Be Good to Your Patient

How the Therapeutic Relationship in the Treatment of Patients Admitted to Assertive Outreach Affects Rehospitalization

Walid K. H. Fakhoury, MPH, PhD, Ian White, PhD,† Stefan Priebe, MD,* and PLAO Study Group*

Abstract: We investigated whether the quality of the therapeutic relationship (TR) between patient and clinician predicts rehospitalization in patients in assertive outreach treatment. Analyses were conducted on 332 "established" (equal to in care for ≥3 months) and 150 "new" (equal to in care for <3 months) patients with severe mental illness sampled from 24 assertive outreach teams in London, England. TR was assessed at baseline using the clinician version of the Helping Alliance Scale. Rehospitalization was assessed over a 9-month follow-up period. Controlling for other predictors, a more positive TR was found to predict fewer hospitalizations in new patients but not in established ones.

Key Words: Assertive outreach, therapeutic relationship, hospitalization, community care, mental illness.

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The role of the therapeutic relationship (TR) between patient and clinician has been increasingly investigated in community psychiatric care. However, there is no evidence on the predictive value of the TR for the outcome of assertive outreach (AO), where multidisciplinary teams provide intensive community care with low staff-patient ratios and shared caseloads for patients who pose ongoing risks and are thus regarded as "difficult to engage." Establishing and maintaining a sustainable TR is one of the aims of AO. Yet, once this has been achieved and patients stay in treatment, does the quality of the TR influence outcome of AO treatment? This study investigated prospectively whether the quality of the TR predicts rehospitalization of patients over a 9-month period, controlling for other factors predicting outcome, i.e., team, staff, and patient characteristics. Because forming a TR in newly referred patients may be a different task from maintaining such a relationship in ongoing care (Priebe et al., 2005), we distinguished newly admitted patients from those who had already been in care for more than 3 months.

*Unit for Social and Community Psychiatry, St. Bartholomew's Medical School, Queen Mary, University of London; and †MRC Biostatistics Unit, Institute of Public Health, Cambridge, United Kingdom.

The work was conducted at the Unit for Social and Community Psychiatry, Barts' and The London School of Medicine, Queen Mary, University of London.

Send reprint requests to Walid K. H. Fakhoury, MPH, PhD, IMS Health, Level 3, Lee House, 109 Hammersmith Road, London W14 0QH, UK. E-mail: w.fakhoury@qmul.ac.uk.

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METHODS

The sample in Pan-London Assertive Outreach (PLAO) Study Group consisted of 580 patients who were drawn from 24 AO teams in Greater London within the PLAO study. In PLAO, the caseload for each team was divided into patients who had been with the team for ≥3 months—referred to as "established" patients—and those who had been on the caseload <3 months—referred to as "new" patients. The 3-month dividing line between new and established patients was agreed upon through discussions by members of the steering and advisory groups of PLAO. The sample consisted of all new patients and a random 0.37 fraction of established patients from each team. New patients were oversampled to increase their sample size and reduce differences between teams being confounded by the length of time patients had been in AO, mostly exclusively established patients in long-running teams. In total, there were 391 established and 189 new patients. The mean age of patients was 36.7 years ($SD = 11.7$). Patients were most frequently male (64.5%), single (72.1%), unemployed (89%), and living alone (52%). A majority had a diagnosis of schizophrenia (73.6%), and had been hospitalized in the last 2 years (71.9%), 55.7% compulsorily. The PLAO methodology and sample characteristics have been reported in more detail elsewhere (Billings et al., 2003; Priebe et al., 2003; Wright et al., 2003).

In this article, the analyses were conducted on 446 patients who had complete data on TR at baseline and hospitalization at follow-up. Data on hospitalization was available for 80% ($n = 150$) of new and 85% ($n = 332$) of established patients.

Semistructured interviews with team managers plus 1 month's prospective process of care data collection were used to collect information on the team organizational characteristics. The Maslach Burnout Inventory was administered to measure staff burnout (Maslach et al., 1996). A case note review was conducted in the teams to obtain data on patients' sociodemographic and clinical characteristics, including diagnosis and hospital admissions. Follow-up information was collected after 9 months, and consisted of measuring rehospitalization during the 9-month period (Priebe et al., 2003).

TR was assessed at baseline using the clinician version of the Helping Alliance Scale (HAS). The HAS is made up of 5 items: (1) "Do you get along with the patient?," (2) "Do you understand the patient and his/her views?," (3) "Do you look forward to meeting the patient?," (4) "Do you feel you are actively involved in the patient's treatment?," and (5) "Do you feel you can help the patient and treat him/her effectively?" All items refer to the last month and are rated on an 11-point visual analogue scale ranging from 0 = not at all to 10 = extremely well. The mean score is taken as indicator of the quality of the TR. Clinicians holding responsibility for care coordination or with the most frequent contact with the patient completed the scale. Self-ratings were not used because patients' informed consent for administering such scales would have been difficult to obtain, resulting in a substantial refusal rate and subsequent selection bias.

The HAS has acceptable psychometric properties (Holzinger et al., 2002; McCabe and Priebe, 2004). Items in the scale weakly to moderately positively intercorrelated with case manager understanding, case manager involvement, and adequacy of treatment (Priebe and Gruyters, 1993). The sum score of the HAS was found to be highly and significantly correlated with the sum score of the patient version, and moderately significantly correlated with the Keyworker version of the Working Alliance Inventory (Bale et al., 2006; Horvath and Greenberg, 1989).

Patients were the unit of analysis. Because patients in the same team shared the same team and staff characteristics, robust standard errors were used, allowing for dependence within teams. To assess the predictive ability of the TR on rehospitalization during follow-up, logistic regression was used. Covariates that were adjusted for were factors found to predict hospitalization at $p < 0.15$ in previous analyses (Priebe et al., 2004). These were (1) staff characteristics [working at weekends (yes/no); working outside office hours (yes/no)], (2) staff morale factors (Maslach Burnout Inventory score on depersonalization; Maslach Burnout Inventory score on personal accomplishment), and patient characteristics referring to the last 2 years from baseline [number of hospital admissions; hospitalization (yes/no); compulsory hospitalization (yes/no); physical violence (yes/no); contact with services other than the AO team (yes/no)]. Missing values of these covariates, but not of TR or hospitalization, were multiply imputed.

RESULTS

For new patients, the TR mean score at baseline was 6.35 ± 2.02, and for established patients 6.66 ± 1.92. Thirty-nine percent ($n = 188$) of all patients ($n = 482$) were hospitalized during the follow-up period, i.e., 49.3% ($n = 74$) of new patients and 34.4% ($n = 114$) of established patients. As shown in Table 1, TR significantly negatively predicted rehospitalization during follow-up in new patients. This held true before ($p = 0.04$) and after controlling for covariates ($p = 0.02$). In the sample of established patients, TR had no statistically significant predictive power on rehospitalization (before controlling for covariates, $p = 0.53$; after controlling for covariates, $p = 0.64$), although there was no significant interaction between the 2 patient groups ($p = 0.14$ unadjusted and adjusted).

DISCUSSION

A more positive TR is significantly associated with a lower rehospitalization rate in newly admitted patients. The predictive association was independent of the predictive power of other baseline variables such as teams' working hours and patients' mental health service usage in the last 2 years. It was also not influenced by staff burnout, a factor reported to affect patient satisfaction with treatment (Leiter et al., 1998). The finding suggests that TR is not merely a reflection of staff morale. Forming a good TR with new

TABLE 1. Multiple Logistic Regression of Hospitalization During Follow-Up on TR for Newly Admitted and Established Patients

	Newly Admitted Patients ($n = 133$)		Established Patients ($n = 313$)	
	Regression (95% CI) Coefficient	*p*	Regression (95% CI) Coefficient	*p*
Model 1				
Unadjusted	−0.21 (−0.42 to −0.01)	0.04	−0.04 (−0.16 to +0.08)	0.53
Model 2				
Adjusted for all covariates	−0.24 (−0.45 to −0.03)	0.02	−0.03 (−0.17 to +0.10)	0.64
Model 3				
Adjusted for one covariate at a time				
Working weekends	−0.21 (−0.42 to −0.01)	0.04	−0.06 (−0.18 to +0.05)	0.29
Working outside office hr	−0.21 (−0.42 to −0.01)	0.04	−0.05 (−0.19 to +0.02)	0.13
Burnout-depersonalization score	−0.22 (−0.42 to −0.01)	0.04	−0.07 (−0.18 to +0.04)	0.21
Burnout-personal accomplishment score	−0.23 (−0.43 to −0.03)	0.02	−0.06 (−0.17 to +0.05)	0.28
No. hospital admissions	−0.22 (−0.41 to −0.03)	0.03	−0.04 (−0.17 to +0.08)	0.50
Voluntary hospitalization in last 2 yr	−0.23 (−0.41 to −0.04)	0.02	−0.04 (−0.17 to +0.10)	0.61
Compulsory hospitalization in last 2 yr	−0.20 (−0.40 to +0.00)	0.05	−0.06 (−0.18 to +0.06)	0.31
Physical violence in last 2 yr	−0.19 (−0.41 to +0.03)	0.08	−0.05 (−0.16 to +0.05)	0.30
Contact with other services in last 2 yr	−0.22 (−0.43 to −0.01)	0.04	−0.04 (−0.16 to +0.08)	0.51

"difficult to engage" patients may not only help treatment adherence, but also prevent rehospitalization. The TR is a process that also seeks to increase patient involvement and therefore help patients gain an increased capacity for self determination and choice, through which they become more autonomous and self determined. In established patients, however, TR was not found to predict outcome. Reasons for the difference in the effect of TR on rehospitalization in the 2 groups of patients merit further investigation. One might speculate as to whether AO care in established patients, who are less often rehospitalized than new patients, has reached a ceiling in the prevention of hospitalization that cannot be improved anymore through a positive TR. In terms of clinical practice, the findings suggest that more focus should be placed on new patients, and the TR should feature more strongly in the training of clinicians.

The study has the following shortcomings: First, only the clinician's perspective of the TR was taken. In psychotherapy, patients' ratings usually have a higher predictive power than those of clinicians, and it remains unclear whether this may also be the case in forms of assertive community care. Second, rehospitalization was the single outcome criterion in the analysis. Although preventing further hospitalizations is certainly a central aim of AO, it is not the only one, and the possible impact of the TR on other outcome criteria such as changes in patients' quality of life and social inclusion are also of interest. And third, there is no data on potentially mediating factors that might explain the link between better TR and fewer rehospitalizations in new patients. However, the study shows that the quality of the TR can be an important predictive factor in the treatment of a most challenging group of patients with severe mental illnesses. The results were gained using a simple global measure of TR that can easily be applied in various settings. The findings may encourage more systematic research on the role of the TR in assertive forms of community treatment and its clinical consideration in routine care.

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