Assertive Community Treatment

Implementation Resource Kit

DRAFT VERSION
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Information for Mental Health Program Leaders

Background

Assertive community treatment (ACT) started when a group of mental health professionals at the Mendota Mental Health Institute in Wisconsin—Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D.—recognized that many people with severe mental illnesses were being discharged from inpatient care in stable condition only to be readmitted relatively soon thereafter. This group looked at how the mental health system worked and tried to figure out what could be done so that individuals with severe mental illness could remain in the community and have a life that was not driven by their illness.

This group recognized that there was an immediate decrease in the type and intensity of services available to people upon leaving the hospital. They also realized that, even when considerable time was spent in the hospital teaching people skills needed to live in the community, people were often unable to apply these skills once they were actually living in the community. Adjusting to a community setting was made worse by the fact that people who experience serious psychiatric symptoms may be particularly vulnerable to the stress associated with change.

The group also recognized that, because the mental health system was complex and services were fragmented, people often had difficulty getting the services and support they needed to prevent relapse. Many programs were only available for a limited time and, once a person was discharged, assistance ended. Sometimes people were denied services, or they were unable to

apply for services because of problems caused by the symptoms of their mental illness. Sometimes the service a person needed did not even exist and no one was responsible for making sure people got the help they needed to stay out of the hospital.

The group's response to these problems was to move inpatient staff into the community to work with people in the settings where they lived and worked. This multidisciplinary team provided people with the support, treatment, and rehabilitation services they needed to continue living in the community. The types of services that were provided and how long those services were provided depended on people's needs. Team members pooled their experience and knowledge and worked together to make certain people had the assistance they needed and that the treatment that was being provided was effective. The team met each day to discuss how each person was doing and services were adjusted quickly when necessary. When people needed more support, team members met with them more frequently. Staff responded to people in the community 24 hours a day, 7 days a week. As people improved, the team decreased their interactions with them, but team members were available to provide additional support any time it was needed. After 30 years, the principles of this model remain the same.

Principles of Assertive Community Treatment

- **Services are targeted to a specific group of individuals with severe mental illness.**
- **Rather than brokering services, treatment, support and rehabilitation services are provided directly by the ACT team.**
- **Team members share responsibility for the individuals served by the team.**
- **The staff to consumer ratio is small (approximately 1 to 10).**
- **The range of treatment and services is comprehensive and flexible.**
- **Interventions are carried out in vivo rather than in hospital or clinic settings.**
- **There is no arbitrary time limit on receiving services.**
- **Treatment, support and rehabilitation services are individualized.**
- **Services are available on a 24-hour basis.**
- **The team is assertive in engaging**

Who is ACT for?

Typically, people who receive services from an assertive community treatment program have not benefited from traditional approaches to providing treatment. People who receive ACT services are those who have the most serious and intractable symptoms of mental illness and experience the greatest impairment in functioning. Impairments may include difficulties with basic, everyday activities like keeping themselves safe, caring for their basic physical needs, or maintaining safe and adequate housing, unemployment, substance abuse, homelessness, and involvement in the criminal justice system.

Evidence of the effectiveness of ACT

Researchers have compared ACT to traditional approaches to care (usually brokered or clinical case management programs). Evidence shows that ACT is superior to comparison conditions in (1) reducing psychiatric hospitalization, (2) increasing housing stability and, (3) improving consumers' quality of life. Studies also show that consumers and their family members find ACT more satisfactory than comparable interventions.

The ACT team leader

The ACT team leader is responsible for program administration and clinical supervision and also provides direct services to consumers. The team leader's administrative responsibilities include hiring and training team members, scheduling, evaluating employee performance, monitoring the program's faithfulness to the ACT model, and various other financial and statistical responsibilities. The team leader is also responsible for clinical supervision. This involves monitoring each consumer's status, assessing team members' performance, and providing feedback to team members in the context of the team's day-to-day activities.

Team and caseload size

The team must have enough staff so that there is a comprehensive mixture of expertise and sufficient coverage for the hours of operation. At the same time, to operate as a team, the team must be small enough to communicate easily and allow each member to be familiar enough with each consumer's status that they can step in to provide care at any time. A team of 10 to 12 members with a total caseload of 100 persons is suggested, although teams serving a large number of individuals with acute needs may find that a smaller caseload is needed until the individuals stabilize. The cost of this more intensive staff may be recouped through a decrease in the use of more expensive inpatient services.

Team composition

Since an ACT team is responsible for providing a broad array of treatment, rehabilitation, and support services, team members must have a wide range of knowledge and experience. A staffing pattern for a team providing 24-hour coverage for 100 consumers might be:

- team leader—one full-time employed mental health professional
- one psychiatrist
- two or more nurses
- two or more employment specialists

- two or more substance abuse treatment specialists
- one full-time consumer/peer specialist
- mental health professionals and paraprofessionals (master level social workers, occupational therapists, rehabilitation counselors, psychologists)
- one program assistant

Team approach

An ACT team is not a consortium of specialists or a group of individual case managers. It is an integrated, self-contained treatment program in which team members work together collaboratively. While certain team members will work more often with some consumers than with others, all team members are familiar with each individual and are available when needed for consultation or to provide assistance. The team, as a whole, rather than any one member, is responsible for providing whatever is needed to assist individuals in their recovery from mental illness. This shared-caseload approach is an important component of ACT and is a characteristic that distinguishes it from other community-based programs. Elements that contribute to the shared-caseload approach include:

- collaborative assessment and treatment planning
- cross-training of team members to the maximum extent feasible
- daily team meetings
- open office layout
- availability of assistance 24-hours a day
- generalist practice, that is, regardless of their area of formal training, all members assist with activities that support individuals in the community such as going with an individual to talk to a landlord, calling about a lost check

Team development

When selecting individuals for an ACT team, team leaders will want to find individuals who not only have expertise in their particular specialties, but who can also work productively in a group. Pragmatism, street smarts, and an optimistic, "can do" attitude are also desirable. Individuals should be willing and able to actively involve consumers in making decisions about their own treatment and services.

Manuals and videos explaining the ACT model are listed at the end of this publication. These materials can provide staff members with an overview of the theoretical and operational principles of ACT. Once staff have a basic understanding of the model, it is recommended that they visit an existing, well-functioning team to observe how the team works with consumers and how they interact with each other. This is followed by several days of classroom instruction before consumers are admitted to the program. During the first one to two years of a new team's existence, there are periodic booster training sessions. Ongoing telephone consultation and side-by-side supervision by an experienced ACT team trainer are important in reducing the chance that staff members will revert to old, more familiar ways of operating.

Cultural sensitivity

Because team members work with individuals in community environments rather than in clinic or hospital settings, they are actively involved in the culture of the individuals they serve. Awareness of and sensitivity to cultural differences take on additional importance in this context. Teams should reflect the cultural diversity of the communities in which they operate and consider the need for bilingual team members. Members of the team should be familiar with and comfortable with the culture of the people being served.

Accountability

Each day the team is updated on the results of the prior day's contacts with people. The activities for the current day are then jointly planned. Throughout the day, team members are in and out of the office and interacting with each other. A nonproductive team member will quickly become obvious.

Administrative issues

Starting a new team means developing policies and procedures that fit the activities of the ACT model. These include establishing:

- a mission statement for the team
- a program budget
- a physical location for the team's headquarters
- admission criteria that clearly identify the population to be served
- a medical record management system
- procedures for managing medications

- management of consumer funds
- procedures for assessment and treatment planning
- policies covering transportation
- mechanisms for monitoring and feeding back outcome and process data

These issues are discussed in detail in The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start–up by Deborah Allness and William Knoedler. A copy can be obtained through www.nami.org

For more information

Information on implementing evidence-based practices

Evidence Based Practices Implementation Website — www.mentalhealthpractices.org

To locate programs to visit or to contact trainers

National Assertive Community Treatment Technical Assistance Center

National Alliance for the Mentally Ill
2107 Wilson Blvd, Suite 300
Arlington, VA 22201–3042
(866) 229 –6264
elizabeth@nami.org
www.nami.org/about/PACT.htm

Assertive Community Treatment Association (ACTA)

Assertive Community Treatment Association, Inc.
810 E. Grand River Ave., Suite 102
Brighton Michigan 48116
(810) 227-1859
cherimsixbey@actassociation.com
www.actassociation.com

Projecting the costs of ACT

The Lewin Group

The LewinGroup
3130 Fairview Park Dr., Suite 800
Falls Church, VA 22042
703-269-5500
karen.linkins@lewin.com

Helpful Books

"Assertive Community Treatment of Persons with Severe Mental Illness" by L. Stein & A. Santos, Norton Publishers	www.wwnorton.com
"PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start–up" by D. Allness & W. Knoedler, NAMI	www.nami.org (866) 229-6264

Videos

"Assertive Community Treatment" (A Brief Introduction to ACT), Duke University, Department of Psychiatry & Behavioral Sciences	toolkit video
"Never Too Far" (describes an ACT program in a rural community), Duke University, Department of Psychiatry & Behavioral Sciences	pasip001@mc.duke.edu 919 684-3332
"Consumers Talk About ACT" (interviews with individuals who receive ACT services), Duke University, Department of Psychiatry & Behavioral Sciences	Elizabeth@nami.org (866) 229-6264
"The Role of Advisory Groups"	Elizabeth@nami.org (866) 229-6264