Assertive Community Treatment

Implementation Resource Kit

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Implementation Tips for Public Mental Health Authorities

Studies of the effectiveness of mental health interventions have evolved to a point that researchers have been able to identify a cluster of practices that consistently demonstrate a positive impact on the lives of adults with serious and persistent mental illness and their families. These practices include:

- Assertive Community Treatment
- Family Education
- Integrated Treatment for Co-Occurring Disorders
- Illness Management and Recovery
- Medication Management
- Supported Employment

The goal of the Evidenced-Based Practice (EBP) Project is to provide mental health system administrators with the information and tools they need to make these practices widely available to consumers. The success of this initiative will depend on the leadership of public mental health system administrators and their ongoing oversight of projects developed in local communities. In planning for the implementation of assertive community we recommend that all members of new Assertive Community Treatment programs take part in the core Assertive Community Treatment training. In addition to basic training in Assertive Community Treatment, we suggest that each new team have at least one member receive training in each of the other evidence-based practices. These individuals can then provide cross training for other members of the team.

Creating a Vision

In the implementation of these interventions, you will first need to assemble all of the stakeholders who will be involved in each implementation initiative. This certainly will involve consumers, family members, related state/public organizations, and provider groups. It may also involve organizations not usually associated with the mental health service system such as those familiar with housing, employment, and substance abuse treatment. From the beginning, you will need to lead this group in understanding and articulating what assertive community treatment is and how it is going to be developed in your mental health service system. Articulating the vision and developing momentum around that vision are essential for the success of the project.

Align Incentives

The mental health authority has the capacity to assure that the incentives in the system will facilitate the implementation of this practice. Attention to the alignment of these incentives in a positive way is vital to the success of the implementation of each of these clinical interventions.

Unfold the Intervention

With a vision firmly in place, the process of unfolding the intervention in the service system can begin. Careful planning of this process will go a long distance in assuring a successful outcome. Implementing this intervention first in pilot or demonstration sites may be useful, both in managing problems that will inevitably arise and in giving constituents the opportunity to see that this intervention works. Multiple pilot sites are preferable to just one site. When only one site is used, idiosyncratic things can happen that give a misimpression of the model. On the other hand, when systems do a system wide 'rollout', it is difficult to adequately train all of the teams or provide enough side-by-side consultation and mentoring. System problems that may have been resolved easily with a few teams can cause havoc.

Sustain the Project

The challenge of assuring the project is sustained needs to be addressed as a central part of the initial planning process. There are too many examples of excellent initiatives that have had a positive beginning involving the enthusiastic support of participants only to flounder at the end of a year for lack of planning around the critical issue of the ongoing maintenance of the project. The public mental health authority can use strategies (e.g. rules, contracts etc) to address this issue and assure that it us attended to in such a way that the project will continue to grow and develop.

The materials in this section those likely to affect costs. We encourage you to share this section, and other Assertive Community Treatment implementation materials, with those individuals in your mental health system whose expertise you will need in setting up appropriate rules and financial structures along with those providers who may be affected by the implementation of Assertive Community Treatment, and consumers and their families.

We have divided "Tips for Mental Health System Administrators" into two parts:

The Assertive Community Treatment Model

Part 1 describes assertive community treatment and the outcomes it is expected to produce. This section also discusses the resources and processes needed to implement and support assertive community treatment programs.

The Lewin Group's Assertive Community Treatment Literature Review

Part 2 is a copy of a report prepared by the Lewin Group. It provides an extensive discussion of variations in the practice of assertive community treatment that will help you understand the basis for the sometimes conflicting information you may hear about Assertive Community Treatment.

Part 1. The Assertive Community Treatment Model

Introduction

There is a growing trend for governmental and professional organizations to see assertive community treatment as a fundamental element in a mental health service system. Based on extensive research, experts consider it an essential treatment for severe and persistent mental illness. Furthermore, assertive community treatment is endorsed in "The Surgeon General's Report on Mental Health" and is one of three best-practice measures of the quality of a state's mental health system described in the new Federal Performance Indicators System developed by the Substance Abuse and Mental Health Services Administration.

This section describes assertive community treatment and the beneficial outcomes that are associated with this service delivery approach. As you read about this evidence-based practice you may think, "This sounds great, but we could never afford it". We want to challenge that notion upfront by telling you that mental health systems that don't have any different access to resources than your system has are in the process of implementing assertive community treatment programs system-wide. What these systems do have is a visionary who recognized the benefits of providing this evidence-based practice and who persisted in overcoming challenges. We hope you are that visionary for your system.

After presenting general information about the model, we discuss in more detail some of the factors such as staffing and hours of operation that will affect the cost of assertive community treatment in your system. Information is also included about the use of program standards and other devices to assure the model is faithfully implemented. This section then concludes with information about a budget simulation tool that has been created for estimating the cost of assertive community treatment and funding options.

Limits of Current Research

We understand that for various reasons (often fiscal), mental health systems may consider varying certain elements of the assertive community treatment model. For example, a mental health system may want to reduce the overall number of staff on an assertive community treatment team or limit the hours of operation. It is at this point that we can no longer offer advice informed by research and administrators will have to rely on the experience of others. What we know from research is that teams that adhere more closely overall to elements of an instrument called the Dartmouth Assertive Community Treatment Scale, or DACTS, are the most likely to achieve the beneficial outcomes associated with assertive community treatment.

Current research is insufficient to tell us which of these elements can or cannot be 'tweaked' under what particular circumstances without adversely effecting outcomes. Further, current research is largely silent on how differences in the quality and actual content of staff-consumer interactions influence outcomes.

As we discuss various aspects of assertive community treatment, where research is lacking, we have chosen to 'default' to describing assertive community treatment as practiced by the originators of the model and/or rely on input from individuals who have experience implementing and managing assertive community treatment programs. The report prepared by the Lewin Group in Section 2 discusses many of the differences that occur between assertive community treatment programs in more detail.

We urge you to read this publication, begin to think about the resources that will need to be realigned in your state, and then identify mental health system administrators in other states that have implemented assertive community treatment and talk to them. Two other resources we encourage you to take advantage of are the National Assertive Community Treatment Technical Assistance Center operated by the National Alliance for the Mentally Ill and the Assertive Community Treatment Association. These organizations can connect you with individuals who can speak from experience about the implications of different choices you might consider.

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

- National Assertive Community Treatment Technical Assistance Center
  National Alliance for the Mentally Ill
  2107 Wilson Blvd, Suite 300
  Arlington, VA 22201–3042
  Phone: (866) 229-6264
  Email: elizabeth@nami.org
  www.nami.org/about/PACT.htm

Finally, you will want to have copies of the following books on hand and make them available to stakeholders and the staff who will implement this model:

- "Assertive Community Treatment of Persons with Severe Mental Illness" by L. Stein & A. Santos, Norton Publishers, http://.www.wwnorton.com
- "The PACT Model of Community Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start- up" by D. Allness & W. Knoedler, National Alliance for the Mentally Ill, see contact information above

How is Assertive Community Treatment Different from Services that are Already Being Provided?

Assertive community treatment uses a transdisciplinary team approach to provide comprehensive and flexible services to those individuals with severe and persistent mental illness who experience the most intractable symptoms, and consequently have the most serious problems living independently in the community. Due to the severe and recalcitrant nature of the symptoms these individuals experience, they are often frequent users of inpatient services, homeless, involved in the criminal justice system, and/or using illegal substances. From a purely fiscal perspective, these individuals are the heaviest users of the most expensive resources. But, more importantly, these are individuals who personally suffer the most extreme and devastating consequences of having a severe mental illness. The mental health system has not traditionally been successful in engaging this group of individuals in effective treatment.

> **Minimum Services Provided by Assertive Community Treatment Programs**
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> - Crisis assessment and intervention
> - Comprehensive assessment
> - Illness management and recovery skills
> - Individual supportive therapy
> - Substance abuse treatment
> - Employment support services
> - Side-by-side assistance with activities of daily living
> - Intervention with support networks (i.e., family, friends, landlords, neighbors, etc)
> - Support services such as medical care, housing, benefits, transportation
> - Case management
> - Medication prescription, administration, and monitoring

Assertive community treatment teams are able to successfully assist individuals with extensive needs to live safely and autonomously in the community because they are equipped to provide intensive and comprehensive services that are customized for each consumer. Team members from a variety of disciplines including psychiatry, nursing, social work, substance abuse treatment, and employment can respond around the clock if necessary to provide the support consumers need to overcome even the most challenging problems. This is one of the reasons

that assertive community treatment is renowned for reducing the use of inpatient psychiatric hospitalization.

Your mental health system may already provide crisis services, community-based programs, or even case management programs which operate in teams. While these services share some characteristics of assertive community treatment, there are important distinctions. First, assertive community treatment is NOT a case management program. It is a self-contained service delivery system. Case management is only one of many services provided by an assertive community treatment team.

What this means is that, rather than sending consumers to different providers for different services as a case management program might, the assertive community treatment team itself provides the vast majority of treatments and services a consumer needs. This results in services that are carefully coordinated and integrated. Because staff with a wide range of skills and experience are working closely together, any of a number of services and supports can be quickly increased or decreased as the consumer's needs and preferences dictate.

Consider, for example, a person who is experiencing psychotic symptoms, living on the streets, abusing illegal drugs, and has a serious medical problem. In the traditional approach to services, the person would most likely be referred to a different provider for each different need. Of course, the consumer may not meet a particular program's eligibility requirements or there may be a waiting list for a service the consumer needs, but nonetheless, assuming the person is admitted to multiple programs, the various providers may or may not communicate with each other or be aware of one another's interventions. If there's a drastic increase in the person's needs, a new provider often has to be found and if the person has a crisis, yet another provider may become involved. At other times, a service may be discontinued simply because an arbitrary time limit has been met that has nothing to do with the person's need for the service.

With Assertive Community Treatment, rather than referring the consumer in this example to different providers, the team would provide the full array of services the person needs. For instance, the team will help the consumer find safe affordable housing and provide side-by-side support to help the person maintain that housing. They will provide ongoing assessment of the person's symptoms and teach the person strategies for minimizing and managing those symptoms. Team members will see the person as many times a day as is necessary to assist in planning and carrying out activities of daily living and other constructive activities. At the same time, the person receives integrated substance abuse treatment from the team. Team members

Step-Down Services

A question that arises is whether consumers who receive assertive community treatment services can be transferred to less intensive services. There are two studies that service system administrators should be aware of. The first study was published in the *Archives of General Psychiatry* in 1980 by originators of the assertive community treatment model, Mary Ann Test and Leonard Stein. They reported that when consumers were transferred to standard care after one year of assertive community treatment, they experienced substantial setbacks. The lesson: **discontinuing assertive community treatment at an arbitrary point in time does not work.**

In the second study published by Michelle Salyers and colleagues (*American Journal of Orthopsychiatry*, 1998), staff from an assertive community treatment program and a step-down program met and made case-by-case decisions about which consumers were appropriate for less intensive services. The consumers selected for the step-down program had, on average, been receiving assertive community treatment services for about 6 years. They tended to be individuals:

- with an affective disorder rather than schizophrenia,
- who did not have a substance abuse problem,
- who had not been hospitalized in over a year
- living in stable housing,
- who were receiving only 1 contact from the team per month, and
- rated by staff as functioning independently.
- Some individuals transferred back to the assertive community treatment program, however, many continued to function well and avoid psychiatric hospitalization.
- This success was attributed to the fact that:
- the decision to transfer consumers was made on a case-by-case basis with careful consideration of individual clinical needs,
- continuity of care was assured before and after transfer,
- the transfer was gradual with overlapping services, and
- consumers could readily transfer back to the assertive community treatment program when needed.

These findings suggest that some individuals, selected on the basis of clinical need, can be transferred to less intensive services without deleterious effects. However, mental health systems that consider step-down programs should recognize that the proportion of consumers in any given year who might be appropriate for transfer using the flexible standards applied in the Salyers study is likely to be small.

Program standards disseminated by the National Alliance for the Mentally Ill suggest that the consumer's ability to functioning independently in all major roles (e.g., work, social, self-care) for two years be an element of discharge criteria for assertive community treatment programs.

will also work with the person to help him or her find paid employment and develop strategies to effectively deal with problems that may arise in the work place. The team psychiatrist and nurses are carefully monitoring the person's medical condition and communicating with medical providers to assure the person receives appropriate treatment. Should a need arise that the team cannot meet (i.e., inpatient medical care), the team will be responsible for making certain the person receives that care.

Another important distinguishing characteristic of assertive community treatment is that there is no preset limit on the length of time a person can receive assertive community treatment services. The consumers targeted by assertive community treatment programs initially have very intensive needs and even when symptoms subside, they remain prone to relapse. Rather than discontinuing services at some arbitrary point or discharging the person the first time he or she experiences a period of progress, the team will decrease the intensity of services but maintain enough contact so that if circumstances change, they can step in quickly to keep the situation from worsening and prevent minor problems from snowballing into crises.

Also, because assertive treatment teams work with individuals who have the

most extensive and difficult problems with day-to-day functioning, the staff to consumer ratio is kept to approximately 1 to 10. It is also important that the team be available to provide services and supports at any time the person needs them. This means that staff are available 24-hours a day, 7-days a week, 365-days a year. It takes a staff of about 10-12 people to provide this coverage. At a ratio of 1 staff per 10 consumers, this suggests a maximum program capacity of about 120 consumers.

Does Assertive Community Treatment Make a Difference?

When new programs come along, one of the things an administrator has to ask is whether the reorganization of resources is worth it: Is the new program really going to make a difference? Extensive research indicates that the answer to this question when it comes to assertive community treatment is 'Yes'.

One of the most impressive aspects of assertive community treatment is the extent to which it has been subjected to rigorous research and the consistency of favorable findings. A detailed discussion of the research, Assertive Community Treatment Literature Review, written by Karen Linkins and colleagues at the Lewin Group, can be found in Section 2 of this publication. Additional information can also be found in the article called Moving Assertive Community Treatment into Standard Practice published in Psychiatric Services in June 2001. A copy of this article was included in the materials distributed with this EBP Project Implementation package.

> **Cost studies have found that the costs of assertive community treatment can be offset by a reduction in hospitalization costs.**

Briefly stated, extensive research has found that assertive community treatment:

- reduces the use of inpatient services;
- increases housing stability;
- leads to better substance abuse outcomes (when programs included a substance abuse treatment component); yields higher rates of competitive employment (when programs included a supported employment component); and
- is more satisfying to consumers and family members.

As an administrator with responsibility for balancing competing fiscal demands, you will be particularly interested in knowing that rigorous economic analyses have found that assertive community treatment is cost-effective when programs adhere closely to the model and serve high at-risk individuals. Further, cost studies have found that the costs of assertive community treatment can be offset in part by reduced hospitalization costs.

Achieving the outcomes associated with assertive community treatment depends on the extent to which programs are faithful in adhering to the model. The extent to which programs follow key elements of the model (which is referred to as program fidelity) is measured by an instrument called the Dartmouth Assertive Community Treatment Scale or DACTS. What we know from studies of assertive community treatment programs is that the higher a program scores on the DACTS, the greater the likelihood of the program achieving the favorable outcomes that are described above.

Simply put, providing assertive community treatment involves a substantial reorganization of resources. The best way to protect your investment is to make certain that programs are actually providing assertive community treatment. The table below describes the characteristics of a program that would have a perfect score on the DACTS. The DACTS, in its entirety, can be found in the section on monitoring implementation and outcomes that is included in this Resource Kit.

Human Resources, Structure, & Staff Composition

- **Staff to consumer ratio:** 10 or fewer consumers per team member excluding team psychiatrist and program assistant
- **Team approach:** 90% or more of consumers have contact with more than 1 team member per week
- **Practicing team leader:** A full-time program supervisor (also referred to as the team leader) provides direct services at least 50% of the time
- **Continuity of staffing:** Less than 20% turn over per year
- **Staff capacity:** Program has operated at 95% or more of full staffing in the past 12 months
- **Psychiatrist on staff:** A 100-consumer program has at least one full-time psychiatrist assigned directly to the program
- **Nurse on staff:** A 100-consumer program has at least two full-time nurses
- **Substance abuse specialist:** A 100-consumer program has at least two full-time substance abuse specialists with a minimum of 1 year specialized training in substance abuse treatment or 1 year supervised experience
- **Employment specialist:** A 100-consumer program has at least two full-time employment specialists with a minimum of 1 year specialized training or 1 year supervised experience
- **Program size:** Program has a total of at least 10 FTE staff

Organizational Boundaries

- **Explicit admission criteria:** the program actively recruits a specifically defined population and all consumers meet the explicit admission criteria.
- **Intake rate:** The highest monthly intake rate in the previous 6 months was no more than 6 consumers per month
- **Full responsibility for treatment:** The program provides all of the following: (1) psychiatric services, (2) case management, (3) supportive counseling/psychotherapy, (4) housing support, (5) substance abuse treatment, (6) employment support, (7) rehabilitative services
- **Responsibility for crises services:** Program provides 24-hour coverage
- **Responsibility for hospital admissions:** 95% or more of inpatient psychiatric admissions are initiated through the program
- **Responsibility for hospital discharge:** 95% or more of discharges are planned jointly with the program
- **Time-unlimited services:** All consumers are served on a time unlimited basis with fewer than 5% expected to graduate annually

Nature of Services

- **In vivo services:** at least 80% of total service time is spent in the community
- **No drop-out policy:** 95% or more of consumers are retained over a 12-month period
- **Assertive engagement mechanisms:** Program demonstrates consistently well thought out strategies including street outreach
- **Intensity of service:** Average of 2 hours per week or more per consumer
- **Frequency of contact:** Average of 4 or more contacts per week per consumer
- **Work with support system:** Each month, team members have 4 or more contacts in the community with members of the consumer's support network
- **Individualized substance abuse treatment:** Consumers with a substance use disorder spend 24 minutes or more per week in substance abuse treatment
- **Dual disorders model:** Program is fully based in dual disorders treatment principles with treatment provided by team
- **Role of consumers on treatment teams:** Consumers are employed as clinicians with full professional status

Defining the Target Population

One of the early decisions a mental health system needs to make is about how to define the specific population to be targeted by assertive community treatment programs. "The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up", written by originators of assertive community treatment, Deborah Allness and William Knoedler, describes guidelines for developing admission criteria that mental health systems will want to consider. Generally, admission criteria will identify:

1. Consumers with severe and persistent mental illness that seriously impairs their functioning in community living.

- Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder because these illnesses more often cause long-term psychiatric disability.
- Individuals with a primary diagnosis of a substance use disorder or mental retardation are not appropriate consumers.

Significant functional impairments include at least one of the following:

- Consistent inability to perform the practical daily tasks required for basic functioning in the community (e.g., maintaining personal hygiene; meeting nutritional needs, caring for personal business affairs, obtaining medical, legal, and housing services, recognizing and avoiding common dangers or hazards to self and possessions),

Assertive Community Treatment as an Adjunct to Criminal Justice Programming

Assertive community treatment programs have a long history of working with individuals with the most difficult challenges – including individuals who have been arrested and incarcerated. In recent years, there has been increasing interest in using assertive community treatment programs to divert individuals with mental illness from the criminal justice system. Such efforts tend to be supported by they mental health community. Treatment is generally viewed as preferable to incarceration so as not to criminalize mental illness and to insure individuals receive adequate and humane treatment. Programs such as Community Treatment Alternatives in Madison, Wisconsin have a history of working successfully with individuals with mental illness who are involved in the criminal justice system.

A study by Phyllis Solomon and Jeffrey Draine published in the 1995 issue of *Evaluation Review* looked at the one year outcomes of individuals with mental illness who were released from jail to one of three programs: assertive community treatment, individual case management, and routine CMHC services. Unfortunately, the researches found that the assertive community treatment program that was studied never implemented the model in terms of staffing or treatment philosophy. In this study, the poorly implemented assertive community treatment model resulted in a greater number of subjects being returned to jail than in the other service models. The authors attributed this to the intensity of the team's involvement with consumers and, consequently greater awareness of probation violations, coupled with the use of criminal justice system personnel's ability to invoke sanctions

The Solomon and Draine study serves to illustrate two points. First, the study points out the importance of assuring that programs are adequately implemented in terms of both organizational structure and the quality of clinical care. Second, the study demonstrates that working closely with corrections adds a very different twist to treatment and that teams must be clear about their role as therapeutic agents.

- Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives,
- Consistent inability to be employed at a self-sustaining level or consistent inability to carry out homemaker roles,
- Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).

2. Consumers with one or more of the following indicators of continuous high-services needs:

- High use of acute psychiatric hospitalization (e.g., 2 or more admissions per year) or psychiatric emergency services,
- Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal)
- Coexisting substance use disorder of significant duration (e.g., greater than six months)
- High risk or a recent history of criminal justice involvement
- Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless
- Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or
- Requiring a residential or institutional placement if more intensive services are not available
- Inability to participate in traditional office-based services

You may find it helpful to contact other mental health systems that provide assertive community treatment and look at how they have operationalized these criteria.

> **Consumers and Family Members as Staff**
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> The inclusion of consumers as staff has been codified in the DACTS. On some teams, consumers hold a position referred to as a *peer specialist.* In some cases, peer specialists may not be able to generate revenue for their services and you will need to plan support for these positions. But, in addition to hiring consumers to fill peer specialist positions, we also suggest consumers be considered for *any* position on the team that they may be qualified for with accommodations, if needed, consistent with the ADA.
>
> More recently, the contribution of family members to assertive community treatment teams has also received recognition. In fact, a study by Lisa Dixon that examined the role of family members on assertive community treatment teams was published in the *Community Mental Health Journal* in 1998. Although, the inclusion of family members on assertive community treatment teams is not an element of the DACTS against which programs are judged, we urge mental health systems to recognize the unique experience family members have to offer and suggest that they be considered for any position on an assertive community treatment team that they might be eligible for.

You will also want to look at data on hospital use to determine what proportion of individuals in your system use the highest number of days of inpatient services and determine if there are any patterns to the communities these individuals come from. This will give you a sense of the proportion of consumers most likely to benefit from assertive community treatment, what your system is currently spending on hospitalization, and communities that might most benefit from having an assertive community treatment program. To the extent information is available, you will also want to know about the number of individuals in jails and homeless shelters who are likely to be eligible for this service and understand the current collateral costs associated with those services.

Staffing

The staff of an assertive community treatment team 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 staff should have at least a master's degree. It is also important that staff reflect the cultural diversity of the communities in which they operate.

Staffing for an assertive community treatment team with 10-12 staff, might consist of:

- Team leader – 1 FTE position providing direct services at least 50% of the time
- Psychiatrist – at least 1 FTE per 100 consumers
- Psychiatric Nurses – at least 2 FTE per 100 consumers (note: teams may find that more nurses are necessary to provide coverage on all shifts)
- Employment Specialist – at least 2 FTE with one year specialized training or supervised experience
- Substance Abuse Specialist – at least 2 FTE with one year specialized substance abuse training or supervised experience
- Mental Health Consumer – these individuals sometimes fill a position called *Peer specialist*
- Program Assistant – person with AA or BA who works with team leader supervision to provide office management and triage situations that emerge throughout the day.

Additional mental health professionals - persons with master's or doctoral degrees in social work, nursing, rehabilitation counseling, psychology, occupational therapy

Consultation for New Teams

In developing a budget for assertive community treatment programs, it is important to understand the role of the team leader and the importance of budgeting for consultation to

provide ongoing mentoring and case consultation to help the team leader implement assertive community treatment in a way that adheres to the model. Consultation may include a lead consultant who periodically involves other consultants at difference times to bring expertise on nursing, substance abuse treatment, employment, or the role of peer specialists.

In an assertive community treatment program, the program manager is referred to as the team leader. She or he is a mid-level manager who is responsible, along with the team psychiatrist, for running the program. The team leader has administrative responsibilities (i.e., hiring, preparing administrative reports, and assuring policies and procedures are developed and followed) and also provides direct services half time. Perhaps more importantly, the team leader along with the team psychiatrist are responsible for assuring that the team operates is a manner consistent with the assertive community treatment model, including assuring the quality and content of staff-consumer interactions. It is through day-to-day leadership that the assertive community treatment model is faithfully carried out.

Leaders of new assertive community treatment programs must learn to work in a system that is structured different from other programs they may have experience with, think differently about the potential of consumers, and facilitate a process were staff work very differently with each other. It is very difficult *for anyone* to grasp everything that has to be learned in a brief time. Also, it is one thing to understand what needs to be done and another to translate that understanding into action. On top of that, the team leader and psychiatrist are also responsible for making certain that all the other staff also 'get it'.

It is very important that the team leader and psychiatrist have someone experienced in managing an assertive community treatment team to provide ongoing consultation and mentorship on organizational and clinical issues for, at a minimum, the first year a new program is in operation.

Lead Mental Health Professional and Lead Registered Nurse
Two members of the team receive somewhat higher salaries than their peers – the lead mental health professional and lead registered nurse. Since the assertive community treatment staff is relatively small, it is hard to justify more than one supervisor position. However, the many functions of the self-contained team require that other staff members assume lead responsibilities to assist the team leader. 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.

Hours of Operation

Having staff available 24-hours a day, seven days a week, 365 days a year is very important in providing the safety net needed to help assertive community treatment consumers live 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. Hours of operation that provide the needed 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. A minimum of two staff work evening, weekend, and holidays and focus primarily on consumers in crises (or intensive interventions to prevent crises), and consumers who need 7-day-a-week assistance.

Transportation

Assertive community treatment teams see consumers in the community and also provide transportation for consumers. In rural areas, staff may be covering substantial distances. You will need to decide whether it is more economical to buy or lease vehicles for the staff to use or require staff to use their personal vehicles and reimburse them for mileage and additional liability coverage. Typically, staff prefer to use program cars because using their personal cars, even with reimbursement, puts many more yearly miles on the cars and adds more than

average wear and tear. The number of cars needed, mileage costs, and costs for additional insurance for personal vehicles are often underestimated. To make certain adequate resources are allocated to transportation, system administrators may want to confer with administrators of other systems in projecting costs.

Program Standards and Certification

Studies of programs that have attempted to replicate assertive community treatment have found that if programs do not achieve outcomes comparable to those of the original program, it was often because of failure to implement all components of the program. According to two of the originators of the model (Deborah Allness and Bill Knoedler), the Rhode Island Division of Mental Health's initiative to implement assertive community treatment represents an excellent system wide dissemination of assertive community treatment. They attribute this success in part to Rhode Island's mental health authority developing program standards that closely follow the assertive community treatment model. Model program standards can be found in "The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses available from the National Alliance for the Mentally Ill (NAMI) or on their website at www.nami.org/ about/pactstd.html.

States have the authority to adopt regulations governing services to persons with mental illness. Such regulations set standards for the quality and adequacy of programs including but not limited to criteria governing staffing and credentials, equipment, required services, records, space, patient rights, and admission and discharge criteria. In New York State (NYS) for example, licensure requirements are established for mental health programs, including billing requirements for Medicaid reimbursed programs. The NYS mental health authority is promulgating regulations related to billing and program guidelines. Whenever a new ACT team is established that will bill Medicaid, it must be licensed by the state mental health authority. The provider's application for license is reviewed by both state and local mental health authorities. Once granted, licenses must be periodically reviewed and renewed to assure that the program continues to meet required state regulations. Licensing assertive community treatment programs has major advantages; it provides a vehicle for States to standardize ACT teams across different jurisdictions and a process for continued quality review and improvement. In addition, it provides a process to assure that providers meet Medicaid criteria for billing ACT services.

Other Ways to Ensure the Model is Faithfully Implemented

It is common for programs to set out to implement one program, but end up with something different. Sometimes these variations are intentional, but often they occur because:

- one administration starts an implementation initiative and another, with different visions and priorities, subsequently assumes leadership
- the model wasn't clearly understood to begin with,
- the staff drifted back to doing things in a way that was more familiar and comfortable.

Some things that systems can do to help ensure that the assertive community treatment model is implemented and followed include:

Stakeholder Advisory Groups

A steering committee can be contractually mandated by the mental health authority that serves in an oversight capacity to ensure that the initiative is sustained as administrations change over time. At the same time, advisory groups with representation from multiple stakeholder group can play a similar role at the team or agency level. The advisory group can also serve as a liaison between the community and the program and other bodies within the provider agency. Such groups are currently used in Oklahoma among other places.

Advisory groups include:

- individuals who are knowledgeable about severe mental illness and the challenges that people with mental illness face in living in the community;
- consumers of mental health services and their relatives; and
- community stakeholders who have an interest in the success of the assertive community treatment program (i.e., representatives of homeless services, the criminal justice system, consumer peer support organizations, community colleges, landlords, employers).

Additional information about advisory groups can be found at www.nami.org/about/pactadvis.html.

Training and Consultation

Well-delineated training, supervision, and consultation can help to ensure that the model is understood initially by the staff who will carry it. This should include having staff visit a well-functioning, high fidelity program, didactic training, and ongoing mentoring and case consultation.

Monitoring Program Fidelity

Ongoing monitoring of program fidelity is important for continued efficiency and effectiveness. The DACTS (described earlier) can be built into program standards and administered on a routine basis as part of the process of certifying programs.

Financing Assertive Community Treatment

Budget Projection

A big question for service system administrators who are implementing a new program is what it will cost and how it can be financed. We have saved this for last because several factors that were previously discussed will influence the cost of assertive community treatment in your mental health system. Fortunately, The Lewin Group, a health services research firm, under a contract with the Health Care and Finance Administration (HICFA) and the Substance Abuse and Mental Health Services Administration (SAMSHA), has developed an Excel-based program that can be used in projecting the cost of assertive community treatment given different parameters.

The goals of the budget simulation model are to enable states to:

- Calculate how different program requirements may affect costs; and
- Estimate the cost of implementing an evidence-based assertive community treatment program.

The model consists of two major parts. First, average cost estimates are produced for an assertive community treatment program using a set of core elements:

- State where program will be implemented;
- Number and type of consumers;
- Staff to consumer ratio; and
- Percentage of community-based (in-vivo) care.

The second part of the model consists of a set of parameters that alter the core's average cost estimates. Based on knowledge gained from an advisory panel and the process evaluation of seven assertive community treatment programs, the model adjusts the average cost depending on the following:

- Urban vs. rural program;
- Program size;
- Age of the program;
- Level of benefit management and/or use of managed care contractor to administer the program.

To obtain a copy of this budget simulation program, service system administrators should contact:

The Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
703 269-5500
Karen.linkins@lewin.com

Revenue Sources

In considering potential funding sources for assertive community treatment, mental health system administrators will need to decide whether their localities will be expected to pay a share of the costs, if Medicaid will be used, and/or whether other outside funds such as grants or money from other state or local agencies (e.g., vocational rehabilitation, substance abuse) will be used. The use of state funds might encompass state aid to localities, redeployment of existing state staff, and/or the use of shared state staff as an adjunct to a locally operated assertive community treatment team. For example, an article written by Susan Essock and Nina Kontos that was published in Psychiatric Services in 1995 describe how the Connecticut Department of Mental Health created assertive community treatment teams by reconfiguring community staff and reallocating staff employed by the state hospital.

Medicaid has become an increasingly appealing option for funding assertive community treatment since 1999 when the Health Care Financing Administration (HCFA) advised state Medicaid directors that programs based on assertive community treatment principles can be supported under Medicaid policy. They also advised states that they should consider the recommendations of the Schizophrenia Patient Outcomes Research Team (PORT) in developing comprehensive approaches to community based-mental health systems. This advisement not only makes clear HCFA's support for evidence-based practices but it strongly encourages states to adopt the principles of assertive community treatment including interdisciplinary treatment teams, shared caseloads, 24-hour mobile crisis teams, individualized treatment in patients' environments, and rehabilitative and supportive services. Some states (for example, New York) have developed a case payment method for Medicaid-funded programs that enables providers to bundle assertive community treatment services under a monthly bill structure. This allows programs to provide a broad range of services without the burden of fee-for-service billing. Mental health system administrators will

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What About Capitation?

In the spring 1999 issue of *Psychiatric Rehabilitation*, Daniel Chandler and colleagues reported the findings from a study that examined the cost-effectiveness of an assertive community treatment program operated with capitated payments in Alameda County, California. The basic capitation rate per person per year was $26,000, with Alameda County and the managed care company sharing the risk for inpatient and emergency room costs. Inpatient and emergency costs up to $60,000 aggregate were paid for by the county and the provider assumed the next $60,000, and over that, the county again was responsible. Medication costs were billed separately to the state through fee-for-service Medicaid. Start-up costs were offset by savings from being able to discharge program participants earlier from the sub-acute facilities from which they were selected.

Costs for individuals referred into the assertive community treatment program were compared to costs for a similar group of individuals receiving routine care. During the first year of capitation, the gross per person cost for individuals receiving assertive community treatment was 25% less than for the comparison group. The net cost to the county (this considers the fact that 100% of facility expenses had been born by the county but only part of the expense for the Medicaid-reimbursable community-based services) were 75% less for the assertive community treatment program.

need to work with their Medicaid counterpart to establish the financial constructs to support assertive community treatment.

Billing Procedures

In preparing to implement Assertive Community Treatment programs, you will need to make sure that any necessary changes are made in billing codes and new programs are educated about billing.