DESCRIPTION OF THE PRACTICE
1. Title of the practice
- 'ASSERTIVE COMMUNITY CARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS' -
2. Organisation responsible for the practice
NGO "Global Initiative on Psychiatry" (Sofia-GIP), Sofia Office, Bulgaria
3. Contact person(s)

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4. National/regional/local context of the practice

At the time of writing, there is no policy that supports the cooperation between the health and social sector. A legislative regulation (No: 40 of the Ministry of Health) stipulates that after being discharged from the hospital, a person with mental health problems is a subject of the system for social care and support, but the implementation of this mechanism is challenging, partly because of the lack of coordination between the Ministries of Health and Social Affairs.

The programme has been recognised as a valid social practice by the relevant authorities, and the Agency for Social Assistance issued a certificate for GIP-Sofia to be a provider of Assertive Community Care. The profession of an expert by experience in social inclusion officially entered the national registry of occupations. However, the programme is not included in the list of government-funded services and still received no state funding. Neither were "experts by experience" financially supported by the national budget.

Inter-institutional collaboration is not regulated by any legal act or ordinance.
Implementing good practices and working together rely on individuals.

5. Summary of the practice

The Assertive Community Care programme aims to support people who are at the highest risk of being neglected due to mental illness in Sofia Municipality, seeking solutions in these people's communities. The activities are focused on solving crisis situations, activating community resources and involving different stakeholders when an emergency situation occurs. Potential beneficiaries of the programme are identified via

different channels but are mostly referred to municipal and health structures in Sofia.

Tandems that consist of a mental health professional along with a peer supporter ("expert by experience") deliver outreach activities, design care plans, and monitor their implementation. A strong focus of the programme is laid on **ensuring that the clients are involved** in the decision-making process concerning the implementation of their care plans and that their rights are respected as per the Convention for the Rights of Persons with Disabilities. It offers active on-site case management, with the minimum administrative burden for the client, as the programme is designed to provide administrative and clinical support.

The Assertive Community Care programme has been implemented by the foundation Global Initiative on Psychiatry – Sofia (GIP-Sofia), with the financial support of Sofia Municipality for the past three years.

Although GIP-Sofia is the direct service provider, the programme mobilises all resources that might assume a role in community support, including social and health care providers, municipal structures, governmental and other administrative institutions and also the immediate surroundings of the person.

Achievements of the programme include a reduction of users' exposure to poverty and neglect, improved health conditions, and improved recognition and coordination by/between several actors.

This practice has proved able to fill the gap between health and social care, especially after hospital discharge, through active outreach work.

6. Staff involved

The programme involves staff from different organisations:

- Sofia Municipality;
- directorates for Social Assistance;
- health facilities;
- non-governmental organisations;
- other relevant government institutions (police, etc.).

The programme for assertive community care is implemented by GIP-Sofia. The outreach service is delivered by three social workers and five "experts by experience" in social inclusion (EE). EEs are people who have personally experienced exclusion due to mental illness and have recovered from it. They have acquired attitudes, skills and knowledge through specialised training in order to apply the extended experience professionally in all areas of the fight against social exclusion. They work in close cooperation with professionals. A supervisor provides professional support for the teams.

The programme serves, on average, 45 clients for a period of nine months.

7. Target group

Adults aged 18 or more with severe mental illness. In most cases, these are people who have been diagnosed with schizophrenia, do not have income or identity documents and/or are homeless or without close relatives and/or friends to provide care; for mental and somatic illnesses.

Due to the characteristics of their psychiatric condition or other life circumstances, they cannot come in contact with the social and health systems and receive adequate high-quality care and support.

8. Aims of the practice

The programme aims at:
- improving the quality of life of people with mental illness and their relatives and friends through the provision of comprehensive, high-quality assertive community-based services and mobilising the resources of their immediate surroundings;
- setting up an efficient model, promoting inter-institutional and inter-disciplinary cooperation and building the capacity of all involved stakeholders;
- Rolling out the practice nationwide, providing sustainability by including it in the official list of government-funded social services.

9. Issues for social services

Service Integration/ Cooperation across Services	X	Service Planning	X	Contracting	
Technology		Skills Development (of the workforce)		Quality of services	

Other: *Peer support; user involvement; mediation between user and services*

ANALYSIS OF THE PRACTICE	

10. Status

Pilot project (ongoing)	
Pilot project (terminated)	
Project (ongoing)	
Project (terminated)	
Implemented practice (restricted areas)	X

Widely spread practice/rolled out	

11. Scope of the practice

Describe the setting of the practice, considering the following criteria:

- *Micro-level practice: a* practice that involves individuals at the local level
- *Meso-level practice: a* practice that involves organisations or communities
- *Macro level practice: a* practice that involves large population groups

Meso-level practice.

The practice takes place on the territory of Sofia Municipality. There is potential and material to expand it nationwide (see transferability section).

12. Leadership and management of the practice

Describe the leadership of the practice, considering the following criteria:

- *Collaborative management*: shared between large partnerships, often of central, regional, and local representation
- *Organisational management*: by one organisation
- *Professional management*: managed by a single person
- *Shared management*: shared with no defined leadership

Regrettably, very often, the roles and responsibilities of the different stakeholders related to a particular case are not clearly defined and communicated to them so that the client could be placed at the centre of a comprehensive support network. There is no official regulation or mechanism of information sharing between workers and between workers and clients/informal carers.

The programme aims to bridge this gap by identifying all relevant stakeholders, organising their support resources, and channelling them toward the client's needs.

In this particular case, Assertive Community Care is a programme delegated by Sofia Municipality to GIP-Sofia. A team leader of the programme has an overall coordination role and is accountable to the programme coordinator from GIPSofia. The coordinator is responsible for the administrative supervision and monitoring, the monthly reporting to Sofia municipality and the effectiveness assessment of the programme, as well as the overall project management.

13. Engaging stakeholders in the practice

Describe the engagement of stakeholders, considering the following criteria:

- *Individual practice*: individuals have sought practice change
- *Network approach*: one or more organisations develop a network
- *Collaborative approach*: large collaboration with relevant stakeholders

The programme was brought forward by GIP Sofia, an NGO that brought other stakeholders together. In the absence of a clear, official framework, the success

of the programme relies largely on individuals' will. Several organisations work together around the person. Broader multi-disciplinary case conferences are organised with psychiatrists, carers and families, social services, housing, and legal advisors.

A network of professionals and services was created. They work cooperatively.

14. Involvement of service users and their families

Describe the involvement of service users, considering the following criteria:

- *Team involvement: service users and carers were part of the practice team*
- *Consultative: a consultative body of users was set up for an ongoing dialogue and feedback ☐ Involvement in care: person-centred approaches to care/support*

The initiative also encompasses carers – families, relatives, friends and other individuals from the user's environment – they receive psycho-education and psychological support when needed; they are consulted when preparing the individual care plan. The programme's guiding principle is: "Nothing for the client without the client." The fact that the services are provided by tandems of mental health professionals and experts by experience, who themselves are people who have experienced mental health problems, is a mechanism of involving the target group in the process of planning and provision of care. All of the activities related to a certain service user focus on individual care, which is developed with his/her participation and the input of all relevant stakeholders: the service user's general practitioner and psychiatrist(s), family, friends, etc.

15. Costs and resources needed for implementation

Describe how the practice is financed, considering the following criteria:

- *Within existing resources:* staff time and other resources are provided 'in-house'
- *Staffing costs:* costs for staff investment
- *Joint/Pooled budgets:* two or more agencies pool budgets to fund services ☐ *Funded project:* external investment

The aim is to coordinate and use existing resources and services efficiently. Start-up funding was required for the recruitment, the development of procedures and the training of staff and peer workers.

Ongoing funding is needed for team staff salaries (including peer workers), further staff training and all office and travel expenses.

16. Evaluation approaches

Describe the evaluation method of the practice, considering the following criteria:

- *Multi-method:* use of both a qualitative and a quantitative approach
- *Single method: a* qualitative or quantitative approach
- *Audit:* looks at data sources such as existing medical records and/or other routinely collected service data.

- *Informal:* refers to in-house service evaluation using locally designed tools and/or collecting opportunistic feedback
- *No evaluation*
- *An evaluation is planned*

The project has been evaluated using an 'action research approach to study complex change processes, which includes all participants in the reflective analysis. Cultural change was assessed by monitoring the attitudinal changes of service users, carers, managers, and practitioners from social and health backgrounds. Several instruments were used to measure the number of involuntary hospital admissions, referral procedures, relapse rates, service response times and quality of life.

A set of qualitative and quantitative indicators have been developed to measure the efficiency of the program on different levels, such as the number of relapses, referral procedures, number of involuntary hospitalisations, the timely response of the different services, etc., which were monitored at the beginning and every third month of the work with the client.

Information is collected through individual interviews, focus group discussions, questionnaires, and some reflection instruments.

17. Measurable effects of the practice and what it has achieved

Service users	n. a.
Formal caregivers	n. a.
Informal carers	n. a.
Organisations	n. a.

18. Anticipated or 'aspirational' effects of the practice and what it has achieved
This category can include outcomes which are not documented, quantified or properly evaluated. They can include such elements as improved knowledge, quality, workforce, etc.

Service users	Service user quality of life is being improved through assisted decision-making, strengths-based approaches and support coordination and planning. Involuntary admissions to hospitals have been reduced. It turned out that for the service users themselves, the adoption of the new practice was not seamless. Initially, they perceive assertive treatment as something incomprehensible and abstract. For clients who are victims of custody abuse and have developed an attitude of learned helplessness, it is difficult to see the process of decision-making separately from the specific problematic situations in which they are immersed. Attitudes changed with gaining experience. Some

	clients were able to use the support to achieve specific life goals. In others, the change occurred in the relationship between them and an essential person in their environment:
Formal caregivers	

Informal carers	Carers experience a reduction in their care burden and well-being and management is improved through psycho-education. Initially, clients' families had difficulty understanding the meaning of the person-centred approach and perceived the new practice as an opportunity to unburden the care for the mentally ill person. For understandable reasons, carers often have fears and resistance towards outsiders becoming involved in a support network. As the programme evolved, users' parents saw a possibility for their children to have a future after they were no longer able to care for them.
Organisations	A network of professionals and services work collaboratively, particularly for clients in complex situations with multiple support needs.

19. How has the practice changed the way the service is provided

A municipal response was given to the gap in national policy, compelling cooperation between health and social services and coordination of existing resources, funding and support for individuals and carers.

20. Sustainability of the practice
Describe if the practice is sustainable, considering the following criteria:

- *Potential for sustainability:* practice was newly started or is ongoing/not yet mainstreamed. How could the practice be sustained (in terms of resources)?
- *Organic sustainability:* service users have been empowered to take the practice forward □
  Established: the project has been operational for several years

There is potential for the programme to be implemented nationwide as a government-funded integrated community mental health service, with methodology, findings and recommendations from the project having been submitted**.** The experience, mechanisms, good practices, cost-effectiveness analysis and impact on target groups have been compiled in a methodology. Training programmes for outreach teams (for experts by experience, social workers, and tandem work) have been designed and proven their efficiency.

21. Transferability of the practice
Describe if the practice has been transferred, considering the following criteria:

- *Transferred:* transfer to other regions, countries, service user groups, etc.
- *Potential for transferability:* there is interest from the outside; elements of the practice have been taken up and used elsewhere; material for transferability (for ex. training material) has been developed

The model and associated training are transferable to other areas where individuals have severe, enduring long-term conditions resulting in disability and the need for complex service support. Elements of the approach, such as supported decision-making, are being implemented in other municipalities (Plovdiv, Stara Zagora).