mental health services. The team comprises of community psychiatric nurses (CPNs), social workers, support workers, a psychiatrist and a psychological therapist. Previously Bradford AOT, the team merged with the Community Drug and Alcohol Team (CDAT) in 2018 as part of a previous service restructure to become Bradford IOT.

Given the challenges in evidencing outcomes for this client group, it can be difficult to evidence the effectiveness of the integrative/assertive outreach approach with traditional outcome measures. For example, absences of hospital admissions or successful diversion of

unnecessary use of emergency services for specific clients are not recorded. This potentially makes Bradford IOT vulnerable to service cuts and transformation initiatives.

## **2.2 Aims**

This service evaluation project (SEP) was commissioned by the Clinical Lead for Psychological Therapies to address this. The SEP aims:

1. To gather Bradford IOT professionals' views on what is considered a good outcome (or positive change) in their service
2. To use those perspectives in the context of national guidance to generate recommendations for the Bradford IOT in order to find ways of evidencing outcomes to commissioners, share with other services to inform referrals, and inform their practice

## **3. Methodology**

### **3.1 Design**

This project used a qualitative method design. Qualitative research aims to understand and express individuals' accounts and actions as they experience particular situations (Elliot, Fischer & Rennie, 1999). A focus group was chosen as they are used to produce information on collective views, which applied in this instance to the team's collective views on defining a positive outcome. A focus group was conducted virtually using Microsoft Teams. The project researcher facilitated the focus group using a Topic Guide (see Appendix 4).

### **3.2 Participants**

All members of the Bradford IOT (24 people) were invited to the focus group via email. This email contained an Online Surveys link which enabled interested participants to read the

Participant Information Sheet (see Appendix 1) and provide their consent if they wished to be involved. The SEP aimed to recruit eight participants as recommended for focus groups (Gill et al., 2008); and aimed to recruit a mixture of disciplines from the MDT. Group mix is an important factor to consider in focus groups as this will affect the data and the level of interaction in the group (Gill et al., 2008). Twelve people consented to take part. It is better to over-recruit to account for non-attenders on the day (Stewart & Shamdasani, 2014), therefore all 12 were invited to the focus group. This included CPNs, social workers, support workers and a psychological therapist.

One participant was unable to take part in the focus group; a semi-structured interview using the same questions from the topic guide was conducted instead.

### **3.3 Data collection**

The focus group took place in July 2021 and lasted 90 minutes. The focus group was recorded and transcribed using Microsoft Teams. When playing the recording, there were some technological faults which meant the whole audio was not available. Therefore, the majority of the analysis was conducted using the transcript.

### **3.4 Data analysis**

Thematic analysis was used to analyse the data using the framework outlined by Braun and Clarke (2006; see Figure 2). Thematic analysis identifies, analyses and reports patterns – or ‘themes’ – within a dataset; it can also make interpretations about aspects of the research topic (Braun & Clarke, 2006).

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

*Figure 2.* Phases of thematic analysis (reproduced from Braun & Clarke, 2006)

The results from the thematic analysis were triangulated with national guidance documents or local service documents to inform recommendations for the service. Guidance was also sought from another local AOT to inform this process. For this, an informal semi-structured interview was conducted with an AOT lead at this service. Questions asked reflected the questions asked in the focus group (e.g. How do you define a good outcome in your service? How do you measure and share success in your service? What guidance documentation do you follow and find most helpful?).

### **3.5 Ethical considerations**

Ethical approval was sought and granted by the University of Leeds School of Medicine Research Ethics Committee (reference DClInREC 20-008) on 22<sup>nd</sup> June 2021. Amended ethical approval to include the possibility of a validity and credibility check of the data was granted on 12<sup>th</sup> October 2021. The project was also registered with the BDCFT Research and Development (R&D) department (Appendix 5).

It was not anticipated that taking part in the focus group would be distressing; however the group were offered a written debrief (Appendix 3).

### **3.6 Credibility and validity check**

A credibility check of the themes was conducted by another Psychologist in Clinical Training, independent of the project. Participant validation of the themes was latterly carried out with a member of the focus group. These are quality checks which address the trustworthiness of the results (Elliott, Fischer & Rennie, 1999).

### **3.7 Reflexivity**

It is important for qualitative researchers to own their own assumptions and perspectives in relation to how these may influence the interpretation of the data (Braun & Clarke, 2006; Elliot, Fischer & Rennie, 1999). Having worked in specialist mental health services, I am aware of the tension that can exist in some settings of struggling to demonstrate outcomes using language (or data) that service commissioners prefer. There can be a belief among clinicians that completing outcomes measures is only a 'box ticking' exercise which does not always suit the preference of the service-users and has limited clinical use. On the other hand, having worked in primary care mental health, outcome measures are essential and are used to inform clinical practice. I was aware of my beliefs that outcome measures may be more suited to particular services or service-users in terms of severity, complexity and need, and that there is a richness of experience that can get 'lost' in outcome measures. I have experience myself of service-users in primary and secondary care settings voicing a strong dislike of outcome measures, as well as service-users in both settings finding them a helpful tool. I was mindful of my experiences and assumptions during the project and the possibility of biasing the results.

## 4. Results

Ten participants attended the focus group and seven people contributed to the discussion. One separate individual interview was conducted. For a breakdown of the superordinate themes, themes, sub-themes, with codes and illustrative quotes see Appendix 6.

Tables 1-3 describe each of the three superordinate themes and their division into themes and sub-themes with illustrative quote(s).

### 4.1 Superordinate theme 1: Measuring and capturing change

Participants discussed factors influencing their ability to measure and capture change. These were reflected in three themes.

Theme 1: Outcome versus process

Participants reflected on the process of change as opposed to a focus on outcome. This theme consisted of three sub-themes.

Sub-theme 1a: Change is a process not an outcome

Participants described how change with their service-users is seen in terms of a gradual process, which involves going through various cycles of change and tolerating tough times.

Theme	Sub-theme	Illustrative quote
Outcome versus process	Change is a process not an outcome	<i>“You know when it's a long, long piece of work. I'm not thinking is this gonna be an outcome at any point soon? It's just that, I don't know, ongoing process with a lot of people. They go up and down over long periods of time and there's never been a point where you thought this person is set to be returned back to</i>

		<i>the CMHT or referred out of services, but there are good times and there are bad”</i>
	Recovery is an individual journey	<i>“she had an alright flat. She had nicer neighbours who weren't exploiting her... And she... Was eating mostly, ... compared to the story of how she was before like that was so much better, like you would never walk in and think oh you know ‘recovery’ but in comparison...”</i>
	Change takes time and resources	<i>“how much effort goes into that [change] might consist of three or four attempted contacts before it happens, so it kind of gets recorded as one thing but that is a piece of work is much bigger than that”</i>
Specific challenges to using measures for Bradford IOT and their service-users	Measures may negatively impact experience of care	<i>“in terms of the flexibility that I might offer in terms of I go for a walk with somebody to talk to them about their unusual experiences rather than being in the clinic room is probably less opportunity to do some of that formal kind of outcome measure taking. I'm not sure how that would fit in with.. a... drive out to a park... I think sometimes those outcome measures formally can make people feel like this is.. Now, this isn't just.. a walk in a park, it is something different, and it [can be a barrier to] ... building relationships with these folks”</i>
	Measures not available for key	<i>“services at a measures level, ... being safe isn't something that gets talked about an awful lot. It's</i>



	aspects of change witnessed	<i>been mentioned a couple of times in kind of the narratives people talked about today. I do think it's really an important part of what we aim to try and help people with, to feel safer."</i>
Potential ideas for capturing change	Hearing from service-users	<i>"Perhaps this is one of the areas we could be better at, collaboration... There would be a good number of people who... Might be willing to collaborate on the terms that [colleague] has outlined"</i>
	Support/training	<i>"You know experienced people in the team, are particularly on it... In sort of ways to write things so it is the service users' perspective"</i>
	Clinicians capturing changes witnessed	<i>"It is quite quite something to see at the minute. You know he's is. It's almost... a different person completely? You know anyone who's been seeing him recently would be struck by how long you can have a conversation with him so much more."</i>

*Table 1.* Themes and sub-themes of superordinate theme 1: Measuring and capturing change

Sub-theme 1b: Recovery is an individual journey

Participants described how recovery is different and relative for each service user and not an objectively held standard.

Sub-theme 1c: Change takes time and resources

Participants reflected on how much time and resources from the team goes into achieving change, and that change may involve something seemingly modest such as engagement with an intervention.

Theme 2: Specific challenges to using measures for Bradford IOT and their service-users

Participants reflected specifically on the challenges and limitations of using traditional outcome measures with their service-users. This theme consisted of two sub-themes.

Sub-theme 2a: Measures may negatively impact experience of care

Participants reflected on how measures can be a barrier to engagement or not reflect service-users goals for recovery, which may negatively impact their experience of care.

Sub-theme 2b: Measures not available for key aspects of change witnessed

A further challenge for using outcome measures for Bradford IOT and their service-users was finding measures which reflected key aspects of change in this client group.

Theme 3: Potential ideas for capturing change

The group shared novel ideas for how change could be captured or recorded in their service-users. This consisted of three sub-themes.

Sub-theme 3a: Hearing from service-users

Participants reflected on wanting to collaborate with service-users to capture their voice in what is helpful in measuring change. This could be done through collecting recovery stories but also capturing their views in the care plans.

Sub-theme 3b: Support/training

Some participants reflected on how some experienced team members have developed skills in capturing service-users' perspective more, which suggests these skills could be trained amongst the team.

#### Sub-theme 3c: Clinicians capturing changes witnessed

Participants often reflected on the changes they observed in service-users over the years, and that sometimes this change is easier to observe from team members who have less direct contact with a particular service-user as the change is more remarkable.

### 4.2 Superordinate theme 2: Context to achieving outcomes

Participants discussed the wider service context and how that can impact on their ability to achieve change or positive outcomes. They further reflected on the service-user context and how this can also impact on outcomes.

#### Theme 1: Service context

Participants reflected on the service contact in terms of pressures and protective factors which impact on the team and their service-users.

#### Sub-theme 1a: Various pressures on service

Participants noted various pressures, demands and changes imposed on the team.

Theme	Sub-theme	Illustrative quote
Service context	Various pressures on service	<i>“there's a number of people who could be referring back to the CMHT and that then obviously we struggle then to take on more referrals, but we do. We don't sort of not take new people on, but it just creates that extra pressure and issues with capacity”</i>

	What helps the team to function	<i>“What we do manage to achieve is actually kind of an outcome of the team approach and... It is that kind of classic, kind of.. Yes, it's cliché, but it's greater than the sum of the parts”</i>
Service user context	Complexity	<i>“They don't want to see us or get a result from us, really. They want to be left alone or wanna be taken off medication or have goals that are kind of rooted in their delusional ideas or very focused on drug use.”</i>
	Beliefs and experiences may impact on care	<i>“A lot of people out there who don't like mental health services see it as an imposition, that kind of authoritarian force in their lives. Telling them what to do, imposing things they don't like on them. Trying to get round that barrier is a big part of what it's about.”</i>
	Service-users often reject care	<i>“Some people might describe it [the team's involvement in their care] as harassment”</i>

Table 2. Themes and sub-themes of superordinate theme 2: Context to achieving positive outcomes

Sub-theme 1b: What helps the team to function

Participants highlighted what helps the team to function, despite these wider services demands and challenges. This included high level of team support, skill and creativity.

Theme 2: Service user context

Participants reflected on the needs and characteristics of the service-users they support, and how this can impact on outcomes.

Sub-theme 2a: Complexity

Participants discussed the complex needs of the service-users in terms of risk, drug use, housing and social isolation.

Sub-theme 2b: Beliefs and experiences may impact on care

Participants reflected on how their service-users' beliefs and experiences may impact on engaging with services and receiving care. This was reflected in service-users feeling unsafe and previous experiences of mental health services as coercive.

Sub-theme 2c: Service-users often reject care

Participants often reflected on service-users' rejection of care.

### **4.3 Superordinate theme 3: Positive outcomes**

Participants discussed what positive outcomes looks like for the team, their service-users and for the wider system.

Theme 1: What the team offers: positive outcomes for the team

Participants reflected on what they offered service-users. This divided into five sub-themes.

Sub-theme 1a: Person-centred care

Participants frequently cited examples of person-centred care and treating service-users as individuals.

Theme	Sub-theme	Illustrative quote
What the team offers: positive outcomes for the team	Person-centred care	<i>“it's trying to support people on their terms as much as possible and trying to hook people in with whatever that might be”</i>
	Emphasis on relationship building	<i>“because we do work as a team and we were trying to identify the best kind of working relationships that are going to work, and if it doesn't work with one care coordinator, we'll try another and... We kind of accept the challenge of trying to make it work for someone, really.”</i>
	Mindset of not giving up	<i>“it's a slow process and quite often based on.. allowing people to go through the same pattern of problems repeatedly whilst staying with them and not judging that and keeping on reflecting potential change to them you know in in, in a non kind of dictatorial sort of way”</i>
	Specialist integrated care	<i>“They're getting quite a holistic and broad range of interventions, often from people within this team, so they're not being referred out for harm minimisation or some intervention around their drug use...They're getting that support directly</i>

		<i>from the people that they built a therapeutic working relationship, and that they trust ... the breadth of skills within the team is quite great really."</i>
	A different experience of mental health services	<i>"I think what we offer is to some extent a landscape that involves a little bit more choice"</i>
What the service-users receive or experience: positive outcomes for service-users	Safety and stability	<i>"I guess we were great at getting people in who are in absolutely terrible states. Moving them from a terrible state too, to relatively safe and kind of stable, but moving them from there to thriving and great, it's more difficult for a lot of those people thriving and great, perhaps isn't even a possibility"</i>
	Opportunities to make choices in their own care	<i>"I kind of like when we can step out of the framework of kind of potentially coercive... You know mental health acts framework such as the Community treatment order arrangements and people make those choices in a in a kind of atmosphere of cooperation rather than compulsion. That seems to be kind of progress and that and they do end up being those choices that keep them well"</i>

	Relational benefits	<i>“When I've asked people about what they get out of the team, it's often just been about individuals. You know that they value the individuals working with them... [and the] consistency and ... approach that we use... you know we have people under the service for a long period of time and they really get to know the people they are working with really well.”</i>
Positive outcomes for others	Benefits to the organisation	<i>“finding other ways to sort of try and support people not to be admitted to hospital or whatever. And often without getting IHT involved”</i>
	Benefits to the community	<i>“because we know what's going on in people's lives and where they were going.. and if we are aware of these problems developing pretty early on, I might well bring them into hospital, but what that's avoided is all the harm to themselves, their families, their communities, anybody else that might have been incurred by them not being brought in promptly and as early as possible”</i>

Table 3. Themes and sub-themes of superordinate theme 3: Positive outcomes



Sub-theme 1b: Emphasis on relationship building

Participants emphasised the importance of building therapeutic relationships with service-users and how this can impact on care.

Sub-theme 1c: Mindset of not giving up

Participants reflected on the importance of supporting service-users through ups and downs of recovery.

Sub-theme 1d: Specialist integrated care

Participants reflected on how their model of integrated care enabled treatment to be accessed by service-users and facilitated engagement.

Sub-theme 1e: A different experience of mental health services

Participants reflected on how they were able to offer a different experience of care than other mainstream mental health services, which meant that service-users were able to access care.

Theme 2: What the service-users receive or experience: positive outcomes for service-users

Participants discussed various positive outcomes for service-users, which included safety and stability, opportunities for service-users to make choices and interpersonal benefits.

Sub-theme 2a: Safety and stability

Safety and stability in various forms (physical and psychological safety) were reflected as positive outcomes. Safety and stability were viewed as achieved in different forms, for example sometimes an admission.

Sub-theme 2b: Opportunities to make choices in their own care

Participants were keen for service-users to make choices in their own care, which often lead to better outcomes for service-users.

#### Sub-theme 2c: Relational benefits

Participants reflected on the positive relational outcomes with service-users. These related to building trust in order to foster therapeutic relationships.

#### Theme 3: Positive outcomes for others

Participants reflected on positive outcomes for others, including the wider organisation and other services, as well as families and communities.

#### Sub-theme 3a: Benefits to the organisation

One positive outcome to the wider organisation was reduced need for further resources.

#### Sub-theme 3b: Benefits to the community

Other positive outcomes could be seen within the family system or the wider community.

### **4.4 Triangulating with national and local guidance**

In discussion with a consultant from another local AOT, guidance was suggested relating to how positive outcomes can be measured. This included wider societal/service costs (e.g. bed days, housing/homelessness and allied costs; though these would be calculated by health economists) and individual measures (e.g. measuring distress, connection, security). He also highlighted the use of engagement scales and physical health measures.

The NHS Long Term Plan and NHS Mental Health Implementation Plan (2019) emphasises adults should have greater choice and control over their care, with specific mention of increasingly personalised and trauma-informed care, including support for self-harm and co-existing substance use. The NHS Five Year Forward Plan (2014) emphasised the need for greater integration of care.

In a guide for commissioners and service providers, Public Health England (2017) recognises that recovery from co-existing drug/alcohol and mental health difficulties may take place over a number of years and requires long-term support. To support this, they recommend practitioners work assertively and flexibly to engage people with chaotic lifestyles. They stress a strong therapeutic alliance, therapeutic optimism and person-centred care are key to delivering effective care. They emphasised that recovery is a highly individual process which is not a straightforward or linear.

## **5. Discussion**

The first aim of this SEP was to define a positive outcome or recovery for Bradford IOT service-users. This question was addressed by the theme ‘positive outcomes for service-users’, which consisted of three sub-themes; safety and stability, opportunities to make choices in their own care; and relational benefits.

Safety (that is psychologically and physically safe), and stability were agreed to be key positive outcomes for Bradford IOT service-users. Given the complexity in service-users’ lives with housing, substance use, risk and social isolation, achieving a level of safety and stability is not without its challenges. These positive outcomes were also achieved despite wider organisational pressures and limited resources. Participants reflected on an absence of outcome measures which sufficiently captured safety and stability.

Feeling psychologically safe may also extend to feeling relationally safe as reflected in the sub-theme ‘relational benefits’. By not coercing service-users and continuing to provide support through the highs and lows of recovery, service-users had a different experience of mental health care and may feel safer in their relationship with services.

Moreover, a level of safety and stability is needed for service-users to access further interventions. This is supported by Maslow's hierarchy of needs (1943) which suggests needs at the base of the hierarchy (e.g. physiological, safety and security) would need to be satisfied before needs higher up the hierarchy can be achieved (e.g. self-esteem, self-actualisation).

'Opportunities to make choices in their care' was a further positive outcome for service-users, and it was reflected that choices made by service-users, as opposed to made for service-users, were often the choices that kept people well in the long-term. This was achieved through offering person-centred care, which sometimes meant stopping medication. This could lead to relapse but the team emphasised the importance of withstanding the inevitable ups and downs of recovery with the service-user. Enabling service-users to make their own choices was particularly seen as vital given service-users previous coercive experiences of care. It is partly these experiences which may have led to a rejection of care and services.

'Relational benefits' were further positive outcomes for service-users; that is service-users benefited from the process of building a therapeutic relationship with the team/clinician. Building a therapeutic relationship has always been emphasised in all aspects of healthcare and is predictive of good outcomes in the long-term (e.g. Priebe, 2008). For this client group, many of whom are socially isolated, have experienced attachment trauma and are rejecting of care, building these therapeutic relationships takes time and persistence. A good therapeutic relationship is central to engagement, therefore nurturing relationships with individuals considered 'difficult to engage' is essential (Mahmood, 2008; Priebe et al., 2005; Sweeney et al., 2021). Thus, developing and sustaining therapeutic relationships with service-users should not be overlooked as a positive outcome.

The above sub-themes reflect principles of the trauma-informed approach (Sweeney et al., 2021); that is trustworthiness and transparency; empowerment, choice and control; and

safety. Trauma-informed practices understand the importance in avoiding coercion and control which often operate in services as they can lead to retraumatisation. Moreover, these sub-themes relate to the first stage of Herman's (2011) three-stage trauma-informed model: safety/stabilisation, relating to social and relational contexts. Thus, working towards achieving safety and stabilisation is the first stage of recovery (Herman, 2011).

A further theme was defining positive outcomes on a wider systemic level, for example positive outcomes for organisations and for the wider community. For the organisation, this included a reduction of service use, typically avoiding hospital admissions. However participants reflected on the conflict between what commissioners and clinicians see as a positive outcome; sometimes hospital admission is the safest choice and therefore should not be seen as a failure to achieve a good outcome.

The final theme of the superordinate theme 'positive outcomes' reflected positive outcomes for the team; this divided into sub-themes of person-centred care, building relationships, not giving up, specialist integrated care and a different experience of mental health services. These reflect the unique approach of the team and what they offer. The approach does not work on the assumption that all people in distress or need are help-seeking and want something from services. By really knowing the individual through relationship building, the team can offer truly person-centred care. This involves being able to access holistic treatment through the team, rather than being referred out where there is a risk of communication breakdown or disengagement. In this way, the team offer something that is unique. These sub-themes mirror AOT principles such as an emphasis on relationships, continuous engagement, and holistic, integrated, and individualised care (Bone & Drake, 2005; Sainsbury's Centre, 1998; Wharne, 2005).

The second superordinate theme was 'context'; reflected in the two themes of service and service-user context. The service context highlighted the various service pressures, such as struggling to move service-users on to CMHT, working with a limited resource, and the changes made to the service configuration. Therefore, the team were also finding a way to survive with external pressures as well as managing the clinical work. Protective factors which helped the team to function in this context, was a high level of team support and skill within the team, with both of these celebrated by various participants.

A safe enough service context is vital to ensure the team can feel supported and valued, so that they can meet the emotional needs of service-users. When staff face constant job insecurity, organisational re-structuring and a pressure to meet certain targets, staff can struggle to manage the consequences of working with a traumatised population (Johnstone & Boyle, 2018). Nevertheless, the team continued to offer person-centred care despite these wider systemic pressures. However, the team may be limited in the progress they can make if the resources in the community (e.g. housing) and wider mental health system are lacking. These wider systemic factors will inevitably impact on outcomes (Sainsbury's Centre, 1998).

The service-user context highlighted the complex needs of the service-users, particularly in terms of risk, substance use, housing and social isolation. Many of the service-users experience psychosis, and experience the world and others as unsafe. Service-users usually have had experienced coercive care under mental health services. Thus, as a result of their beliefs, experiences and complex circumstances, a safety strategy is often to reject services.

Participants answered wider questions such as what may be challenging about using outcome measures or measuring change with their service-users. This was seen in the superordinate theme 'measuring and capturing change'. One theme 'change is a process not an outcome' reflected how participants saw the nature of change, that is occurring in cycles with ups and

downs, with rocky patches. A further theme was ‘recovery is an individual journey’, reflecting that there are various ideas of what constitutes recovery, depending on the service-user and their particular circumstances. A final theme was the ‘change process takes time and resources’; change was seen to often be slow and incremental, and the effort, time and resources that went into a piece of work for someone was not often clearly reflected in the outcome. The idea that recovery is a process, is subjectively defined and means different things to different people is reflected in the definition of ‘personal recovery’ in the recovery literature (Slade & Longden, 2015).

A further theme related to specific challenges to measures; for example measures may not be appropriate for (all) service-users, as they can be a barrier to engagement. Measures did not reflect anything meaningful to the service-users, nor were there any available to measure key aspects of change in relation to safety or risk. Thus, measures were seen as not acceptable or meaningful to service-users or useful to the clinicians. Such difficulties with measuring change in individuals with severe mental health difficulties is well documented (Repper, 1998; Rose et al., 2011; Slade, 1999).

Finally, when considering alternative ways to measure change, the team shared ideas about collaborating with service-users, collecting recovery stories and receiving support/training. Active collaboration and consultation with people with lived experience of mental health difficulties at all levels of service delivery is the gold standard, and ensures services are trauma-informed and acceptable to the population it serves (Johnstone & Boyle, 2018).

These findings are important to hold in mind when considering the second aim of the SEP. This was to use the findings from the focus group and the context of national guidance to generate recommendations for the Bradford IOT in order to find ways of evidencing

outcomes to commissioners, share with other services to inform referrals, and inform their practice. For recommendations please see Table 4.

### **5.1 Strengths and limitations**

A strength was that the focus group enabled participants to engage in group discussion and share views. Completing quality checks aimed to ensure trustworthiness of the findings.

However, a major limitation was that the audio recording was not available, and that some of the transcript data was not of sufficient quality to use in the analysis. Furthermore, not all members of the focus group participated and not all disciplines had their views represented.

### **5.2 Conclusion**

The SEP aimed to understand what defines a good outcome for service-users in the Bradford IOT, to inform recommendations on how change or outcomes can be captured. The results addressed this question, but also wider related questions such as the specific challenges of measuring change with their service-users. Some of the themes reflected principles of trauma-informed care such as ‘safety’, ‘trustworthiness’, ‘choice’, ‘collaboration’ and ‘empowerment’ (Fallot & Harris, 2009).

### **5.3 Recommendations**

1. Setting up a service-user and carer group with whom to consult on ideas for appropriate outcome measures; understanding if, when and how to best to complete these.
2. During the course of conducting research for the SEP, a list was collated of the type of outcome measures used in other AOTs, currently and historically. This is available upon request. Consultation with staff and service-user group to discern if any feel appropriate.



3. Consultation with service-user group to create an outcome measure (see model outline in Rose et al., 2011)
4. A measure which relates to safety (physical, psychological and relational safety) and stabilisation may be a good fit and relates to a key principle of trauma-informed care; however at the time of writing none seem to directly measure this. An alternative may be proxy measures which assess level of need e.g. in relation to housing, self-care, etc (the CANSAS, which may be completed by a service-user, clinician or carer. This is freely available).
5. Narrative approaches can be an alternative or complement to outcome measures for people with psychosis (France & Uhlin, 2006); narratives may be more acceptable to service-users and could be discussed in consultation with the service-user group; with a proforma to guide and prompt service-users; completed with/without clinicians' assistance.
6. Using clinician completed measures, completed in collaboration with the service-user where possible, depending on the clinician's best assessment as to whether this would be helpful or hindering exercise for the service-user e.g. CANSAS.
7. Upon referral the service could ask for information e.g. number of contacts with Criminal Justice System (past 6 months), admissions in past 12 months, durations of in-patient stays, contact with crisis resolution teams (past 12 months); this data could be collected while serve-users are under the care of the team to assess any wider organisational impact.
8. Protected staff time for reflective practice groups to notice and reflect on positive outcomes to support job satisfaction and further enhance team cohesion (a protective factor for this service).

9. Training/support for how clinicians can capture service-users' voice in the paperwork to make it more meaningful.
10. Collection of recovery stories to celebrate outcomes on service level and evidence outcomes to commissioners.
11. Measuring outcomes on a wider, societal and organisational level is possible but requires advanced data analysis typically undertaken by health economists and has obvious cost implications.
12. Evidencing and highlighting Bradford IOT offer trauma-informed, integrated care and emphasise empowering service-user choice which is in line with national guidance (e.g. Public Health England, 2017; NICE, 2016; NHS Long-Term Plan, 2019).

*Table 4. Suggested recommendations for Bradford IOT*

#### **5.4 Dissemination**

- The findings were presented at the University of Leeds SEP conference in October 2021
- The findings were shared with the project commissioner and will be shared with the wider Bradford IOT
- The findings will be shared at BDCT's clinical psychology forum in March 2022
- If appropriate, the SEP will be prepared for publication

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## 7. Appendices

### 7.1 Appendix 1: Participant Information Sheet

#### Participant Information Sheet

**A service evaluation project to explore what defines positive outcomes and recovery in Bradford Integrated Outreach Team: a qualitative study with Bradford IOT staff**

*You are being invited to take part in a service evaluation project (SEP). Before you decide to take part, it is important for you to understand why the SEP is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.*

#### **What is the purpose of the project?**

*Bradford IOT offer a specialist and vital treatment which often serves to stabilise service-users so that they may access more traditional community mental health teams or primary care services. Many IOT service users have a psychosis diagnosis; rehabilitation from psychosis is considered to be a priority within the NHS Long Term Plan. However, due to the*

*nature of the work by IOTs, it is hard to demonstrate positive change in a traditional way.*

*This is a challenge for this service when commissioning relies on evidencing outcomes.*

*This SEP seeks to capture these positive outcomes through a qualitative design. Chiefly it will ask 'what does a good outcome for this client group look like?'*

### **Why have I been chosen?**

*We are looking to recruit participants from Bradford IOT staff. We would like to recruit a mix of staff disciplines to ensure that all members of the multi-disciplinary team have their views heard.*

### **Do I have to take part?**

*No, taking part is completely voluntary. If you do decide to take part, you will be asked to declare your consent to take part in the study on the next webpage. Or you may want to have a think about taking part having read this information. If so, you can exit this webpage, and simply follow the same link if you do decide to take part later on. You can also request a copy of this Participant Information Sheet to keep if required. At any time, you may ask any questions about the purpose of the study or what is expected from participants. You have the right to withdraw from the project at any time. You will not be required to give any explanation as to your decision to do so, nor will there be any penalty for this.*

### **What do I have to do if I take part?**

*All that will be required is for you to take part in a focus group. This focus group will be conducted virtually and during working hours (Mon-Fri 9-5) so you can choose to take part from wherever you normally conduct your clinical work.*



**What are the possible disadvantages and risks of taking part?**

*As the focus group is during working hours, one possible disadvantage is time away from your clinical duties. This is a low risk study with very low potential for distress.*

**What are the possible benefits of taking part?**

*The benefit would be the outcome of the evaluation; recommendations will be discussed with the IOT and operationalised where appropriate. The report will provide a starting point for the team to begin to think about how they may evidence the effectiveness of the service using other means. This could be shared with commissioners which may provide rationale for the existence of the service in times of future financial strain. It is also hoped that sharing positive outcomes and change about clients will be an exercise of personal reflection which benefits staff wellbeing.*

**What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?**

*You will be asked to share your name, job title and work email initially, although all participants will have a pseudonym in the report write up. The questions asked in the focus group will be around the theme of what a good outcome is for this client group and this is in line with the SEP's aim.*

**What will happen to the results of the research project?**

*It is expected that the results of this SEP will be disseminated and shared with Bradford IOT.*

*It is hoped that this SEP will produce recommendations which could be operationalised by Bradford IOT. The results will potentially contribute to further plans or projects which aim to consider how the service evidences their outcomes.*

**Use, dissemination and storage of research data**

*An informed consent form will be completed using Online Surveys. Online Surveys is GDPR compliant.*

*The audio from the focus group will be recorded and transcribed; the data will be held on University of Leeds cloud storage in line with University of Leeds Data Protection Policy. All results will be pseudo anonymised in the report and when transcribed.*

*It is planned this data will be written up and shared with the service. The service will be responsible for storage of the data in the long-term, following completion of the report. In such instances, data will remain anonymised. All personal data will be deleted following completion of the study.*

**What will happen to my personal information and responses given in the focus group?**

*Any personally identifiable data which is required to be stored, such as name and profession, will be stored on a password-protected storage system. No identifiable data will be included in the analysis or write up of the study. Only the lead researcher will have access to the raw data; a supervisor will also have access to the data via transcripts but this will be in an anonymised form.*

*We will never share your information with third parties (unless we were required to for your own or others' safety and protection).*

*Following completion of the study, all personal information records will be deleted.*

*You have the right to withdraw your personal data from the project at any time; this means that any personal information (e.g. name, email, demographic information) will be deleted.*

*You may also withdraw your participation at any point in the project without giving a reason.*

*However, we reserve the right to keep the anonymised data provided in the focus group. Any*

*data provided in the focus groups will also be anonymised; this includes whether you choose to withdraw from the project or not.*

*Please click this link to see the [Research Privacy Notice](#).*

*If during the course of your participation with the project, you disclose any intention to harm yourselves or others then it is not possible for this to be kept confidential.*

### **Who is organising/ funding the research?**

*This research is part of the Clinical Psychology Doctorate training and is funded by the NHS.*

### **Ethical review of the study**

*The project has been reviewed and given ethics approval by the University of Leeds Psychology School of Medicine Research Ethics Committee.*

*This research is being conducted by Clare Pickett (Clinical Psychologist in Training), under the supervision of Dr Emma van der Gucht (Field Supervisor) and in collaboration with Paul Carr (IOT Team Leader).*

### **Contact for further information**

Lead Researcher – Clare Pickett – [umcpi@leed.ac.uk](mailto:umcpi@leed.ac.uk)

Academic Supervisor (Department of Psychological & Social Medicine) – Dr. Rebecca Yeates.

In the event of a complaint please contact Dr Rebecca Yeates – [r.a.yeates@leeds.ac.uk](mailto:r.a.yeates@leeds.ac.uk)

Thank you for taking the time to read through this information sheet. Please seek further information from the lead researcher should you have any further questions now or at any point in the study.

If you would like a copy of this Participant Information Sheet, please contact Clare.

Further guidance is available at <http://ris.leeds.ac.uk/involvingresearchparticipants> and at <https://dataprotection.leeds.ac.uk/information-for-researchers>.

## 7.2 Appendix 2: Consent Form

### Participant Consent Form

**Consent to take part in: A service evaluation project to explore what defines positive outcomes and recovery in Bradford Integrated Outreach Team: a qualitative study with Bradford IOT staff**

I confirm that I have read and understand the Participant Information Sheet explaining the research project and I have had the opportunity to ask questions about the project.

I understand that my participation is voluntary and that I am free to withdraw my participation at any time without giving any reason. I understand there will be no negative consequences for doing so. In addition, should I not wish to answer any particular question or questions, I am free to decline.

If I do decide to withdraw, I understand my personal data given will be deleted. However, under the principle of 'public task' in the Data Protection Act I understand that any data/response already provided in the focus group will be retained due to the nature of a focus group. I understand that all responses provided in the focus group will be anonymised.

I understand that members of the SEP team may have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that if quotations are used anonymity will be preserved.

I understand that my responses will be kept strictly confidential.

I understand that the data collected from me may be stored and used in relevant future research in an anonymised form

I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research.

I agree to take part in the above research project and will inform the lead researcher should my contact details change.

**If you wish to give you consent to take part in the study, please type your name here**

\_\_\_\_\_

By typing your name you are confirming you have read the above information and consent to take part in the study.

### 7.3 Appendix 3: Debrief

*A service evaluation project to explore what defines positive outcomes and recovery in*

*Bradford Integrated Outreach Team: a qualitative study with Bradford IOT staff*

#### **Participant Debrief Page**

Thank you for participating in this study. Your time and contributions are greatly appreciated. We think that this is an important area to evaluate and we hope that you have found participating interesting.

If you have found participating in the SEP to be distressing and you wish to speak to someone involved in the project, please contact: Clare Pickett on [umcpi@leeds.ac.uk](mailto:umcpi@leeds.ac.uk).

If you have any specific concerns, it may be helpful to speak to your Team Leader Paul Carr on [paul.carr@bdct.nhs.uk](mailto:paul.carr@bdct.nhs.uk).

You may also benefit from contacting your Trust's Staff Wellbeing Service:

Confidential Staff Support: 01274 251909

Email: [psychologicalstaffsupport@bdct.nhs.uk](mailto:psychologicalstaffsupport@bdct.nhs.uk)

Resources: [Staff Support and Therapy Service \(sharepoint.com\)](#) which can be accessed via the Trust intranet – please contact Staff Wellbeing Service for further information.

## 7.4 Appendix 4: Topic Guide

5 MIN intro and welcome

### RECORD AND TRANSCRIBE

OPENING (what is offered/what is the service) – 15 MINS

1. In one sentence, who are your client group? What are their characteristics? What kind of support do they need? [to what extent can this client group articulate their goals for recovery?] 5 MIN
2. What are the strengths and advantages of assertive or integrative outreach as compared to standard care? 5 MIN
3. What are the characteristics of the interventions you offer? What do you offer? What's good/bad about that/useful to SUs? What is the core activity/intervention of the service? 5 MIN

INTRODUCTORY (what is it like working for Bradford IOT) – 15 MINS

1. What is challenging and what are the rewards about working for Bradford IOT?
2. What is Bradford IOT doing well?
3. What is the unique contribution of Bradford IOT in the context of the wider mental health service in Bradford?
4. Is there anything you feel it could do better?

TRANSITION (measuring change with this client group) 15 MINS

5. Do you know what AOTs/other IOTs do/how they measure outcomes?
6. How would that work for Bradford IOT?
7. If you were to create/use a measure to capture the impact of your service, what would be on that measure? [What is missing from traditional outcome measures?]
8. What is challenging (and rewarding) about measuring change in Bradford IOT?

KEY (what does change/recovery/positive outcomes look like for this group) – 40 MINS – 45 mins **BE HERE BY 2.15 ISH**

1. Think back to a successful case, can you tell me about them briefly and how you know when it's been successful – 10 min
2. What does change look like for service-users who access your service – 10 min
3. What is it that the people you support value most about the service/what you offer – 10 min
  - a. Think back to the last person on your caseload who you was discharged and you feel made some recovery, what would they say about their recovery?  
What was helpful for them about the care and support they received?
  - b. Holding in mind someone you've worked with, what are they looking for from the service when they get referred? Would they say they receive that?



4. What feedback does the service gets (formally or informally) from current or former service users, families other teams/agencies - and what they make of that feedback?

10 min

### **7.5 Appendix 5: R&D approval letter**

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28/05/2021

#### **Re: Clare Pickett, Service Evaluation Project**

To whom it may concern,

I am writing to confirm that Clare has registered a Service Evaluation project within Bradford District Care NHS Foundation Trust (BDCFT) to explore what defines positive outcomes and

recovery in Bradford Integrated Outreach Team (IOT). This is a qualitative study within IOT and has been approved by Emma Van Der Gucht, Clinical Psychologist.

If you have any further questions, please do not hesitate to get in touch.

Kind Regards

Joanna Shinnars

Clinical Audit Lead

## 7.6 Appendix 6: Themes, sub-themes, codes and quotes

### 1. MEASURING & CAPTURING CHANGE

#### Outcome versus process

*Change is a process not an outcome*

Over emphasis on the final outcome

You know when it's a long, long piece of work. I'm not thinking is this gonna be an outcome at any point soon? It's just that, I don't know, ongoing process with a lot of people. The goes up and down over long periods of time and there's never been a point where you thought this person is set to be returned back to the CMHT or referred out of services, but there are good times and there are bad times with you know.

Cycle of change

And our service users are never so straightforward, so that they don't always kind of go through those cycles of relapse as well so they can be ready at one moment but because they've been with us for three or four months too long, they'll end up relapsing and you know the circle begins again, you know.

Tolerating tough times

[after making change to care plan] .. you know it will rocky for a while

*Recovery is an individual journey*

Different ideas of a positive outcome/recovery

And she was.. that wouldn't change. She had, you know, she had an alright flat. She had nicer neighbors who weren't exploiting her and and. And she, you know she...Was eating mostly, we think, like I think, that you know compared to the story of how she was before like that was so much

better, like you would never walk in and think oh you know 'recovery' but in comparison... That was years and years and years of work from the team.

Over emphasis on the final outcome

Change is slow and incremental

*Change process takes time and resources*

Effort, time and resources not reflected in the final outcome

I've got in mind the person that you are referring to, and I think that is about the relationship that works and built with that person over years and years and years and maybe CMHT would have never got into that flat to see drug paraphernalia and or been persistent enough to see neighbors or other people around to kind of get that kind of collateral information that helps make that kind of assessment and informs the sort of care and support there's been being offered so that speaks to the persistence and the flexibility of the approach of what is being offered by people in IoT.

of how much effort goes into that might consist of three or four attempted contacts before it happens, so it kind of gets recorded as one thing but that is a piece of work is much bigger than that and kind of a consideration of the effort that goes into one intervention from the planning, the discussion and then the actual seeing that plan through can be kind of, you know, have multiple people involved and just how that's kind of quantified. I think that gets lost...

Change is slow and incremental

I've been working with someone [from] over 10 years ago. This person was in this situation and this is kind of compare and contrast as to where they are they are now, and that's a really important part of maybe understanding progress that there's this point in time that you can refer back to and think how that might have changed over quite a long period of time and maybe with you know like KPI's and that kind of stuff they're asking for, sort of like monthly information, and maybe that the taking a bit of a step back and sort of taking a broader sort of view of the progress people have in our team might be a helpful way of looking at things. I don't know what other people think...

## Specific challenges to measures for Bradford IOT/Sus

*Measures may negatively impact experience of care*

Measures may be a barrier to engagement

in terms of the flexibility that I might offer in terms of I go for a walk with somebody to talk to them about their unusual experiences rather than being in the clinic room is probably less opportunity to do some of that formal kind of outcome measure taking. I'm not sure how that would fit in with.. a... You know a drive out to a park...Walk around, talk about someone's voices.. You know that would seem a little bit outside of, you know kind of.. [it wouldn't] sit as nicely as it would in [other] services where that's just a core part of what people are expected to do. .. I think sometimes those outcome measures formally can make people feel like this is.. Now, this isn't just.. a walk in a park, it is something different, and it [can be a barrier to] ... building relationships with these folks.

**Losing the individual in measures/paperwork**

because that [paperwork] becomes not about them. It's about what the trust wants, so the trust wants to see that all paperwork is completed which means that we lose out on doing the quality stuff which really does make a difference to people I think.

who said, that you know when it came to assessment tools and outcome measures, that they found them far too standardized and not enough personalized. So it was like, you know, 'I should be in charge of my recovery. I should tell you what's working right. I should be the one who makes a decision. I don't want somebody to sit with a piece of paper that means nothing to me.'

***Measures aren't available for key aspects of changes witnessed in this SU group*****Measures don't capture safety**

a little bit in terms of just how, how, maybe kind of services at a measures level, kind of being safe isn't something that gets talked about an awful lot. It's been mentioned a couple of times in kind of the narratives people talked about today. I do think it's really an important part of what we aim to try and help people with, to feel safer.

Yeah, I mean there's supposed to be... This outcome measures that you might use within psychological therapy, but I'm not.

I don't know whether any of those kind of totally capture what, what I was talking about, I suppose.

**There are aspects of change hard to evaluate [e.g. risk]**

We've talked about with him, all remarked, how [person] isn't in the Red List anymore the last couple of weeks and you know ...

[He's] Held in stone [there] normally.

And you know, we manage quite a lot of risk within the service and you know something that's obviously quite hard to evaluate, but we do quite a lot of you know what IHT would do, but we keep it within the team, so increasing visits, sharing it out like Amy said within the team.

**? Practical issues for measures****Potential ideas [from team] for measuring change*****Hearing from Sus*****Capturing Sus voice/views**

how do we record their voice in kind of statements are really really important.

### Wanting to collaborate with sus

Perhaps this is one of the areas we could be better at, collaboration.

There would be a good number of people who... Might be willing to collaborate on the terms that [colleague] has outlined.

### Recovery stories / celebrating achievements

Well, [we could] collect more recovery stories and maybe a be little bit more proactive in kind of like blowing our own trumpet.

### Support/training

#### Support/experience enables staff to individualise care plans

You know experienced people in the team, are particularly on it... In sort of ways to write things so it is the service users perspective.

### *Clinicians capturing changes witnessed*

#### Clinicians goals for change for su

#### Clinicians' observations of change

Now that... took a lot of doing by his involved care coordinator, the time, lots of working through really thorny capacity issues and so on, but... Getting him established on Clozaril, when we were so hesitant, and wary about actually sometimes even leaving a box of olanzapine and.. It is quite quite something to see at the minute. You know he's is. It's almost... a different person completely? You know anyone who's been seeing him recently would be struck by how long you can have a conversation with him so much more.

#### Knowing the individual

## 2. CONTEXT TO ACHIEVING POSITIVE OUTCOMES & OFFERING PERSON-CENTRED CARE AT BRADFORD IOT

### SU context

#### *Complex SU group with complex needs: basic needs often not being met*

#### Managing risk/complexity

And you know, we manage quite a lot of risk within the service and you know something that's obviously quite hard to evaluate, but we do quite a lot of you know what IHT would do, but we keep it within the team, so increasing visits, sharing it out like Amy said within the team.

### Working with complexity/drug use

They don't want to see us or get a result from us, really. They want to be left alone or wanna be taken off medication or have goals that are kind of rooted in their delusional ideas or very focused on drug use.

### Complexity/housing

we have a lot of services users who will have complex housing needs and things and that does make it you know, difficult for us sometimes to... For people to be discharged

### Complexity/isolated

They might have very limited other relationships with anybody, anybody else. Also how they kind of distinguish kind of what they get from us versus maybe what they get from friends and family or other supportive relationships. They might not have any.

### *Sus beliefs/experiences may impact on care*

#### Sus often have psychosis dx [world often feels unsafe, ppl cannot be trusted]

A lot of the sort of psychosis that people are experiencing is about threat and feeling unsafe then and I think...I dunno what the percentage would be, but there is as much kind of genuine being in unsafe areas, being around unsafe people, being in unsafe relationships, that kind of practical, unsafe, real kind of problem. And then there's a lot of just feeling unsafe more generally in terms of people's belief systems and their understanding of the world. And their place in it.

#### Experiences of MH services as coercive

"A lot of people out there who don't like mental health services see it as an imposition, that kind of authoritarian force in their lives. Telling them what to do, imposing things they don't like on them. Trying to get round that barrier is a big part of what it's about."

### *As a result of their beliefs, experiences, complex circumstances, Sus safety strategy is often to reject care*

#### Rejection of care

"A lot of people out there who don't like mental health services see it as an imposition, that kind of authoritarian force in their lives. Telling them what to do, imposing things they don't like on them. Trying to get round that barrier is a big part of what it's about."

Some people might describe it [the team's involvement in their care] as harassment, I think

## Service context

### *Various pressures on the service*

*Team continue to offer person-centred care while also trying to survive external pressures and internal pressures: it is a positive outcome for the team to survive systemic and structural pressures while also providing person-centred care*

### Wider organisational limitations/changes/demands

there's a number of people who could be referring back to the CMHT and that then obviously we struggle then to take on more referrals, but we do. We don't sort of not take new people on, but it just creates that extra pressure and issues with capacity

### A service stretched/ Working with a limited resource

I think treating people as an individual is a massive part of it [engaging people] isn't it, you know.

But being creative, creative as we can within our, you know the resource is we've got, which can be, you know, limited at times, but... And it's trying to support people on their terms as much as possible and trying to hook people in with whatever that might be. Again, that might be difficult with resource and covid and things's

### Sus not receiving right kind of support/misuse of the service

we know particularly with CMHTs, they've got big waiting lists. It's just sort of not possible really to get anybody moved back.

So you could argue this group of people, they are not getting the kind of required support. As a result, and you could, you know, not to be too melodramatic about it, but you know someone's not on the required pathway. They're not on the required pathway to recovery.

### AOTs have changed

"we were 24 hour, seven day a week team working actively until 8:00 o'clock every night. So that that's been kind of lost over the years. Due to kind of funding reasons I suppose."

### Clinicians/Sus need more time

... I would love to have more opportunity to really develop relationships with people. I think like there's some people I can think of in particular that I would, I think. My ability to work directly with them would be really benefited by like going out for coffee once a week and but it's that kind of thing that gets pushed back because other things kind of jump in, you know, and become the priority because they have to.

### *What helps the team to function: protective factors*

**High level of team support**

“... What we do manage to achieve is actually kind of an outcome of the team approach and... It is that kind of classic, kind of.. Yes, it's cliché, but it's greater than the sum of the parts.

My own experience of work is you know one which you know... I would describe work as constantly very busy. And just like every person here in the room, every moment is kind of marked by..there's competing demands at any one time. So it's kind of like...It's unavoidably potentially stressful. And the ability to kind of like manage that and get through is only an outcome of a really very generous collaborative team effort.”

**High level of skill in team**

I think the level of sort of expertise that we have within the team around So say harm minimisation is, it is well beyond anything I've ever experienced working in the CMHT or working in early intervention Services even. That is a real strength of this service.

**3. POSITIVE OUTCOMES**

**What the team offers: positive outcomes for the team [what contributes to SU outcomes; reciprocity between what is offered and what is received/experienced]**

*Person-centred care (beyond lip service); SU may experience feeling understood as an individual and receive the right support*

**Offering person-centred care**

And it's trying to support people on their terms as much as possible and trying to hook people in with whatever that might be

**Treating people as individuals****Knowing the individual**

This is how it will be completely different for each person like trying to think. In my case, like there's no two people the same, like there's no particular sign that you look for within all of them, everybody's... You know, uh, what might might be. I don't know, really, kind of positive change with one person might be really negative change with another. And I don't know like for some person that one person it might be like when things are getting worse, you hear from them all the time with someone else it might be when things are getting worse, you just you can't lay eyes on them for weeks and it's just it's different from person to person.

**Trying to understand the individual**



I, I mean, I've got in mind the person that you are referring to, and I think that is about the relationship that works and built with that person over years and years and years and maybe CMHT would have never got into that flat to see drug paraphernalia and or been persistent enough to see neighbors or other people around to kind of get that kind of collateral information that helps make that kind of assessment and informs the sort of care and support there's been being offered so that speaks to the persistence and the flexibility of the approach of what is being offered by people in IoT.

### Getting the right support

Recently somebody where you know we sort of used to harm minimization approach for somebody... So gently supported them to open up about the drug use and you know they have ended up in drug treatment. You know, I think that's taken quite a bit of work and persistence, but in quite a sort of gentle way. Really working with the service user on their terms again.

### *Building a relationship between the SU and the team*

#### Building trust is key [to engagement]

Yeah, you gotta earn the right to have your advice taken seriously by people you know they've got no reason to trust us lot really.

#### Emphasis on relationships between clinician/SU

"I think what we offer is to some extent a landscape that involves a little bit more choice because we do work as a team and we were trying to identify the best kind of working relationships that are going to work, and if it doesn't work with one care coordinator, we'll try another and... We kind of accept the challenge of trying to make it work for someone, really."

### *AOT mindset of 'not giving up'; SU may experience people won't abandon me when things go wrong/I feel overwhelmed with distress*

#### Persistence

"The main thing I guess it's, uh, the team approach the smaller caseload and that kind of ethos of we aren't going to give up or keep on trying to engage people, whereas your mainstream secondary care, no criticism implied to them but if you missed two or three appointments you are going to be discharged, whereas that's our inclusion criteria. Missing appointments."

#### Responsive

we're very agile, we're fast moving. WE're able to kind of meet a lot of the demands that arise unforeseen at quite short notice.

### Added benefit of team approach

I personally I think I like the way how you know the team is very proactive around getting people to come in and get the depot injections or to get their medications and things like that. If you are in the CMHT, they wouldn't... You know, follow you up in the way we do.

### Tolerating tough times

But it's a slow process and quite often based on.. allowing people to go through the same pattern of problems repeatedly whilst staying with them and not judging that and keeping on reflecting potential change to them you know in in, in a non kind of dictatorial sort of way.

[consequence for SU]

*Specialist integrated care – often inhouse which means that care is provided through trusted relationships; SU may experience continuity of care with clinicians they have grown to trust and so will accept help from*

### Dual diagnosis/integrated care team

### Interprofessional/interagency care

we do have quite strong links with voluntary sector organisations. I think we probably do that. I don't know if it's different to other teams. I kind of think it is.

### High level of skill in team

### Emphasis on relationships between clinician/SU

“I think what we offer is to some extent a landscape that involves a little bit more choice because we do work as a team and we were trying to identify the best kind of working relationships that are going to work, and if it doesn't work with one care coordinator, we'll try another and... We kind of accept the challenge of trying to make it work for someone, really.”

[talking about harm minimisation] so quite a lot of that stuff is kind of being done, done in house and kind of probably really in the only way that someone might accept it, in that they might have built a relationship with a worker from IoT over years and years and years, but that you know, there's resources within the team that there theyre getting access to, but not necessarily from let's say a specialist service that might... They might never get to or might never get to see them potentially.

*Potentially a different experience of mental health services; SU may learn to accept help; to take a chance on others*

**We're different to other mental health services**

, I think within the CMHT that I worked in, there was a very kind of rigid... rigid kind of clinic type approach to medical input like 'this is where my clinic is and this is when my next available slot is' Yeah, I mean. It could well be different in other CMHTs. Here I find them very kind of flexible and like available, kind of around, because things just happen, only in having that person around can you immediately respond.

**Working in a different way**

They're getting quite a holistic and broad range of interventions, often from people within this team, so they're not being referred out for harm minimisation or some intervention around their drug use.

They're getting that support directly from the people that they built a therapeutic working relationship, and that they trust so that we're doing.. You know, the breadth of skills within the team is quite great really.

**Different offer of care**

**Accepting help**

acceptance, if you like, of service users, own vulnerabilities on their own part.

I'm talking about gentleman, who we got about two years ago who was on depot medication, who was very much opposed to it. Absolutely anti it, was still quite psychotic even when it was being given to him, who had a repeated problematic admissions with kind of distressing situations for his family. Who after we took him off the depot still...That being what he wanted had several more relapses. But eventually decided the accepting and continuing to accept it as oral treatment was a good idea. And he's been quite stable since then. For about six months now, I guess.

## **What the Sus receive or experience: positive outcomes for Sus**

*Safety in various forms/Safety and stability*

*Physical safety*

**Sus safer in hospital**

'cause sometimes hospital admissions are really appropriate and needed, and the most safe place for folk

Just sometimes getting someone into hospital is a massive achievement because just finding them and making them, you know getting them into the into a place where they're safe where maybe they haven't been for weeks and weeks. You know it can be. It can be a really... Obviously it's tricky to say, but it can be something that we've been working on really hard for a long time. And then finally, you know it happens. So kind of seeing that as a negative outcome. It doesn't really make sense with the people that...

[physically] Safer...but not [psychologically] thriving

I guess we were great at getting people in who are in absolutely terrible states. Moving them from a terrible state too, to relatively safe and kind of stable, but moving them from there to thriving and great, it's more difficult for a lot of those people thriving and great, perhaps isn't even a possibility.

Feeling better

### *Stability*

Helping Sus to achieve stability and benefits of that

[name] ...I mean he's a success story. There's no doubt about it, it needs to be continued and developed, but he's safer. He's got a much more dignified living arrangement than they had before.

Offering/receiving practical support

Getting the right support

Feeling better

### *Psychological safety*

Helping sus to *feel* safer

it is about sort of that relearning safety. A lot of the sort of psychosis that people are experiencing is about threat and feeling unsafe then and I think...I dunno what the percentage would be, but there is as much kind of genuine being in unsafe areas, being around unsafe people, being in unsafe relationships, that kind of practical, unsafe, real kind of problem. And then there's a lot of just feeling unsafe more generally in terms of people's belief systems and their understanding of the world. And their place in it. And kind of that... We're sort of trying to help people feel safer in both of those realms of their life, both practically and psychologically and.

Feeling better

Tolerating tough times

*Opportunities to make choices in their own care*

Capturing Sus voice/views

I kind of like when we can step out of the framework of kind of potentially coercive... You know mental health acts framework such as the Community treatment order arrangements and people

make those choices in a in a kind of atmosphere of cooperation rather than compulsion. That seems to be kind of progress and that and they do end up being those choices that keep them well.

### *Letting the team in/interpersonal/relational support*

Tolerating tough times

Building trust is key [to engagement]

Benefiting from relationships

When I've asked people about what they get out of the team, it's often just been about individuals. You know that they value the individuals working with them so that you know about consistency and you know the approach that we use and you know we have people under the service for a long period of time and they really get to know the people they are working with really well.

### **Positive outcomes for others**

#### *Benefits to organisation*

Reducing need for further resources

"And finding other ways to sort of try and support people not to be admitted to hospital or whatever. And often without getting IHT involved,"

#### *Benefits to community*

Impact on family system/Considering the SU's system

specific supervision spaces are considering families and systemic approaches too not working with just individuals that are on our caseload but the families and support network that they have around them, children, significant others

Protecting others e.g. community/society (not just SU)

because we know what's going on in people's lives and where they were going.. and if we are aware of these problems developing pretty early on, I might well bring them into hospital, but what that's avoided is all the harm to themselves, their families, their communities, anybody else that might have been incurred by them not being brought in promptly and as early as possible.