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ASSERTIVE OUTREACH (RURAL) OPERATIONS POLICY

Policy Sponsor:	Joint Locality Manager S&E Dorset Area
Implemented:	April 2001
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Due for Review:	April 2006
Approved by:	Joint Governance Team, April 2004
Disseminated to:	Team Co-ordinators for Purbeck, Christchurch and Wimborne & District Adult CMHTs

Core Service Statement

This Service will aim to provide safe, sound and supportive help that will enhance recovery, reduce social disability, increase social inclusion and decrease stigma.

1.0 SUMMARY OUTLINE OF THE SERVICE

- 1.1 The Assertive Outreach Service will aim to provide safe, sound and supportive help that will enhance recovery, reduce social disability, increase social inclusion and decrease stigma.
- 1.2 This aim will be achieved by providing an evidence based service which will determine and meet service user needs through collaborative working practices. Emphasis will be placed on engaging service users who are difficult to engage through practices that are meaningful, helpful and enjoyable to the service user.
- 1.3 The service model is based on a rural adaptation of the Programme of Assertive Community Treatment as described by Teague et al (1995), Lachance (1995).
- Focuses on people living in predominately rural and semi rural areas (including the towns of Christchurch, Wareham, Swanage, Wimborne) with serious and enduring mental illness who for whatever reason avoid using other mental health services.
 - The service is provided through the Community Mental Health Team (CMHT) in each of the three geographical areas of Christchurch, Wimborne, Purbeck. The assertive outreach function is incorporated into each CMHT through the provision of a dedicated assertive outreach practitioner in each team who is supported by Richmond Fellowship staff who are able to provide 84 hours a month across the three areas. The assertive outreach practitioner will provide the main point of contact for allocated service users but will co-ordinate the input of other CMHT members as required dependent upon need, with the support of social services colleagues.
 - Each CMHT will have around 10 – 12 service users depending on complexity of needs who require the assertive outreach service.
 - The work is based on engaging with service users positively through meeting their needs and promoting social inclusion rather than restrictive control.
 - Assertive Outreach takes place in the service users own community and meetings take place as frequently and for as long as necessary.
- 1.4 Outcomes will reflect the core statement through attempting to improve the following:
- Quality of life
 - Improved social functioning
 - Better mental and physical health
 - Motivation to work with mental health care services
 - Satisfaction with mental health care services
 - By reducing the frequency of Mental Health Act detention and contact with the criminal justice system.
- 1.5 These outcomes will be measured through using a combination of tools which allow for quantitative analysis and evidence drawn from qualitative enquiry.

2.0 INTRODUCTION

- 2.1 This policy sets out the working arrangements for the new Assertive Outreach Service in the rural and semi rural areas of East Dorset covering the geographical areas of Christchurch, Wimborne and Purbeck (including their associated towns). The service is co-terminus with the local authority boundary of Dorset County Council Social Services Directorate and the area of the South and East PCT. A separate service and operational policy is in place for service users referred from the Local Authority boundaries of Bournemouth and Poole, the IICPA and Risk Management Polices.
- 2.2 The policy should be read in conjunction with the agreed joint Trust/Social Services Operational Policies for Community Mental Health Teams (CMHTs), the Dorset Forensic Service and the Urban Assertive Outreach Service for Bournemouth and Poole.
- 2.3 South West Regional Policy initiatives have been used to inform this policy as core criteria for the achievement of assertive outreach in this region have been developed (Onyett, 2001).
- 2.4 This policy is based upon current resource arrangements and will be changed and developed as additional resources permit.

3.0 DEFINITION

- 3.1 Assertive Outreach Services are provided for people with a primary serious mental disorder often co-existing with substance misuse who are difficult to engage, have frequently failed to comply with treatment programmes, exhibit poor social functioning, are often excluded from many aspects of daily life and are deemed to be a risk to the local community and/or themselves, carers, families or significant others. Traditional services tend to have difficulties in meeting their needs and they often demand input from several agencies concurrently. They are a very challenging and service intensive group, with erratic lifestyles. They are most likely to exhibit a repeated cycle of care in which crisis, inpatient care (often under the Mental Health Act 1983,) discharge, disengagement, breakdown and re-admission are followed repeatedly (Sainsbury Centre for Mental Health, 1998).

4.0 AIMS AND OBJECTIVES

- 4.1 The aims and objectives of local assertive outreach services are:

- To develop and maintain a long-term supportive and therapeutic relationship with the service user through assessment, help and care in the service users own community.
- To provide flexible support and help that is meaningful and acceptable to the service user that aims to improve quality of life.
- To seek meaningful and acceptable methods of engaging service users.
- To use hospital admissions as part of a community care plan, where possible on a planned basis for example as part of an early intervention plan which will reduce the need both for emergency admission and re-admissions and unnecessarily long periods of hospitalisation.
- To use evidence based biopsychosocial approaches as part of the service users care programme formulated from individual assessment.

- To support each service user to obtain or retain the most suitable accommodation, appropriate to their needs.
- To maintain relationships and develop supportive social networks.
- To provide a wide range of practical support aimed at increasing social inclusion opportunities for example ,employment and leisure.
- To increase carer satisfaction, education, training and support, through the use of the ICPA, Carers Assessment/Care Planning process.

5.0 REFERRAL CRITERIA

5.1 Service users will be assessed for entry into the service if they are living in the geographical areas served by Christchurch, Wimborne and the Purbeck CMHTs which are co-terminus with Dorset Social Services. They will be over the age of 18, and under the age of 65. The assertive outreach service is aimed at people with an enhanced IICPA with a diagnosis of serious mental disorder who meet the criteria. The service is provided through existing CMHTs, however, individuals who are not previously known to the local service will be encouraged through an engagement process to register with a GP who can then formally refer to the team. The following criteria is based on the acknowledged work of Deborah Allness and William Knoedler (1998).

5.2 Essential Criteria:

- Service users with a severe & persistent mental disorder who have complexed needs and are vulnerable with priority given to people who experience psychosis.
- Service users who are reluctant to engage with services i.e there is an inability or reluctance to keep appointments or work with mental health care services to the detriment of the persons health.

5.3 Additional Criteria

Priority will be given to service users who have the following profile issues:

- Service users with significant functional impairment for example daily living skills, finance management, housing, occupation.
- Service users at risk of self neglect or harm to themselves or others.
- Service users with a co-existing substance abuse problems.
- Service users with a high use of in patient care or emergency services.

5.4 Exclusions:

Although there is no diagnostic eligibility criteria, the service is not aimed at people who have organic brain disorders such as dementia, learning disabilities or whose primary needs may be better met through other services for example addiction or forensic services. Service users whose problems are such that assertive outreach is unlikely to meet their needs and indeed may cause a further exacerbation or escalation of their problems would also not be suitable.

5.5 Adherence to the above criteria is essential in order to ensure that:-

- Those service users in greatest need of assertive outreach receive it.
- The focus of the team does not dissipate to include individuals with less complex needs.

5.6 In cases where there is evidence of Personality Disorder, the multi-agency framework and algorithm for Personality Disorder should be used to guide treatment.

6.0 **MODEL OF SERVICE**

6.1 Service users are served by their geographically defined Community Mental Health Team (CMHT). The assertive outreach function is incorporated into each CMHT through the provision of a dedicated assertive outreach practitioner in each team who is supported by Richmond Fellowship staff who are able to provide 84 hours a month across the three CMHTs and support for social work staff as appropriate to the delivery of care. The assertive outreach practitioner will provide the main point of contact for allocated service users but will co-ordinate the input of other CMHT members as required dependent upon need.

6.2 Each CMHT will have around 8 service users who require the assertive outreach service.

6.3 Working hours will be based predominantly on a 5 day a week (Monday – Friday) service will be available on an 9am – 5pm basis with some flexibility for evening working and weekend working where this is identified in the care plan.

6.4 Intensive, high frequency daily contact can be made available

6.5 Service is provided in predominately informal settings.

6.6 Individually designed care plan which are ambitious, realistic and sustainable, based on strengths, aspirations and needs.

6.7 Full risk assessment and management plan to reduce crisis and self/other harm. Issues of 'safety' will underpin the work of practitioners and the service will operate formal mechanism to ensure the safety of its staff. These mechanisms will include regular 'reporting in' arrangements and maintaining contact with base. Each member of staff will have access to a mobile phone.

6.8 Involvement of service users and the carers in the 'active' development of care plans and subsequent delivery of care. Wherever possible, to encourage and involve users, carers and families to make a rational choice about their management which will in turn lead to them owning and taking responsibility for their own treatment, as this may prove to be a powerful factor in compliance and subsequent relapse prevention.

6.9 User and carer involvement is a high priority and service users/carers will be actively encouraged to be involved in their IICPA. The assertive outreach worker will be responsible for ensuring users and carers have access to information on existing support groups and carer networks and provide any additional input or support as required. Information leaflets, booklets and videos will be available.

6.10 Use of safe and effective drugs with low side effect profiles to improve compliance.

6.11 Use of effective psycho-social interventions and programmes The service will help to meet social needs such as finding housing, claiming welfare benefits, finding work opportunities, accessing physical health care, education and training.

6.12 Close liaison and co-ordination with other areas of service both statutory and voluntary.

7.0 **RELATIONSHIP BETWEEN ASSERTIVE OUTREACH SERVICE AND DORSET FORENSIC SERVICE (DFS)**

7.1 The Assertive Outreach Service will support some people who have a history of offending, where there is also evidence of mental disorder, and there is a need for assertive outreach and the criteria is met.

7.2 The Assertive Outreach Service will work in partnership with the DFS and avoid duplication of input to service users with a history of offending behaviour, and importantly to ensure that service users with complex needs and risky behaviour receive the necessary care.

7.3 The Assertive Outreach Service will access the DFS for specialist assessment on offending behaviour and/or the DFS specialist treatment programmes for offending behaviour. In such circumstances, Care Co-ordinator responsibilities will remain with the Assertive Outreach Service.

7.4 Assertive Outreach Service will inreach where appropriate.

8.0 **RELATIONSHIP BETWEEN ASSERTIVE OUTREACH SERVICE AND IN PATIENT SERVICES.**

8.1 The Assertive Outreach Service will accept nominations for people who are currently in an in-patient setting.

8.2 Nominations will be assessed whilst the service user is in hospital and if suitable a process of working with the service user will commence whilst the service user is an in-patient.

8.3 The Assertive Outreach Service will liaise and work closely with in-patient services during periods of in-patient admission. During such admissions service users will continue to be seen by the Assertive Outreach Workers (Assertive In-reach). The Assertive Outreach Worker will be involved in initiating and planning both admission and discharge arrangements as the Care Co-ordinator (Onyett. 2001).

9.0 **REFERRAL PROCEDURE**

9.1 The Assertive Outreach Service is a service accessed through the CMHT and the appropriate CMHT will accept referrals from GP's, inpatient services, homelessness services, addiction services, forensic services and rehabilitation services.

10.0 **STAFFING**

10.1 The rural assertive outreach service will be made up of the following staff in each of the 3 CMHTs; a designated worker to fulfil the Assertive Outreach Function in addition, 84 hours per month of support worker time is made available across the 3 teams provided by the Richmond Fellowship and appropriate social care agreed as part of the care plan.

- 10.2 The dedicated assertive outreach practitioner will be required to be part of the generic out of hours rota service.

11.0 HOURS OF OPERATION

- 11.1 The service will be provided over five days per week (Monday – Friday) principally during the hours of 9am – 5pm with some flexibility for evening and weekend working.
- 11.2 The Community Mental Health Nurse Evening and Weekend Service will be the first line of contact for all service users registered with the Assertive Outreach Service who are in crisis and do not have any planned visits up to 9.00pm on weekdays and from 9.00am to 5.00pm during weekends. Outside of these hours the existing On-Call Consultant Psychiatrist and Out of Hours (Social Services) will be the first point of contact. Service users will have care plans that are based on a full 24 hour day and will be shared with partner agencies and services such as the Evening and Weekend Community Mental Health Nursing Service and the Out of Hours Service (Social Services).
- 11.3 Clinical information will be available to on call GPs between 9pm and 9am through Dorset HealthCare NHS Trust PEAK information system.

12.0 MANAGEMENT ARRANGEMENTS

- 12.1 The CMHT manager South and East Dorset will be responsible for the management of the Assertive Outreach Service to whom all members will be accountable. Richmond Fellowship staff will be managed by and accountable to the local Richmond Fellowship manager. Both the Richmond Fellowship manager and the CMHT manager South and East Dorset will be accountable to the integrated joint monitoring group.

13.0 MANAGEMENT OF REFERRALS/CASELOAD MANAGEMENT

- 13.1 The Assertive Outreach Worker will offer a swift response to all nominations/referrals received. All nominations/referrals will be seen within 5-working days for initial screening for suitability for assertive outreach. Nominators will be notified of the outcome of screening within 48 hours. If appropriate initial contact with a service user might be made jointly with the nominator/referrer.
- 13.2 It is essential that all CMHT referrals should be in writing. Nominations/referrals in the form of telephone conversations and/or copy discharge letters/outpatient letters will not be accepted.
- 13.3 All nominations/referrals where possible will include a detailed history with description of any significant mental health/psychological issues, current pattern of offending behaviour where appropriate, and known risk factors.
- 13.4 The CMHT and designated assertive outreach practitioner (care co-ordinator) will work with up to 10 – 12 service users depending on complexity of needs at any one time.
- 13.5 The service assumes a comprehensive Care Co-ordinator role, not constrained by professional boundaries and a dress appearance which is congruent with the service users expectations.

13.6 Each Care Co-ordinator is responsible for:-

- Co-ordinating the work of the CMHT for the individuals they are key working.
- Identifying regular reviews and the care planning process.
- Co-ordinating regular reviews and the care planning process.
- Actively engaging carers and working with them including their assessment of needs.

13.7 It is expected that all staff in the CMHT should be familiar with the assertive outreach caseload team as a whole to ensure a multi-disciplinary case management approach, and the ability to provide care when the Care Co-ordinator is not working.

14.0 **CARE PLANNING/REVIEW OF CARE**

14.1 The Assertive Outreach Worker will adhere to the agreed Integrated Care Programme Approach/ Policy/Procedures and all care plans will be recorded on PEAK.

14.2 All service users must have an up-to-date documented care plan which is present in their notes and which:-

- Identifies the Care Co-ordinator
- Is documented on the standardised documentation
- Identifies treatment and care needs and proposed interventions
- Risk assessment and management plan
- Known indicators for early onset of relapse, including action
- Contingency plans for out-of-hours intervention in a crisis, etc.
- Records who was involved in deciding the plan (including carer/relative where possible) and whether it was copied to the GP
- Has a review date
- Is signed by the Care Co-ordinator and Service user

A copy of each plan and key information will be kept in the Trust Out-of-Hours office, and accessed via the PEAK system.

14.3 All assertive outreach service users will be subject to enhanced IICPA.

14.4 All cases will require regular formal multi-disciplinary/agency review at a minimum of six-monthly intervals. The RMO and Care Co-ordinator must be present at all reviews, and invitations extended to other relevant organisations including primary care, housing and the voluntary sector. Where possible, relatives and carers will be invited.

15.0 **COMMUNICATIONS**

15.1 Effective and ongoing communication with individuals from all agencies is of vital importance to the daily operation of the service.

15.2 Care Co-ordinators are responsible for ensuring that in addition to clear written communication with GPs, Housing, voluntary organisations and all other agencies involved in the provision of care/support, that there is regular ongoing verbal communication.

16.0 PRIMARY CARE

- 16.1 Joint working arrangements with Primary Care to support service users will be developed with GPs fully involved in a patient care plan. The Care Co-ordinator will be responsible to ensure this happens.

17.0 CARERS

- 17.1 All carers will receive an individual assessment of their needs and if appropriate a specific care plan tailored to their needs in accordance with the agreed integrated ICPA Policy.

18.0 RISK ASSESSMENT/SAFETY

- 18.1 The team will follow the jointly agreed Health/Social Services Risk Management Policy.
- 18.2 Risk assessment and contingency planning are a routine part of the daily work of assertive outreach services.
- 18.3 All team members will have access to mobile phones.
- 18.4 Team members are encouraged to raise any concerns about safety immediately with the team and these will be discussed formally at clinical review meetings. Staff should never visit anyone alone if they have any concerns about their safety
- 18.5 Staff working with assertive outreach service users must let the CMHT co-ordinator know of their whereabouts at all times. At times when a practitioner assesses it necessary they should ask the CMHT co-ordinator to contact the CMHT Manager East Dorset if they do not report in after a specified time. This policy should be read alongside the Trust wide policy governing Community Setting Working.

19.0 TRANSFER / DISCHARGE ARRANGEMENTS

- 19.1 Where engagement is a problem, transfer / discharge shall only occur after full discussion with the team and primary care. It is expected that a prolonged period of contact and persistence will be attempted before transfer / discharge is considered. This will usually involve assertive attempts to engage the service user for a period of one year. After this period a multi agency meeting will be called and a agreed plan formulated.
- 19.2 Transfer/discharge will also be considered once the service user has maintained a period of stability and sufficient support is in place. For example:
- a) When the service user has not been admitted to hospital for a period of 12 months and has not experienced mental health crises during this period.
 - b) When the service user is settled in a supportive home/environment.
 - c) The service user no longer needs the intensity of assertive outreach.
 - d) Where evidence exists that service user has less complex needs, reduced vulnerability and risk is lessened significantly.

19.3 A decision regarding whether to hand back to the CMHT generic workers or to the GP will be made in full discussion with the relevant CMHT.

19.4 It is expected that a minimum of 10% of the caseload will be transferred back to CMHTs each year. This will allow new service users be accepted to the service

19.5 The assertive outreach Care Co-ordinator is responsible for managing transfer of care. This will be through joint visits involving the assertive outreach Care Co-ordinator and the proposed Care Co-ordinator in the new service. Normally these transfer arrangements should continue for 3 months in order to ensure smooth transition.

20.0 **HOSPITALISATION**

20.1 Individuals are maintained in the community, wherever possible. However, admission to hospital for treatment is recognised as an important and valuable part of care.

20.2 Any service user requiring hospital admission will be admitted to those beds designated for the geographical area for which they reside or wherever they are living at the time of admission.

20.3 Service users will be visited as appropriate by their Care Co-ordinator whilst an in-patient. The Care Co-ordinator will ensure that the service user receives news on or has access to their home community and social networks.

20.4 The Care Co-ordinator will play an active role in the inpatient management of the service user and be working with inpatient staff to keep admission duration to a minimum.

20.5 The Care Co-ordinator must be actively involved in all arrangements for discharge planning.

21.0 **INFORMATION/CLINICAL RECORDS**

21.1 All referrals and discharges must be registered on the PEAK Trust Information System.

21.2 Team members must on a weekly basis input information about clinical contacts or arrange for this to be done. All Care Plans will be recorded on PEAK and updated as appropriate.

21.3 The Assertive Outreach Service operates the Trust/Social Services joint integrated record.

21.4 Contact with service users should ideally be recorded at the end of each shift but certainly within one working day. Entries for service users in remote areas where it is not possible for the practitioner to gain access to office based notes should be made as a weekly summary.

21.5 Service users, carers and families will be routinely offered a written information pack to include details of the team, emergency access points to the Trust/Social Services their illness and relevant treatments.

22.0 **MEDICATION**

22.1 Where medication compliance, either deliberate or accidental, is identified as an issue it may require the Assertive Outreach team/worker to hold the service user's prescribed medication for daily transporting and dispensing. In this circumstance the service user will sign an authority for

their medication to be held in a locked cupboard at the base and for the Assertive Outreach team/worker to transport and dispense the appropriate dose.

- 22.2 The Assertive Outreach worker, as the named responsible worker, must ensure the service user's medication is recorded in the pharmacy folder, stating the medication, dose, frequency and date of acceptance. The number of tablets should be checked by the Assertive Outreach worker and the total recorded in the folder, a prescription chart for dispensing the medication must be produced to record acceptance/refusal of medication and for the purpose of audit by the pharmacy. The prescription chart must be carried with the medication for dispensing and transport.

23.0 **TRAINING/DEVELOPMENT**

- 23.1 The Trust and Social Services is committed to promoting understanding of Assertive Outreach Community Treatment for all staff through training and educational opportunities.

- 23.2 Training and development will reflect the needs of the service and of the individual member of staff, as identified as part of their personal development plan.

- 23.3 Staff will attend statutory/mandatory training sessions to include Assessment and Management Risk, Mental Health Act, Mental Health Act Code of Practice, Lifting and Handling, Child Protection, Control & Restraint, Breakaway, Health and Safety, Personal Safety Awareness on an annual basis.

- 23.4 Staff working in the service will have a range of therapeutic skills. The following is an example of the range of skills available:

- Thorn Family Therapy
- Cognitive Behavioural Therapy
- Motivational interviewing
- Dialectical Behavioural Therapy
- Dual Diagnosis Care

- 23.5 The rural assertive outreach service will have annual team away days for the purpose of reviewing activities, policies and team building. This may be in conjunction with the urban Assertive Outreach Team if appropriate.

- 23.6 Networking opportunities with other local, regional and national assertive outreach services will be arranged and encouraged.

24.0 **COVER ARRANGEMENTS**

- 24.1 For purposes of annual leave, sickness and training this will necessitate the absence from normal duties for assertive outreach practitioners. Cover arrangements will apply and must be discussed in advance in order that specific cover can be put in place for service users. Cover will usually be made within individual CMHT, however, under special circumstances cover might also be made with assertive outreach practitioners from one of the other CMHTs in the area.

25.0 MEETINGS

25.1 Clinical team meetings take place weekly in each of the CMHTs at these venues the assertive outreach care co-ordinator can review each service user and co-ordinate the activities of other members of the Community Mental Health Team.

25.2 Group clinical supervision will be arranged with the nurse consultant (assertive outreach/dual diagnosis) as required. Extra sessions can be arranged according to service needs.

25.3 Peer group supervision amongst the three assertive outreach practitioners will be made available fortnightly.

25.4 There will be regular liaison meetings as follows :

Time 1.00 – 2.00 pm on Friday's.

1st Friday of the month : Purbeck Locality – Wareham Local Office

2nd Friday of the month : Wimborne Locality – Jessopp House

3rd Friday of the month : Christchurch Locality – Fairmile House

4th Friday of the month : Service Management/Development – Jessopp House

All those engaged in the Assertive Outreach service should attend their own locality meeting as a matter of priority.

The lead assertive outreach workers should attend the service management and development meeting with the Joint Locality Manager and other agencies.

All who work in the South and East Dorset locality are welcome to attend any of the Friday meetings.

26.0 RESEARCH AND AUDIT

26.1 The service will actively participate in clinical research and audit. An evaluation of the service would be carried out after 18 months (subject to available resources) and would consider one year before and one year after evaluation of care received, before and after being taken on by the Assertive Outreach Worker :-

- Hospital bed days
- Employment / education days
- Accommodation status
- Contact with the criminal justice system
- Use of the Mental Health Act
- Quality of life
- Social functioning
- Mental and physical health
- Motivation to work with mental health care services
- Satisfaction with mental health care services

26.2 The following routine standardised assessment / outcome measures will be used as part of routine practice and be utilised in auditing the service for its clinical impact.

- Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) – Slade et al, 1999.
- Health of the National Outcome Scale (HoNOS) – Department of Health, Wing et al 1996
- Brief Psychiatric Rating Scale (BPRS) – Overall & Goram, 1962
- Social Functioning Scale (SFS) – Birchwood et al, 1992
- Psychiatric Care Satisfaction Questionnaire (PCSQ) – Barker & Orrell, 1999

26.3 Other measures will be used dependent upon need and clinical / social presentation.

27.0 **CONFIDENTIALITY**

27.1 The service will follow the Joint Agency Management of Service User Implementation (confidentiality) policy and ensure user understanding at the earliest opportunity. Explanatory leaflets for users will be available.

28.0 **COMPLAINTS**

28.1 All members of the Assertive Outreach Service have a responsibility to resolve informally service user and/or carer complaints. Formal complaints will be dealt with in accordance with existing Trust/Social Service procedures.

29.0 **REVIEW**

29.1 The Assertive Outreach Operational Policy will be subject to a joint Trust / Social Services annual review.

30.0 **REFERENCES**

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