Assertive Community Treatment

Implementation Resource Kit

DRAFT VERSION
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Implementation Resource Kit User's Guide

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Development team for the Assertive Community Treatment implementation resource kit

Charlene Allred
Marsha Antista
Charity Appell
Steve Baron
Gary Bond
Mimi Chapman
Judy Cox
Elizabeth Edgar
Bridget Harron
Barbara Julius
Karin Linkins
Gary Morse
Kim Mueser
Michael Neale
Melody Olsen
Dawn Petersen
Tom Patittuci
Joe Phillipps
Robert Rosenheck
John Santa
Mary Woods

Co-leaders of the development team for the Assertive Community Treatment implementation resource kit

Susan D. Phillips
Barbara J. Burns

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Steering committee, Implementing Evidence-Based Practices Project, Phase I

Charity R. Appell
Barbara J. Burns
Michael J. Cohen
Robert E. Drake
Howard H. Goldman
Paul Gorman
H. Stephen Leff
William C. Torrey
Laura Van Tosh

Project manager, Implementing Evidence-Based Practices Project, Phase I

Patricia W. Singer

Foreword

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) is a proud sponsor of this implementation resource kit for Assertive Community Treatment. As the federal agency responsible for promoting the quality, availability, and accessibility of services for people with mental illness, CMHS is responsible for identifying treatments for mental illness that work. The materials in this resource kit document the evidence for the effectiveness of Assertive Community Treatment and provide detailed information to help communities to implement the practice in real world settings. During development of the implementation resource kit, we placed special emphasis on 1) strengthening the consensus-building process, 2) expanding the involvement of consumers and families, 3) including practical orientation to issues involving service organization and financing, and 4) insisting on paying careful attention to issues of ethnic and cultural sensitivity and overall cultural competence. We are well pleased with the result.

Many other organizations contributed to developing this implementation resource kit. This broad coalition of researchers, providers, administrators, policy makers, consumers and family members, gives the resource kit its strength and vitality. We are especially appreciative of the support provided by The Robert Wood Johnson Foundation that sponsored the early stages of the Project, when evidence-based Assertive Community Treatment was identified as a practice ready for widespread implementation. We agreed. Assertive Community Treatment is critical for many persons with serious mental illness because it provides for comprehensive, structured services and supports in a community setting. It is supported by over 25 years of research, yielding a strong evidence base with generalizability to a variety of settings. With the Olmstead decision by the Supreme Court in 1999, community integration has been put into the forefront of mental health systems planning. The Assertive Community Treatment model is synonymous with moving persons with severe and persistent mental illness from institutionalized or more restricted settings of care toward more independent and community-based systems of care.

This implementation resource kit reflects the current state-of-the-art concerning evidence-based Assertive Community Treatment. It addresses both the "key ingredients" of the clinical model and many practical considerations essential for successful implementation. It also describes the need for each community to adapt the model to its particular needs and characteristics. Careful attention to unique community needs, coupled with fidelity to the key ingredients of the practice, equals successful implementation. The closer the kit user comes to following the implementation resource kit guidance, the more likely the practice will yield good results for consumers.

As mental health services research and evaluation progress, CMHS hopes to support the development of implementation resource kits for additional evidence-based practices, and to refine this and other previously-developed resource kits to take new evidence into account. Indeed, evaluation of planned pilot projects for implementing this resource kit and associated implementation strategies will tell us much about how to make improvements in future versions. We hope that this and other evidence-based practice implementation resource kits will be helpful to communities across the nation as they strive to provide the most effective services possible for persons suffering from mental illness.

This document is part of an evidence-based practice implementation resource kit developed through a contract (no. 280-00-8049) from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) and a grant from The Robert Wood Johnson Foundation (RWJF). These materials are in draft form for use in a pilot study.
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Introduction

Welcome to the Assertive Community Treatment implementation resource kit. It has been produced by the Implementing Evidence-Based Practices Project as part of an effort to promote treatment practices in community mental health service settings that are known to be effective in supporting the recovery of adults with severe mental illnesses. The goal: to improve the lives of consumers by increasing the availability of effective mental health services.

The User's Guide begins by providing general information about the Implementing Evidence-Based Practices Project, including the goals and values of the project. This is followed by descriptions of the materials contained in the resource kit and their proposed role in the implementation process. The basic structure of an implementation plan is outlined. Specific suggestions for implementing the practice of Assertive Community Treatment are presented in the Implementation Tips documents. This guide also contains a list of annotated references on Assertive Community Treatment and a special populations appendix which provides a review of the literature addressing the range of populations for which this practice has demonstrated efficacy or effectiveness.

If you have any questions or comments about these materials or the implementation process, please contact Kristine Knoll at the NH-Dartmouth Psychiatric Research (e-mail address: Kristine.M.Knoll@Dartmouth.EDU). We look forward to supporting your efforts to improve services to people with severe mental illness. Also, please share your experience in using these materials. Feedback from users will help refine and improve future versions of these implementation materials.

Background

What are "evidence-based practices"?

Evidence-based practices are services for people with severe mental illness (consumers) that have demonstrated positive outcomes in multiple research studies.

Over the past 15 years, researchers in mental health service systems have gathered extensive data to support the effectiveness of several psychosocial and pharmacological treatments. In 1998, the Robert Wood Johnson Foundation convened a consensus panel of researchers, clinicians, administrators, consumers, and family advocates to discuss the research and to determine which practices currently demonstrated a strong evidence base. This project is an offshoot of these efforts.

The six evidence-based practices

Six practices were identified as currently demonstrating a strong evidence base:

- standardized pharmacological treatment
- illness management and recovery skills
- supported employment
- family psychoeducation
- assertive community treatment
- integrated dual disorders treatment (substance use and mental illness)

Other evidence-based practices for the treatment of persons with severe mental illnesses are being identified and will be promoted as the research evolves. This project is only a beginning attempt to establish models and procedures. This list of identified practices is not intended to be complete or exclusive. There should be many evidence-based practices in the future. Some promising practices being researched currently include peer support programming, supported housing, trauma services, and treatment for people with borderline personality disorder.

What is an implementation resource kit?

An implementation resource kit is a set of materials—written documents, videotapes,PowerPoint presentations, and a website—that support implementation of a particular treatment practice.

Specific materials in this resource kit have been developed for each of the key stakeholder groups involved in the implementation effort:

- consumers of mental health services
- family members and other supporters
- practitioners and clinical supervisors
- program leaders of mental health programs
- public mental health authorities

Research has shown that providing practice guidelines to practitioners alone does not change practice. Change is most likely to occur and be sustained if all the major stakeholders in the mental health system are engaged and involved in the process of change. Therefore the materials and guidelines in this implementation resource kit are geared toward five different stakeholder groups. The materials for each specific stakeholder group were either written by representatives of that group or in close collaboration with them.

The resource kit materials are also designed to address three stages of change:

- engaging and motivating for change (why do it)
- developing skills and supports to implement change (how to do it)
- sustaining the change (how to maintain and extend the gains)

What is an implementation package?

An implementation package is a set of implementation materials (the resource kit) combined with complementary training and consultation that support implementation of the evidence-based practice. The resource kit materials are designed to be most effective when used with consultative and training services. As part of the Implementing Evidence-Based Practices Project, EBP implementation centers are being established in various states across the country to provide consultation and training (see www.mentalhealthpractices.org).

How was this implementation resource kit developed?

A team made up of multiple stakeholders developed each resource kit: researchers, clinicians, program managers and administrators, consumers, and family members. Documents oriented toward specific stakeholder groups were either written by the stakeholders or in close collaboration with them. A consensus panel, also comprised of multiple stakeholders, reviewed the materials developed for all of the six implementation resource kits to ensure consistency of presentation and attention to the various perspectives of the different constituencies.

For more information

For a more detailed discussion of the project and the implementation strategies, refer to the enclosed *Psychiatric Services* articles:

Drake RE, Goldman HH, Leff HS, et al: Implementing evidence-based practices in routine mental health service settings. Psychiatric Services 52:179–182, 2001.

Torrey WC, Drake RE, Dixon L, et al: Implementing evidence-based practices for persons with severe mental illnesses. Psychiatric Services 52:45–50, 2001.

Project Philosophy and Values

The project rests on two philosophical tenets:

First, mental health services for people with severe mental illnesses should have the goal of helping people to develop high-quality, satisfying functional lives. That is, services should aim not just at helping consumers stay out of the hospital and reducing or stabilizing symptoms, but also at helping them to pursue their own personal recovery process. People want services that help them to manage their illnesses and to move ahead with their lives.

Second, consumers and their families have a right to information about effective treatments, and in areas where evidence-based practices exist, consumers and family members have a right to access effective services.

Evidence-based practices are not intended to be exclusive, mandatory, or rigid. Rather, they imply self-knowledge, self-determination, choice, individualization, and recovery.

Defining recovery

There have been many efforts to define the recovery philosophy. The Consumer Advisory Panel for the Implementing Evidence-Based Practices Project drafted the following brief statement. The principles of recovery that informed the development of the implementation resource kit materials are:

- hope
- personal responsibility
- education
- self-advocacy
- support

The cessation of symptoms is not necessarily equal to recovery. Each person develops their own definition of recovery, which many view as a process rather than a destination.
It is important to know what is meant by “support.” While the support of others is a valuable element in recovery, it does not include solving problems for another person or giving advice.

Empowerment is another critical component to recovery. A person becomes dis-empowered when choices are made for them, even when well-meaning supporters do it. Dis-empowerment also occurs when assumptions or judgments are made concerning an individual and their choices. Recovery is most easily achievable when a person and those around them recognize the individual as a whole and complete person regardless of symptoms. One of the most valuable things a person can do for someone with psychiatric symptoms is to listen.

For more information

Copeland, Mary Ellen. Wellness Recovery Action Plan. 1997. Peach Press.

Ralph, Ruth O. Review of Recovery Literature: A Synthesis of a Sample of Recovery Literature 2000. Report produced for NASMHPD/National Technical Assistance Center for State Mental Health Planning.

Components of the Assertive Community Treatment Implementation Resource Kit

The following describes the purpose and content of the individual resource kit materials. This section is followed by a description of the use of these materials in the implementation process.

Implementation Resource Kit User's Guide

This document describes the implementation resource kit and how to use it. It includes annotated references for the particular evidence-based practice.

Introductory Videotape

This short videotape functions as an introduction for all stakeholders to the evidence-based practice. Much of the film consists of different stakeholders speaking of their experience or demonstrating the practice in action. A Spanish-language version of this videotape is also available.

www.mentalhealthpractices.org

This website contains basic information about each of the six evidence-based practices. It includes references and links to other relevant websites. Information for consumers and family members is available in Spanish.

Information for Stakeholders (five documents)

These documents describe the evidence-based practice and highlight features of the practice most pertinent to the particular stakeholder being addressed. These are engagement pieces that address the question: why should I, as consumer, family member, practitioner, program leader, or administrator be interested in this practice? The documents for consumers and family members are available in Spanish-language versions.

Statement on Cultural Competence

This document addresses the need for practitioners and policymakers to integrate the design and delivery of the evidence-based practices within a culturally responsive context.

Practice Demonstration Videotapes

These videotapes model clinical skills critical for the implementation of the practice. They are designed for use in training and supervisory settings.

Workbook

The workbook is designed as a primer for practitioners regarding skills needed to provide the evidence-based practice. It emphasizes the knowledge and skill practitioners need in order to provide an effective intervention, one with high fidelity to the model. It is designed for use in training or supervisory settings.

Implementation Tips for Mental Health Program Leaders

This document provides practical guidance for agency program leaders on how to implement the evidence-based practice in a community mental health setting. It includes strategies for building consensus in organizations preparing for change and tips on how to develop policies and procedures to support the practice.

Implementation Tips for Public Mental Health Authorities

This document provides practical guidance for public mental health authorities on how to provide incentives and remove barriers to implementation of the evidence-based practice within their mental health system. Advice is given based on the experiences of mental health systems that have been successful in implementing the practice. This document emphasizes the importance of consensus building, creating incentives for change in practitioner and agency behavior, and identifying and removing barriers to change.

Client Outcome Measures

Using outcome measures to evaluate and track consumer gains and program success is critical for effective implementation of an evidence-based practice. Simple outcomes are identified that can be monitored as part of routine clinical practice. The tracking of outcome measures is used as a feedback mechanism for clinicians, supervisors, and administrators.

Fidelity Scale

Research indicates that the quality of implementation of the practice—adherence to principles of the model—strongly influences outcomes. The fidelity scale enables mental health program leaders to evaluate their program in comparison to the recommended principles.

Articles

Copies of general articles about evidence-based practices and implementation and an article describing the research evidence for this particular practice are included in the implementation resource kit.

Additional Implementation Materials

PowerPoint presentations are available to supplement the Assertive Community Treatment resource kit materials. Contact the West Institute at the New Hampshire-Dartmouth Psychiatric Research Center (603-271-5747).

How to Use the Resource Kit Materials—An Implementation Plan

Effective implementation of evidence-based practices is best achieved by using the materials with a structured complementary consultative and training program. As part of this project, a number of evidence-based practices implementation centers have been established throughout the country. For more information on these centers, go to www.mentalhealthpractices.org.

A brief description of a basic implementation plan that includes these supports is provided below. See the Implementation Tips for Mental Health Programs Leaders and Implementation Tips for Public Mental Health Authorities for more detailed suggestions regarding the implementation of Assertive Community Treatment.

Consensus building

Build support for change

- identify key stakeholders
- provide information to all stakeholders
- develop consensus regarding a vision for the practice at your agency
- convey a vision and a commitment to all stakeholders

Enthusiasm for the implementation of the evidence-based practice can be generated by communicating how the practice benefits consumers and family members.

Use implementation resource materials:

- Distribute information materials to the key stakeholder groups.
- Hold informational meetings with key stakeholder groups. Have opinion leaders within the different stakeholder groups co-host these meetings. Include a viewing of the introductory videotape. An introductory PowerPoint presentation can be used to structure the informational meeting.

Developing an implementation plan

An action plan

- identify an agency implementation leader
- establish an implementation steering team that includes representatives from all stakeholder groups
- secure a consultant from an EBP implementation institute
- develop an implementation plan

Responsibilities of the implementation leader and implementation steering team include identifying and utilizing personnel, resources, and processes (administrative support and system changes) needed to support the evidence-based practice; an assessment of training needs; and development of an implementation timeline.

Consultants from EBP implementation centers can work with public mental health authorities and program leaders to inform them about the practice, to evaluate an agency's or system's commitment to change, and to assess current realities of financial incentives, staffing, and structure.

By developing partnerships with community organizations including peer support programs, consumer and family advocacy groups, police, homeless shelters, food banks, department of vocational rehabilitation, and others depending on the specific practice, the implementation leader and the implementation steering team can most effectively develop support for the practice. These groups may contribute to the development of an implementation plan.

Use of implementation resource materials:

- *Implementation Tips for Public Mental Health Authorities* is designed for individuals at the municipal, county, or state mental health authority.
- *Implementation Tips for Mental Health Program Leaders* is designed to be shared with the individuals in an agency that make and carry out decisions about the local resources and processes. This includes people who have responsibility for program management, training, policy development, program standards, data management, and funding.

Enacting the implementation

Making it happen

- involve agency personnel at all levels to support the implementation
- host a "kick-off" training where all stakeholders receive information about the practice
- host a comprehensive skills training for agency personnel who will be providing the practice
- arrange opportunities to visit programs that have successfully implemented the practice
- work with an implementation center for off-site support for the practice
- review current agency outcome measures relative to the practice and modify outcome data to monitor the practice. Learn how to make use of outcome measures in clinical practice and supervision
- work with a consultant/trainer to learn how to use the fidelity scale to identify strengths and weaknesses in the implementation effort

Trainers can work with the agency to offer an initial or "kickoff" training for all stakeholders. The trainer can then provide comprehensive skills training for those personnel within the agency who will be providing the practice. The trainers may offer to visit the program at least one day per month for the first six months, then one day every other month for the next six months, for ongoing training, consultation, supervision as needed by the program. The trainer may also be available on a weekly basis for phone consultation.

Use of implementation resource materials

Many agencies find it useful for the implementation leader and agency staff to familiarize themselves with the structure and processes of the practice by visiting an existing program. Before a site visit, the implementation leader and clinical supervisor(s) should review:

- Information for Practitioners and Clinical Supervisors
- Information for Mental Health Program Leaders
- Implementation Tips for Mental Health Program Leaders
- Workbook for Practitioners and Clinical Supervisors

Materials that support training and clinical supervision

- Workbook for Practitioners and Clinical Supervisors
- Practice demonstration videotapes
- PowerPoint training presentation (available from the West Institute)

Trainers may also serve as consultants to the administrators of the program. This includes demonstrating the usefulness of outcomes data as a clinical feedback tool. See Monitoring Client Outcomes.

Monitoring and evaluation

Sustaining change: How to maintain and extend the gains

- establish a mechanism for continuous feedback regarding how the practice is being provided in an agency
- publicize outcome improvements from the practice
- use fidelity scales to monitor the practice implementation

Monitoring and evaluation occur in several ways. First, the use of consultants to provide side-by-side, ongoing consultation during the first one to two years of the program is very helpful. Consultants who are experienced in the practice can recognize problems and recommend changes to address them.

Use of implementation resource materials

It is useful for programs to become comfortable early on with the measures that will be used for monitoring and evaluating the delivery of the practice: outcome measures and the fidelity scale. The information collected can be used not only to identify areas that are problematic, but also to identify areas of excellence. See *General Organizational Index*. Feedback from these measures may be used to promote and strengthen clinical and programmatic effectiveness.

A Word About Terminology

Terms used in the Implementation Resource Kit materials

The materials were developed by people from a variety of backgrounds and perspectives. During development, it became evident that many different terms are used to describe the key stakeholders. For the sake of clarity and consistency, in most instances common terms are used to identify these groups throughout the implementation resource kits. In some situations more precise, or alternative, terminology is used. For instance, in the Supported Employment implementation resource kit, the term 'employment specialist' is often used rather than "practitioner."

Consumers, clients, people who have experienced psychiatric symptoms

These terms refer to persons who are living with severe mental illness and who use professional mental health services—the consumers of mental health services. The term 'consumer' is most frequently employed in the resource kit materials. In the Integrated Dual Disorders Treatment workbook and in the outcome measures document, the term 'client' is used. The Illness Management and Recovery resource kit uses the term 'people who have experienced psychiatric symptoms'.

Family and other supporters

This terminology refers to families and other people who provide support to a consumer, and recognizes that many consumers have key supporters who are not family members.

Practitioners and clinical supervisors

The term practitioner refers to the people who deliver the evidence-based practice. This is used instead of clinician, case manager, nurse, psychiatrist, therapist, etc. except when referring to a specific kind of role (e.g., the employment specialist in supported employment, or the prescriber in medication management). The term clinical supervisor is used to distinguish between an administrative supervisor and the person supervising the clinical work of the practitioner.

Mental health program leaders

This term is used to describe the person at the mental health provider organization who is trying to put the practice into effect. This term is used instead of program supervisor, operations director, program manager, or program administrator. The term is used because it makes it clear that this person's job is to lead with the support of the agency's administration.

Public mental health authorities

This term is used to describe the people who determine the regulations and funding structures of the public mental health system. We recognize that evidence-based practices are also implemented and overseen in the private sector.

Implementing Evidence-Based Practices Project

The Implementing Evidence-Based Practices Project was planned to take place in three phases over a five to six year period, as described below.

Phase I: Development of the Implementation Resource Kits—Fall 2000 to Summer 2002

During Phase I the core principles and critical elements of each of the six evidence-based practices were identified and guidelines for their implementation developed. This resulted in the development of a comprehensive implementation plan—production of implementation resource kits and development of a structured program of training and consultation—to facilitate the adoption of evidence-based practices in routine clinical settings.

Phase II: Pilot Testing the Implementation resource kits—Summer 2002 to Summer 2005

Phase II entails a multi-state demonstration of implementation using the resource kit materials in conjunction with a structured program of consultation and training. The goals are (1) to demonstrate that evidence-based practices can be successfully implemented in routine practice settings; (2) to improve the implementation resource kits including the recommendations for consultation and training support based on information gathered from pilot experiences; and (3) to learn more about the range of variables that facilitate or impede implementation in routine treatment settings.

Phase III: National Demonstration—starting in 2006

Phase III is designed to be a broad implementation effort in which the modified implementation resource kits will be made available throughout the United States.

Selected Annotated Bibliography for Assertive Community Treatment

Overview

Selected publications on assertive community treatment and related issues are listed in this annotated bibliography. The materials are grouped under the following headings:

- Implementing Assertive Community Treatment
- Critical Ingredients
- Transfer to Less Intensive Services
- Effectiveness Research
- Special Populations
- Consumers and Family Members

Implementing Assertive Community Treatment

Allness DJ, & Knoedler WH, (1999). The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-UP. Waldorf, MD: NAMI.

- Practical guidance on starting and operating an assertive community treatment program from originators of the model. This manual describes the conceptual framework of assertive community treatment and details the day-today operations. Available from www.nami.org.

Stein LI, & Santos AB, (1998). Assertive Community Treatment of Persons with Severe Mental Illness. New York: Norton.

- Dr. Leonard Stein, an originator of the assertive community treatment program, places assertive community treatment in the historical context of the treatment of persons with severe and persistent mental illness. Key principles of assertive community treatment are discussed along with issues related to financing and administration, and the operations of an effective assertive community treatment program.

Critical Ingredients

Lewin Group. (2000). Assertive Community Treatment Literature Review. Falls Church, VA: Author.

- Describes variations in assertive community treatment programs and critical ingredients associated with successful consumer outcomes

McGrew J, & Bond GR, (1995). Critical ingredients of assertive community treatment: judgments of the experts. *Journal of Mental Health Administration, 23*,113-125.

- Reports experts' opinions on the ideal specifications of the assertive community treatment model. Describes two subgroups of experts - those who advocated large multidisciplinary teams (100 or more clients) with day and evening shifts, and those who advocated smaller, often generalist, teams (approximately 50 clients).

Teague G, Bond G, & Drake, R, (1998). Program fidelity in assertive community treatment: development and use of a measure. *American Journal of Orthopsychiatry, 68*(2), 216-232.

- Describes the development of the Dartmouth Assertive Community Treatment Scale (DACTS) and the results of its application to fifty diverse programs.

Transfer to Less Intensive Services

Salyer M, Masterton T, Fekete D, et al.(1998). Transferring clients from intensive case management: impact on client functioning. *American Journal of Orthopsychiatry, 68*(2), 233-245.

- Evaluates the effects of transferring consumers from assertive community treatment to a less intensive case management programs

Stein LI, Barry KL, Van Dien G; Hollingsworth EJ; et al. (1999). Work and social support: a comparison of consumers who have achieved stability in ACT and clubhouse programs. *Community Mental Health Journal*. *35*(2), 193-204.

- Brings data to bare on the debate about whether consumers with serious mental illness, who have achieved stability in assertive community treatment programs can e transferred to less intensive services.

Effectiveness Research

Bond G, Drake R, Mueser K, & Latimer E, (2001) Assertive community treatment for people with severe mental illness: critical ingredients and impact on patients. Disease Management & Health Outcomes, 9(3), 141-159.

- Summarizes results of 25 studies of the effectiveness of assertive community treatment. Includes information on cost effectiveness and fidelity.

Burns BJ. & Santos AB, (1995). Assertive community treatment: an update of randomized trials. Psychiatric Services, 46(7), 669 - 675.

- Reviews outcomes of randomized controlled trials of assertive community treatment including studies of special populations (i.e., homeless, dual diagnoses)

Clark RE, Teague GB, Ricketts SD, et al (1998). Cost-effectiveness of assertive community treatment versus standard case management for person with co-occurring severe mental illness and substance use disorders. Health Services Research. 33:1285-1308.

- Examines the cost-effectiveness of assertive community treatment in comparison to standard case management

Essock S, Frisman L, & Kontos N, (1998). Cost-effectiveness of assertive community treatment teams. American Journal of Orthopsychiatry, 68(2), 179-190.

- Reports on the cost-effectiveness of assertive community treatment over an 18-month period

Latimer E, (1999). Economic impacts of assertive community treatment: a review of the literature. Canadian Journal of Psychiatry, 44, 443-454.

- Focuses on economic impact of assertive community treatment on hospital use, emergency-room use, use of outpatient services, housing costs

Mueser KT, Bond GR, Drake RE, (1998). Models of community care for severe mental illness: a review of research on case management. Schizophrenia Bulletin, 24, 37-74.

- Reviews results of 75 studies of community care for persons with severe mental illness and compares the effectiveness of assertive community treatment and intensive case management

Rosenheck R, & Neale M, (1998). Cost effectiveness of intensive psychiatric community care for high users of inpatient services. *Archives of General Psychiatry, 55*(5), 459-466.

- Evaluates the costs of 10 intensive psychiatric community care programs at Department of Veterans Affairs medical centers in the northeastern United States.

Special Populations

Rural

McDonel E, Bond G, Salyers M, et al, (1997). Implementing assertive community treatment programs in rural settings. Administration and Policy in Mental Health, 25(2), 153-173.

- Reports results of a controlled evaluation of a rural adaptation of assertive community treatment. Describes challenges to implementation of complex service models.

Santos A., Deci, P., Dias, J., Sloop, T., Hiers, T., & Bevilcqua, J. (1993). Providing assertive community treatment for severely mentally ill patients in a rural area. *Hospital and Community Psychiatry, 44*(1), 34-39.

- Addresses differences between traditional mental health services and urban and rural assertive community treatment programs

Homeless

Lehman A, Dixon L, Kernan E, et al, (1997). A randomized trial of assertive community treatment for homeless persons with severe mental illness. *Archives of General Psychiatry, 54*(11), 1038-1043.

- Reports effectiveness of assertive community treatment compared to usual community services

Tsemberis S, (1999). From streets to homes: an innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology, 27*(2), 225-241

- Describes a supported housing program that provides immediate access to permanent independent housing to individuals who are homeless and have psychiatric disabilities

Morse G, Calsyn R, Klinkenberg W, Trusty M, et al.,(1997). An experimental comparison of three types of case management for homeless mentally ill persons. *Psychiatric Services, 48*(497-503).

- Compares the effectiveness of assertive community treatment and brokered case management for people with severe mental illness who are homeless or at risk of homelessness

Dual Diagnoses

Drake R, McHugo G, Clark R, et al. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: a clinical trail. *American Journal of Orthopsychiatry, 68*(2), 201-213.

- Compared the effectiveness of integrated mental health and substance abuse treatment within an assertive community treatment program with a standard case management approach

Consumers Involved in the Criminal Justice System

Solomon P, Draine J, (1995). One-year outcomes of a randomized trial of case management with seriously mentally ill clients leaving jail. *Evaluation Review, 19*, 256-274.

- Compares the effectiveness of assertive community treatment and two case management conditions on seriously mentally ill inmates leaving jail

Consumers & Family Members

Dixon L, Stewart B, Krauss N, Robbins J, et al., (1998). The participation of families of homeless persons with severe mental illness in an outreach intervention. *Community Mental Health Journal, 34*(3), 251-259.

- Describes the role of a family outreach worker on an assertive community treatment team and how the family outreach worker interacts with homeless persons with severe mental illness and their families

Felton C, Stastny P, Shern D, Blanch A, et al.(1995). Consumers as peer specialists on intensive case management teams: impact on clients. *Psychiatric Services, 46*(10), 1037-1044.

- Examines the effect of peer specialists on consumers' quality of life and reduction in major life problems

Special Populations Appendix

A review of the literature addressing the range of populations for which assertive community treatment has demonstrated efficacy or effectiveness, including geographic location, institutional setting, age, race, ethnicity, gender, and sexual orientation.

Assertive community treatment began in Mendota, Wisconsin nearly 30 years ago. A vital part of the history of assertive community treatment is a tradition of rigorous research and evaluation. The accumulated body of research on assertive community treatment shows this treatment approach to be effective in various settings and with consumers with diverse demographic characteristics.

Since its inception, assertive community treatment programs have been implemented in 35 states and in Canada, England, Sweden, and Australia [1-4]. Programs operate in rural communities as well as in urban areas [5-8]. Assertive community treatment has also been implemented successfully in community mental health systems and in the VA system [9].

There has been increasing interest in using assertive community treatment as a jail diversion program or with individuals who are involved in other ways with the criminal justice system. When working with the criminal justice system, conflicts may arise between ethical responsibilities to consumers and obligations to report consumers' behaviors to criminal justice entities. It is particularly important that programs working with criminal justice populations establish clear boundaries between their clinical role and their commitment to criminal justice agencies [10].

Studies of assertive community treatment have demonstrated positive outcomes in consumer populations where the most common diagnoses are schizophrenia, schizoaffective disorder, and bipolar disorder. Substantial functional impairment is another common characteristic of consumers in studies of assertive community treatment [1-4]. Benefits have also been documented for consumers with co-occurring substance abuse disorders [11-12]. This approach to treatment, however, may not be as effective as conventional treatments for individuals with personality [13].

The effectiveness of assertive community has been documented in programs with consumers from diverse ethnic backgrounds, males and females, and a wide range of age groups [14]. Although the relative effectiveness of assertive community treatment for individuals in different demographic groups has not been specifically established, no adverse effects have been noted.

Some consumer factors have not been systematically examined in the literature. For example, no current studies have examined sexual orientation and how that might affect outcomes in assertive community treatment programs.

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