

Assertive Community Treatment

Implementation Resource Kit



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Implementation Tips for Mental Health Program Leaders

An Assertive Community Treatment team is different from other programs that may be operating in your agency. First, the consumers targeted by this program are those who have the most severe and persistent psychiatric symptoms and who, consequently, have the most severe problems with social functioning. People served by an assertive community treatment program are typically those who have extensive histories of psychiatric hospitalization, are homeless, have co-occurring substance abuse or medical problems, and/or involvement in the criminal justice system. They are also people whose needs have not traditionally been well met by the mental health system.

One of the reasons an Assertive Community Treatment program is able to help individuals with these types of challenging needs live safely and autonomously in the community is because the program staff assumes responsibility for providing all the services the person might need. This might be assistance with housing, parenting, benefits, symptom management, medical care, substance abuse treatment, and/or employment. Rather than referring people to other providers for these services, the team itself provides them. To do this, the program is staffed by experts with a variety of skills and experience who carefully integrate interventions and provide support around the clock if necessary.

The program is run by a team leader who is a mid-level manager, clinical supervisor, and practicing clinician. The team psychiatrist also actively provides clinical leadership. It is these two individuals who are responsible on a day-in, day-out basis for assuring that the program follows the Assertive Community Treatment model. We encourage you to make this section of the Resource Kit available to candidates for these positions during the hiring process so they will understand what they will be asked to do. It will also be important for the people who are selected for these positions to have an active role in

setting up the structures needed to support the Assertive Community Treatment team and in establishing the processes that channel the team's dynamic energies and abilities.

This section of the Resource Kit is intended to help the leaders of a new program think through and prepare for developing an Assertive Community Treatment team. In preparing this section, we could think of no one better to advise new team leaders on the tasks involved in starting a new team than people who have worked successfully with Assertive Community Treatment programs. Therefore, the information in this manual is based on the experience of veteran team leaders and administrators.

Because building an effective, well-functioning team is very much a developmental process, we encourage you and the team leader to revisit this section periodically throughout the first year of the new program. We believe that these materials will take on new meaning as the process of implementing an Assertive Community Treatment team evolves.

Resources and Processes

Part I describes the resources and administrative processes that will need to be in place before consumers can be admitted to the program. This material is adapted from *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-up* which was written by Deborah Allness, MSSW and William Knoedler, MD - two of the originators of the assertive community treatment model. This book is more commonly referred to as *The PACT Start-up Manual*. Many of the processes you will need to understand, as well as forms, position descriptions, and model policies and procedures are provided in *The PACT Start-up Manual*. We encourage you to order copies of the manual for your own use and for use by the team leader and program staff. Copies of *The PACT Start-up Manual* are available from the National Alliance for the Mentally Ill (NAMI) and can be ordered by calling (703) 524-7600 or emailing elizabeth@nami.org.

Voices from Experience

Part 2 is a series of three interviews with people familiar with assertive community treatment programs. The interviews contain information that we believe will help team leaders anticipate some of principles and practical challenges associated with leading an assertive community treatment team.

The Assertive Community Treatment Team as a Complex Adaptive System

Part 3 addresses the building and nurturing of the team process. The team leader will find that while assertive community treatment teams are made up of people from multiple disciplines, it is not technically a multidisciplinary team, but rather a *transdisciplinary* team. Section 3 is an article explaining key organizational functions of such teams and the role of the team leader in enhancing team behaviors that support this type of a team.

How Ready Are You?

Part 4 contains checklists to help you and the team leader check on your understanding of important aspects of assertive community treatment and make concrete plans for the work that will need to be done to implement this service.

Part 1. Resources and Processes

Adapted from The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental illnesses: A Manual for PACT Start-up by Deborah Allness, MSSW and William Knoedler, MD, published by the National Alliance for the Mentally Ill (1999). Used with permission.

Program Staff

When individuals enter an assertive community treatment program, they often have multiple serious problems that need close monitoring and careful attention. For example, consumers may be experiencing acute psychiatric symptoms (e.g., command hallucinations, suicidal thoughts). Even if acute symptoms have subsided, there may be concern about relapse until an effective and reliable symptom management strategy is developed. Some consumers will have medical problems such as HIV, Hepatitis, and diabetes that need careful attention. There may also be consumers who are living on the streets or in shelters whose safety is a concern. Even when a consumer has housing, it may be in an environment where they are at risk for being victimized, or the person's behavior or problems managing money might present an ongoing concern about eviction. Further, consumers may not have a support network they can rely on beyond the team.

The point is, assertive community treatment programs target services to those individuals with the most serious and challenging problems. In order to assure that these individuals are safe and have the level of support they need to live autonomous and self-directed lives in the community, the team must have the capacity to respond around the clock, if needed, with a variety of interventions as dictated by the consumer's needs.

What this means in terms of staffing and staff roles is that:

- there must be adequate coverage for days, nights, weekends, and holidays;
 - the team must be composed of highly competent individuals with a wide variety of expertise;
 - the staff to consumer ratio must be kept low;
 - staff participate in special leadership roles; and
 - there must be a process for assuring the clinical quality of the work the team does.
- This section provides basic information about each of these issues as well as practical tips on hiring staff for an assertive community treatment team.

1. Adequate Coverage¹

Having staff available 24-hours a day, 7-days a week, 365-days a year is very important in helping assertive community treatment consumers live safely and successfully in the community. When a team does not provide any evening, weekend, or holiday staff coverage, problems that might be addressed by preemptive interventions become crises and consumers are more likely to be hospitalized or entangled in the criminal justice system.

Hours of operation that would provide adequate coverage are:

- Monday through Friday: two 8-hour shifts per day (e.g., 8:00-4:30, 1:00-10:00);
- Saturday and Sunday: 8-hour shift each day (e.g., 10:00-6:00)
- Holidays: 8-hour shift (e.g., 10:00-6:00)
- A team member is *on call* all hours team members are not on duty

The majority of staff work the weekday shifts because most of the work needs to be done during these hours. Evening, weekend, and holiday staff focus primarily on consumers in crises (or intensive interventions to prevent crises), and consumers who need 7-day-a-week assistance. Staff should rotate evening, weekend, and holiday hours. Rotating this coverage ensures regular participation by *all staff* in the daily team meeting.

The team leader must set a policy regarding how many team members can be on vacation at a time – ideally this will be no more than one team member at a time.

Because evening, weekend, and holiday tasks require competent and independent clinical judgment and skill, these hours should be primarily assigned to and rotated among members with this level of ability. It is optimal to have a registered nurse on every shift. Paraprofessional mental health workers should work these hours only when paired with more highly trained team members. Teams that serve non-English speaking consumers will need to plan for how each shift will have access to staff who speak the appropriate languages.

Teams in rural areas may have to coordinate services with the on-call service of the larger mental health system.

Where the total number of consumers is too small to justify a 10-person team (for instance, in some rural areas), there will not be enough staff to cover all evening, weekend, and holiday shifts. If the rural team is very well organized, does careful assessments, anticipates and plans for consumer needs, and does not have serious problems with staff attrition or staff absences, schedules can be coordinated with the on-call services in the larger mental health system to provide necessary services on a case-by-case basis in the evening and on weekends.

¹ Examples of staff work schedules for two consecutive weeks can be found in Chapter 3 of *The PACT Start-up Manual*

2. Team Composition²

Team members share many roles and strive to function interchangeably

The staff is composed of members of the various professions and disciplines needed for the team to be the primary provider of comprehensive services and support. The majority of the team have a masters degree or above and experience working with individuals with severe and persistent mental illness. Team members must collectively possess a wide range of aptitudes and professional skills, be able to work both independently and collaboratively in the community, and to establish a quality clinical relationship focused on recovery.

Teams should reflect the cultural diversity of the communities in which they operate.

Because team members work with individuals in community environments rather than in clinic or hospital settings, they are actively involved in the lives of the individuals they serve. Awareness of and sensitivity to cultural differences and preferences of individuals takes on additional importance in this context. Teams should reflect the cultural diversity of the communities in which they operate and must consider the need for bilingual team members. Resources must also be available when needed to allow the team to work with individuals with hearing and visual impairments.

In order to have a sufficient range of expertise represented on the team and enough staff to cover evenings, weekends, on-call duty, and vacations, the team, in most cases, should be made up of 10-12 FTE positions.

- **Team leader** – a 1 FTE team leader who provides direct services at least 50% of the time. The team leader is the clinical and administrative supervisor and should of the team and should have at least a masters degree in nursing, social work, psychiatric rehabilitation, or psychology.
- **Psychiatrist** – at least 1 FTE per 100 consumers. The psychiatrist shares responsibility with the team leader for monitoring each consumer’s clinical status and delivery of clinical services.
- **Psychiatric Nurses** – at least 2 FTE per 100 consumers³. Psychiatric nurses carry out medical functioning including basic health and medical assessment and education; coordination of health care provided to consumers in the community; psychiatric medical assessment, treatment, and education; and psychotropic medication administration.
- **Employment Specialist** – at least 2 FTE with one year specialized training or supervised experience. Employment specialists provide work-related services, including assessment of the effect of the consumer’s mental illness on employment, and plan and implement an ongoing employment strategy to enable consumers to obtain and retain jobs.
- **Substance Abuse Specialist** – at least 2 FTE with one year specialized substance abuse training or supervised experience. Substance abuse specialists provide and coordinate substance abuse assessment, treatment planning, and services delivery tailored to the needs of individual consumers.

² FTE specifications are based on the Dartmouth Assertive Community Treatment Scale (DACTS) included in the Outcome Monitoring publication for this EBP Implementation Package.

³ While the DACTS specifies 2 FTE nurses, teams will find that it takes 5 nurses to have nurses available on all shifts

- **Mental Health Consumer** – these individuals sometimes fill a position called *Peer Advocate*, however individuals with mental illness should be considered for any position on the team for which they are otherwise qualified.
- **Mental Health Professionals** (persons with master’s or doctoral degrees in social work, nursing, rehabilitation counseling, psychology, occupational therapy). Mental health professionals have responsibility for providing case management; teaching illness management and recovery skills; developing, directing, and providing other treatment and support services.
- **Program Assistant** – This program assistant organizes, coordinates, and monitors all clinical operations of the team, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for consumer and program expenditure; and triaging and coordinating communication between the team and consumers.

3. Staff to Consumer Ratio

In general, assertive community treatment teams should plan on a staff to consumer ratio of no more than ten consumers per staff, not including the program assistant and psychiatrist. Keep in mind that, although we talk of a staff-to-consumer ratio, this is simply for planning purposes because, in practice, *staff do not have individual case loads*. Instead, the team *as a whole* is responsible for *all* consumers in the team’s caseload.

The total caseload size is affected by the total number of staff (10-12 FTE) and the average number of consumers per staff (10:1). Therefore, the maximum program capacity is about 120 consumers (12 FTE x 10 consumers per staff).

Total case size is small enough to ensure that all team members know all consumers and that good communications are maintained

There is a limit to the number of consumers for which the staff can maintain effective communication no matter how well a team is organized or how competent they may be. When this maximum number of consumers is exceeded, work effectiveness breaks down. When this happens, the team will find themselves reacting to crises (or the imminent threat of crises) rather than helping consumers take proactive steps toward recovery.

The total caseload for which a team can provide intensive services and maintain the intimate communications that are needed to assure quality care will be affected in part by the acuity of the consumers being served. That is, teams serving consumers who have been receiving services for several years and who are having relatively few crises and require less frequent contact may be able to handle slightly more consumers per staff. On the other hand, when a team is working with a majority of individuals who require frequent contacts they may find that the staff-to-consumer ratio (and consequently the total case size) may need to be smaller. The same is true in situations where consumers’ living conditions are chaotic, housing is hard to secure, and daily living is very stressful, or the majority of consumers have co-occurring substance abuse issues or complicated medical needs.

4. Organization of Staff

Much of the success of assertive community treatment is due to developing treatment plans that address an individual's need wholistically, assuring that the details of those plans are carried out, and responding swiftly when a plan does not appear to be working or a new need arises. Teams have found ways of organizing staff roles to assure that a high level of attention can be paid to each consumer's needs and interventions can be carefully monitored. These include designating a lead mental health professional and registered nurse to assist the team leader with certain leadership responsibilities, assigning a shift manager to coordinate each day's work, and assigning primary responsibility for individual consumers to specific groups of team members.

Lead Mental Health Professional and Lead Registered Nurse

The many functions of the self-contained team require that staff members assume lead responsibilities to assist the team leader and the psychiatrist. This is particularly necessary if the psychiatrist is only part-time. Two team members are assigned leadership responsibilities to support the team leader- the lead mental health professional and the lead registered nurse. The lead mental health professional assists in providing supervision in comprehensive assessment and treatment planning and in the delivery of services. The lead registered nurse serves as the lead nurse in medication, pharmacy, and other medical-service activities. These individuals should be paid higher salaries.

Initially, the team leader is very involved in preparing the schedule. When a routine is established, the program assistant can prepare it.

Shift Management

A staff member is assigned as shift manager on a daily basis to organize and schedule that day's activities, make assignments for work that wasn't planned, and assure follow-through on work that couldn't be carried out as planned. This person:

- coordinates and writes the daily staff assignment schedule during the daily organizational staff meeting,
- supervises and monitors the daily staff assignment schedule throughout the day to ensure that all daily assignments are completed or rescheduled, and
- shifts the schedule or reassigns work activities to accommodate emergency and other urgent situations that arise.

Individual Treatment Teams⁴

Within one week of a new consumer being admitted to the program, the team leader designates team members who will be responsible for establishing a good relationship with the consumer and providing continuous and integrated services. This lead group of team members is referred to as the Individual Treatment Team or IIT. The IIT is also continuously responsible for:

- Assessing the consumer's status and needs
- Developing a treatment plan with the consumer and the consumer's family or guardian
- Providing the majority of the consumer's treatment and support services

⁴ Chapter 4 of *The PACT Start-up Manual* contains a detailed description and diagrams of how the IIT and other members of the team relate with each other to coordinate the delivery of services over time, as the intensity of a consumer's needs change. New team leaders will need to be familiar with this information. Information on ordering *The PACT Start-up Manual* can be found at the beginning of this publication in the section titled "How to Use this Publication."

- Coordinating the consumer's care across the whole team

To perform these responsibilities, members of the ITT must collectively possess a blend of treatment and rehabilitation skills. In urban areas where there are large assertive community treatment teams, the ITT is made up of the following team members:

- **Primary case manager** - a mental health professional who coordinates and monitors the activities of the individual treatment team; has primary responsibility to write the treatment plan; provides individual supportive therapy, illness management education, ensures immediate revisions to the treatment plan as the consumer's needs change; and advocates for the consumer's rights and preferences. The primary case manager is usually the first staff contacted when the consumer is in crisis and provides the primary support to the individual consumer's family.
- **Backup case manager** - also a mental health professional. This individual shares tasks related to coordinating care and is responsible to perform them when the primary case manager is absent.
- **Psychiatrist** - performs duties in regular coordination and collaboration with the individual treatment team
- **Registered nurse** - arranges and coordinates the consumer's medical care with community medical providers. The nurse may carry out some physical assessments and treatment; however, her or his primary responsibilities are psychiatric, not medical.
- **Other team member(s)** - individual is selected to best match consumer's needs and interests. For instance, if the individual has a co-occurring substance abuse disorder, one of the team's substance abuse specialists may be assigned to the consumer's ITT. If the consumer is interested in work, an employment specialist may be assigned. These other members are expected to know each consumer's family members and to assist them when they need help.

In rural areas, teams may not be able to exceed three team members per ITT

Although the majority of a consumer's service contacts are with the members of the assigned ITT, the larger team is also involved in providing services. To keep treatment coordinated, the ITT continuously monitors the services the consumer is receiving, coordinates all staff activities, and provides information and feedback to the whole team.

The daily organization staff meeting and the treatment planning meetings provide opportunities for exchange of information between the ITT and the larger team. If some team members are not working effectively with a consumer or disagree with the treatment plan, the ITT's role is to discuss the plan, problem solve, and get consensus so there is consistency in service implementation across the whole team.

5. Continuous Clinical Supervision

Clinical supervision of the staff is shared by the team leader and psychiatrist. This involves the continuous review of each consumer's status and assuring that staff have and apply the knowledge and skills needed to deliver comprehensive consumer-focused services. Clinical supervision is the process that will, to a large extent, determine whether the staff will simply be a menagerie of mental health professionals doing what they've always done, or whether they will 'step outside the box', and think and act in new ways. In

Team leaders should be familiar with the contents of the Assertive Community Treatment Team Development Workbook that is part of the EBP Project Implementation materials. This workbook contains specifics about day-to-day clinical processes. Since part of the team leader's role is to assist the staff in implementing these clinical practices, she or he should be intimately familiar and comfortable with them. The team leader should review the workbook and prepare questions for to ask his or her mentor or consultant.

providing clinical supervision, the team leader and psychiatrist set the quality standards and translate a new way of working into the day-to-day actions of team members. It is therefore essential that *the team leader and psychiatrist* thoroughly grasp the qualitative differences in how an assertive community treatment teams understand and interacts with consumers. For this reason, the two most important things you can do to prepare these individuals for their responsibilities in providing clinical supervision for the team are (1) to arrange for them to visit an existing assertive community treatment team, and (2) identify an experienced team leader who can provide ongoing consultation.

Because part of the team leader's time is dedicated to direct services, the team leader will work with and be familiar with all consumer's served by the team. This is important in providing clinical supervision since the team leader and psychiatrist will be talking about people that they know personally, not just 'cases' presented by the staff. Clinical supervision is provided primarily in the context of the team's day-to-day work with consumers.

- **Daily team meeting:** Each consumer's status and response to treatment are assessed. The team leader and psychiatrist give direction regarding individual cases to ensure good clinical care and provide feedback on staff performance.
- **Treatment planning:** the team leader, with the participation of the psychiatrist, leads the treatment planning meetings and supervises individual treatment teams in developing and reviewing written treatment plans. To supervise treatment planning, the team leader must master the technical and analytical aspects of individualized treatment planning.⁵
- **Side-by-side supervision:** the team leader and psychiatrist provide individual, side-by-side supervision to assess

performance; give feedback; and model interventions while accompanying individuals team members to meet with consumers in regularly scheduled and/or emergency meetings.

- **One-to-one meetings:** the team leader and the psychiatrist are regularly available at office headquarters or by beeper or cell phone to consult with team members.
- **Individual supervision:** team leader also may schedule regular meetings with individual team members to review cases, evaluate performance, and give feedback.

⁵ Team leaders must be familiar with the details of Chapter 6 of *The PACT Start-up Manual* ("Consumer-Centered Approach"). Information on how to order *The PACT Start-up Manual* can be found at the beginning of this publication in the section titled *About this Publication*.

6. Tips on Hiring Staff

Ideally, you want to recruit people to staff the assertive community treatment team who are interested in working in the community as opposed to involuntarily reassigning people from other existing programs. The team leader should be actively involved in the process of selecting and hiring staff for the program.

You will want to look for individuals who have strong clinical and rehabilitative skills, knowledge of mental illness, possess the personal attributes suited to working in a team environment, and providing intensive, long-term, recovery-focused services to people with severe and persistent mental illnesses. Hiring and retaining staff is directly related to salary level. If salaries are not similar to the going rates for each discipline in other health settings in your community, attracting and retaining qualified candidates will be very difficult.

The following tips concerning hiring staff may be helpful:

- **Develop task-specific position descriptions for each team position.** A good position description clarifies to job applicants whether a particular position matches their skills and expectations. After hiring, the job description allows the team leader to effectively supervise the new employee and allows the employee to focus on the basic elements of the job. The position description should outline the main task categories and detail specific duties.
- **Expose candidates to the team and its work.** All candidates who are being seriously considered for employment should be invited to spend half a day or more with the team so that they can see the team at work firsthand. Applicants can then better evaluate how well they might fit in and can make a more informed decision about the job. This visit also gives team members a chance to talk with and observe candidates, and offer their feedback in the hiring process.
- **Conduct thorough reference checks.** The best predictor of work performance is likely to be the candidate's performance in previous jobs, particularly jobs that required some of the same skills and personal qualities desirable for assertive community treatment staff. The team leader should talk to previous supervisors, inquire in detail about a candidate's previous work responsibilities and performance, and ask for opinions about his or her capabilities in team-based work with persons with severe and persistent mental illnesses. If the candidate has had little experience in the mental health field or has just finished school, valuable information can be gathered from field supervisors, training mentors, and teachers.

Model position descriptions are found in *The PACT Start-up Manual*.⁶

Screening can weed out people who may be too authoritarian or patronizing to be appropriate for an assertive community treatment program.

⁶ Information on how to obtain a copy of *The PACT Start-up Manual* is provided in *About this Publication* at the beginning of this publication.

- *Evaluate a candidate's responses to typical situations.* Determine applicants' understanding, skill, and commitment to working with people with severe and persistent mental illnesses by asking the candidates how they would approach typical work situations such as managing and planning for a suicidal consumer, prioritizing goals for a consumer with multiple problems, establishing an employment plan with an unemployed consumer, negotiating with an agency to provide services for a consumer, and educating consumers about the pro's and con's of taking medications. Applicants' responses should indicate their level of understanding and skill.

7. Tips on Training Staff

Part of developing a new assertive community treatment team is providing team members with adequate training so that they understand and are comfortable with the model. One resource for training members of new teams is to have them participate in training based on the Evidence-Based Practices Project training materials. In addition to this basic training on assertive community treatment, we also suggest that you have at least one member of team attend training in each of the other evidence-based practices. These include: supported employment, treatment of dual diagnoses, family psychoeducation, teaching illness management and recovery skills, and medications. The individuals trained in these complimentary practices can then return to the team and provide cross training to other members.

Program Facility

There are two key things to keep in mind in deciding where the program will physically be located. One is the need for the program to be readily accessible by consumers and staff. The other is the need for a workspace that is laid out in a way that facilitates communication.

1. Accessibility

Members of the assertive community treatment team spend the majority of their workday in the community, returning to the office intermittently between appointments to get messages and consult with other team members. For this reason, the program office must be in a convenient central location that allows the staff to easily reach the neighborhoods where consumers live. There also needs to be parking close to the office for program and/or personal vehicles so that team members and consumers can easily and safely come and go. The building must be open all hours that the team works, including evenings, weekends, and holidays. The office should also be directly accessible by consumers and their families so that when they come to the office, they can immediately reach the team's reception area without having to check in at other reception counters (as is the case in many community mental health centers medical clinics).

2. Office Layout

Team members share a common work area rather than having individual offices. This provides a free flow of conversation and an opportunity for the informal exchange of information and ideas.

A room is also needed in which substance abuse treatment groups can be held. This room should allow for privacy.

The assertive community treatment program facility or offices requires:

- *reception area* is directly accessible
- *large meeting and work room* with a conference table and chairs, several telephones, treatment records, storage space for treatment record supplies, and individual staff storage space
- *medication room* with a sink, medical exam equipment (e.g., thermometer, scale, blood-pressure cuff) locked storage capacity for medication, refrigerator for specimen storage, and work space for the medical staff to set up medications
- *interviewing rooms* which can also serve as office space for the team leader and the psychiatrist or for interviewing or quiet work space for all team members to use
- *space for temporary storage of consumer possessions* as well as for purchased and donated clothing, furniture, household supplies, and for use by consumers
- *space for office machines* (e.g., copy machine, fax machine) and storage of office supplies
- *parking* for program and staff personal vehicles

Transportation

Transportation is a practical as well as an economic issue in starting an assertive community treatment team. It must be dealt with up front by administrators and payers. The team sees consumers in community settings and provides consumers transportation when necessary because most consumers will not have cars. Many consumers may have difficulty using public transportation, if it exists. Administrators and payers must decide whether it is more economical to buy or lease program cars for team use or to require staff to use their personal cars and reimburse them for mileage and liability insurance. Also, agencies that have only provided clinic-based services may also need to develop written policies and procedures concerning transportation.

Consumer Service Funds

Consumer service funds are allocated in the assertive community treatment budget to provide direct financial grants or loans to consumers, for example, when disability benefit payments have not started, a benefit check is delayed, or the first check from a new job is insufficient to cover expenses. Consumer services money might be used for:

- emergencies
- rent
- security deposits
- food
- clothing
- recreation
- consumer transportation costs

The program will need to have written policies and procedures to cover the disbursement and tracking of these funds.

Consumer Records

You will need to maintain a record for each consumer and safeguard it and its contents against loss, tampering, and unauthorized use. The record should be consistent with JCAHO and Medicaid requirements. You will need to plan on the purchase of materials for creating records (e.g., binders, forms) and for appropriate storage. There should also be written policies and procedures for documentation and maintenance of records. Team member will need to be educated and supervised in the required documentation practices.

Because assertive community treatment teams serve individuals who often have many immediate needs and because staff spend most of their time in the community, keeping up with documentation and progress notes can be a particular challenge. Some teams have found that it is necessary to designate times in the team schedule for team members to spend on documentation.

Medication Administration System

This medication system is managed and operated by the team's psychiatrist and registered nurses with other team members participating in non-medical aspects of the system such as delivering medication and assessing consumers' response to medications. You will need to work closely with the team psychiatrist and nurses to set up a system that assures medications are being used wisely. The system will need to address:

- recording of medication orders,
- filling orders,
- procuring medications,
- storing medications,
- coordination with medical providers,
- consumer education,
- strategies for helping consumers take medications as prescribed,
- assuring necessary lab work is done in a timely manner, and
- keeping staff informed of changes in medication and the side effects and benefits to monitor.

As you think about medications, you will want to keep in mind that unit dosing of each medication administration may be preferable to undivided bottling or packaging. If an undivided supply is sent, one of the nurses must take the time to separate the medication into the unit doses which can be very time consuming especially when the nursing staff have to package unit doses for a large number of consumers. Further, in systems with fee-for-service reimbursement structures, this chore may not be billable. If undivided packaging is unavoidable, consider having nurses prepare medications for several days at once.

Model policies and procedures concerning medication administration can be found in *The PACT Start-up Manual*.

Also, you will find that some consumers are not able to afford some or all of the medications they need. The team should budget money to purchase medications for consumers in these instances and aggressively solicit the indigent consumer programs of pharmaceutical companies. The psychiatrist and nurses can also work with the representatives of these companies to obtain medication samples. Collectively, these measures can adequately cover many indigent consumers.

The details of setting up medication administration practices and systems for delivering medication to consumers are discussed in much more detail in *The PACT Start-up Manual*. We urge you to obtain a copy of this manual and to have the team's psychiatrist and nurses review it carefully and help you plan the program's medication system. Information on how to obtain *The PACT Start-up Manual* is in the section of this publication titled *About this Publication*.

Also, you may wish to speak to a consultant pharmacist to find out if she or he can potentially help devise a streamlined system for ordering, dispensing, and storing medications. A consultant pharmacist can also provide upfront and ongoing education to staff on the appropriate use of medication, resolve billing problems, and manage quality assurance processes. You can find out more about how a consultant pharmacist may be of help to you by contacting the American Society of Consultant Pharmacists at 800-355-2727 or email info@ascp.com.

Rules of medication administration and distribution may vary from state to state. Be familiar with the rules for your state.

Budget

It is important for the team leader and psychiatrist to understand the program budget and revenue sources so that they can actively participate in the budgeting process, make informed management decisions, and understand where collateral revenue sources are most needed.

1. Projected Expenditures

In preparing or reviewing the budget, it is important to assure that the following items have been budgeted for:

- competitive staff salaries and fringe benefits
- rent, utilities, and facility maintenance
- telephone and communication equipment including pagers and cell phones
- office supplies (e.g., treatment charts, binders and dividers, progress notes and other forms)
- office equipment (e.g., fax machine, copier, printer, chart racks, storage cabinets, file cabinets)
- office furniture
- travel and transportation (e.g., vehicle leaser or purchase, travel reimbursement, parking and liability insurance for personal vehicles)
- medication and medical supplies and equipment (e.g., scale, blood-pressure cuffs, stethoscopes, thermometers, injection supplies, small refrigerator, otoscope, first-aid kit)
- professional insurance
- consumer services money

- staff education and training
- consultation

2. Revenues

The team leader should understand how the program generates revenue. In some mental health systems, assertive community treatment programs receive a fixed rate per person served by the team. In other systems, the team is only reimbursed based on the specific service provided during any given encounter with the consumer. If the latter is the case, the team leader will need to be very familiar with which staff can capture billing for what services. The team leader will also need to know the billing process and billing codes.

Sometimes, teams find it helpful to procure other forms of funding to supplement revenues generated through the mental health system. For instance, a team might pursue a grant to subsidize housing for consumers, or a grant to cover the costs of the dual diagnosis group, or to pay for a peer advocate.

There is a danger that programs must be aware of and avoid; that danger is that the mission and work of the program over time will be defined by the funding that is coming into the program. You must be aware of the principals of assertive community treatment and be vigilant that funding opportunities are used to support the model rather than allowing funding to shape and corrode the model.

Clinical Administrative Processes

1. Program Admission

You will need to set up a process for identifying individuals who are appropriate for your program, and acquainting referral sources with referral procedures. You will also need to have a process for explaining your program to consumers in a way that lets them make an informed decision about accepting services. Finally, when a consumer decides he or she wants to receive services, you will need a process for identifying and addressing the consumer's most pressing needs. As the team begins to meet these needs, the consumer and staff to get to know each other and begin to build a relationship. As this work continues, the team has the opportunity to gather much more extensive information about the person so that a more detailed treatment plan can be developed.

Model policies and procedures and the necessary forms for setting up consumer records can be found in *The PACT Start-up Manual*

Admission Criteria.

Admission guidelines for assertive community treatment programs should target individuals with severe and persistent mental illnesses who experience the most severe symptoms and, consequently, have chronic problems functioning in basic adult roles in the community. Some programs focus on very specific groups of individuals such as those with coexisting substance abuse disorders, individuals who are homeless, those involved in the criminal justice system, or those who have been repeatedly hospitalized. The team leader is responsible for operationalizing these criteria, and identifying and educating referral sources about the assertive community treatment program. When the team receives a referral, the team leader confirms that the person meets the program's admission criteria and the process of getting to know the person begins.

The number of new consumers admitted to the program is deliberately restricted to 5-6 per month. This allows new teams time to become thoroughly acclimated to new processes without being overwhelmed by trying to serve a large number of individuals with multiple, complex needs all at once.

Admission Meeting

After the team leader has confirmed that a person meets the program's admission criteria, a meeting is arranged that includes the current provider (e.g., crisis services, inpatient unit, etc), the team leader, and the consumer. The admission meeting may also include:

- family members, significant others, or guardians if the consumer is agreeable
- team members who will be consistently working with the new consumer
- the team psychiatrist
- At the admission meeting, team members introduce themselves and explain the assertive community treatment program. If a person is acutely ill, it may take several contacts to feel comfortable that the person understands the services that are being offered. Sometimes, consumers will want time to think about whether or not they want to receive services. In these instances, there may be a follow-up meeting. During these meetings, the consumer is learning about the program, but team members are also learning about the consumer's immediate history and current needs, as well as getting to know family members and other supporters.
- When a consumer decides that he or she wishes to receive assertive community treatment services, the team immediately opens a record and schedules initial service contacts with the consumer for the next few days.

2. Assessment

The initial assessment addresses the consumer's most urgent needs. As the team begins to address these needs, a more thorough assessment is done. The process facilitates the bringing together of the expertise of different professionals in understanding the consumer's history and needs. Since many consumers will have a long history of receiving fragmented services, there also needs to be a way of piecing together the person's history in a way that allows the team to get a clear picture of the person's experience with mental illness and previous treatments. After this information is gathered and organized, it is brought together and presented at a treatment planning meeting.

A copy of the forms for completing the initial assessment and treatment plan can be found in *The PACT Start-up Manual*.

Initial Assessment and Treatment Plan

Based on information obtained from the consumer, referring treatment provider, and family or other supporters who participate in the admission process, an initial assessment is completed. This documents information concerning the:

- reason for admission,
- consumer's psychiatric history including onset, course, effects of illness, past treatment, status, and diagnosis;
- physical health;
- use of alcohol or drugs;
- education and employment;
- social development and functioning;
- activities of daily living; and

- family structure and relationship
- Based on the initial assessment, an initial problem-oriented treatment plan is formulated listing the consumer's concerns for which services are offered.

Comprehensive Assessment

Unlike traditional office-based assessment procedures, the assertive community treatment staff conduct their assessments, for the most part, as they are working with the consumer in the community delivering the services outlined in the initial assessment. This has the advantage of allowing team members to actually observe how the consumer manages in the community and what the consumer's environment is like. The purpose of the comprehensive assessment is to collect information from multiple perspectives about the consumer and how his or her life is being affected by mental illness, and then assemble the information into a coherent manner. There are seven parts to the comprehensive assessment:

The forms used to guide these assessments are in *The PACT Start-up Manual*.

- Psychiatric history, mental status, and diagnosis
- Physical health
- Use of drugs or alcohol
- *Education and employment
- Social development and functioning
- Activities of daily living
- Family structure and relationships

The primary case manager and other members of the individual treatment team, under the supervision of the team leader, are responsible for completing the comprehensive assessment within 30 days of admission.

Psychiatric/Social Functioning History Timeline

An important tool for organizing and making sense of information about the consumer's history and the interrelationships among experiences is the psychiatric/social functioning history timeline. The primary case manager and other members of the IIT are responsible for obtaining appropriate releases of information.

A sample of the form that you will need for the psychiatric/social functioning history timeline is in *The PACT Start-up Manual*.

3. Treatment Plans

Treatment planning involves taking the information in the psychiatric/social functioning history timeline and comprehensive assessment and translating it into objective goals based on the consumer's preferences. The treatment plan is person-specific, that is, it is built to address each consumer's goals and the services a particular consumer needs to reach his or her goals. The treatment plan details the specific interventions or services that will be provided, by whom, for what duration, and where each service will be provided.

The treatment plan meeting is lead by the team leader and attended by all other team members who can attend. Depending on the consumer's preference, he or she may also attend. Because so many team members work with each consumer and have input to the individual treatment team regarding consumer status and needs, treatment plans require total team understanding and agreement.

Although developing a treatment plan seems straight forward, new teams often struggle with developing person-specific plans that consider the consumer's unique experience of mental illness and personal goals. Team members often have a hard time thinking of the consumer's history in terms of his or her experience of mental illness rather than just behavior. Some team members will have a hard time giving up the notion that they know what's best for the consumer and letting consumers work on what's important to *them*. Clinical consultation from experienced team leaders is highly recommended.

4. Delivering Services

Weekly Consumer Schedule and Daily Team Schedule

The specifics concerning the services and interventions outlined in the treatment plan (i.e., what will be done when, by whom, where, how often) are transcribed onto a Weekly Consumer Schedule. The IIT is responsible for recording this information and for updating it whenever there is a change. The Weekly Consumer Schedule is a form printed on 5 x 8 inch index cards. Team members write the weekly consumer schedule in pencil so that changes can be easily made. These are kept in a central file in the team meeting room.

Then, to make sure consumers receive the interventions and services that were planned, the person who has been designated shift manager for the day reviews each consumer's weekly schedule. The activities scheduled for that day are written on the Daily Team Schedule. If needed, adjustments are made during the daily team meeting to assure that all the work that needs to be done to carry out consumers' treatment plans occurs. This may require some minor adjustments in the schedule. For instance, if a person's primary case manager is scheduled to take the person grocery shopping, but overnight another person that the case manager works with is victimized, the team may decide that the case manager needs to see the person who was victimized and another team member will take care of the trip to the grocery store.

Ongoing Assessment

Ongoing assessment consists of information and understanding gained through day-to-day interactions and experiences between the consumer, team members, and people in the larger community. Sources of information might include observations of the consumer, family, landlords, employers, friends, and others with whom the consumer interacts. This information provides details about the consumer's functioning in everyday activities and the effectiveness of interventions.

A copy of the Daily Team Schedule can be found in *The PACT Start-up Manual*.

Continuous Treatment Planning

Information provided by the ongoing assessment is used to fine-tune the treatment plan on a daily basis. This occurs at the daily team meeting. The daily team meeting process also makes it possible to determine when a treatment plan needs substantial revision and to assign team members to make changes ahead of the regularly scheduled treatment plan review when needed.

Daily Communication Log

The Daily Communication Log is a three-ring binder that is filed with dividers and lined notebook paper. There is one divider for each consumer. During the team meeting, a team member takes responsibility for the Communication Log and reads out each consumer's name in turn. When a consumer's name is read, the team members who had contact with that person during the past 24 hours briefly describe the contact and the outcome of that contact in behavioral terms. The information is written in the Communication Log. Anyone on the team can pick up the communication log and quickly have up to the minute information on the consumer's current situation without having to track down charts. This is a particularly important resource for the person(s) covering the evening shift.

A sample Weekly Consumer Schedule can be found in *The PACT Start-up Manual*.

Coordinating with Inpatient Services

There will be times when, despite everyone's best efforts, inpatient psychiatric hospitalization will be necessary. Hospitalization typically occurs in collaboration with the consumer. When this happens the goal is for the team to make the transition from outpatient to inpatient status and back again as smooth as possible, to keep resources such as housing in place, and to coordinate discharge plans to keep the stay as brief as possible.

Outcome Monitoring

When properly implemented, assertive community treatment reduces the amount of time consumers spend in the hospital. When employment specialists and integrated substance abuse treatment is a part of the program, employment rates and the use of illegal substances also improve. The Outcome Monitoring publication that is distributed as part of the Implementing Evidence Based Practices Project implementation materials for assertive community treatment provide information on how to set up a system for monitoring these outcomes.

In addition to monitoring consumer outcomes, you will need to monitor how closely your program is following the assertive community treatment model. This is done using an instrument called the Dartmouth Assertive Community Treatment Scales or DACTS. Your mental health system may arrange for someone external to your program to rate your team using the DACTS. However, we encourage you to complete this instrument yourself periodically (perhaps quarterly). This will give you a heads up if your team is drifting away from the assertive community treatment model and let you plan with your team the actions you need to take to get back on track.

Another area of evaluation that many teams undertake involves interviewing consumers and family members to find out from them how your team is performing. Some teams may have team members

other than those who work most closely with a consumer conduct these interviews. In other cases, the interviews are done by a consumer or family advocacy group.

Your state mental health system may also monitor certain outcomes or process indicators. For instance, the state may monitor adherence to state standards for assertive community treatment, review treatment records, ask for data on days individuals have been incarcerated, or want information about the number of hours staff spend in different activities. There may also be other information you will need to provide for Medicaid or JCAHO. You should check with your mental health system administrators early so that collecting required data can be built into your program's administrative processes.

Model policies and procedures can be found in *The PACT Start-up Manual*

Written Policies and Procedures

One of the administrative tasks involved in starting any new program is developing written policies and procedures. These should be consistent with Medicaid and JCAHO standards and should cover:

- Admission and discharge (e.g., admission criteria, admission process, discharge criteria, discharge documentation)
- Personnel (e.g., required staff, staffing ratios, qualifications, orientation and training)
- Hours of operation and coverage, service intensity, staff communication and planning emphasizing a team approach and recovery, and staff supervision
- Assessment and treatment (e.g., initial assessment, comprehensive assessment, treatment planning, progress notes)
- Management of consumer services money
- Medication, pharmacy, and medical services
- Informed consent for treatment including medication
- Maintenance of consumer records
- Consumer rights and JCAHO Behavioral Managed Care Rights, Responsibilities, and Ethics Standard
- Program evaluation and performance

Consultation or Mentoring

Developing an assertive community treatment team is a complex undertaking. Establishing the initial processes that need to be in place to provide quality, integrated services requires great attention to detail. It is strongly recommended that team leaders visit an existing high-quality program as part of their preparation for leading a team.

It is also important that once the program has been launched, the team leader not allow the team to revert to older and more familiar ways of doing things that may be more comfortable to them because of their training and previous experience working in mental health programs. We strongly urge new team leaders to work closely with a consultant or mentor who is experienced in running an assertive community treatment program. If such a consultant has not been arranged by the mental health system

that is sponsoring your assertive community treatment program, we encourage you to find one on your own. Two places where you might identify a mentor are:

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

<http://www.actassociation.com>
National Alliance for the Mentally Ill
2107 Wilson Blvd, Suite 300
Arlington, VA 22201-3042
phone: (703) 524 -7600
email: elizabeth@nami.org
<http://www.nami.org/about/PACT.htm>

Part 2. Voices of Experience

Interview 1: Michael Neale, Ph.D., Veterans Administration

It is very important from the beginning to have a sense that assertive community treatment is a crusade. It's a crusade for possibility, opportunity, hope, and recovery in the face of difficulty, stigma, and despair.

Be aware that you're stepping into a revolution in health care. Think about managed care, consumer advocacy, and psychosocial rehabilitation. The Americans with Disabilities Act, also known as the ADA, itself was a revolution - the whole idea of having legislation saying that people with disability have to be treated equally. In addition, there's the information/communication technology revolution. These have all changed *how* services are provided and *where* they're provided. You're going to see a piece of all these revolutions in assertive community treatment, and a piece of assertive community treatment in all of these revolutions.

Congratulations! You're the Team Leader

Many of the assertive community treatment team leaders within the VA have not previously been managers. The typical selection process goes something like: "You look like you're a good person and you've done work in the community. We want to start a program. Congratulations! You're the team leader."

So, now you have to learn to be part administrator and part clinician. In our system, we expect half of the team leader's time to be focused on direct clinical services and half on administrative linkage. Of course, when you're first starting it's more administrative because there are so many details to be worked out: you've got to work with your staff; get sub-processes going within the team; develop certain policies and procedures; do education; and meet with administrative and clinical leaders within your system.

Getting Resources in Place

Assertive community treatment is a crusade to change the way people think and behave regarding serious mental illnesses and the people who have them. The first question is whether the system is interested in joining that crusade. You have to fight *that* battle before you can get the resources for an assertive community treatment program.

The earlier you begin to work with the system, the better chance you have of getting the leadership to understand what's expected and you'll have fewer battles later on. That way the team's energy can be directed toward providing community-based care and not spent fighting about why you need a certain number of cars, or a certain kind of office space, or a social worker on the team, or whatever resource it might be.

It's very important to be sure that resources and people are in place, that they're organized properly, and that you're targeting the right people, developing a system for treatment planning and service delivery that addresses the needs of those consumers, and that you look to see that you're getting the outcomes you want. Within the VA, we use a 'yes/no' checklist to help programs figure out if they have the fundamentals in place: Do you have this, or do you *not* have this? If not, why not? By going over the checklist, people can identify things they haven't thought about or issues that need to be resolved.

Embedded within the checklist are factors and outcome variables that we use to monitor programs. Right from the beginning, we say to the program, “This is what we’re going to train you to do, what we’re going to monitor, and the outcomes we expect. And, if you have big issues with any aspect of this, we should address them up front.” The checklist is a way for the programs to focus from the very beginning on what they’re doing and what they’re trying to achieve. It also becomes the basis for monitoring the development of the team.

Mentors

When resources are in place, members of the team undergo training on the content and structure of assertive community treatment. As part of their training, team members visit a mentor site. The legacy of assertive community treatment is that we’ve all made a pilgrimage either to Madison (where assertive community treatment began) or to some other site that has done this work to see how it operates, to shadow a team, and to see how home visits are conducted. It’s important that people being trained in assertive community treatment have this experience.

At the mentor site, new team members observe a team meeting, and they shadow the team throughout the day. That usually generates a long list of questions. Ideally, the new team stays in contact with the mentor site and has conference calls. The visit is followed by onsite visits to the new program to see that processes and practices are being put in place.

It’s important for people who are planning to do this program to look around to see who they can learn from. It is important to have consulting, technical assistance, and side-by-side support to help team leaders through the process of developing a program. Otherwise, the tendency is for new team leaders to see the assertive community treatment program through the eyes of a traditional treatment provider. While traditional programs have value, assertive community treatment requires a conceptual and attitudinal shift. A consultation structure is very important; if one isn’t in place, try to figure out how to set it up. Contact someone as a consultant, or just ask if you can call him or her periodically.

Program Monitoring

You want to set up a process in which data is collected as part of intake, and implement a regular follow-up process. Within the VA, we do this on thousands of veterans. We have to be collecting data with the right level of detail to catch what we think are interesting and meaningful variables without weighing down the clinical process by collecting so much data that everybody has to spend extra time on it. The goal is to facilitate that process - not weigh it down.

Our monitoring system makes it possible for us to go to our database and look at the services that were provided – not just by the team but by the rest of the system as well. Using that data, we can assess, for example, the impact of community services on hospital use and costs for each veteran. Most state systems have a data system similar to ours, but people aren’t used to looking at it, and they’re not used to asking that the output be organized in a way that can be made meaningful to the team.

We publish a report that includes information on how every team is doing on every variable we collect. We see how the teams compare. We look at the extent teams vary on critical variables. We look to see if any teams are doing particularly poorly, but we also look for teams that are doing particularly well. The latter we look to as centers for excellence.

As part of monitoring, we’re looking at who receives assertive community treatment services. You want to make sure programs target the people who most need their services because these services are relatively expensive and not every one needs services that are this intensive.

Our monitoring in the VA also looks at who provides the services - are there in fact the staff resources available that are supposed to be there? We look at what services are provided; how the staff organizes themselves; where they deliver services; what kind of outcomes they're getting; and what it's costing.

In addition to monitoring whom the program targets and how it's set up, we also conduct consumer interviews at the very beginning when a person first enters the program, at 6-months, and then at a year. After a year, interviews are conducted annually. At each of those points in time, the team also assesses how a person is doing in the program, and what services the program provided. Then, each fiscal year we ask each team to give us an account of which veterans are still in the program, who has been discharged, and any big events that have happened on their team.

There are two basic reasons for monitoring: one is to provide feedback so that adjustments can be made if the program isn't achieving expected outcomes; the other is to check to see if the program is eroding. There's a lot of pressure on people who provide assertive community treatment services to increase caseloads, reduce staffing, and to do things in as minimized a way as possible. That pressure tends to eat away at teams: staff get pulled away, positions don't get filled, or all of a sudden you have double the caseload you're suppose to have. This undermines the fundamental principals of intensive community-based services.

One of the reasons this happens is that ACT programs operate in settings dominated by traditional mental health programs. Within the VA, most administrators learned mental health work in a traditional service delivery model. Even programs at CMHC's use a traditional model (e.g., day treatment, inpatient care, outpatient office-type services). They're not really familiar with or trained to do services where the quintessential work is done out in the community.

Monitoring how programs are structured and how they're operating echoes the original assertive community treatment program in Madison, Wisconsin. Once the first assertive community treatment program demonstrated success, there was an initiative to replicate it. Bill Knoedler, one of the originators of the model, realized that while various sites were operating programs that they thought replicated the original program, there were differences between the programs. He said, "Okay, you're talking about *this* over here, and someone else is talking about *that* over there. You're both saying you're doing the same thing, but you're not. Let's come up with some consistent way to describe what's being put in place."

The key elements of what Dr. Knoedler and others thought was assertive community treatment were put into a standardized checklist that evolved into the Dartmouth Assertive Community Treatment Scale or DACTS. There are about 20 elements measured by the DACTS using Likert-scale items. Greg Teague and his colleagues used the measure to see which programs had better outcomes. Although the results aren't definitive, it certainly appears that teams that adhere to more elements described in the DACTS tend to do better and have better outcomes.

Getting Connected

A lot of this work is about connections - connections between team members, between consumers and staff, between consumers and family members, and connections with other agencies so they understand how your program functions and you know how they can help you. And, potentially it's about connections that generate new resources. In our system, we've had occasions when new teams got going and when folks in the community learned about the team, they'd say, "You know, if you guys are going to do this, I'll give you a house, or a group of houses, or jobs." When people see there's a reliable structure out there willing to help, they're often willing to pitch in, too.

New teams have the luxury of time. Some of that time can be used going out and getting to know your community: the storekeepers, law enforcement, other agencies and providers, church programs. Introduce yourself; describe what you're trying to do so you're not seen as aliens in the real world out there.

In the VA, we're very hospital-based, but we also have outpatient clinics that need to be educated when a new program starts. In another system, it might just be the mental health people at the CMHC, or you might start dealing with the benefit people in your area, or with state vocational rehabilitation people. You need to have their phone numbers, directories, and fax numbers, and they need to have yours so you can communicate. You need to learn what resources they have to offer and they should know what services you're going to provide and how someone gets into your program.

You'll also want to invite people to participate in a meeting with your staff, particularly when you have relationships with emergency people or other service teams. You might either go to their program or invite them to come to your site.

Finally, have people in leadership accompany you on home visits. That's the best way for people to get an idea of what you're taking on. People will feel uncomfortable about it and it's easy to say, "Oh, she's too busy. She's a department head." I think it's easy to bail out on this process and leave it to clinicians to take care of everything, but certainly leaders should be able to spend an hour or two to see what their staff and consumers are doing.

I also encourage people to set up structures for information flow, whether its email groups or conference calls, to link with other teams or consumer-community advisory groups.

Sharing a Caseload

It's very easy for people to say, "Oh good, we're going to do community-based treatment. Here's my 10 people, there's your 10 people." That's not a good idea because if you leave, then your 10 people are my 10 people. So, the caseload is shared. That doesn't mean that everybody does everything (although there's definitely an element of generalization of skills), but that the individuals receiving services are connected to the team and not just one person. They may have a favorite person, but the *team* is the factor. That way, the absence of a staff member doesn't become the basis for a dramatic upset.

It's tricky to move people away from 'owning' consumers. One thing that helps is to repeatedly articulate the differences in people's skills and how those skills can be combined to better serve the consumers. Team members will have different skills, talents, and experiences that have nothing to do with their formal training. When you get out in the community, your professional training may take a back seat to your life experience and your innate abilities. For instance, some people may be particularly good at skills training even though they don't have the same degree as another person. It may be the way they relate to people or because they know about teaching. You want to know what skills your team members have and make sure you have a mixture of what you need on the team. That involves more than just saying, "I have a nurse, a social worker, a substance abuse specialist, a psychiatrist, psychologist and a rehab worker." You're looking for people skills, and relationship skills, and people who are good at dealing with legal issues, or issues that come up around housing. Everybody on the team needs to have some of each of these skills, but there are people who will excel in some areas.

To move people toward a shared caseload, you have to communicate the rationale that we're doing this because it's a way for everyone on the team to participate in a person's care. It *truly* puts the

skills of a multidisciplinary team in the service of the consumer. It's very different from a multidisciplinary model where the person just has a social worker unless he or she has a medical appointment; or the person only sees a doctor unless he or she needs to apply for benefits.

The idea is to create a team that works together and maximizes its specialties, but at the same time, there's less specialized tasks - going shopping, taking people to set up a bank account, meeting with a landlord. There are certain things that have to happen that are related more to the staff's personal experience than their professional training, not that you couldn't be better trained and more effective at those things, but they call for a more general approach to life rather than highly specialized training.

In addition to the generic aspect of what everybody has to do, there's an expectation that team members strike a balance between the specialty work of their particular disciplines, and what they can train others on the team to do that's related to their discipline. Early on in a new team, you may want to have people do home visits in pairs, teaming up people from different disciplines. What happens is that those people cross-teach each other. The social worker asks questions that are different from the questions the nurse asks; the nurse asks questions that are different from the ones the social worker asks. Each person gets to know there are things he or she needs to monitor even though they're not specific to his or her discipline. That doesn't mean the social worker all of a sudden tries to practice medicine, but there's an extent to which all team members can monitor signs and symptoms and relay that information back to the team.

Looking Down the Road

Sharing caseloads can be tricky. If you're not as good as I'd like you to be, I might have to tell you that. Or, you might have to tell me I'm not as good as you'd like *me* to be. Or, what if I might tell you what I think's going on with a person or what my guts are telling me and you discount it or tell me I'm naïve or uninformed.

Not only do we place ourselves in a more vulnerable position with our co-workers, but also we're more vulnerable with our consumers. When you turn the wrong way down a one-way street with a consumer in the car who says, "You know - I've done that," you've allowed your consumer to see you as another person who can have problems just like he or she has. That vulnerability is a very essential piece of the work.

But, that vulnerability is also a double-edged sword. When you're working in the community, you don't have little buttons to push and you don't have a crisis team around the corner, and you're not likely to say, "Hey, wait a minute, I'm going to restrain you." You have the same thing anyone else does. If there's a major problem and you can't de-escalate the situation, you can dial 911 or you can run. It's not that you particularly need to do those things, but there's an awareness of greater vulnerability.

Not all people diagnosed with a mental illness behave or act the same, but some can look or sound a little scary, and some of the places some consumers live might be a little frightening. At first, going out in the community individually or even in pairs can be a scary process. For many people, the most anxiety filled thought to begin with is: "Can I press that cell phone button fast enough?"

The truth is, people who experience psychiatric symptoms are just people. They're not predisposed or wired to go running around beating people up. There may be people who use aggression as a coping strategy and that may need to be dealt with through behavior modification or even, potentially, the criminal justice system. But that's a minority. Most people are friendly and want the support you're offering.

What the team really needs to be thinking about is what they can do to keep issues from coming up in the first place. It's like driving: if you only focus on the steering wheel and immediately in front of the car, you may miss an important road sign or the congestion on the road up ahead. The best way to drive is by checking what's ahead. Not that you ignore what's right in front of the car, but you have to look down the road.

Even though we're talking about a minority of people, the risk is that team members who may not be expecting difficulties will get in over their heads. That's why you need to think ahead, do careful assessments and treatment planning, and trust your guts. As a team leader, you also have to create an atmosphere where everybody's free to express when they're feeling anxious and concerned, and put that on the table. That's why you have a team process rather than individuals functioning solo.

In your assessment, you want to know if somebody has a history of assaulting people, but that doesn't mean a lot. If you sufficiently antagonize anyone, that person could assault you even if he or she has never before assaulted someone. And, that's usually the basis for incidents that occur - setting down limits or walking into a difficult situation and trying to impose limits.

So, what you want to do is say, "I need to get to know this person in a situation like an interview or in a neutral location and find out how he or she responds to different things," and the team needs to share information about that sort of thing. A key feature of assertive community treatment is the cohesiveness and communication of the team. When the team is anticipating a visit to a difficult person, you want to know if he or she has weapons. If there is a weapon, has it been an issue in the past? If it has, you might talk to the person about that. If there are weapons in the house, will they be out? If they are out, you might propose meeting somewhere else.

It may not be your consumer who is the concern but, people in the consumer's environment. You'll want to get to know the neighborhoods and communities where your consumers live. If you know that in a certain neighborhood there's likely to be drug dealers sitting outside, you might ask the person to meet you at the door. That way you can go in together with the consumer, so you're not seen as a person who might be law enforcement and therefore a threat to the dealers. It all depends on the nature and circumstances, but you're trying to anticipate what it's going to be like when you're there. The more you do it, the easier it gets, but when you're first starting it's worth nibbling around the edges to get familiar with your communities.

As you get to know people, you'll get to know when they're acting as if they aren't taking their meds or they're getting more irritated. When you see that happen, you will want to time your visits differently and use phone calls differently. You can have the person communicate to you. You may have him or her leave a phone message or send an email. You might want to anticipate what the weekend will be like. Rather than just waiting to see what happens, you might ask the person, "How are you going to handle yourself this weekend when you meet with this person? Do you need to call somebody after that or do you want me to set up something?"

There's a lot of looking down the road to prevent things. There are still many things that are going to come up that you can't anticipate, but you do the best job you can and it gets better the more you have a multidisciplinary perspective.

Assessment and Treatment Plans

The stigma of mental illness is ever present - not just in our community; not just on TV; but also in ourselves, in our fellow providers, and in the systems we work in. It can be found in the way we talk about people; when we include them, and when we don't.

The tendency has been to treat people who have a mental illness differently, to isolate them, and to dictate to them. When you do an assessment, you need to ask yourself if you're assessing the person from where they're at, or are you saying, "This is how we operate." "This is the way things are supposed to be." "This is what you're supposed to do next."

I think many folks fall into 'pigeon holing' people when they do an assessment. It's partly because that's how we work as humans. We categorize things and pigeon hole things. If you start doing that with people, it's not therapeutic, it's not beneficial to them, and it disrespects their individuality and rights.

An in-depth, comprehensive assessment that looks at each person in context and considers his or her preferences and goals is an important part of assertive community treatment. You can't do this all at once. It takes a bit of time to get to know where someone's strengths lie, where his or her weaknesses lie, and what that person's hopes and aspirations are.

To illustrate how an in-depth community-based assessment differs from other assessments, I often ask people to imagine the information they get about a person in an inpatient setting and what the advantages and disadvantages are for learning about people and helping them to change their behavior. Then, I ask them to think about day treatment, then outpatient services, and finally community-based services. Community services have the advantages of flexibility, intensity of services, seeing things as they happen, seeing who is facilitating something or interfering with something, engaging other people to help, and you can do this over time. Other modes of treatment don't have these advantages. They're either artificial or so stress inducing what you see in the way of behavior is not particularly where that person's really at. The setting is driving it. If you wanted to stress someone out just to see how they handle it, put them on an inpatient unit, give them a set of rules, and tell them they have to follow them or they lose privileges.

A thorough assessment paves the way for the team to develop a treatment plan that addresses problems, in context, based on the priorities of that period. The treatment plan is flexible, it isn't cast in stone, and it isn't a template. We all know the standard lingo: "Will deal appropriately with peers," etc. That leads to a repetitiveness that's not connected to what's going on with the patient.

Consumers can be overwhelmed in a big meeting so, after the treatment plan is developed, we have the person's primary contact person on the team and maybe another team member sit down and say, "Look, the team has gone over this and this is what we're thinking. Let's talk about this and see how you feel about it." And we make sure there's a comfortable understanding there.

Several times a year, the consumer gives feedback on the program as part of the follow-up assessment. We also assess the therapeutic alliance between the consumer and staff. The staff knows if their alliance scores and satisfaction scores are going down. If that's happening, there's probably some miscommunication. There are other ways you'll know if the consumer doesn't feel like they're being heard: they'll leave, they'll act out, they'll go in the hospital, or they'll look for treatment elsewhere.

Hopefully that isn't an issue because you're basing the treatment plan on what folks want to accomplish and what you're trying to do is help them do what they want to do. You have them sign the treatment plan on that basis. It's not like having them rubber-stamp what you've decided to do.

To have meaningful and effective treatment plans, you have to have a cohesive group that meets regularly and that systematically reviews the people in the program, ensures the treatment plans are put into effect, and that they're revised if they're not appropriate. It's a much different approach than doing a treatment plan, than setting it aside and dealing with current events, and then coming back 6 months later and saying, "Did we do any of this stuff?" This is where you'll see the subtle, insidious effect of increasing caseloads. What you should get with an assertive community treatment team is attention to detail and consistency over time so you have a basis for judging how people are doing, what kind of changes need to be made in the treatment plan, and how far you can go.

The Daily Meeting

The spine of treatment is translating the treatment plan into services on a day-to-day basis. This process begins with translating the treatment plan into a monthly or weekly schedule of services for a particular person. We use a monthly schedule because it's a calendar. You have a blank calendar for each person for each month that lists the scheduled contacts based on the treatment plan, and it says whose going to be there, when they're going to be there, and what they're going to do. And, to facilitate the shared caseload, it isn't always the same person.

In the daily morning meeting, we take the services listed for that day on the monthly calendar and integrate them with the available resources on that day (who showed up) and with the real world. For example, you might find out that the night before someone called because he was thrown out of his house and the team needs to help him. Unplanned things come up that have to be accommodated. That's what the team meeting is about. Your making sure that everything that needs to happen that day, does happen.

You are also making sure people have the vehicles they need. Sometimes you may need a van for an activity at one point in the day, so you need to have that free. That means the person that starts the day with the van has to come back and trade it for a car.

There's a bit of fine-tuning based on who can do what or based on who can help with what. If there are two things in a particular geographic area or someone needs a 'reminder' a team member might say, "Since you're going to see him anyway, would you bring this paper with you."

That's the essence. That's the art of laying out the work. Of course there's traffic jams and stuff that comes up all of a sudden - like maybe someone's suicidal and you have to spend half a day with them. You need cell phones and the capacity for communication so you can make adjustments when they're needed. However, having developed the schedule and having gone through it, you'll know who's going to be where and when.

Building a Cohesive Team

You have to have a cohesive team and communication is a very important part of that. You have to be comfortable saying what's going on in your head and your gut. If you're not able to do that with the team of people you're working with, you're not going to be providing effective services.

It's particularly important as you're bringing people in early on to establish the norm of open communication. The team leader can model this by saying, "I don't know what's going on here. I can't figure this one out. What are we going to do about it?" By doing that, what you're saying to the team is, "Your anxiety, your concern, your irritation, the despair, is real." These feelings should be on the table...but not running all over it or dominating a meeting. You just put it out there and say, "I heard him talk about his daughter he hasn't seen in 10 years. It was amazing, all of a sudden he was talking coherently and he hasn't done that before." Expressing the feelings that go with the work is

what binds the group and then the group can be more willing to take chances and risks with each other.

The essence of clinical work is being objective. Part of being able to step back is to know where the feelings are and what you're thinking and what the situation requires. That's where boundaries come in and being able to sort yourself out from the situation to say, "Look, this isn't appropriate." The consumers aren't carrying the boundaries, you are.

In the meeting, you need to be able to say, "Let me tell you this one." It's to share with the team what's going on and what your reaction was. It's not to make fun of anybody or to abuse it. It's sharing and grounding. Those episodes and incidents become anchor points and signposts for the team in forming their boundaries and approach. You need open communication and if you have people who are being shut down or who are shutting themselves down, that's a bad process and it's not going to work and the team won't be as cohesive.

It's very important for the team leader to be sensitive to cohesiveness and spend time on it. I try to make sure right from the beginning individuals (particularly someone who seems shy or is a paraprofessional) feel as if they can say what they want.

Cohesiveness is important if the team is going to have a stable membership. Sometimes you're going to go overboard and you're going to be too hung up on one thing and not enough on another. That balancing process is something the team gets better and better at as you go along. But, if that cohesiveness isn't there, you won't go on together because someone is going to leave and you'll have to do a new thing. It's not the end of the world, but the more you can keep that crew of people together the better the team is going to function.

The daily meeting is a key factor in team cohesion. The team needs to renew itself and reassert its cohesiveness, which is what a morning meeting is doing. It grounds you and refocuses you.

Real World, Real Time Interventions

You have to realize that out in the real world - the community- you are going to make smaller interventions and you have to expect small increments of change. But, the changes that occur take effect in the real world. When you work with people in an artificial setting, those changes may not translate to the real world. One of the key features of assertive community treatment is that you can make a difference where it's needed. You can see how someone reacts, process that on the spot, and not wait until the next session a week later or the next hospitalization to talk about it. You have the immediacy of the circumstance and the observational data.

It's All Advocacy, All the Time

Once you start doing assertive community treatment, you become an agent of mental health care for whomever you encounter. It's all advocacy, all the time because that's the mode you go into when you start doing community-based services. You don't know where, when, and how, but you know you'll do it. And you need to. You need to educate everybody; all the stakeholders from yourself to your consumer, family members, others out in the community, other providers, providers on your team, providers back in your system, and community members. It's the whole spectrum of education about what you do, what the potential is for people diagnosed with a serious mental illness and how mental health treatment can work. Essentially, you're trying to change perception and behaviors at every level.

Interview 2: Barbara Julius, Outreach Program, South Carolina

In 1987, the South Carolina Department of Mental Health gave our not-for-profit organization, Palmetto Pathway Homes (PPH), funding to replicate the Program for Assertive Community Treatment (PACT) that operated in Madison, Wisconsin. Until that point, our agency had only operated a residential treatment program. At about that same time, Al Santos, a psychiatrist at the Medical University of South Carolina, received a grant to research the effectiveness of assertive community treatment. The grant allowed Charleston to start two new, separate assertive community treatment programs: the Outreach Program operated under the not-for-profit umbrella of PPH, and the Onsite Program within the Charleston Mental Health Center. The mission of these programs was to decrease hospitalization, increase community tenure, and improve quality of life for people with serious and persistent mental illness.

The first consumers targeted for eligibility were those who were costing the state the most money. These consumers tended to fall into one of two groups. One group was people who had been institutionalized at the State Hospital for many years. Frequently these people didn't have family to go home to or their towns didn't want them back because they had been so disruptive. They had literally been living in the hospital for years, which was miserable for the consumers and cost the state a fortune. The other group was people who had a high recidivism rate. For one reason or another, these individuals had been in and out of the emergency room and the hospital, and tended to have multiple contacts with the police and the judicial system.

As the director of Outreach, I began by hiring staff, and creating the infrastructure to support the new program. The mental health center staffed their team by re-deploying and re-training existing staff, which was a challenge. The director of the Onsite Program was working with people who were accustomed to the "old way" of providing services. The staff also had "old ways" of thinking about what consumers could achieve in their lives. It was difficult at first for the team to embrace community-based services because they were so used to meeting with consumers in their offices once a week for an hour. I had the advantage of getting to start with staff who were new to the program.

When the Outreach Program started, I did not have a lot of experience working with people diagnosed with schizophrenia. When it was time for me to review charts and I began to read about the bizarre behavior and incidents that had led to people being in the State Hospital for long periods of time, I found myself thinking, "Oh no! This person could never live in the community. That would be a huge risk. What about our program's liability? This isn't possible!"

During a consultation with Debbie Allness, a member of the original program for assertive community treatment team, I shared these concerns and I remember her saying, "**If you think this is impossible, maybe you shouldn't be doing the work.**" Her comment was a turning point for me. I realized that if you can't, as a team leader or program director, hold the dream of possibility for another person, then you shouldn't be leading an assertive community treatment team. If you can't envision people who experience a severe and persistent mental illnesses "getting better" and you think they'll require constant supervision, then why do assertive community treatment?

Admitting and Assessing New Consumers

As the process of finding consumer candidates began, we used a printout from the State Hospital which listed the number of days consumers had spent in the hospital over the last few years. We

used this rather than the number of hospitalizations because some consumers had only been hospitalized once, but the hospitalization lasted for months or years.

In the early days, our intention was to weed out people who had a primary diagnosis of substance abuse, those with profound mental retardation, and people who were sociopathic. Many of the people who were admitted to our program had some history of violence or problems with the law. That alone didn't dissuade us. The question was whether the problems were related to their illness or whether they had been violent or committed criminal acts when they weren't sick.

After we examined the consumer's chart, we talked with hospital staff, social workers, attendants, and therapists. Eventually, I would meet the potential consumer to introduce myself and describe the program. The hospital staff would also help to prepare consumers for our program. Sometimes we would arrange for the consumer to come to Charleston to visit before they were discharged from the hospital. We also got permission to talk with relatives and other significant people in the person's life so that we could lay the groundwork for a smooth transition.

Most consumers were thrilled to get out of the hospital. We found out that, over the years, some people had formed very close relationships with other consumers and staff at the hospital and we had to respect these. We found that after the initial excitement of being discharged was over, being alone and "independent" could be pretty lonely and stressful. To ease the transition, we would often take people back for visits at the hospital to see their friends when we interviewed new prospective consumers.

Each consumer who left the State Hospital had a unique situation. Some had been institutionalized so long, they didn't have the skills needed to take care of everyday activities. In these extreme cases, an option might be to start by placing the person in a board and care home knowing the ultimate goal was to move them quickly into an independent living situation. For others leaving the State Hospital, we were able to immediately find them an apartment and provide the support required to transition into the community.

Day-to-Day Team Leadership

The day-to-day running of an ACT program is like a dance in the sense that there are a lot of things going on at the same time. A critical part of running an ACT program is creating a cohesive team. To that end, staff didn't have individual offices; all work was done in a large meeting room. The theory behind this is that when staff members are in close contact with each other small pieces of information about consumers are exchanged in casual conversation. Also, because most of the clinical work was done outside the office, it wasn't necessary to have separate offices. There were rooms available for private conferences and the physician and some support staff had individual offices but the team operated in a shared space.

Every morning the team would gather around a large table and do "rounds" by reading through the cardex. The cardex was a working document that held a schedule and monthly treatment plan for each consumer. During the day, if a clinician scheduled an appointment for a consumer, it was noted on their cardex. As the group leader, I would move the meeting along. As each consumer's name was read, we quickly reviewed that consumer's schedule. Some consumers might just need medication delivery, others might be scheduled to go grocery shopping, spend time cleaning their apartment, or meet with a landlord to talk about a complaint. Not every consumer had something planned each day.

As I read off the "to do" list, somebody else would write down what needed to be done for the day on the team schedule. During the meeting, staff quickly reported any potential concerns,

observations, and alerted the team to any problems. Complicated, non-emergency situations were put on another list to be covered in depth during a weekly staffing. In a well-run meeting, it took about 40 minutes to cover 130 consumers.

After going through the cardex, assignments were made for the day. Our program was under a lot of pressure to “capture time” through Medicaid billing because it was our only source of income. During the morning meeting, as the team leader I was thinking about which consumers needed to be seen, who on the team could best provide a service, who could capture billing for what, and whether a variety of staff were having contact with the consumers.

Usually one of the nurses would stay in the office to assist with any “walk ins,” dispense medications, or give injections if necessary. If it was a day when the doctor was in, the nurse would assist with medication changes. This might involve working with a pharmacist to order a new medicine in a way that Medicaid would cover the expense. If the program held medicine for a consumer, the nurse would meet with the consumer weekly to assist them in filling their “med-minder.” This would be an opportunity for the nurse to teach people what each medication was, to get feedback on side effects and, in general, assess how the person was doing. The “in-house nurse” also had the task of coordinating and labeling small packets of medication that were taken from individual med-minders so they could be delivered by the staff that evening and early the next morning.

Initial Assessment

When someone comes into your program and you’re taking total responsibility for their well being, the first needs you look at are the primary needs – food, clothing, shelter, safety. Where are they living? Are they sheltered? What medicines are they taking? What about their health? What are they eating? The needs we determined at that point would begin to shape our interventions.

When a consumer first entered the program, the first thing we would do is send somebody into the community to do a clinical assessment. Usually it was a nurse. It wasn’t so much that we needed the nurse to do a psych assessment but we needed the nurse to find out if there were medical problems.

Many of the consumers in our program had been living on the streets and had no resources. Coordinating care and acting as a liaison and advocate involved making sure entitlements were in place and working with the homeless shelter to find housing and guarantee that the person’s medical needs were getting attention.

Our initial visits helped new consumers become acquainted with the staff and program. Most visits took place in consumers’ homes. In a very short period, an appointment was set up for the doctor to see the consumer – either in the office or in the community. We were lucky to work with a doctor who felt comfortable going into the community, wherever that may be - under bridges, in dangerous neighborhoods, or in the hospital.

Quite often, one of the staff would bring the consumer by the office, introduce him or her to whoever was around, and begin to familiarize them with the program. For some consumers, this initial visit was very difficult; particularly for those who experienced paranoia or who didn’t think they were ill. It might take weeks with these individuals to build enough of a trusting relationship with a staff member, that they would be willing to visit the office.

A Period of Re-Learning

When consumers had a history of going in and out of the hospital, we often found that their lives were largely defined by being “sick.” There is usually extreme chaos that surrounds such lives. We

would often find that people's family had often become their social workers, friends, or police rather than just being able to relate to the person as family. Some families had given up hope of being able to help their loved ones. We also often found the consumers who were admitted to our program had pending legal charges. Many had "friends" who had exploited them in one-way or another. Sometimes, consumers had learned that when life became too overwhelming they could use the hospital as a place to "crash" and knew how they needed to behave to be admitted.

For a number of individuals, our program would begin by taking on the bulk of the responsibility for meeting their needs. We would encourage them to give their systems a chance to recover and focus on having them get used to a lifestyle that wasn't driven by being 'sick'. This period of re-learning allowed people to build confidence and hope. It was an opportunity for the person to relax and open their eyes and once again see the world around them.

We started with the basic needs – food, clothing, shelter, and safety. Until there was a period of stability, we might deliver medications to consumers, take them shopping, and meet with them to plan ways they could spend their time. During this initial period, we might see consumers at their homes or in the community five times a day and then give them a call at night to check in and say hello. Since our work was focused on supporting people so they could care for themselves, manage their illness, and build a life in the community, as a person got better, we gradually withdrew our support. For instance, if the team was delivering a person's medication twice a day, we might start dropping off the evening medicine and leaving the morning dose for the person to take on his or her own. Then, the next morning we would call them to make sure it was taken.

There is no perfect path to recovery. Some people did well for a while and then would think they were 'cured' and stop taking their medicine. There would also be times when people wouldn't want to take medications at all, or they would be abusing street drugs, or getting into arguments with their landlords, or wandering around and getting into trouble. Despite everything, consumers were never "fired" or transferred somewhere else because they "failed" or were "noncompliant" in anyway.

There were times when individuals would need to be hospitalized. Staff would work closely with the consumer and hospital staff in these instances to assure a smooth and comfortable transition. When someone went into the hospital, an Outreach staff person would attend hospital rounds to offer help and insight. The hope was that by coordinating care, the hospital stay could be less upsetting to the consumer, the stay could be shortened, entitlements could be kept in place, and there would be a home and place for the person to be discharged.

Time-Unlimited Services

One of the premises of ACT is that the program is there for consumers "for life." Working with a consumer across time is really a luxury and privilege. Because you have time, there is less pressure for a quick fix and you can forge an alliance that respects the person and their individual needs and preferences. For instance, if someone did not like a medicine he or she had been prescribed for some reason, we would change it or see what else was available. Together with the consumer, we learned what worked, what needed to be fine-tuned, and what needed to be set aside.

Because of the long-term relationship that develops between the consumer and the team, a critical task that a team leader has to do is have the consumer bond with the team and program rather than with individual staff members. Many people who receive assertive community treatment services will need support for the rest of their lives. Of course, that support may get to a point where it's very minimal as people recover, and are able to do things they value. Over time, people may reach the point where they only come in once every three months to be seen by the doctor for a medication

check. Staff on the other hand, come and go and if a person has bonded with just one person, it's difficult when that person leaves.

Consumer-Staff Relationships

There's perhaps a tendency for professionals on an ACT team to develop closer relationships with consumers than in office-based practice because you're in people's homes and lives in ways that are more intimate. Therefore, it is particularly important for the staff to maintain their integrity and sense of who they are as a professional. Some boundaries are inviolate: you do not have personal relationships with consumers outside of the context of clinical intervention. But, in other ways, boundaries may be different from what mental health professionals are used to.

The team leader tends to set the general tone for staff relationships with consumers, but to some extent, boundaries are personal. For instance, because I'm a person who likes to bring people into my life I don't mind consumers knowing about my children, my pets, what I like to do in my free time. I think that sharing these sorts of personal things helps the consumer to see him or herself relating to someone in a role other than that of patient. That's what I'm comfortable with. Other staff were more private or shy and maybe even a little reserved in the way they interacted with consumers. These differences are perfectly okay as long as staff care about and value the consumers as individuals.

Relationships are very important to the success this program. Staff develop relationships with the consumers that are more than the traditional mental health relationship. In the traditional relationship, a consumer comes to your office and sees you for an hour once or twice a week. In an assertive community treatment program there's much broader involvement in the sense that staff are taking consumers places in their cars, meeting their friends, meeting parents, dealing with their children, talking to their medical doctors. All of these things bring us closer to the consumers over time.

Call

If you're running a smooth program, you shouldn't have many after-hours calls, so being called really isn't a burden. Some people might be worried that they're going to be called all night long. If you are doing your job right during the day, you are going to have a very quiet night.

It is important to help consumers understand that call is for emergencies. I discouraged consumers from using calls for trivial things like whether they should make a hot dog or a hamburger for dinner. What we would do instead is to put 'pre-emptive' on our 'to-do' list for the evening staff. For instance, we might do this in cases where we knew a consumer was not doing well and we wanted to check on them, or to remind somebody to do something. If there was someone we thought just wouldn't be able to resist calling an "emergency" at three in the morning, we might make a call to them at nine o'clock just to ask if they were okay and see how things were going. We tried to be proactive rather than reactive.

When there were true emergencies and staff had to go out to work, we always had them call the backup person who was either the Assistant Director or myself. Everybody had phones and beepers. Naturally, we were concerned about safety and unless the staff knew the consumer and their surroundings well, the backup person would go with them. If a staff person went out on call alone, we would stay in constant contact. It was often the case that the on call person would be contacted after the police or local mobile crisis team had been pulled into a situation. Because we had good working relationships with them and were known in the community, these events were handled quickly and smoothly.

Team Members as Investigators

As a team leader, one of the important things that you have to do is be an investigator. It isn't always apparent why a consumer begins to experience an increase in symptoms. After going through some of the common reasons, (the person stopped taking a medication or is using drugs) you start thinking creatively about the whole picture. For instance, we had a consumer who had been successfully living on his own, but then his life started getting out of hand on a regular basis and he would wind up in the hospital in a manic state. We knew he had been taking his medication, he loved where he lived, he had many friends, and he was happy with the program. We were stumped and the multiple hospitalizations were taking a toll on him. They seemed to be happening more frequently and he was having more difficulty bounding back.

To figure out what was going on, we went back through his records and made a timeline. That helped us to detect a pattern.

It turned out that this individual was diagnosed with schizoaffective disorder. He was also a heavy smoker and had bad asthma. As we charted the timeline, we saw that when he had an asthma attack he would use his inhalant. The inhalants tended to make him feel 'wired' which, in turn, led to him smoking more cigarettes. As he got more wired, he would move around and do too much which worsened his asthma, and eventually everything spiraled out of control.

We began to identify contributing factors like which months were particularly bad. and found that when he cut the lawn for his mother an acute asthma attack would occur. Once we saw the pattern, we shared it with him. Then we formulated a treatment plan where we held onto his cigarettes and gave him a pre-determined number each day. He agreed that if he was up to three spritzes of inhalant a day, he would need to go to the hospital *before* he was in an acute manic state. Over time, he was able to break the pattern that we had observed.

Timelines helped us participate with consumers to get a picture over time of their life and illness. When you recognize the patterns, you can work consumers to think about ways of changing those patterns.

One of the most important things staff, consumers, and their families need to learn is how to identify the consumer's pre-morbid symptoms. What are those very small things that begin to occur that tip us off that consumers might be beginning a relapse? For some reason, those small characteristics are usually the same. If a person gets ill and becomes delusional, their delusion is always the same. For consumers who become manic, there are subtle changes that you and the consumer need to learn to recognize. Once, our team worked with a consumer who would fill small glass dishes with colored water and build amazing structures with them when he began experiencing manic symptoms. Everyday the structure grew and got more elaborate. It got to the point where we recognized that when there were three colored dishes on the table, he needed to be seen by the doctor for a possible increase in medication.

Medication

In order to work with people diagnosed with a severe mental illness, you have to know about medications. Even though the social workers on the team didn't dispense medications, they had to know about the medicine, dosages, side effects, and the types of changes to look for. We not only had to deal with psychotropic medications but frequently consumers were taking other medications for a variety of reasons.

When there was a medication change, it was reported during the morning meeting. Whoever took the order would make a note on the consumer's cardex so the team would be aware of what to look

for in the way of side effects. During the morning meeting we could talk about why the medication had been changed and the staff would know to check on how the consumer was feeling, and whether they were getting better or worse.

Some consumers would not be taking medications when they entered the program. In many cases it wasn't that they had made a decision not to take medication, but because they couldn't keep up with refilling prescriptions, or the way they were supposed to take the medication was too hard to remember, and the whole process was too confusing and complicated.

If you think about it, Medicaid pays for three prescriptions a month. If, those three prescriptions were used for psychotropic medications and, say, an antibiotic, and a doctor prescribed a medication for another ailment, how would you get it and pay for it? Our nurses were able to organize the medical regime so that orders could be staggered and they worked with the local pharmacist to bulk order certain items.

The program might begin by "housing" a consumer's medicine. However, consumers would come in and organize their medication minders. This was an opportunity to educate consumers about the medications they were taking and to create an alliance. I would say that within one year to three years, most consumers progressed to the point where they could come in, fill their med minders with a week's worth of medication, and take it home to take on their own. Naturally, there were those folks who could handle their medication regime just fine and we had no need to help in that area.

There were also people who just didn't want to take medications because they didn't like them or think that they benefited from them. In those situations, we would respect their choices and focus our work on other issues the consumer might have (i.e., housing, transportation, etc). Even though a person might choose not to take medicine, we continued to support them in all other ways and, if they become psychotic and were a risk to them or someone else, we would arrange and coordinate hospitalization.

Some people would come to realize that when they didn't take medications, they would get sick and end up in the hospital. They began to recognize what being hospitalized costs them - not money wise, but in terms of the disruption to their lives.

For people who took medication, a big part of the process was working very carefully with the psychiatrist to triturate medications and find which medications had an optimal effect. With ACT, you have the luxury of time to be respectful of people's needs. I remember a consumer who just hated Lithium, but it was the medicine that seemed to do well for her in terms of her mood. She disliked it because her skin would break out. We worked with her for 15 years and many, many, many times we worked closely with her to switch her medicines around to give her a break from Lithium.

Sometimes, we would feel strongly about not wanting to change someone's medicine - particularly when we had been witness to repeated episodes of acute symptoms. One of the costs of continued psychotic breaks is that it often takes longer for the person to get back to baseline (one's optimal health) and there can be cognitive decline following a severe break. It just gets harder for people to bounce back. For some people the risk of fiddling with their medications was so huge that we might really try to discourage them from changing their medications. In the end, however, we respected their choice.

Housing

The need for housing is a need that never goes away. The team has to be prepared for a lot of moving. One piece of advice I can give is to encourage your consumers to sign up for housing programs as soon as they come into the program. Even though the wait may be years, time goes by and before you know it the consumer is eligible for affordable housing. Until then, be prepared to help consumers move!

Over the years, we tried many different things. A friend of mine in Charleston started a not-for-profit organization called the Humanities Foundation. Her husband was a real estate developer and she partnered with Volunteers of America. They would build low-cost housing and then Volunteers of America would come in and run it. Some of the consumers were able to take advantage of this option. Another thing we did was to try to set up roommate situations. Sometimes we would rent houses and try to put three people together, mostly to keep costs down so housing would be affordable. At one point, our agency owned a home that had four bedrooms. Four of the consumers being served by the program moved in there together, but it began to feel like a program and we realized it wasn't optimal; after all, we were trying to move away from the institutionalized setting to a more normal situation.

Working in the Community

Frequently the consumers in our program lived in neighborhoods where there was a lot of drug activity and crime. There would be times when consumers would be exploited. Some of our female consumers were involved in prostitution and there would be pimps in their homes. Drug dealers might hang out in someone's apartment to do their transactions. In return, the dealer might make drugs available to the consumer.

There were situations where we asked the police to help us. We would coordinate our visit so that before our staff arrived, the police would do a couple of "drive-throughs" to scatter the drug dealers. Then the staff would drive up, do what they needed to do and leave. If staff felt frightened about going to a particular place, they might take another team member with them.

Of course, what constitutes a 'bad' neighborhood depends on who you are, where you're from, and what you've done. My background was with Hospice, so I was comfortable going to lots of different neighborhoods. What I found working for Hospice is that neighbors know what is going on with people. They know who is sick and needs help. They are usually grateful that the person is getting the help they need and will be your allies. Neighbors can let you know about potential problems, provide support, and help you locate people if necessary.

Celebrate Success

It is also important for the team leader to help the staff keep perspective. Progress can seem very slow and it can be difficult for team members to see the progress individual consumers are making on a day-in, day-out basis. The team leader helps the team focus on the positive by pointing out progress. For instance, it might seem to the staff that a consumer is making little progress and continuing to go in and out of the hospital. Yet, when you count the number of days he or she spent in the hospital since entering the program and compare it to the year before, you see the person was hospitalized 50 days less! That's when you celebrate and acknowledge that you're making a difference. Remember to look at the whole picture. Maybe success means that the consumer has a friend, or stayed within their budget for the week, or only called after hours 5 times in a week instead of 50 times. For staff who want to see a quick fix, this is the wrong job.

Interview 3: Dawn Petersen, MS, Gulf Coast Treatment Center

Teaching versus Doing

Assertive Community Treatment is about teaching people to be more independent. You need to adopt the mindset that, 'I'm going to teach somebody something today', rather than "I'm going to do something for somebody today." Teaching people is what helps people become more independent, gain self-esteem, and gives them a sense of what they are capable of achieving.

Assertive Community Treatment is about teaching people how to manage their symptoms so that they can advocate for themselves and take control of their lives. The goal is for consumers to be in charge of their recovery. It is very exciting when a consumer reaches a place where he or she can say to the doctor, "You know, my depakote level was 35 last week and I haven't been feeling well. I feel like I'm starting to get depressed again, what if we increase my depakote?"

We know that in the long-run people are going to have some really good periods and they're going to have some really bad periods. We're going to like them no matter what and we're not going to kick them out of the program because they're going through a bad period. We're going to work with the person to figure out what's not working and come up with something that will work.

I want to emphasize that assertive community treatment is looking at *every* aspect of a person's life. If a consumer has diabetes, we're going to work with that individual to figure out how he or she can get whatever support is needed, and if the support isn't available, we're going to figure out how *we* can provide it. We're looking at how the person is interacting with their peers, their family, the social aspect, and we're doing what fits each person's goals.

ACT Tools

The most important thing a new team leader needs to understand are the tools of assertive community treatment. By tools, I'm referring to timelines, comprehensive assessments, consumer-centered treatment plans, the daily/weekly cardex, the daily schedule, the communication log, and the daily team meeting. The team leader is the person responsible for making sure these tools are used. Initially, it can be very difficult to get into the routine of making sure team meetings occur every day, that timelines are done, and comprehensive assessments are pieced together. But once you have these tools in place and you're using them the way they're supposed to be used, you become very efficient and you can do more than you ever thought possible.

One of the things that new team leaders sometimes have a problem grasping is the way assertive community treatment programs do assessments. From a clinical perspective, the quality of the assessment and the thorough evaluation of the outcomes of contacts with consumers is what really makes a difference.

The assessment process starts with a historical timeline. The timeline is a tool for doing 'detective work'. What you're doing with the timeline is piecing together a person's life history. It's likely that no one has ever taken the time to do this before. You start from the time the person first started to have unusual behaviors. That could be when the person was 9, or 17, or 25. The timeline helps you identify the pieces that are missing so they can be tracked down.

Another tool is the comprehensive assessment. The assessment process occurs over a 30-day period. It's not a 'sit down' assessment; instead, you're gathering information in a casual environment while you're helping an individual meet his or her basic needs. It may be while you're at the grocery store

or while you're helping them look for an apartment. Many times, you get a lot more information if you just do a lot of listening and get out of the office atmosphere. When you piece together the comprehensive assessment it looks very structured, but gathering the information occurs informally. The comprehensive assessment is completed within 30 days, but assessment is really ongoing because you're gathering pieces of information as you work and, even after the initial 30 days, you can continue to add information to your timeline and assessment.

Once you have the assessment, you start finding out what the consumer wants in his or her own words. You're asking the person: "How are we going to get to these steps?" "What are you willing to buy into?"; and "What can we do for you?." The actual plan is what the staff is going to do and a schedule for doing it. We might decide that every Monday we're going to do 'X', and every Tuesday we're going to do 'Y', and every Wednesday we'll do 'Z'; and everything is treatment oriented to keep people moving towards their goals.

The nice thing is that if the plan isn't working, the team comes back together and says "What are *we* doing wrong, how can we present this in a different way, or has that person's goal changed and do we need to revise the treatment plan?" Usually the problem is that we're not doing something right and we need to be creative and try a different approach.

The scheduled contacts are listed on the weekly cardex. The cardex describes what contacts we'll have with people on a daily basis and the reason for those contacts. Those become the basis for the daily schedule so when you're putting together the daily schedule it relates specifically back to the treatment plan. Once you do the daily contact, then you already know what the purpose was and so you write your SOAP note based on that purpose and whether or not the plan is being changed. Then you go back to the assessment. It's a complete circle. It's just constantly going around. If you don't have movement and it's stagnant, then you're not doing what you need to do.

At the daily team meeting you want to review in a behavioral fashion what has happened with each person in the past 24 hours. You do it in short concrete statements – this is what happened. That way if someone is working the nightshift, they can step in and figure out quickly what's been happening with a person. During the daily meeting, one person takes the daily log and starts calling out consumers' names. We use a 3-ring binder that has a section for each consumer. When the consumer's name is called, team members report what has happened in the last 24 hours and the person with the log makes a brief note. If you need to do some treatment planning, that happens after the team meeting.

We also use a team calendar. What we put on that calendar are appointments that aren't necessarily part of the ongoing treatment plan. It might be an appointment with a neurologist, a dental appointment, or it might be a staff person's dental appointment. We also have a team schedule that shows who's working when, it has time blocked out for paperwork, time for nurses to reorder medicines, the dual diagnosis group, and standing administrative obligations like program director meetings. The person putting together the daily schedule knows if there's a special appointment or if a staff person's is not going to be available.

We're very respectful of the times staff block out for paperwork. It can be a challenge to get paperwork completed in a way that it doesn't become overwhelming. What happened to us is that staff were spending so much time with the consumers they would be doing their paperwork at home or falling behind on paperwork. Getting paperwork done was probably the team's biggest stressor. I would guess that staff turn over is probably directly related to not having enough time to do paperwork, so scheduling time to get it done and then respecting that schedule is very important.

Supervising Staff

Team leaders teach primarily through modeling. They don't just sit in their office and delegate, but they go out and work side-by-side with each team member to teach them how to do the informal assessment process, how to work with people in the consumers support network, etc. A team leader is very involved with staff and consumers. Typically, at least 50% of the leader's time should be spent in direct services and supervising staff. The best way to supervise staff is to go with them on consumer contacts.

Red Tape

One of the things a team leader has to do is break down barriers so that his or her staff can do what they need to do. That might mean changing policies or procedures within the parent agency, figuring out how to do something in a legal and safe way, and constantly advocating, not just for the consumers, but also for the team.

For example, one of the challenges in the mental health arena is that mental health hasn't traditionally monitored medications as closely as an assertive community treatment team is going to. There's usually no regulations covering this in the mental health system - it's more a home health agency type of contact for the doctors and nurses. You have to know what your state nursing guidelines are and have an understanding that there's a difference between a mental health clinic nursing standard and community home health standard and figure out what will work within your state's guidelines. Another key part is how the doctor orders the medications because that's where a lot of your support for change is going to come from - the doctor saying he or she wants the medication delivered daily.

Billing

As a team leader, you have to know what is reimbursable and what is not. One of the choices this team had to make several years ago was - because we don't have a set rate for assertive community treatment teams- whether we were going to do case management or rehabilitation. What we found was that a majority of our work was NOT case management, but rehabilitation. That is, we were teaching individuals how to become more independent versus linking them somewhere else. We decided we wanted to continue doing that. Then we had to figure out how to get reimbursed. You have to identify within your state what is reimbursable and whether you're going to be able to generate enough revenue doing what an ACT team is suppose to be doing. If not, you need to have plans for bringing about change.

We also write grants - capitol funds for the building, housing subsidies, a dual-diagnosis grant. You really have to be creative and identify what the needs are and how you can address those needs.

Outcomes Monitoring

There is a wonderful tool for measuring fidelity - that is, how closely your team is following the assertive community treatment model. I use it as the team's 'treatment plan'. I don't think you can ever be a perfect ACT team and if you think you are, you're in trouble. What you want to do (it's just like the consumer's treatment plan) is to have continuous ongoing movement. If you're not moving closer towards meeting fidelity and you're staying set in your ways, you're not going to see the benefits for consumers that are expected with this model.

What our team does is, once a quarter we meet to see where we're at on the fidelity checklist and plan where we want to go. It's a program assessment - Have we taken a couple steps back in this area? Are we doing what we need to be doing? Where are we doing well? Can we do even better?

We also do consumer satisfaction surveys. We have our consumer advocacy group administer them and we hopefully get very good feedback. We also have a level of functioning scale we use - it monitors 14 areas, residential, employment, and that type of thing. When we see a dip, we assess what changes we need to make to see improvement. When we see something that's working we figure out what we need to do to sustain it. For instance, if we have more consumers employed than ever before, what are we doing different? If the number of consumers who are employed has dropped, what do we need to do?

Safety

Safety is probably one of the biggest issues that new teams are going to have. My response to them is that the key to safety, and what is different about assertive community treatment, is the thorough, detailed, assessment that is done on each individual. This is actually a safer place to be than intake or an inpatient unit because you've done the leg work and determined what a person's symptoms are, what makes him or her have an increase in symptoms, whether the person is likely to be symptomatic. You're piecing together this information and you know what helps and what doesn't help.

One of the nice things about working with the team, and one of the important things about the daily team meeting, is that you know whether a situation is escalating or not. You can figure out if you need to double team, or involve the police department or sheriff's office because you're constantly communicating with the team and you know what's going on with the consumer.

Usually, the consumer isn't the safety issue but the environment we're going into. In my mind, I always say that if I don't feel comfortable going into an environment, why would we have the consumer living there. It may be the consumer's choice, and so we try to figure out why they feel comfortable there and we try to help them take steps toward moving away from dangerous environments.

Payees

Finances are a big issue for anyone, regardless of whether they have a serious and persistent mental illness or not. Many times our Social Security Administration will not allow people to be their own payee, especially if that person has a history of substance abuse or dependency. So, we try to create a situation where the person can be as independent as possible with the limitation that has been placed on them by social security. Also, we find that to get involved with someone clinically you cannot be involved with their finances because this is seen as having control over someone's life and not conducive to good clinical care. One of the things we work hard on - and it's very challenging - is having a payee outside of the clinical treatment team. We may serve as liaison and make special requests to make sure the consumer's needs are met, but we don't become payees.

Part 3. The Assertive Community Treatment Team as a Complex Adaptive System

Charlene Allred, RN, Ph.D.

An ACT team performs various complex activities in response to continuous changes in the status of consumers served by the team. People and other resources are brought together *across* disciplinary boundaries. On any given day, the situations encountered by the team might range from the routine to the “never been heard of before.” Leaders come to the forefront and recede into the background based upon the needs of consumers and which team members have relevant information, experience, or skills. The team knows that what worked with one consumer may not necessarily work with the next or in a similar situation. Therefore, in working with consumers, the team is constantly organizing and reorganizing its activities.

To be effective the ACT team must be alive—it must be adaptive, flexible, intelligent, reflective, renewing, resilient, and constantly learning. The ACT team is a living system that has an identity that shapes what it sees and does. It is nourished by an abundance of information, and lives and learns within a web of relationships.

The Assertive Community Treatment Team as a Cognitive and Social Process

An ACT team is comprised of individuals from a variety of disciplines. The key challenge for team leaders is helping team members to combine their knowledge in order to develop innovative and efficient strategies to help people with severe and persistent mental illnesses reach their recovery goals.

The ACT team operates as a *transdisciplinary* team. In a transdisciplinary team, the team members relate to one another in a highly integrated fashion. They make a commitment to teach, learn, and work *together across professional boundaries* for all aspects of care that affect a consumer’s life in the community. ACT team members are accountable to one another. *Together* they assess the consumer, develop a comprehensive treatment plan, monitor and review the plan, and support one another in whatever way is necessary to assure the treatment plan is implemented in the most effective way.

In order to come up with creative strategies to help consumers reach their goals, an ACT team engages in *knowledge-producing activities*. Knowledge is embedded in the expertise of the team’s members and in their interactions. The team members must share this knowledge so that the team functions as a single unit of expertise. *An effective team is greater than the sum of its parts*. That is, an effective team is more than a collection of well-coordinated, discrete individuals representing different professions.

Two strategies are used to release the knowledge embedded in ACT team members and their interactions. These strategies are:

1. **sensemaking**
2. **self-organization**

Sensemaking. Sensemaking is a way to reduce confusion about what might be going on with a consumer. The first thing that the ACT team does when engaging in sensemaking is to gather information. An example of the team trying to make sense of a situation is when the team gathers to review a comprehensive assessment. *Together*, the team members blend their perspectives or viewpoints in ways that result in a collective or shared understanding of the consumer’s needs. This dynamic interaction of information gathering and perspective blending is what enables the ACT team to envision solutions to complex problems and even new creative possibilities.

Self-organization. Once the team has devised a treatment plan, the team must organize itself to implement the plan. Self-organization emerges from the interactions and patterns of relationships between team members, the consumer, and the community. It refers to the team’s ability to spontaneously change in such a way that a new behavior or process can emerge in response to consumer needs.

Imagine the ACT team as an improvisational jazz ensemble. A jazz ensemble typically has no designated leader but all the members have a similar focus – music making. Through the music, they develop an unspoken connection with one another. Each musician’s contribution to the music is based upon what his/her fellow musicians are doing within the context of a particular piece of music. The fantastic music that emerges could not have been predicted by listening to anyone musician alone nor would it necessarily sound the same the next time these musicians joined.

Like the jazz ensemble, the complex and well-coordinated activities of the ACT team are more than the sum of its individual members. Sometimes the most unusual or unexpected behaviors may drive the team to greatness.

Tools for Sensemaking

The tools that ACT team members need for sensemaking include (but are not necessarily limited to):

- Contributing
- Representing
- Subordinating
- Understanding
- Collaborating
- Learning

The tools of contributing, representing, and subordinating help team members *create a system of interrelated activities*. That is, all of the team’s activities are related to one another and, at the same time, directed toward helping consumers reach their recovery goals. Nobody is working at cross-purposes – the team operates as a single unit of expertise.

Contributing. *Contributing* refers to the *action(s)* taken by a team member. The team member must *act with an awareness of how his or her behaviors fit into the “big picture.”* To act with awareness then, you first must understand the “big picture.” But sometimes, the big picture is not immediately or exactly clear. Therefore, this means that you must learn to *pay attention*. Contributing team members pay attention to discrete pieces of information and, in thoughtful ways, notice patterns that emerge over time relative to the consumer, team, or community.

- For example, one day you visit a consumer and notice that there are some dishes of water stacked on the table. While you’re helping the consumer with cleaning up his apartment, you simply wash the dishes and return them to the kitchen cabinet. A few days later, you once again notice dishes of water stacked on the table and once again wash them and return them to the cabinet.

Unbeknownst to you, other team members have observed and did the same thing. No one who observed this behavior mentioned it at the daily team conference. The following week, the consumer is picked up by police in an adjoining state and is experiencing an acute manic episode.

At the next day’s team conference, a team member mentions they observed dishes of water stacked on the table during a visit. You mention a similar observation and so do other team members. A behavior pattern – filling dishes with water and stacking them - begins to emerge, suggesting that, for this particular consumer, this pattern may be an early warning sign of relapse.

Representing. In the above example, each team member took an action – putting the dishes back into the cabinet - and concluded that the “isolated event” was not anything that needed to be reported at the daily team conference.

When team members *represent*, they construct their actions with a *conscious awareness that their actions are part of a system of joint actions* – other team members will interact with the consumer and take their own actions based upon the actions of others who have seen the consumer prior to them.

For an ACT team to be successful, its team members must remember that their individual actions are connected to the actions of others. The idea that an action, such as returning dishes to the cabinet, is connected to other team members’ actions was lost in the above example. The team members did not interact with care because they failed to see their own behavior as part of a system of joint actions.

Subordinating. Subordinating means that ACT team members always *interrelate their actions with the actions of other team members*. They subordinate their individual action to the team’s larger system of joint actions.

Continuing with our example, subordinating would have meant that each individual team member interrelated their actions to the actions of others by reporting the incident and their own actions to the entire team at the daily team conference. Had the team members brought this information forward the team would have been able make sense of the consumer’s behavior and create an action plan that may have thwarted the relapse or at least minimized its severity.

Understanding, Collaborating, Learning. Successful ACT teams generate solutions to complex challenges. Carrying out these solutions represents a well-defined system of interrelated activities among the team members. *When team members are tied together by trust they are able to interrelate their activities more easily than when there is suspicion.* Through understanding, collaborating, and learning, team members listen, share information, and connect in a manner that builds trust.

One kind of understanding that builds trust is *interpersonal understanding*. Interpersonal understanding means that team members develop an appreciation of one another’s preferences,

concerns, strengths, and weaknesses. Individual personalities, skills, values, work styles, professional and personal experiences, and agendas all affect how the team interacts and the level of trust among team members. Exercises that provide opportunities for team members to share information about these traits can facilitate interpersonal understanding. Set aside time for team members to get to know other team members.

Successful ACT team members cooperate rather than compete with one another. They are able to do so because they have *trust in the team process*. They trust that fellow team members will work toward team goals rather than individual goals. They trust that each member of the team will complete their tasks successfully either by themselves or involving others with the appropriate expertise.

Collaboration is enhanced when team members:

- Listen;
- Avoid premature judgments;
- Communicate in a way that stresses coordinated action over everyone having to agree all the time;
- Show respect for differences rather than unrestricted candor;
- Contribute in an ongoing way, not just once in a while;
- Share information over and above the minimal amount required by each person to do the job; and
- Think of the team goals rather than personal goals.

Solving complex consumer problems requires that team members *continuously learn*. *Learning within the team emerges from the connections and communications* between members and others possessing diverse perspectives and areas of expertise. When team members connect with one another, they share information from many viewpoints and develop a common understanding of the consumer's strengths, weaknesses, and goals. When the consumer's goals are understood in a new way, new knowledge is created. In other words, team learning has occurred and this opens new possibilities for team response options and a better future for the consumer.

Team members can encourage learning by being:

- Trustworthy;
- Willing to share information;
- Open and nonjudgmental in their communications;
- Issue oriented rather than personality oriented;
- Willing to discuss mistakes openly;
- Willing to give and receive feedback;
- Comfortable communicating thru a variety of channels including face to face, phone, meetings, written documents, and email, etc.;
- Open to questioning, exploring, experimenting, discovering, and innovating;
- Reflective upon prior experiences including actions and consequences;
- Ready to experience events more richly through a variety of interpretations;

- Willing to ask the tough questions like “What if?”; and
- Receptive to a work environment where responsibilities and priorities are clear but roles are fluid.

Tools for Self-Organizing.

The tools that ACT team members need for self-organization include (but are not necessarily limited to):

- Decision making
- Creativity

Decision Making. The quality of the ACT team’s decisions is the cornerstone of the team’s overall effectiveness. The decisions represent the ACT team’s response to a consumer problem or goals. The reason that we’ve emphasized the group member skills of contributing, representing, subordinating, understanding, collaborating, and learning is that all of these skills come together as ACT team members participate in the decision-making process. We encourage participation in the decision-making process by *all* team members.

The scope of participation will be determined by the need or problem to be solved and a team member’s area of expertise. How intensively a team member participates in the decision making process is dependent upon a variety of activities that connect the team member to the decision making process.

The ways that team members can participate in the decision making process include:

- Taking necessary actions to thwart a problem or meet the need (including teaching the consumer the skills to solve the problem or meet the need);
- Engaging in direct and frequent contact with other team members, the consumer, and community as it relates to the identified problem or need;
- Raising issues related to the problem or need;
- Providing information that will help to define, shape, and communicate the problem or need;
- Using reflection, discussion, scenario analysis, and brainstorming to generate a variety of possible solutions to the consumer’s problem or ways to meet a need;
- Imagining potential reactions from the consumer and community in response to each possible solution *before the final decision is made*;
- Supporting a selected solution while understanding the perfect solution is often impossible; and
- Recognizing that once a solution is implemented, changes may be necessary in the solution chosen, how it is being implemented, or in even how the original problem was defined.

Creativity. Self-organizing occurs when the conversations between ACT team members results in behavior(s) that solve a consumer problem or meet a consumer need. In other words, the team has

identified a plan, now they must organize themselves to implement it. Plan implementation is more complex when there are no routines or procedures to guide team member actions and the team must “invent” a procedure for implementing the solution. Hence, if the ACT team is going to be successful, creativity is an essential skill for team members. Creative team members have active, exploratory minds and are inventive, resourceful, imaginative, and even ingenious!

A creative approach to problem solving requires ACT team members to:

- Embrace diversity in viewpoints and relationships;
- Think in terms of relationships, not specific roles;
- Form weak ties with a variety of individuals rather than strong ties to just a few – social pressure to conform with the status quo will be less;
- Notice connections, patterns, subtle changes, or emerging events;
- Use timelines, maps, models, or visual images to notice connections or relationships between seemingly small events;
- Be imaginative–use artistic representation to visualize things quite differently than the way they appear in the real world;
- Trust intuition and go with your “gut” --facts and reason may reveal themselves at a later point in time;
- Improvise – normally we plan an action and then execute it but sometimes things don’t go as planned and we have to think on our feet or plan as we go along;
- Use existing rules or procedures in new ways or new situations;
- Experiment by figuring out how to make things work with what you have on hand; and
- Be tolerant of uncertainty or ambiguity – the tension it creates is a vital source of creative energy.

The Role of the ACT Team Leader

The ACT team leader facilitates the team’s sensemaking and self-organization actions by recognizing that *relationships are everything*. The ACT team functions as a single unit of expertise, and an indivisible, dynamic whole because team members’ actions are highly interrelated.

The role of the ACT team leader is to support the development and growth of crucial relationships by making sure that team members are diverse in their expertise, constant recipients of information, and well-connected to others. Relationship building tools available to the ACT team leader include (but are not necessarily limited to):

- Meaning Creation
- Designing

Meaning Creation. When the ACT team “loses meaning” they are unable to comprehend or make sense out of what is going on with a consumer. If this goes on for a long time, the consumer may be at risk. Leaders create meaning by helping the ACT team members to make sense out of consumers’ behaviors. The result is that team members have a common or shared understanding of the situation.

Hence, the leader's goal is to help minimize confusion so that the team can come up with a solution to the consumer's problem(s) or a way of helping the consumer meet goals.

The ACT team leader can help the team members create meaning by:

- Accepting that the world is unpredictable and giving up trying to plan for and control everything;
- Talking less and listening more;
- Maintaining a unified vision that blends different viewpoints and at the same time manages conflict;
- Building trust and seeking individuals who are able to be attentive, alert, honest, and caring;
- Building a culture that supports open communication, questioning, exploring, and learning;
- Seeking diversity in team members experiences and knowledge;
- Building trust within the ACT team related to team orientation and technical competence – ACT team members must know that their fellow team members are working toward team goals rather than personal goals and that they have the competencies to complete the tasks that are critical to the consumer's well-being;
- Seeking team members with "T-shaped skills" – these are persons who are expert in a specific area with an equally deep understanding of how their expertise relates to the expertise of other team members;
- Developing "A-shaped skills" – effective leaders have the ability to combine the insights of different team members (who actually represent different areas of expertise) in ways that produce a new understanding of a complex situation;
- Encouraging informal leadership – as the number of informal leaders on a team increases, team member ownership of the team process and team cohesion increase;
- Encouraging rich, personal interactions among team members in the form of direct (face to face), and frequent (daily), contact through informal channels;
- Recognizing that the team is not a society for historical preservation and rewarding team members for discarding the obsolete and unlearning "old ways"; and
- Focusing on real-time learning – or learning as the team is acting.

Designing. Once the ACT team is up and running, it is by no means a finished work! The team is constantly "becoming" because it is always in communication with its own members, the consumer, and the community. As the team, consumer, and community interact, they "adjust" to one another whereby they are changed or made different in some way because of the interactions. These interactions are crucial to team effectiveness because they contain vital information that enables the team, consumer, and community to adapt to the situation at hand. Therefore, a successful relationship between the team, consumer, and community can only happen if they work from sources of information that are rich and varied. In other words, information is the life force behind an effective team.

Designing is a tool that an ACT team leader can use to make sure the team, consumer, and community are supplied with a continuous flow of information. The goal of designing is to create sets of relationships among people who are different from each other, where each represents a source of critical information for team sensemaking and self-organization. Successful design strategies include (but may not necessarily be limited to):

- Building a variety of connections between people that have a rich capacity for information exchange so that people can work together to identify goals and develop action alternatives;
- Including more of a variety of people in the decision making process;
- Seeking diversity among the team because individuals with heterogeneous backgrounds tend to take in more and see significant patterns and relationships more quickly than a group of individuals with homogeneous backgrounds;
- Teaching team members what other team members are doing by encouraging overlapping roles and knowledge sets because under pressured or novel conditions, even if the team disintegrates the roles will remain alive in people's mind;
- Avoiding over commitment to existing ways of doing things;
- Remembering that creativity exists on the boundary between order and disorder; and
- Maintaining an attitude of wisdom by avoiding over cautiousness or over confidence.

Part 4. How Ready Are You?

Even though you have reviewed this publication and *The PACT Start-up Manual*, you may still have questions or be unclear about topics and processes that have been discussed. This is to be expected and it is why we strongly recommend that new team leaders work closely with an experienced team leader or other assertive community treatment consultant in establishing a new team. It is particularly important that you understand the work that lies ahead of you, because you will be responsible to assuring that the work of the team is appropriately carried out by your staff.

We urge you to take the time to answer the questions on the next few pages. This will help you keep track of where you are in tending to all the processes and administrative tasks required to start a new team. After answering these questions, you will have a set of specific questions to ask your implementation consultant and a 'to-do' list to guide your next steps in implementing assertive community treatment.

Place a check mark next to any of the following that you do NOT feel you *totally* understand at this time.

___ Principles of staffing including total case size, total staff size, and staff to consumer ratios

___ Role of the shift manager

___ Role of lead mental health professional

___ Role of lead nurse

___ How to select an ITT for a consumer

___ How the ITT involves other team members in a consumer's care

___ Responsibilities of clinical supervision and how they are carried out

___ How to supervise your staff in implementing the clinical practices described in the *Assertive Community Treatment Team Development Workbook*

___ How to organize and conduct an admission meeting

___ The specific admission criteria for your program

___ Who is responsible for doing the initial assessment and how it is documented

___ Who is responsible for the initial treatment plan and how it is documented

___ How the comprehensive assessment is done

___ How to do a psychiatric/ social functioning timeline

___ How to develop a treatment plan that is individualized, objective, measurable, and based on the goals of the consumer

___ How to develop the Weekly Consumer Schedule from the treatment plan and set up a cardex file

___ How to use the Weekly Consumer Schedule in developing the Daily Team Schedule

___ How to conduct the Daily Team Meeting

___ How to use the Daily Communication Log

_____How continuous assessment and continuous treatment planning are done

_____How the assertive community treatment team relates to advisory groups

_____How your program's fidelity to the ACT model will be measured

_____How the system for collecting consumer outcome data will work

_____Other areas where you still have questions that were not listed above:

Make a note in the space below of the areas where you still are unclear or have questions. Arrange to speak to your program implementation consultant about these areas.

Start-up Checklist

Place a check mark next to each item in the left-hand column of the table below that *is already in place or that you have already completed*.

In the right-hand column, note the next steps you will take to obtain or complete the remaining items.

Staffing Checklist	Next steps
<p>1. ____ A total of 10-12 FTE</p> <p>Including a <i>minimum</i> of:</p> <p> ____ 1 FTE psychiatrist</p> <p> ____ 2 FTE psychiatric nurses</p> <p> ____ 2 employment specialists</p> <p> ____ 2 substance abuse specialists</p> <p> ____ 1 mental health consumer (either as a peer advocate or in another position on the team)</p> <p> ____ 1 FTE program assistant</p> <p>2. ____ Staff reflect the cultural diversity of the community in which the program will operate</p> <p>3. ____ Task-specific job descriptions for each position on the team</p> <p>4. ____ Several potential questions to ask job applicants to evaluate their response to typical situations</p> <p>5. ____ A schedule that provides coverage 24-hours a day, 365 days a year with staff rotating evening, weekend, and holiday coverage</p> <p>6. ____ Written personnel policies that address required staff, staffing ratios, qualifications, orientation, training, etc.</p>	

Facility and Equipment Checklist	Next steps
<p>1. ____ Program office is centrally located in the community the program covers</p> <p>2. ____ Desks and office furniture including a conference table and chairs, file cabinets, secure storage for consumer records</p> <p>3. ____ There is one large room where staff work rather than individual offices</p> <p>4. ____ There is direct access to the reception area</p> <p>5. ____ Parking is available for staff and consumers</p> <p>6. ____ There are one or more rooms where private interviews or a group can be conducted</p> <p>7. ____ There is space to store consumer belongings and donated items</p> <p>8. ____ Telephones</p> <p>9. ____ Fax machine</p> <p>10. ____ Copier</p> <p>11. ____ Computer(s)</p> <p>12. ____ Printer</p> <p>13. ____ There is a medication room that can be secured</p> <p>14. The medication room contains:</p> <p> ____ Sink</p> <p> ____ Thermometer</p> <p> ____ Scale</p> <p> ____ Blood pressure cuff</p> <p> ____ Refrigerator</p> <p> ____ Medication storage</p>	

Medication Administration	Next steps
<p>1. ___ Team psychiatrist and nurse have reviewed Chapter 8 of <i>The PACT Start-up Manual</i> (Managing Medications) and have participated in the development of policies, procedures, and processes</p> <p>2. ___ A system is in place for medication administration Including,</p> <p>___ Knowing the rules for your state concerning medication administration and delivery</p> <p>___ A medication administration record (MAR) for each consumer where new medications or changes in medications are noted</p> <p>___ A plan for a master MAR or computer print-out for nurses to use when packaging medications for individual consumers</p> <p>___ A procedure for either obtaining unit doses of medication from pharmacies or for nurses to package unit doses for delivery</p> <p>___ Time set aside in the staff schedule for nurses to tend to medication ordering, packaging, and documentation</p> <p>___ A system for team members to return undelivered medications</p> <p>___ A procedure for new information about medications to be shared with the team</p> <p>___ A system for scheduling and tracking lab work</p> <p>___ A procedure for changes to be made to the consumer's weekly schedule when changes in medication require a change in team members' activities (e.g., change in frequency of delivering medications, scheduling of lab work, etc)</p> <p>3. ___ Pharmaceutical companies with programs for indigent consumers have been identified and contacted</p> <p>4. ___ Pharmaceutical company representatives have been contacted about providing samples to consumers who cannot pay for them</p> <p>5. ___ Written policies and procedures concerning medication administration and related quality assurance issues</p>	

Consumer Records	Next steps
<p>1. ____ The contents/sections of the consumer treatment record have been determined</p> <p>The records:</p> <p> ____ Comply with Medicaid requirements</p> <p> ____ Comply with JCAHO requirements</p> <p>2. ____ Written policies and procedures have been developed concerning consumer records</p> <p>3. ____ Supplies are available for assembling records</p> <p>Including,</p> <p> ____ Necessary blank forms/pages</p> <p> ____ File folders or binders</p> <p> ____ Section dividers</p> <p>4. ____ The style for writing progress notes has been determined</p> <p>5. ____ There is adequate space for storing records</p>	

Program Budget	Next steps
<p>1. The program budget includes:</p> <ul style="list-style-type: none"> ___ Competitive salaries and fringe benefits ___ Somewhat higher salaries for the lead mental health profession and lead registered nurse ___ Rent, utilities, and facility maintenance ___ Telephone and communication equipment including pagers and cell phones ___ Office supplies (e.g., consumer record binders, dividers, progress notes, pens, zerox paper, toner, etc) ___ Office equipment (e.g., fax machine, copier, printer, chart racks, storage cabinet, file cabinets) ___ Office furniture (desks and chairs, conference table and chairs) ___ Travel and transportation (vehicle lease or purchase, travel reimbursement, parking, reimbursement for liability insurance for personal vehicles) ___ Medication and medical supplies and equipment (e.g. scale, bp cuff, etc) ___ Professional insurance ___ Consumer services funds ___ Staff education and training ___ Consultation on assertive community treatment implementation ___ Consultant pharmacist (if you decide to use one ___ External evaluators (if needed) <p>3. ___ Team leader understands how the program generates revenue</p> <p>4. ___ Billing processes have been set up</p> <p>5. ___ There are written policies and procedures concerning disbursement and accounting for consumer services funds</p>	

Administration of Clinical Processes	Next steps
<ol style="list-style-type: none"> 1. ____ The program has specific admission criteria 2. ____ Forms are available for documenting the initial assessment and initial treatment plan 3. ____ Forms are available for documenting the psychiatric/social functioning history timeline 4. ____ The program has a supply of release of information forms 5. ____ The program has an initial supply of Weekly Consumer Schedules and a file box for storing active schedules 6. ____ The program has an initial supply of Daily Team Schedule Forms 7. ____ A Daily Communication Log has been set up 	
Monitoring	Next steps
<ol style="list-style-type: none"> 1. ____ A system for monitoring fidelity to the ACT model is in place 2. ____ A system for monitoring consumer outcomes is in place 3. ____ Any elements that will be monitored by the state mental health system, Medicaid, or JCAHO have been identified 4. ____ Team members know the elements that are being evaluated. 5. ____ The details of how data is collected and entered into spreadsheets has been specified. 	