

# Ethical aspects of assertive outreach

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## Abstract

Assertive outreach is a specialized way of delivering community mental health in the UK and elsewhere. Ethical problems arise from the fact that assertive outreach is supposed to promote independence in a non-engaging individual while at the same time forcing him or her to engage with mental health services. The ethical analysis of assertive outreach presented here is based on Beauchamp's ethical grid and refers to the four categories: beneficence; harm; autonomy; and justice. This is evaluated in light of newer research on the effectiveness of assertive outreach in the UK. Two case examples are presented, illustrating the practical difficulties with this. Ethical dilemmas are highlighted (persistence versus coercion; public protection versus risk aversion; empowerment versus negligence; support versus harassment) and the importance of ethical considerations in the future development of assertive outreach is stressed.

**Keywords** assertive community treatment; assertive outreach; ethics

Assertive outreach is a newly established approach in community psychiatry, geared especially towards non-engaging and high-risk patients. Assertive outreach teams are characterized by the following:

- a service focused on severely mentally ill (SMI) patients with greatest needs
- a low patient caseload (typically 12)
- a team approach with daily handover meetings
- active and persistent follow-up of patients in the community
- intensive case management including hands-on support
- promoting independence
- medication supervision and help with benefits
- delivery of a comprehensive range of interventions.<sup>1,2</sup>

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Assertive outreach is an important part of psychiatric services in the UK, the US and Australia and has become an integral part of almost all mental health provision in the UK over the past 7 years. Stein and Test proved that the original model of assertive community treatment (ACT) implemented in the 1970s in Madison, Wisconsin, was effective regarding outcome and costs in comparison to standard practice at that time (which, in terms of community psychiatry, was virtually non-existent).<sup>3</sup> The characteristics of ACT provision<sup>4</sup> are very similar to what was later defined as assertive outreach. However, newer studies in the UK have not shown an advantage of assertive outreach compared with community mental health team (CMHT) care,<sup>5</sup> which, as we will see later, might have considerable ethical implications.

## What are the ethical issues in assertive outreach?

There are certain inherent difficulties in assertive outreach, i.e. in promoting independence in a non-engaging individual while at the same time forcing him or her to engage with mental health services. Assertive outreach therefore brings into sharp focus a number of ethical issues that are pertinent to all community psychiatry.<sup>6</sup> The following issues are highlighted, based on Beauchamp's ethical grid (Table 1).<sup>7-9</sup>

- Is assertive outreach beneficial?
- Is assertive outreach harming patients?
- Is assertive outreach impacting on patient's autonomy?
- Is assertive outreach fair?<sup>6</sup>

## Is assertive outreach beneficial?

Beneficence could be defined as improved measurable outcome, i.e. number and length of hospital admissions, amount

### Beauchamp's four principles approach to medical ethics to judge the ethical dimension of medical interventions

#### Beneficence

The obligation to provide benefits and balance against risks. Requires positive action rather than merely the omission of harmful activities.

#### Non-maleficence

The obligation to avoid the causation of harm. Goes back to the Hippocratic tradition 'do no harm'.

#### Respect for autonomy

The obligation to respect the decision-making capacities of autonomous persons. Concerns personal freedom, privacy, voluntariness and choice.

#### Justice

The obligation of fairness in the distribution of benefits and risks (e.g. do poorer people have the same access to treatment as richer people?)

Source: Philpot, 2004.<sup>9</sup>

Table 1

of psychopathology, number and severity of serious incidents, engagement and adherence to medication, quality of life, social adjustment, vocational functioning and so on.

According to the results of a recent randomized controlled trial, assertive outreach in an inner London borough did not have a significant influence on hospital admission, violent incidents or social functioning. However, improvement was shown in rates of engagement and satisfaction.<sup>5</sup> A possible explanation for this would be that well-functioning CMHTs are able to achieve results similar to those achieved with assertive outreach, thereby questioning the justification for implementing a service which is more costly and potentially drains resources from other areas of community psychiatry.

Another explanation is that assertive outreach would need more than the 18-month observation interval of this study to show effect.

### **Does assertive outreach cause harm?**

According to the study mentioned above, no harmful effects of assertive outreach in comparison with CMHT care were observed. In other words, assertive outreach does not seem to increase hospitalization (as observed by some teams, at least initially) and the study did not report any detrimental effects on suicide figures and violent incidents. It might be argued that medication, which otherwise may not have been taken by a patient, might cause side effects. Several other harmful effects have been proposed (see below), most of which pertain to the patient's autonomy.

### **Does assertive outreach have a negative impact on the patient's autonomy?**

The essence of the assertive outreach philosophy is the intensive persistence with which patients are followed up – the 'never accept "no" for an answer' approach. This has resulted in the accusation that assertive outreach impedes patients' rights to privacy and self-determination.<sup>10</sup> Other similar arguments are that assertive outreach is coercion of non-consenting individuals, that it deskills patients, makes them helpless and is more focused on medication adherence and social control than improved care. Newer criticism, which goes beyond the impact on the patient's autonomy, sees a danger of assertive outreach becoming a form of reinstitutionalizing patients in the community. There is concern that patients might become dependent on this new delivery form of community psychiatry, with both patients and staff becoming reluctant to discharge.<sup>11</sup> Certainly all of these problems are inherent to community psychiatry, but they are much more pronounced in assertive outreach. To add to the problem, most of these constructs are difficult to measure, although it has emerged that the satisfaction of assertive outreach clients with the service is higher than with standard care.<sup>5</sup> It might be important to include qualitative research in this perspective, to obtain a view from the client's side.<sup>12,13</sup>

### **Is assertive outreach fair?**

#### **Who benefits and who does not?**

Are there patients who, by referring them to assertive outreach, are prevented from harming others or themselves, thereby

justifying this much more expensive approach, and one which potentially impedes a patient's civil rights?

Recent research suggests that there might not be a difference between assertive outreach and standard community care in the UK in terms of prevention of violence or forced hospital admissions.<sup>5</sup> This contrasts with the experience of staff working in assertive outreach, who – at least in some patients – see a clear improvement, fewer admissions and less conflict with the social environment. The impact of assertive outreach on violent crimes committed by mentally ill patients, however, will be difficult to prove by quantitative statistics, as these are rare incidents.

### **What is the legal basis of an assertive approach, if this is not covered by the Mental Health Act?**

This highlights the current discussion about the new Mental Health Act (amendment). Is it right to forcibly treat patients in the community? Because of this dilemma, assertive outreach may take up the new powers readily to place patients on a clear legal basis for following interventions. It is interesting to note here that in other European countries such as Germany and Italy, the implementation of such an approach without a legal basis might be impossible.

### **Are CMHT patients deprived of additional resources by implementing assertive outreach?**

This, as with other specialized teams such as Early Intervention or Home Treatment, will be a question of increasing importance in the NHS, as resources are looked at more closely, and savings will have to be made on a continuing basis.

### **Within assertive outreach, are resources allocated according to individuals' needs or on the basis of estimated risk and prevention of harm?**

A risk-conscious community focus might lead to neglecting patients in hospital, thereby impacting negatively on admission duration and early discharge planning.

### **Case histories**

The following cases are descriptions of typical assertive outreach patients. They are presented here to highlight some of the ethical dilemmas present in this area (all names and personal data have been changed).

#### **Case 1**

John is a 25-year-old patient who has suffered from paranoid schizophrenia since he was 17. He has minimal 'activities of daily living' (ADL) skills. He is living in his own flat but is not able to clean it sufficiently. John responds frequently to hallucinations, shows formal thought disorder and has acted in a bizarre manner in the past (e.g. he urinated into bottles and kept these in his flat for weeks). At times he has been aggressive towards neighbours. He has not been compliant with his medication, although he has accessed the service when he needed something (e.g. when he lost his keys or ran out of money).

He was admitted to an acute ward last year in a perplexed state. The ward then advocated a supported housing project, but John was adamant that he wanted to continue to live independently, as he had been in residential care in the past.

The assertive outreach team supported him over the following year with daily supervised medication (watching to see that medication is swallowed), help with cleaning his flat (on several occasions, team members had to be rather assertive towards John to allow entry to staff) and support with his benefits, linking with other support agencies and repeated psychiatric assessments. John denied access more than once and slammed the door on staff, but the team always came back. In the team meetings, the following questions were discussed.

- How many of John's problems are 'health'-related and could possibly benefit from medical interventions (e.g. clozapine)?
- Would John benefit from a longer inpatient admission in terms of his ADL skills, and could this be justified despite his reluctance to be admitted to hospital?
- Is a decent life possible for John, even if nothing much changes?
- What are the risks for assertive outreach staff in being assertive with John regarding the hygiene in his flat?

Finding a practical way to manoeuvre between the apparent mental health and social needs of this patient and his wish to remain in the least restrictive environment often seemed like walking a tightrope.

### Case 2

Maria is a 45-year-old Black Caribbean patient with a 25-year-old son who lives with her. She has been admitted four times over the past year, has regularly defaulted on her medication when discharged and does not show any insight into her condition. Maria's philosophy is to attribute everything to God, occasional sleeping problems and worries about her family. She trusts in the healing power of her religion. Maria usually presents in a confused state when admitted. She shows formal thought disorder, the delusion that impostors have replaced her relatives, and aggressive behaviour. Maria improves quickly once on the ward, but the repetitive experience of this cycle has not changed her attitude towards treatment with medication.

Assertive outreach has tried to tackle her frequent relapses with daily supervised medication and activity planning, which Maria accepted for a while before deciding that she is not ill and therefore does not need medication or regular visits. To stabilize her in the community, she is sent on increasing leave from the ward; once she feels better, she usually discharges herself.

Maria is highlighted in the community as a 'revolving door' patient; however, assertive outreach is powerless if she does not cooperate. She is usually not a risk to herself or others and her breakdowns happen so rapidly that there is often no time for formal Mental Health Act arrangements.

The strategy here is to be persistent without becoming too coercive in the daily contacts, to monitor her mental health and to pick up a deterioration as soon as possible, to accept her autonomy in decision-making whilst adapting a long-term view with the aim to educate her further, promote medication taking, agree on mutual goals and involve her social environment (i.e. via a carer's assessment) in supporting her.

### Summary

Ethical dilemmas in assertive outreach result from the contradictory nature of the approach (at the same time promoting

## Ethical dilemmas in assertive outreach

### Persistence versus coercion

Do assertive outreach teams have the right to follow up patients who do not want to engage?

### Public protection versus risk aversion

What is the threshold for a hospital admission?

How much risk is tolerable?

### Empowerment versus negligence

What amount of autonomy can be tolerated (including non-engagement)?

What kind of interventions foster dependence?

### Support versus harassment

What is the least restrictive environment for the patient?

How do possible different values and ethnicity come into the equation?

Table 2

independence and potentially exerting a higher amount of social control) and unproved assumptions about the effect of this model on outcome.

Ethical problems in assertive outreach bring into sharp focus general ethical problems in psychiatry, and especially community psychiatry. They offer a rich ground to discuss difficulties with engagement, psychopathology, medication adherence and risk, with patients and staff alike. In practice, continued ethical reflection is necessary to agree on the best way forward.

Table 2 presents typical ethical dilemmas in assertive outreach – on the left-hand side of the heading a positive view of what is provided and on the right-hand side of the heading a critical interpretation of the same approach, with typical questions arising in clinical practice. The pronounced shape of both sides of this coin makes the discussion of ethics in assertive outreach a fascinating subject.

How the pros and cons of this service will be weighed in the future will, apart from overall cost aspects, also depend on further research into the benefits and 'side effects' of assertive outreach, and might well lead to a re-evaluation of this service model. The discussion of ethical aspects will play an important role in this. ◆

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