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Building
Your Program

**Assertive
Community
Treatment**

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Building Your Program

Building Your Program is intended to help mental health authorities, agency administrators, and ACT leaders think through and develop the structure of ACT programs. Although you will work closely together to build ACT programs, for ease, we created two separate sections of tips that target your specific needs:

- Tips for Mental Health Authorities
- Tips for Agency Administrators and ACT Leaders

In preparing this information, we could think of no one better to advise you than people who have worked successfully with ACT programs. Therefore, we based the information in this booklet on the experience of veteran ACT leaders and administrators, and the booklet ends with their words of advice.

Assertive Community Treatment

For references see the booklet, *The Evidence*.

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Assertive Community Treatment KIT that includes a DVD, CD-ROM, and seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

Building Your Program

Training Front-Line Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP

EVIDENCE-BASED
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What's in *Building Your Program*

Assertive Community Treatment

Building Your Program

How Assertive Community Treatment Began

Assertive Community Treatment (ACT) started when a group of mental health professionals at the Mendota Mental Health Institute in Wisconsin—Arnold Marx, M.D.; Leonard Stein, M.D.; and Mary Ann Test, Ph.D.—recognized that many consumers were discharged from inpatient care in stable condition, only to be readmitted relatively soon afterward. Practitioners and consumers were frustrated.

This group looked at how the mental health system worked and tried to figure out what could be done so that consumers could remain in their communities and have a life that was not driven by their illness.

They recognized that the type and intensity of services available to consumers immediately decreased after they left the hospital. The group also realized that, even

> **Finally, staff looked at the unit leaders, Dr. Marx and me, and declared, "We don't want to do another one of these programs where we try to get patients ready for life in the community. Even though they appear 'ready' when we discharge them, they come right back. What good are we doing?"**
>
> Test, M.A. The Origins of PACT, *The Journal,* Volume 9, Issue 1, 1998, Sacramento, California

when hospital staff spent considerable time teaching consumers skills that they needed to live in the community, consumers were often unable to apply these skills once they actually lived in the community.

> **Our patients work very hard at getting better and getting ready to live in the community, and we work hard to help them. They leave B-2 (the hospital) in pretty good shape, but they always return. Their efforts and ours seem in vain.**
>
> Test, M.A. The Origins of PACT, *The Journal,* Volume 9, Issue 1, 1998, Sacramento, California

Adjusting to a community setting was worsened by the fact that consumers who experience serious psychiatric symptoms may be particularly vulnerable to the stress associated with change. Consumers often had difficulty getting the services and support they needed to prevent relapse because the mental health system was complex and services were fragmented.

Many programs were available only for a limited time. Once consumers were discharged, assistance ended. Sometimes consumers were denied services or they were unable to apply for services because of problems caused by the symptoms of their mental illness. Sometimes the service consumers needed did not even exist, and no one was responsible for making sure consumers got the help they needed to stay out of the hospital.

> **Eventually, one of the paraprofessionals commented, "You know, the patients that Barb Lontz works with intensively don't come back. Maybe we should all go out and do what Barb does."**
>
> Test, M.A. The Origins of PACT, *The Journal,* Volume 9, Issue 1, 1998, Sacramento, California

What the originators did

The group learned from the actions of a social worker, Barb Lontz. They moved inpatient staff into the community to work with consumers in the settings where they lived and worked. They created multidisciplinary teams which gave consumers the support, treatment, and rehabilitation services they needed to continue living in the community.

The types of services that were provided and how long those services were provided depended on consumers' needs. Team members pooled their experience and knowledge and worked together to ensure that consumers had the help they needed and that the treatment they received was effective.

Every day, ACT team members met to discuss how each consumer was doing; they quickly adjusted services, when necessary. When consumers needed more support, team members met with them more frequently.

Team members responded to consumers in the community 24 hours a day, 7 days a week. As consumers improved, team members decreased their interactions with them, but remained available to give additional support any time it was needed. After 30 years, the principles of this model remain the same.

Principles of ACT

- ACT is a service-delivery model, not a case management program.

- The primary goal of ACT is recovery through community treatment and habilitation.

- ACT is characterized by:

  - **a team approach** — Practitioners with various professional training and general life skills work closely together to blend their knowledge and skills.

  - *in vivo* **services** — Services are delivered in the places and contexts where they are needed.

  - **a small caseload** — An ACT team consists of 10 to 12 staff members who serve about 100 consumers, resulting in a staff-to-consumer ratio of approximately 1 to 10.

  - **time-unlimited services** — A service is provided as long as needed,

  - **a shared caseload** — Practitioners do not have individual caseloads; rather, the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals.

  - **a flexible service delivery** — The ACT team meets daily to discuss how each consumer is doing. The team members can quickly adjust their services to respond to changes in consumers' needs.

  - **a fixed point of responsibility** — Rather than sending consumers to various providers for services, the ACT team provides the services that consumers need. If using another provider cannot be avoided (e.g., medical care), the team makes certain that consumers receive the services they need.

  - **24/7 crisis availability** — Services are available 24 hours a day, 7 days a week. However, team members often find that they can anticipate and avoid crises.

- ACT is for consumers with the most challenging and persistent problems.

- Programs that adhere most closely to the ACT model are more likely to get the best outcomes.

What ACT Is

ACT is a way of delivering comprehensive and effective services to consumers who have needs that have not been well met by traditional approaches to delivering services. At the heart of ACT is a transdisciplinary team of 10 to 12 practitioners who provide services to about 100 people.

ACT teams directly deliver services to consumers instead of brokering services from other agencies or providers. For the most part, to ensure that services are highly integrated, team members are cross-trained in one another's areas of expertise.

ACT team members collaborate on assessments, treatment planning, and day-to-day interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure that each consumer receives the services needed to support recovery from mental illness.

The course of recovery from serious mental illness, and what it means to have a life that is not defined by a serious mental illness, differ among consumers. Consequently, ACT services are highly individualized. No arbitrary time limits dictate the length of time consumers receive services.

Most services are provided *in vivo*, that is, in the community settings where problems may occur and where support is needed rather than in staff offices or clinics. By providing services in this way, consumers receive the treatment and support they need to address the complex, real-world problems that can hinder their recovery.

Every day, ACT teams review each consumer's status so that the ACT team can quickly adjust the nature and intensity of services as needs change. At times, team members may meet with consumers several times a day but, as consumers' needs and goals change, the nature and frequency of contacts with them also change.

How we know that ACT is effective

Since the original ACT program began in Madison, Wisconsin nearly 30 years ago, programs have been implemented in 35 States and in Canada, England, Sweden, Australia, and the Netherlands. As ACT spread, researchers carefully studied its effectiveness. Reviews of ACT research consistently conclude that, compared with other treatments (e.g., brokered or clinical case management programs), when faithfully implemented, ACT greatly reduces psychiatric hospitalization and leads to a higher level of housing stability.

Research also shows that, compared to other treatments, ACT has the same or a better effect on consumers' quality of life, symptoms, and social functioning. In addition, consumers and family members report greater satisfaction.

While studies consistently show that ACT is associated with many beneficial outcomes, the Patient Outcomes Research Team (PORT), consisting of researchers from the University of Maryland and Johns Hopkins University, found that people who might benefit from ACT often did not receive this intervention (Phillips, et. al., 2001). Those findings ultimately led to creating this KIT.

In a growing trend, governmental and professional organizations see ACT as a fundamental element in a mental health service system. The Centers for Medicare and Medicaid Services (CMS) authorized ACT as a Medicaid-reimbursable treatment and ACT has been endorsed as an essential treatment for serious mental illness in the Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services, 1999).

In the federal performance indicator system that the Substance Abuse and Mental Health Services Administration (SAMHSA) developed, accessibility to ACT services was one of three best-practice measures of the quality of a state's mental health system. Disseminating the ACT model has also been a top priority for the National Alliance on Mental Illness. For more information about the effectiveness of the ACT model, see *The Evidence* section of this KIT.

Core ACT services

- 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 (family, friends, landlords, neighbors, etc);

- support services, such as medical care, housing, benefits, transportation;

- case management; and

- medication prescription, administration, and monitoring.

Building Your Program

Tips for Mental Health Authorities

Why should mental health authorities be interested in ACT?

ACT is for a relatively small group of consumers who are diagnosed with serious mental illness, experience the most intractable symptoms, and, consequently, have the most serious problems living independently in the community. Because of the severe and recalcitrant nature of their symptoms, these consumers are more likely to:

- frequently use emergency and inpatient medical and psychiatric services,

- be homeless or live in substandard housing,

- be involved in the criminal justice system, or

- use illegal substances.

From a purely fiscal perspective, these consumers are the heaviest users of the most expensive resources. More importantly, they personally suffer the most extreme and devastating consequences of having a serious mental illness.

Traditionally, the mental health system has not been successful in engaging these consumers in effective treatment. However, ACT teams can successfully help consumers who have extensive needs to live safely and autonomously in the community.

Can ACT make a difference?

Whenever new programs come along, administrators have to ask whether reorganizing resources is worth the effort: **Is the new program really going to make a difference?**

When it comes to ACT, extensive research shows that the answer is "**Yes**." Most impressive is the extent to which ACT has been subjected to rigorous research and the consistency of favorable findings.

Briefly stated, extensive research (Phillips et al., 2001) shows that ACT:

- reduces the use of inpatient services,

- increases housing stability,

- leads to better substance-abuse outcomes (when programs include 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 who must balance competing fiscal demands, you will be particularly interested in knowing that rigorous economic analyses have found that ACT is cost-effective when programs adhere closely to the model in serving high-risk consumers. Studies have found that reduced hospitalization offset the costs of ACT (Bond et al., 2001; Essock et al., 1998).

For more information, see *The Evidence* section of this KIT.

Aren't we already doing this?

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 ACT, important distinctions exist.

First, **ACT is not a case management program; it is a self-contained service delivery system.** Case management is only one of many services that ACT teams provide. Rather than sending consumers to different providers for different services as case management programs might, ACT teams provide the vast majority of treatments and services that consumers need.

This approach results in services that are carefully coordinated and integrated. Because team members with a wide range of skills and experience work closely together in ACT teams, they can quickly increase or decrease any number of services and supports as consumers' needs and preferences dictate.

Consider this example

A consumer has a serious medical problem and experiences psychotic symptoms, lives on the streets, and abuses drugs. In the traditional approach to services, that consumer would most likely be referred to a different provider for each need. Of course, the consumer may not meet a particular program's eligibility requirements or a waiting list may exist for a service that the consumer needs.

Assuming that the consumer is admitted to multiple programs, various providers may or may not communicate with one another. They may be unaware of one another's interventions.

If the consumer's needs drastically increase, a new provider may have to be found. If the consumer has a crisis, yet another provider may become involved. At other times, a service may be discontinued simply because an arbitrary time limit has arisen; that time limit may have nothing to do with the consumer's need for the service.

Rather than referring the consumer in this example to different providers, an ACT team would provide the full array of services the consumer needs. For instance, the team would help the consumer find safe affordable housing and provide side-by-side support to help maintain that housing.

The team would assess the consumer's symptoms and teach the person strategies to minimize and manage those symptoms. Team members would see the consumer as often as necessary to help plan and carry out activities of daily living and other constructive activities.

At the same time, the consumer would receive integrated substance-abuse treatment from the team. ACT team members would also work with the consumer to help find paid employment and develop strategies to effectively deal with problems that may arise in the work place.

The team psychiatrist and nurses would carefully monitor the consumer's medical condition and communicate with medical providers to ensure that the consumer receives appropriate treatment. If a need arises that the team cannot meet, such as inpatient medical care, the team would make certain that the consumer receives that care.

Will ACT work in your mental health system?

The ACT model has been adapted to a wide range of mental health systems and to the needs of severely ill consumers.

Some teams target their programs to serve homeless consumers. Others focus on veterans diagnosed with a serious mental illness or consumers with dual diagnoses. Some have had the goal of increasing competitive employment. Still others have included consumers and family members as active members of ACT teams.

ACT programs have been implemented throughout the United States as well as in Canada, England, Sweden, Australia, and the Netherlands, and they operate in both urban and rural settings.

How can mental health authorities support ACT?

As you read about ACT, you may think that it sounds great but unaffordable. We want to challenge that notion—mental health systems with the same access to resources as your system are in the process of implementing ACT programs system-wide.

These systems have visionaries 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.**

For ACT initiatives to be successful, mental health authorities must lead and be involved in developing ACT programs in local communities.

Be involved in implementing ACT

- Help create a vision of how ACT programs can be integrated into the service delivery system.

- Develop administrative rules that support ACT.

- Create program standards to sustain high-fidelity ACT programs.

- Share this information with those in your mental health system whose expertise you'll need in setting appropriate rules and financial structures.

Create a vision

Agencies commonly set out to implement one program, but end up with something entirely different. Sometimes these variations are intentional, but often they occur because:

- one administration starts an initiative and another with a different vision and priorities subsequently assumes leadership,

- the model wasn't clearly understood to begin with, or

- the staff drifted back to doing things in a way that was more familiar and comfortable.

Articulating the vision and developing momentum for that vision are essential if you are to successfully implement an ACT program. You can help ensure that the ACT model is implemented appropriately if you contractually mandate that stakeholder advisory groups guide the implementation initiative.

Form advisory groups

Consider forming groups on the State and agency levels. State-level advisory groups may include:

- stakeholders from different State agencies (housing, employment, substance abuse, criminal justice departments) that would be invested in the initiative,

- leadership from implementing agencies, and

- representatives from consumer and family State advocacy organizations.

Local advisory groups can serve as a liaison between the community and participating mental health agencies. Community stakeholders with an interest in the success of ACT programs include representatives of:

- local homeless services,

- the criminal justice agencies,

- community colleges,

- landlords, employers, and

- local consumer and family organizations.

From the beginning, you need to lead your advisory groups in understanding and articulating what ACT is and how it is going to be developed in your mental health service system. For training materials that you can use to help stakeholders develop a basic understanding of ACT, see *Using Multimedia to Introduce Your EBPs* in this KIT. For additional information about advisory groups, go to **www.nami.org.**

With a vision firmly in place, the process of unfolding ACT programs across the service system can begin. Carefully planning this process will help ensure a successful outcome.

Implementing ACT programs 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 ACT works. Multiple pilot sites are preferable to just one. When only one site is used, idiosyncratic things can happen that misrepresent the model.

On the other hand, when systems do a system-wide "rollout," it is difficult to adequately train all of the teams. In that case, system problems that may have been resolved easily on a smaller scale with a few teams can cause havoc.

Establish program standards

Studies of agencies that have tried to replicate ACT have found that, if agencies do not achieve outcomes comparable to those of the original program, it was often because they failed to implement all of ACT's components. Mental health authorities have the capacity to ensure that the incentives in the system will help implement ACT. Attention to aligning these incentives in a positive way is vital to successfully implementing ACT.

States have the authority to adopt regulations that govern services to consumers. These regulations set standards for the quality and adequacy of programs, including criteria that govern:

- admission and discharge,

- staffing and credentials,

- service intensity and capacity,

- program organization and communication,

- assessment and treatment planning,

- required services,

- consumer medical records, and

- consumer rights and grievance procedures.

According to two originators of the model (Deborah Allness and Bill Knoedler), the Rhode Island Division of Mental Health's initiative represents an excellent system-wide dissemination of ACT. The originators attribute this success, in part, to the fact that Rhode Island's mental health authority developed program standards or administrative rules that closely follow the ACT model.

For more examples of State initiatives to implement ACT, see *The Evidence* in this KIT.

Develop administrative rules for admissions

One of the early decisions that a mental health system must make is how to define the specific population that the ACT program will target. ACT studies have demonstrated positive outcomes in programs where the most common diagnoses were schizophrenia, schizoaffective disorder, and bipolar disorder or when consumers showed substantial functional impairment (Calsyn, et al., 1998; Chandler, et al., 1996; Dixon, et al., 1998; Hadley, et al., 1997).

Other studies have documented benefits for consumers with co-occurring substance abuse disorders (Drake, et al., 1998; Teague, Drake & Anderson, 1995). ACT's effectiveness has been documented in programs with consumers from diverse ethnic backgrounds, both males and females, and from wide-ranging age groups (Bond, et al., 1991).

For this reason, admission guidelines for ACT programs should target consumers with mental illnesses that seriously impair their functioning in community living. Give priority to consumers with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder because these illnesses more often cause long-term psychiatric disability. Consumers with a primary diagnosis of a substance-use disorder or mental retardation are not considered appropriate.

Significant functional impairments include at least one of the following:

- Consistent inability to perform practical daily tasks needed to function in the community:

  - maintaining personal hygiene;

  - meeting nutritional needs;

  - caring for personal business affairs;

  - obtaining medical, legal, and housing services; and

  - recognizing and avoiding common dangers or hazards to one's self and one's possessions.

- Persistent or recurrent failure to perform daily living tasks, except with significant support or help from others, such as friends, family, or relatives;

- Consistent inability to be employed at a self-sustaining level or to carry out homemaker roles; and

- Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).

Consumers with one or more of the following indicators of continuous high-services needs are also prioritized:

- High use of acute psychiatric hospitalization (e.g., two or more admissions per year) or psychiatric emergency services;

- Intractable (i.e., persistent or recurrent) severe major symptoms (e.g., affective, psychotic, suicidal);

- Coexisting substance-use disorder of significant duration (e.g., greater than 6 months);

- High risk or a recent history of being involved in the criminal justice system;

- in substandard housing, homeless, or at imminent risk of becoming homeless;

- Living in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live more independently if intensive services are provided; and

- Inability to participate in traditional office-based services.

Look at data on hospital use to determine what proportion of consumers in your system use the highest number of days of inpatient services. Then determine if any patterns are evident about the communities from which these consumers come. This will give you a sense of the proportion of which consumers are most likely to benefit from ACT, what your system currently spends on hospitalization, and which communities might most benefit from having an ACT program.

To the extent that information is available, you also want to find out how many consumers in jails and homeless shelters are likely to be eligible for this service. Understand the current collateral costs associated with those services.

Develop administrative rules for discharge

Often administrators ask whether consumers who receive ACT services can eventually be transferred to less intensive services. Two studies shed light on this issue.

The first study found that, when consumers were transferred to standard care after 1 year of ACT, they experienced substantial setbacks (Stein & Test, 1980). **The lesson: Discontinuing ACT at an arbitrary point in time does not work.**

In the second study, team members from an ACT program and a step-down program met and made case-by-case decisions about which consumers were appropriate for less intensive services (Salyers, et al., 1998). On average, the consumers selected for the step-down program had received ACT services for about 6 years. They tended to be consumers who:

- had an affective disorder rather than schizophrenia,

- did not have a substance abuse problem,

- had not been hospitalized in over a year living in stable housing,

- received only one contact from the team per month, and

- were rated by team members as functioning independently.

Some consumers transferred back to the ACT 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, carefully considering individual clinical needs.

- Continuity of care was ensured before and after transfer.

- The transfer was gradual with overlapping services.

- Consumers could readily transfer back to the ACT program when needed.

These findings suggest that **some consumers, 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 in any given year the proportion of consumers who might be appropriate for transfer using the flexible standards applied in the Salyers study is likely to be small.

Program standards in *A Manual for ACT Start-Up* (Allness & Knoedler, 2003) suggest that consumers' ability to function independently in all major roles (e.g., work, social, and self-care) for 2 years should be an element of discharge criteria for ACT programs.

Another important distinguishing characteristic of ACT is that no preset limit exists on the length of time that consumers can receive ACT services. The consumers targeted by ACT programs initially have very intensive needs. Even when symptoms subside, they remain prone to relapse.

Rather than discontinuing services at some arbitrary point or discharging consumers the first time they experience a period of progress, ACT teams 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 can prevent minor problems from snowballing into crises.

Devise administrative rules for staffing

We encourage mental health authorities to develop administrative rules to support the staffing requirements under the ACT model. ACT teams are composed of members of the various professions and disciplines. Achieving the right mix and number of professionals on ACT teams is essential to ensure that they will be able to serve as the primary provider of comprehensive services.

The intense nature of ACT programs and the types of consumers targeted make it necessary for programs to use qualified and competent team members. Most team members should have at least a master's degree.

It is also important that ACT teams reflect the cultural diversity of the communities in which they operate.

Typically, two team members are assigned leadership responsibilities to support the ACT leader—the lead mental health professional and the lead registered nurse. The lead mental health professional helps supervise comprehensive assessment, treatment planning, and delivering services. The lead registered nurse serves as the lead nurse in medication, pharmacy, and other medical-service activities. The many functions of self-contained teams require that other team members, however, assume lead responsibilities.

Include consumers and family members as ACT team members

Including consumers as team members has been codified in the ACT Fidelity Scale. On some ACT teams, consumers hold a position called *peer specialist*. In some cases, peer specialists may be unable to generate revenue for their services; you must plan support for these positions.

In addition to hiring consumers to fill peer specialist positions, we also suggest that consumers fill any position on the team for which they are qualified with accommodations, consistent with the Americans with Disabilities Act, if needed.

More recently, the contribution of family members to ACT teams has also received recognition (Dixon et al., 1998). Although including family members on ACT teams is not on the ACT Fidelity Scale, we urge you to recognize the unique experience that family members have to offer and suggest that you consider using them to fill any position on an ACT team for which they might be eligible.

Who is on a typical ACT team?

ACT teams with 10 to 12 staff members might include:

- **ACT leader** — One full-time employed mental health professional who provides direct services at least 50% of the time

- **Psychiatrist** — at least one full-time employee per 100 consumers

- **Psychiatric nurses** — at least two full-time nurses per 100 consumers (You may find that you need more nurses to cover all shifts.)

- **Employment specialists** — at least two full-time specialists who have 1 year of specialized training or supervised experience

- **Substance abuse specialists** — at least two full-time specialists with 1 year of specialized substance abuse training or supervised experience

- **Mental health consumer** — these people sometimes fill a position called peer specialist

- **Program assistant** — person with an Associate or Bachelors degree who works with the ACT leader to provide office management and to triage situations that emerge throughout the day

- **Additional mental health professionals** — people with Master's or doctoral degrees in social work, nursing, rehabilitation counseling, psychology, or occupational therapy

Create administrative rules for operations

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

ACT team hours of operation are:

Monday–Friday:
Two shifts per day
(e.g., 8 am-4:30 pm, 1 pm-10 pm)

Saturday–Sunday:
8-hour shift each day
(e.g., 10 am-6 pm)

Holidays:
8-hour shift
(e.g., 10 am-6 pm)

A team member is on call during all other hours.

Most ACT team members work the weekday shifts because most of the work must be done during these hours. At least two team members work evenings, weekends, and holidays and focus primarily on consumers in crises (or intensive interventions to prevent crises), and consumers who need help 7 days a week.

If you are interested in developing administrative rules to define these and other minimum program requirements to support ACT implementation, review the model program standards in *A Manual for ACT Start-Up* (Allness & Knoedler, 2003). You may also want to contact other mental health systems that provide ACT to look at their administrative rules.

Achieve high-fidelity ACT

Programs that adhere more closely to the ACT model are more effective. To ensure that your community receives the full benefit of this model:

Step 1 **Set up State and local advisory groups** made up of key stakeholders

Step 2 **Designate a clinical coordinator** at the State or county mental health office who has experience with the ACT model to provide side-by-side assistance to new teams.

Step 3 **Assess programs' fidelity to the ACT model** regularly using the tools in *Evaluating Your Program* in this KIT.

Step 4 **Include program standards in State plans and contracts.** Make adherence to those standards part of a certification process.

Achieving the outcomes associated with ACT depends on how faithfully agencies adhere to the model. Too many excellent initiatives had positive beginnings and enthusiastic support but floundered at the end of a year because they did not plan how they would maintain the ACT program.

As a central part of the initial planning process, you must address how ACT programs will be sustained. You can use strategies (e.g., rules, contracts) to address this issue and ensure that it is attended to in such a way that ACT programs will continue to grow and develop.

The ACT Fidelity Scale measures how well programs follow key elements of the ACT model. Adhering to the model is called *ACT fidelity*. Studies of ACT programs tell us that the higher an agency scores on the ACT Fidelity Scale, the greater the likelihood that the agency will achieve the favorable outcomes described above (Bond & Salyers, 2004; Teague et al., 1998).

Simply put, **providing ACT involves substantially reorganizing resources.** The best way to protect your investment is to make certain that agencies actually provide ACT.

The characteristics of an ACT program that would have a perfect score on the ACT Fidelity Scale are shown on the next page. For the entire ACT Fidelity Scale, see *Evaluating Your Program* in this KIT.

Characteristics of an ACT program that would have a perfect score on the ACT Fidelity Scale

Human resources, structure, team composition	
■ **Staff-to-consumer ratio:** 10 or fewer consumers per team member, excluding team psychiatrist and program assistant	■ **Nurse on staff:** A 100-consumer program has at least two full-time nurses
■ **Team approach:** 90% or more of consumers have contact with more than one team member per week	■ **Substance-abuse specialist:** A 100-consumer program has at least two full-time substance abuse specialists with at least 1-year specialized training in substance abuse treatment or 1-year supervised experience
■ **Practicing ACT leader:** A full-time program supervisor (also called *program leader*) provides direct services at least 50% of the time	■ **Employment specialist:** A 100-consumer program has at least 2 full-time employment specialists with at least 1 year specialized training or 1 year supervised experience
■ **Continuity of staffing:** Less than 20% turnover per year	
■ **Staff capacity:** Program has operated at 95% or more at full staffing in the past 12 months	■ **Program size:** A total of at least 10 FTE staff
■ **Psychiatrist on staff:** A 100-consumer program has at least one full-time psychiatrist	

Organizational boundaries	
■ **Explicit admission criteria:** The program actively recruits a specifically defined population and all consumers meet the explicit admission criteria	■ **Responsibility for crisis services:** Provides 24-hour coverage
■ **Intake rate:** The highest monthly intake rate in the previous 6 months was no more than six consumers per month	■ **Responsibility for hospital admissions:** 95% or more of inpatient psychiatric admissions are initiated through the program
■ **Full responsibility for treatment:** The program provides all of the following: ❑ psychiatric services, ❑ case management, ❑ supportive counseling and psychotherapy, ❑ housing support, ❑ substance abuse treatment, ❑ employment support, and ❑ rehabilitative services.	■ **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	■ **Work with support system:** Each month, team members have four or more contacts in the community with members of the consumer's support network
■ **No drop-out policy:** 95% or more of consumers are retained over a 12-month period	■ **Individualized substance abuse treatment:** Consumers with a substance-use disorder spend 24 minutes or more per week in substance-abuse treatment
■ **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	■ **Dual disorders model:** Program is fully based in dual disorders treatment principles with treatment provided by team
■ **Frequency of contact:** Average of four or more contacts per week per consumer	■ **Role of consumers on treatment teams:** Consumers are employed as practitioners with full professional status

Other issues to consider

Adapt the ACT model

We understand that for various reasons—often fiscal—mental health systems may consider varying certain elements of the ACT model. For example, a mental health system may want to reduce the overall number of team members on an ACT team or limit the hours of operation. At this point, we can no longer offer advice informed by research; administrators will have to rely on the experience of others.

Research shows that ACT teams that adhere more closely to elements of the ACT Fidelity Scale are most likely to achieve the beneficial outcomes associated with ACT. Current research is insufficient to tell us which elements can or cannot be "tweaked" under what particular circumstances without adversely affecting 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 ACT, where research is lacking, we have chosen to "default" to describing ACT as the originators of the model practiced it or rely on input from those who have experience implementing and managing ACT programs.

We recommend that you encourage agencies to obtain high-fidelity ACT and develop a system to routinely monitor fidelity and outcomes before adapting components of the ACT model. This way, ACT programs can monitor how adaptations effect the desired client outcomes.

Provide non-coercive ACT services

Many consumer groups and providers have expressed concerns about the potential for coercive practices within the ACT framework. One in ten consumers felt ACT was too intrusive or coercive. While the ACT model does not advocate using coercive measures, some suggest that a fine line exists between "assertive" and coercive treatment practices.

What are coercive practices?

Often legal status and other objective measures that rely on incidences of seclusion, restraints, and forced medication are used to predict whether a consumer experiences coercion. However, coercive practices are more widespread than these objective measures. For many consumers, coercion is endemic to the experience of mental illness and mental health treatment. Stigma, confinement, monitoring, and the pressure to follow a treatment plan may lead to feelings of being coerced or controlled (Scheid, 2001).

Monahan and colleagues found that in hospital admission settings, using negative pressures, such as threats and force, tends to engender feelings of coercion while using positive pressures, such as persuasion and inducement, do not (Monahan et al., 2001). Further, consumers who believe that they have been allowed a "voice" and have been treated with respect, concern, and good faith by family and practitioners experience fewer feelings of coercion.

How coercion is harmful

Using coercive measures fails to recognize the fundamental value of consumer choice and the rights of consumers to share responsibility for their recovery. Research generally suggests that coercion elicits fear of mental health services, noncompliance, hopelessness, confusion, and sadness and, therefore, can undermine efforts towards recovery (Monahan et al., 1995; Campbell, 1997; Hiday, 1996; Penny, 1995).

Traditional services were developed with a biomedical approach to mental health treatment and, therefore, focus on reducing symptoms and preventing relapse. With ACT services, team members *partner* with consumers to define recovery goals and help them to fulfill their goals.

ACT teams must be true to the recovery principles within the ACT model. Team members should be careful not to replicate those elements of traditional services that simply emphasize medication compliance with at-home drug deliveries.

Since ACT is a 24-hour, 7-days-a-week service that is available on a continuous basis for an unlimited time, it can easily interfere with individual autonomy. For example, if a consumer of an ACT team does not show up for work, a team member would go to the consumer's home to help with problems that were interfering with the consumer's ability to work. The consumer's medical status would be carefully monitored and treated and, routinely, medication would be prescribed (Davis, 2002). Such attention does not automatically respect the consumer's wishes. Consumers may interpret these services as coercive if team members do not listen and understand their experiences and focus on their preferences.

Coercive actions employed by ACT team members can include a range of behaviors from friendly persuasion to using force (Diamond, 1996). Financial management of consumer money and steps taken to ensure treatment compliance are controlling elements in ACT services. Whether they are undertaken in a coercive or an assertive way may determine the effectiveness of these strategies.

Provide assertive, not coercive treatment

The value of consumer choice in service delivery and the importance of consumer perceptions of coercion must be infused in how ACT services are provided. Most team members have never examined their own attitudes and behaviors about consumer recovery and, therefore, uncritically accept many social control functions without paying attention to how disempowering these practices are for consumers.

In recovery-based ACT services, establishing a trusting relationship is critical. Consumer-provider interactions should be based on mutuality and respect. Providers should:

- be challenged to listen to, believe in, and understand consumers;
- take into account consumers' reasons for "noncompliance;"
- focus on consumer-defined needs and preferences; and
- accept consumer choice in service delivery.

Like any mental health practice, ACT has the choice of using negative coercion or assertive strategies that support empowerment. ACT services that are provided "assertively" mean that team members go the extra mile to support and empower consumers to achieve their individual goals.

Mental health authorities can facilitate providing non-coercive ACT services by:

- clearly explaining consumer rights in the mental health authority's administrative rules;
- encouraging agencies to incorporate recovery principles, consumer rights, and discussions about the difference between assertive and coercive treatment into team members' training;
- holding community forums using the multimedia in the KIT;
- involving consumers in State and local advisory groups; and
- encouraging the inclusion of consumers as members of ACT teams.

Develop a training structure

Team members who implement evidence-based practices (EBPs) are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of ACT.

We encourage you to support agency administrators in their efforts to develop a training structure for ACT implementation.

The training plan should include:

- basic training for key community stakeholders, including:
  - ❏ consumers,
  - ❏ families,
  - ❏ mental health authorities, and
  - ❏ staff from key community organizations

- basic training for staff at all levels across the agency;

- intensive training for ACT team members; and

- basic training for selected ACT team members on complementary EBPs.

See *Using Multimedia to Introduce Your EBP* for materials to support basic training. Once trained, ACT team members will be able to use these materials to conduct routine community workshops and in-service seminars.

Choose your trainer

You may design an intensive training plan for ACT team members in several different ways, but you must first decide who will conduct the training. Initial training for ACT team members may be facilitated by the ACT leader using the training tools in *Training Frontline Staff*. Some choose to hire an external trainer.

One successful strategy in training ACT teams entails having members of a new team visit an existing, well-functioning, high-fidelity team to observe how the program works and the roles of team members. Members of new teams will benefit most from this visit if they have a basic understanding of the ACT model.

Effective training is ongoing

Throughout the first year, we encourage you to offer intermittent booster training sessions and ongoing onsite and telephone consultation, particularly for ACT leaders. Along with the team psychiatrists and the lead mental health professionals, ACT leaders are mid-level managers who are responsible for running the ACT program. ACT leaders have administrative responsibilities, such as hiring, preparing administrative reports, and ensuring that policies and procedures are developed and followed. ACT leaders also provide direct services.

Perhaps more importantly, ACT leaders are responsible for ensuring that the team operates with fidelity to the ACT model, including ensuring the quality and content of staff-consumer interactions. Through day-to-day leadership, the ACT model is faithfully carried out.

Leading an ACT team requires a complex set of administrative and clinical skills. Clinically, it requires a shift in thinking about consumers and their potential, about how services are delivered, and about how colleagues work together. Leaders of new ACT programs must learn to work in a system that is structured differently from other programs with which they are familiar. They must think differently about the potential of consumers and facilitate a process where team members work very differently with one another.

It is very difficult for anyone to grasp everything that has to be learned in a brief time. Understanding what needs to be done and translating that understanding into action are different processes. ACT leaders and psychiatrists are also responsible for making certain that all other team members understand.

Well-delineated training can help to ensure that ACT team members understand the ACT model. For at least the first year a new program is in operation, ACT leaders need someone who is experienced in managing ACT teams to provide ongoing consultation and mentorship on organizational and clinical issues. Consultation ranges from integrating ACT principles into the agency's policies and procedures to case consultation.

Consultation may also include having a lead consultant periodically involve other consultants with expertise on nursing, substance-abuse treatment, employment, or the role of peer specialists.

Some states develop teams in stages so that the first teams developed can help train teams that are developed later. It may take 2 to 3 years for a new team to become sufficiently proficient in the ACT model to assume the added responsibility of training other teams.

A state- or county-wide clinical coordinator who is experienced with the ACT model can also help facilitate developing new teams through ongoing contact, assessment, and troubleshooting.

ACT as an adjunct to criminal justice programming

ACT program staff have a long history of working with consumers who have the most difficult challenges, including those who have been arrested and incarcerated. In recent years, interest has increased in using ACT programs to divert consumers from the criminal justice system. The mental health community tends to support such efforts.

Treatment is generally preferred to incarceration so that mental illness is not criminalized and to ensure that consumers receive adequate and humane treatment. Programs, such as Community Treatment Alternatives in Madison, Wisconsin, have a history of working successfully with consumers who are involved in the criminal justice system.

However, problems arise when the boundaries between clinical staff and criminal justice personnel or probation officers become blurred. The argument has been that, when consumers view ACT team members as part of the criminal justice system working in concert with those who have the power to revoke their liberty, the therapeutic alliance is strained or at least qualitatively altered.

A study by Solomon and Draine looked at the 1-year outcomes of consumers who were released from jail to one of three programs: ACT, individual case management, and routine community mental health center services (Solomon, & Draine, 1995). Unfortunately, the authors found that the ACT program was not fully implemented in terms of staffing or treatment philosophy.

The poorly implemented ACT program resulted in a greater number of consumers being returned to jail than in the other two other service models. The authors concluded that, since the team members of this poorly implemented ACT team worked closely with consumers, they were more aware of probation violations. The connections with the criminal justice system resulted in the high number of sanctions.

This study illustrates two points:

- The study points out the importance of ensuring that ACT programs are appropriately implemented in terms of both organizational structure and the quality of clinical care.

- The study demonstrates that working closely with corrections adds a very different twist to treatment. Teams must be clear about their role as therapeutic agents.

Financing ACT

What ACT costs

Rigorous economic studies have found that when ACT teams adhere closely to the ACT model, reduced hospitalization costs offset the costs of the ACT program (Bond et al., 2001; Essock et al., 1998).

While many factors affect the cost of ACT, **a ballpark figure is $9,000 to $12,000 per year per person** (Linkins et al., 2002).

Budget projections

Several factors will influence the cost of ACT in your mental health system. In 2002, the Lewin Group, Inc., a health care and human services consulting firm, under a contract with SAMHSA and the Centers for Medicare and Medicaid Services (CMS), developed *A Resource Guide for State Officials Implementing and Financing Assertive Community Treatment Programs.* A companion tool was created for this guide in the form of an Excel-based program that can be used to project the cost of ACT given different parameters.

Parts of the ACT budget simulation model

Part 1 **Average cost estimates are produced for an ACT program using a set of core elements:**

- State where program will be implemented

- number and type of consumers

- staff-to-consumer ratio

- percentage of community-based (in vivo) care

Part 2 **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 ACT programs, the model adjusts the average cost depending on:

- urban vs. rural program

- program size

- age of the program

- level of benefit management and use of managed care contractor to administer the program

As an example of why the model adjusts the average costs, consider when ACT teams see consumers in the community and also provide transportation for them. In rural areas, team members may cover substantial distances. To make certain that adequate resources are allocated to transportation, you may want to confer with administrators of other systems when they project costs.

ACT programs must decide whether it is more economical to buy or lease vehicles for team members or whether team members should use their own vehicles and be reimbursed for mileage and additional liability coverage. Typically, team members prefer using program cars because using their own cars, even with reimbursement, greatly increases mileage on their cars and adds to wear and tear. Programs often underestimate the number of cars needed, mileage costs, and costs for additional insurance for personal vehicles.

For more information on Lewin's ACT budget simulation model, contact:

The Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042
(703) 269-5500

www.lewin.com

The Human Services Research Institute (HSRI) has also developed a computer simulation model. In this model:

■ consumers are categorized according to their functional levels and service needs,

■ service package options and their costs are identified for each consumer group, and

■ the effects of service packages on outcomes are estimated in terms of functional level improvement.

The model can then estimate a variety of aspects of system operations, including service use (e.g., hospital beds, residential beds, ACT teams), costs, outcomes, and revenue generation over any time period.

For more information and technical support for using this model contact:

Human Services Research Institute (HSRI)
2336 Massachusetts Avenue
Cambridge, MA 02140
(617) 876-0426

http://modeling.hsri.org

How ACT is funded

ACT is a Medicaid-reimbursable service; however, it may require an amendment to the State plan. Service system administrators will want to work closely with your State's Medicaid authority to develop the appropriate financial constructs for ACT.

Revenue sources

In considering potential funding sources for ACT, mental health system administrators must decide whether:

■ their localities will be expected to pay a share of the costs,

■ Medicaid will be used, or

■ other outside funds, such as grants or money from other State or local agencies (e.g., vocational rehabilitation, substance abuse) will be used.

Using State funds might encompass giving State aid to localities, redeploying existing State staff, and using shared State staff as an adjunct to a locally operated ACT team. For example, the Connecticut Department of Mental Health created ACT teams by reconfiguring community staff and reallocating staff employed by the State hospital (Essock, & Kontos, 1995).

Medicaid has become an increasingly appealing option for funding ACT since 1999 when CMS advised State Medicaid directors that programs based on ACT principles can be supported under Medicaid policy. CMS 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 it clear that CMS supports EBPs, but it strongly encourages States to adopt the principles of ACT, including:

■ interdisciplinary treatment teams,

■ shared caseloads,

■ 24-hour crisis availability,

■ 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 ACT services under a monthly bill structure. This practice allows programs to provide a broad range of services without having the burden of fee-for-service billing.

Mental health system administrators must work with their Medicaid counterpart to establish the financial constructs to support ACT.

What about capitation?

Chandler and colleagues reported the findings from a study that examined the cost-effectiveness of an ACT program operated with capitated payments in Alameda County, California (Chandler et al., 1999).

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; over that amount, 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 consumers referred into the ACT program were compared to costs for a similar group of consumers receiving routine care. During the first year of capitation, the gross per person cost for consumers receiving ACT was 25% less than for the comparison group.

The net cost to the county (considering that 100% of facility expenses, but only part of the expense for the Medicaid-reimbursable community-based services, had been borne by the county) was 75% less for the ACT program.

For more information, we encourage you to take advantage of two other resources:

Assertive Community Treatment Association
810 East Grand River Avenue, Suite 102
Brighton, MI 48116
(810) 227-1859
www.actassociation.com

National Alliance on Mental Illness
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-304
(800) 950-NAMI
www.nami.org

Through these organizations, you can find people who can speak from experience about the implications of different choices you might consider.

Building Your Program

Tips for Agency Administrators and ACT Leaders

Whether your agency is interested in enhancing an existing program or developing a program anew, you will need a broad range of activities to successfully implement ACT. This section outlines the range of implementation activities in which agency administrators and ACT leaders are often involved.

Recruit team members for your ACT program

ACT teams are different from other programs that may operate in your agency. The consumers who are eligible for ACT are those who have the most serious psychiatric symptoms and who, consequently, have the most severe problems with social functioning.

Typically, ACT programs serve consumers who:

- have extensive histories of psychiatric hospitalization,
- are homeless,
- have co-occurring substance abuse or medical problems, and
- are involved in the criminal justice system.

They are also consumers whose needs have not traditionally been well met by the mental health system. (See *Develop policies and procedures, Admissions and discharge* in this section.)

ACT programs can help consumers with these challenging needs to live safely and autonomously in the community because members on ACT teams assume responsibility for providing all the services consumers might need. These services might include helping consumers with:

- housing,
- parenting,
- benefits,
- symptom management,
- medical care,
- substance abuse treatment, and
- employment.

Rather than referring consumers to other programs, the team provides them. To do this, practitioners with a variety of skills and experiences compose the ACT team. They carefully integrate interventions and provide support as necessary.

To ensure that services are comprehensive, you must achieve an appropriate mix and number of team members on your ACT team. Your ACT team must be small enough to communicate easily. Each team member must be able to become familiar enough with consumers' status that they can step in to provide care at any time.

To have a sufficient range of expertise on the team and enough team members to provide adequate coverage (See *Providing adequate coverage* in this section.), we suggest that you have a team of 10 to 12 FTE positions with a total caseload of 100 persons. (See *Monitor staff–to–consumer ratio.*)

Who is on a typical ACT team?

- an ACT leader — 1 full-time employed mental health professional;
- 1 psychiatrist;
- 2 or more nurses;
- 2 or more employment specialists;
- 2 or more substance abuse treatment specialists;
- 1 full-time consumer/peer specialist;
- mental health professionals and paraprofessionals (master-level social workers, occupational therapists, rehabilitation counselors, psychologists); and
- 1 program assistant.

Choosing an ACT leader

It is important to hire or designate a leader for your ACT program. Successful ACT leaders have administrative and clinical skills and authority.

Their administrative responsibilities include:

- hiring team members,
- training team members,
- managing the team,
- monitoring the program's faithfulness to the ACT model, and
- overseeing various other quality control and financial responsibilities.

ACT leaders' clinical responsibilities include:

- monitoring consumers' status,
- delivering direct services to consumers,
- supervising the clinical performance of team members, and
- providing feedback to team members.

ACT leaders are often mid-level managers who have the authority to make or suggest administrative changes within the agency. We suggest that ACT leaders be full-time employees whose time is 100% dedicated to the ACT program and who commonly provide direct services at least 50% of the time. ACT leaders should have at least a master's degree in nursing, social work, psychiatric rehabilitation, or psychology.

We encourage you to make the KIT available to candidates during the hiring process so they will understand what they must do. As an ACT leader, they must have an active role in setting up the structures and processes needed to support the ACT team.

Because building an effective, well-functioning team is very much a developmental process, we encourage you and the ACT leader to revisit the information in the KIT 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 ACT team evolves.

Choosing a psychiatrist

Psychiatrists play several important roles on ACT teams. Psychiatrists:

- share responsibility for monitoring consumers' clinical status,
- deliver clinical services,
- provide clinical leadership, and
- share responsibility with ACT leaders for ensuring that quality ACT services are provided.

We suggest that you recruit or designate at least one full-time psychiatrist for every 100 consumers in your ACT program.

Selecting other team members

In addition to the ACT leader and psychiatrist, ACT teams have:

- **Psychiatric nurses**—at least 2 FTE per 100 consumers—who 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 specialists**—at least 2 FTE with 1 year's specialized training or supervised experience. Employment specialists provide work-related services, including assessing the effect of consumers' mental illness on employment, and planning and implementing an ongoing employment strategy to enable consumers to get and keep jobs.

- **Substance abuse specialist**—at least 2 FTE with 1 year's specialized substance abuse training or supervised experience. Substance abuse specialists provide and coordinate substance abuse assessment, treatment planning, and services delivery tailored to consumers' needs.

- **Peer specialist**—a person with serious mental illness who functions as a fully integrated team member and who:
  - ❏ shares personal, practical experience to benefit the team and its consumers;
  - ❏ provides expertise about symptom management and the recovery process;
  - ❏ promotes a team culture that maximizes consumer choice and self-determination;
  - ❏ provides peer counseling to ACT consumers and families; and
  - ❏ carries out other rehabilitation and support functions.

- **Mental health professionals**—people with master's or doctoral degrees in social work, nursing, rehabilitation counseling, psychology, or occupational therapy. Mental health professionals:
  - provide case management;
  - teach illness management and recovery skills; and
  - develop, direct, and provide other treatment and support services.

- **Program assistant**—This team member 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.

Requirements for ACT team members

- Be interested in working in the community.
- Be pragmatic and "street smart."
- Be willing to work non-traditional hours.
- Be willing to work both independently and collaboratively as a team.
- Have strong clinical and rehabilitative skills.
- Have specific knowledge of mental illness.
- Be willing and able to actively involve consumers in making decisions abou their own treatment and services

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Reflect your community's cultural diversity

Teams should reflect the cultural diversity of the communities in which they operate. Because team members work with consumers in communities rather than in clinic or hospital settings, they are actively involved in the lives of the consumers they serve. In this context, it is more important that teams are aware of and sensitive to cultural differences and consumer preferences.

Teams that reflect the cultural diversity of the communities in which they operate should include bilingual team members as needed. Your team must also have resources available to allow it to work with consumers who have hearing and visual impairments.

Consider these hiring tips

The ability to hire and retain team members has been linked to salary level. If salaries are not similar to the typical rates for each discipline in other health settings in your community, attracting and retaining qualified candidates will be very difficult.

We also recommend that you thoroughly check references for job candidates. 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 that are desirable for ACT team members.

The ACT leader should talk to previous supervisors, inquire in detail about candidates' previous work responsibilities and performance, and ask for opinions about their capabilities in team-based work with consumers. If candidates have had little experience in the mental health field or have just finished school, you can gather valuable information from field supervisors, training mentors, and teachers.

You should invite all candidates who are being seriously considered for employment to spend half a day or more with your team so that they can see the team at work. Candidates can then better evaluate how well they might fit in and can make a more informed decision about taking the job.

This visit will also give ACT team members a chance to talk with and observe candidates. Ask them to offer their feedback during the hiring process. This type of screening may help you weed out people who may be too authoritarian or patronizing to be appropriate for an ACT program.

Develop policies and procedures

Starting a new team means developing policies and procedures that fit the activities of the ACT model. These policies and procedures should be consistent with Medicaid and Joint Commission on Accreditation of Healthcare Organization standards. For model policies and procedures, see *A Manual for ACT Start-Up* (Allness & Knoedler, 2003).

Admission and discharge

You must set up a process to identify consumers who are appropriate for your program and acquaint referral sources with referral procedures. ACT studies have demonstrated positive outcomes in programs where the most common diagnoses were schizophrenia, schizoaffective disorder, and bipolar disorder and consumers showed substantial functional impairment (Calsyn et al., 1998; Chandler et al., 1996; Dixon et al., 1998; Hadley et al., 1997). Other studies have documented benefits for consumers with co-occurring substance abuse disorders (Drake et al., 1998; Teague et al., 1995).

The effectiveness of ACT has been documented in programs with consumers from diverse ethnic backgrounds, males and females, and a wide range of age groups (Bond et al., 1991).

For this reason, admission guidelines for ACT programs should target consumers who experience the most severe symptoms and, consequently, have chronic problems functioning in basic adult roles in the community. Some ACT programs focus on very specific groups of consumers, such as those with coexisting substance abuse disorders, those who are homeless, or those who have been repeatedly hospitalized.

What policies and procedures should cover

- admission and discharge (e.g., admission criteria, admission process, discharge criteria, discharge documentation);

- personnel issues (e.g., staff-to-consumer ratios, job descriptions);

- hours of operation, coverage, and service intensity;

- communicating with staff, emphasized by the team approach and recovery;

- administering medications and delivering services;

- planning assessment and treatment;

- managing consumer service funds;

- maintaining consumer records;

- ensuring consumers' rights; and

- evaluating program and staff performance.

There has been increasing interest in using ACT as a jail diversion program or with consumers who are involved in other ways with the criminal justice system. When working with the criminal justice system, conflicts may arise between ethical responsibilities to consumers and obligations to report consumers' behaviors to criminal justice entities. It is particularly important that programs working with criminal justice populations establish clear boundaries between their clinical role and their commitment to criminal justice agencies (Solomon & Draine, 1995).

The ACT leader must put these criteria into operation and identify and educate referral sources about the ACT program. You also need a process for explaining your ACT program to consumers in a way that lets them make an informed decision about accepting services.

The number of new consumers admitted to the program is deliberately restricted to five to six 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 consumers with multiple, complex needs all at once.

Schedule an admission meeting

When your team receives a referral, the ACT leader should confirm that the person meets the program's admission criteria. Arrange a meeting that includes:

- the current provider (e.g., crisis services, inpatient unit, etc.);

- the ACT leader;

- the consumer;

- family members or significant others of the consumer's choice,

- team members who will be consistently working with the new consumer; and

- the team psychiatrist.

At the admission meeting, have team members introduce themselves and explain the ACT program. If the consumer is acutely ill, it may take several contacts before you feel comfortable that the person understands the services that are being offered.

Sometimes consumers want to think about whether they want to receive services. In these instances, you may conduct a follow-up meeting. During these meetings, consumers learn about the program, but team members also learn about consumers' immediate history and current needs. They also get to know family members and other supporters.

When consumers decide that they wish to receive ACT services, your team should immediately open a record and schedule initial service contacts for the next few days.

> **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 a 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.**
>
> Barbara Julius, Outreach Program, South Carolina

Monitor the staff-to-consumer ratio

Generally, ACT teams should plan on having a staff-to-consumer ratio of no more than 10 consumers per team member, 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. In practice, team members do not have individual caseloads; instead, the team as a whole is responsible for all consumers in the team's caseload.

To figure your program capacity:

Total number of team members = 10-12 FTE

Average number of consumers per team member = 10:1

	12	FTE
X	10	consumers per team members
	120	maximum program capacity

This staff-to-consumer ratio is small enough to ensure that all team members know all consumers and that good communication is maintained. No matter how well a team is organized or how competent team members may be, the team cannot maintain effective communication if its caseload is too large.

If you exceed the maximum number of consumers, work effectiveness breaks down and the team will react to crises (or the imminent threat of crises) rather than help consumers take proactive steps toward recovery.

If your ACT team serves a large number of consumers with acute needs, you may find that you need a smaller caseload until consumers stabilize. The total caseload for which your team can provide intensive services and maintain the intimate communication needed to ensure quality care will be affected in part by the needs of the consumers you are serving.

That is, if your team serves consumers who have received services for several years, have relatively few crises, and require less frequent contact, you may be able to handle slightly more consumers per team member.

If most of the consumers that your team works with require frequent contacts, you may find that the staff-to-consumer ratio (and consequently the total case size) may need to be smaller. The same is true if consumers' living conditions are chaotic, housing is hard to secure, and daily living is very stressful, or if most of the consumers have co-occurring substance abuse issues or complicated medical needs.

You may recoup the cost of this more intensive staff by decreasing the use of more expensive inpatient services because ACT team members share many roles and strive to function interchangeably.

Create useful job descriptions

You should develop task-specific descriptions for each team position. A good description clarifies for job applicants whether a particular position matches their skills and expectations. In the position description, outline the main task categories and detail specific duties. For model position descriptions, see *A Manual for ACT Start-Up* (Allness & Knoedler, 2003).

After hiring, job descriptions allow ACT leaders to effectively supervise new employees. They also allow employees to focus on the basic elements of their job.

Hours of operation and service intensity

Having team members available 24-hours a day, 7-days a week, 365-days a year is very important in helping ACT 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 pre-emptive interventions often become crises and consumers are more likely to be hospitalized or entangled in the criminal justice system.

To ensure adequate coverage, your ACT leader should set a policy about how many team members can be on vacation at a time; ideally this will be no more than one team member at a time. All hours that ACT team members are not on duty, a team member must be on call to respond to crises.

ACT team hours of operation are:

Monday–Friday:
2 shifts per day
(e.g., 8 am-4:30 pm, 1 pm-10 pm)

Saturday–Sunday:
8-hour shift each day
(e.g., 10 am-6 pm)

Holidays:
8-hour shift
(e.g., 10 am-6 pm)

A team member is on call during all other hours.

Since most work for ACT teams is done during traditional business hours, most staff will work regular weekday shifts. When possible, have your team members rotate shifts for evening, weekend, holiday, and on-call duty to ensure that all team members regularly participate in daily team meetings.

Rotating team members may not be possible if some members of your ACT team are not trained to handle crises. Since assistance provided during evening, weekend, and holiday hours primarily focuses on consumers in crises (or intensive interventions to prevent crises), it is optimal to have a registered nurse on these shifts.

Paraprofessional mental health workers should work these hours only when you pair them with more highly trained team members. If your team serves non-English speaking consumers, you should plan how each shift will have access to team members who speak the appropriate languages.

If the total number of consumers is too small to justify having a 10-person team (for instance, in some rural areas), you will not have enough staff to cover all evening, weekend, and holiday shifts. If your team is in a rural area, you may have to coordinate with the on-call service of the larger mental health system.

Communicating with team members— the team approach and recovery

An ACT team is not a consortium of specialists or a group of individual case managers. Rather, it is an integrated, self-contained treatment program in which team members work together collaboratively. While certain team members will work more often with some consumers than with others, all team members should be familiar with each consumer and should be available when needed.

As a whole, the team is responsible for providing whatever is needed to assist consumers in their recovery from mental illness. This shared-caseload approach is an important component of ACT and is a characteristic that distinguishes it from other community-based programs.

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.

Michael Neale, Ph.D., Veterans Administration

Skills to help build effective teams

Contributing

Contributing team members pay attention to discrete pieces of information and, in thoughtful ways, notice patterns that emerge over time concerning consumers, the team, or the community. For example, a contributing team member may notice a consumer's early warning sign of relapse. By sharing this information with the team, you can help the consumer avoid a crisis.

Representing

For an ACT team to be successful, team members must remember that their individual actions are connected to the actions of others. It is important for each team member to update other members about all their interactions with consumers.

Subordinating

ACT team members value the decisions and actions that the team agrees on more than their own individual decisions and actions. Effective team members always interrelate their actions with the actions of other team members.

Learning to trust

Successful ACT team members cooperate rather than compete with one another. They are able to cooperate well because they trust the team process. They trust that members of the team will complete their tasks successfully either by themselves or by involving others who have the appropriate expertise.

An atmosphere of trust is facilitated when team members listen, avoid premature judgments, respect differences rather than unrestricted candor, share more than the minimal amount of information required by each person to do the job, and think of the team goals rather than their own goals.

Daily team schedule and team meeting

The daily team schedule and daily team meeting facilitate the team approach. Initially, the ACT leader is very involved in preparing the daily schedule. Once you establish a routine, assign team members as daily shift managers to organize and schedule that day's activities, make assignments for work that wasn't planned, and ensure follow-through on work that couldn't be carried out as planned.

Have the shift manager:

- coordinate and write the daily team schedule during the daily team meeting,

- supervise and monitor the daily team schedule throughout the day to ensure that all daily assignments are completed or rescheduled, and

- shift the daily team schedule or reassign work activities to accommodate emergency and other urgent situations that arise.

Daily team meetings give you opportunities to exchange information. Each day, update the team on the results of the previous day's contacts with consumers. Then jointly plan the activities for the current day. If some team members are not working effectively with a consumer, have the team problem solve and agree on what steps to take so that you consistently offer service across the whole team.

> **The daily meeting is a key factor in team co-hesion. The team needs to renew itself and reassert its cohesiveness, which is what a morning meeting is doing. It grounds you and refocuses you.**
>
> Michael Neale, Ph.D., Veterans Administration

Throughout the day, ACT team members move in and out of the office. When team members connect with one another, they share information from many viewpoints and develop a common understanding of consumers' strengths, weaknesses, and goals. When you understand consumers' goals in a new way, you open new possibilities for the team to respond and for better consumer outcomes.

All team activities relate to one another and, at the same time, are directed toward helping consumers reach their recovery goals. Nobody works at cross-purposes—the team should operate as a single unit of expertise, with ACT team members being accountable to one another.

ACT leaders may help team members work together as a team by making sure that team members' expertise is diverse. You should recruit team members with expertise in specific areas but who also deeply understand how their expertise relates to the expertise of other team members. Effective ACT leaders have the ability to combine the insights of different team members (who represent different areas of expertise) in ways that produce a new understanding of a complex situation.

You can also increase team cohesion by encouraging informal leadership. As the number of informal leaders on a team increases, team members' ownership of the team process increases as well.

Once your ACT team is up and running, it is by no means a finished work! To be effective the ACT team must be alive—it must adapt and be flexible, intelligent, reflective, renewing, resilient, and constantly learning.

The ACT team is a living system with 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.

Administering medications

Work closely with your team's psychiatrist and nurses to set up procedures that ensure medications are being used wisely. Procedures should also guide other team members who participate in non-medical aspects of the system, such as delivering medication and assessing consumers' responses to medications.

Procedures should include guidelines for:

- recording medication orders,
- filling orders,
- procuring medications,
- storing medications,
- coordinating with medical providers,
- educating consumers about their medication,
- ensuring that necessary lab work is done in a timely manner, and
- keeping team members informed of changes in medication and medication side effects.

As you think about medications, keep in mind that unit dosing of each medication may be preferable to undivided bottling or packaging. If an undivided supply is sent, a nurse must take the time to separate the medication into the unit doses, which can be very time consuming, especially when the nursing team has to package unit doses for a large number of consumers.

Also, in systems with fee-for-service reimbursement structures, this chore may not be billable. If you can't avoid undivided packaging, consider having nurses prepare medications for several days at once.

Some consumers cannot afford some or all of the medications they need. The team should budget money to purchase medications for consumers in these instances (see budgeting below) 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.

Rules of medication administration and distribution may vary from State to State. Make sure you are familiar with the rules for your State. Consider also speaking to a consultant pharmacist to find out if she or he can devise a streamlined system for ordering, dispensing, and storing medications.

Consultant pharmacists can:

- provide upfront and ongoing education to team members on appropriately using medication,

- resolve billing problems, and

- manage quality assurance processes.

To find out more about how a consultant pharmacist may help you, contact:

American Society of Consultant Pharmacists
1321 Duke Street
Alexandria, VA 22314
www.ascp.com
703-739-1300

Delivering services

In addition to the daily team schedule (discussed before), ACT teams use two tools to organize the way they deliver services:

- the *Weekly Consumer Schedule* and

- the Daily *Communication Log*.

The Weekly *Consumer Schedule* includes the specifics (i.e., what will be done when, by whom, where, how often) about the services and interventions outlined in the treatment plan. The Individual Treatment Team (ITT) should record this information and update it whenever it changes. Write the *Weekly Consumer Schedule* in pencil on 5″ x 8″ index cards so that changes can be easily made and keep these cards in a central file in the team meeting room.

Then, to make sure that consumers receive the planned interventions and services, have the designated shift manager for the day review each consumer's weekly schedule. Write the activities scheduled for that day on the daily team schedule. If needed, adjust it during the daily team meeting to ensure 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 consumer's primary case manager is scheduled to take the person grocery shopping but another consumer with whom that case manager works is victimized overnight, your team may decide that the case manager must see the consumer who was victimized. In that case, have another team member take care of the trip to the grocery store.

The *Daily Communication Log* is a three-ring binder that has an index tab for each consumer, followed by several sheets of notebook paper. During the daily meeting, the team member who is responsible for the *Daily Communication Log* states the first consumer's name. Anyone who has had contact with that person in the last 24 hours briefly describes the purpose of that contact and what happened. The person with the *Communication Log* writes a brief statement in the log.

Any team member can pick up the 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 those who cover the evening shift.

> The most important thing a new team leader needs to understand are the tools of ACT... timelines, comprehensive assessments, treatment plans, daily/weekly schedules, the communication log and the daily team meeting...
>
> 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.
>
> Dawn Petersen, MS, Gulf Coast Treatment Center

At times, despite everyone's best efforts, inpatient psychiatric hospitalization will be necessary. Hospitalization typically occurs in collaboration with consumers. 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, keeping resources, such as housing, in place and coordinating discharge plans to keep the stay as brief as possible.

Planning assessment

Many consumers have a long history of receiving services. The assessment process is a way of piecing together consumers' history in a way that allows the team to get a clear picture of each person's experience with mental illness and previous treatments.

The initial assessment addresses consumers' most urgent needs.

What the initial assessment documents

- 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.

After you gather and organize this information, bring it together and present it at a treatment planning meeting. Based on this assessment, you can formulate an initial, problem-oriented treatment plan.

As your team begins to address these needs, you will conduct a more thorough assessment. The team approach helps bring together the expertise of different professionals in understanding consumers' histories and needs.

Unlike traditional office-based assessment procedures, ACT team members conduct comprehensive assessments as they work with consumers in the community delivering the services outlined in the initial treatment plan.

This approach has the advantage of allowing team members to actually observe how consumers manage in the community and what the consumers' environment is like.

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."

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 ACT.

Michael Neale, Ph.D., Veterans Administration

The purpose of the comprehensive assessment is to collect information from multiple perspectives about consumers and how their lives are affected by mental illness and then to assemble the information coherently. Under the supervision of the ACT leader, the primary case manager and other team members are responsible for obtaining the appropriate releases of information and for completing comprehensive assessments within 30 days after consumers are admitted.

Parts of a comprehensive assessment

- psychiatric history, mental status, and diagnosis;

- physical health;

- use of drugs or alcohol;

- education and employment;

- social development and functioning;

- activities of daily living; and

- family structure and relationship

Another tool that ACT team members use to organize and make sense of vast amounts of information collected during comprehensive assessments is the *Psychiatric/Social Functioning History Timeline*. Your procedures for conducting comprehensive assessments should encourage your team to use this tool. For a more detailed discussion of each of these tools, see *Training Frontline Staff*.

Planning treatment

Within 1 week after new consumers are admitted to the program, the ACT leader should designate team members who will be responsible for establishing relationships with them and for providing continuous and integrated services.

This lead group of team members is called the Individual Treatment Team (ITT). The ITT is also continuously responsible for:

- assessing consumers' status and needs,

- initiating the treatment planning process with consumers and families, and

- providing the majority of consumers' treatment and support services.

Key members of the ITT

To coordinate consumers' care across the whole team, the ITT must collectively possess a blend of treatment and rehabilitation skills. In rural areas, you may not be able to exceed three team members for each ITT, but in urban areas where large ACT teams exist, the ITT should have the following team members:

■ **Primary case manager**—a mental health professional who coordinates and monitors the activities of the ITT

❏ has primary responsibility to write the treatment plan;

❏ provides individual supportive therapy and illness management education;

❏ ensures immediate revisions to the treatment plan as consumers' needs change; and

❏ advocates for consumers' rights and preferences.

The primary case manager is usually the first team member contacted when consumers are in crisis and provides the primary support to consumers' families.

■ **Backup case manager**—also a mental health professional—shares tasks related to coordinating care and is responsible for performing them when the primary case manager is absent.

■ **Psychiatrist**—performs duties that are regularly coordinated and collaborated with the ITT.

■ **Nurse**—arranges and coordinates consumers' medical care with community medical providers. Nurses may carry out some physical assessments and treatment; however, their primary responsibilities are psychiatric, not medical.

■ **Other team members**—team members selected to best match consumers' needs and interests. For instance, if a consumer 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.

One strength of ACT is that the entire ACT team, not just the ITT, participates in the assessments and treatment planning process. The collaborative process ensures that:

■ treatment plans holistically address consumers' needs,

■ the details with treatment plans are carried out, and

■ goals and objectives are revised when new needs arise.

Treatment plans are specific to consumers

Treatment planning involves taking the information in the comprehensive assessment and *Psychiatric/Social Functioning History Timeline* and translating it into objective goals based on consumers' preferences. Treatment plans are person-specific; they are built to address each consumer's goals and the services a particular consumer needs to reach those goals. Treatment plans detail the specific interventions or services to be provided, including *who* will provide them, as well as *how long* and *where.*

Although developing treatment plans seems straightforward, new teams often struggle with developing person-specific plans that consider consumers' unique experience of mental illness and personal goals. Team members often have difficulty thinking of consumers' histories in terms of their experience of mental illness, rather than just their behavior. Some team members will have a hard time giving up the notion that they know what's best for consumers and letting consumers work on what's important to them. We highly recommend clinical consultation from experienced ACT leaders.

Although most consumers' service contacts are with members of the assigned ITT, the larger team is also involved in providing services. To coordinate treatment, the ITT continuously monitors the services consumers receive, coordinates all team members' activities, and provides information and feedback to the whole team.

> **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 system 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.**
>
> Michael Neale, Ph.D., Veterans Administration

The treatment planning meetings give the ITT opportunities to exchange information with the larger team. ACT leaders run the treatment plan meeting, which all other team members attend when possible. Depending on consumers' preferences, they may also attend.

Because so many team members work with each consumer, treatment plans require total team understanding and agreement. If some team members do not work effectively with a consumer, or if they disagree with the treatment plan, the ITT's role is to discuss the plan, problem solve, and get consensus so the whole team consistently implements service.

Managing consumer-service funds

Your program needs written policies and procedures to cover disbursing and tracking consumer-service funds. ACT budgets allocate consumer-service funds to provide direct financial grants or loans to consumers, for example, when disability benefit payments have not started, when benefit checks are delayed, or when the first check from a new job is insufficient to cover expenses.

You may use consumer-services money for:

- emergencies,
- rent,
- security deposits,
- food,
- clothing,
- recreation, and
- consumers' transportation costs.

Your policies and procedures should cover how, when, and under what circumstances team members may access these funds.

Maintaining consumer records

You must maintain records for each consumer and you must safeguard the records and their contents against loss, tampering, and unauthorized use. The records should be consistent with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Medicaid requirements.

If you are creating a new recordkeeping system, you need to buy materials to create records (e.g., binders, forms) and to store them appropriately. You also need written policies and procedures for documenting and maintaining records. Educate your team members and supervise them in the required documentation practices.

Because ACT teams serve consumers who often have many immediate needs, and because team members spend most of their time in the community, maintaining documentation and progress notes can be particularly challenging. Some teams have found that they must designate times in the team schedule to spend on documentation.

Ensuring consumers' rights

Many consumer groups and providers have expressed concerns about the potential for coercive practices within the ACT framework. One in ten consumers felt ACT was too intrusive or coercive. While the ACT model does not advocate using coercive measures, some suggest that a fine line exists between "assertive" and coercive treatment practices.

What are coercive practices?

Often legal status and other objective measures that rely on incidences of seclusion, restraints, and forced medication are used to predict whether a consumer experiences coercion. However, coercive practices are more widespread than these objective measures.

For many consumers, coercion is endemic to the experience of mental illness and mental health treatment. Stigma, confinement, monitoring, and the pressure to follow a treatment plan may lead to feelings of being coerced or controlled (Scheid, 2001).

Monahan and colleagues found that in hospital admission settings, using negative pressures, such as threats and force, tend to engender feelings of coercion while using positive pressures, such as persuasion and inducement, do not (Monahan et al., 2001). Further, consumers who believe that they have been allowed a "voice" and treated with respect, concern, and good faith by family and practitioners experience fewer feelings of coercion.

How coercion is harmful

Using coercive measures fails to recognize the fundamental value of consumer choice and the rights of consumers to share responsibility for their recovery. Research generally suggests that coercion elicits fear of mental health services, noncompliance, hopelessness, confusion, and sadness and, therefore, can undermine efforts towards recovery (Monahan et al, 1995; Campbell, 1997; Hiday, 1996; Penny, 1995).

Traditional services were developed with a biomedical approach to mental health treatment and, therefore, focus on reducing symptoms and preventing relapse. With ACT services, team members *partner* with consumers to define recovery goals and help them to fulfill their goals.

ACT teams must be true to the recovery principles within the ACT model. Team members should be careful not to replicate those elements of traditional services that simply emphasize medication compliance with at-home drug deliveries.

Since ACT is a 24-hour, 7-days-a-week service that is available on a continuous basis for an unlimited time, it can easily interfere with individual autonomy. For example, if a consumer of an ACT team does not show up for work, a team member may go to the consumer's home to help with problems that were interfering with the consumer's ability to work. The consumer's medical status would be carefully monitored, treated, and routinely medication would be prescribed (Davis, 2002). Such attention does not automatically respect the consumer's wishes. Consumers may interpret these services as coercive if team members do not listen and understand their experiences and focus on their preferences.

Coercive actions employed by ACT team members can include a range of behaviors from friendly persuasion to using force (Diamond, 1996). Financial management of consumer money and steps taken to ensure treatment compliance are controlling elements in ACT services. Whether they are undertaken in a coercive or an assertive way may determine the effectiveness of these strategies.

Providing assertive, not coercive treatment

The value of consumer choice in service delivery and the importance of consumer perceptions of coercion must be infused in how ACT services are provided. Most team members have never examined their own attitudes and behaviors about consumer recovery and, therefore, uncritically accept many social control functions without paying attention to how disempowering these practices are for consumers.

In recovery-based ACT services, establishing a trusting relationship is critical. Consumer-provider interactions should be based on mutuality and respect. Providers should:

- be challenged to listen to, believe in, and understand consumers;

- take into account consumers' reasons for "noncompliance;"

- focus on consumer-defined needs and preferences; and

- accept consumer choice in service delivery.

Like any mental health practice, ACT has the choice of using negative coercion or assertive strategies that support empowerment. ACT services that are provided "assertively" mean that team members go the extra mile to support and empower consumers to achieve their individual goals.

Administrators and program leaders can facilitate providing non-coercive ACT services by:

- clearly explaining consumer rights in ACT policies and procedures;

- offering training on recovery principles, consumer rights, and the difference between assertive and coercive treatment;

- holding community forums using the multimedia in the KIT;

- involving consumers in local advisory groups; and

- including consumers as members of ACT teams.

Evaluating program and team member performance

When properly implemented, ACT 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 use of illegal substances also improve.

Evaluating the performance of your ACT program will help you provide high-quality services to consumers. We recommend developing procedures for ACT program evaluation early using the guidelines in *Evaluating Your Program* in this KIT.

Additionally, develop procedures for how you will supervise and evaluate your ACT team members. Clinical supervision is the process that will, to a large extent, determine whether the team will simply be a menagerie of mental health professionals doing what they've always done or whether they will truly change and provide services in an evidenced-based way.

We recommend that ACT leaders and psychiatrists share responsibility for clinically supervising ACT team members. The lead mental health professionals and nurses may assist with clinical supervision when ACT leaders or psychiatrists are absent.

Because 50% of ACT leaders' time is dedicated to direct services, ACT leaders will be familiar with all of the consumers that the team serves; ACT leaders will not just review "cases" that team members present.

Clinical supervision is provided in the context of the team's daily work. Daily work in an ACT team includes daily team meetings, that assess each consumer's status and response to treatment. ACT leaders and psychiatrists direct each case to ensure good clinical care and provide feedback on team members' performance.

Daily work in an ACT team also includes treatment planning. ACT leaders, with the participation of the psychiatrists, supervise individual treatment teams in developing and reviewing written treatment plans. They help team members master the technical and analytical aspects of individualized treatment planning.

ACT leaders and psychiatrists also provide individual, side-by-side supervision to assess performance, give feedback, and model interventions. ACT leaders may schedule regular meetings with individual team members to review cases, evaluate performance, and give feedback. ACT leaders and psychiatrists should be regularly available at office headquarters or by beeper or cell phone to consult with team members as needed.

In providing clinical supervision, ACT leaders and psychiatrists translate a new way of working into the daily actions of team members. It is essential that ACT leaders and psychiatrists thoroughly understand the ACT model. For training tools and recommendations, see *Training Frontline Staff* in this KIT.

If the ACT team is working with a consultant, the ACT leader should involve the consultant in the supervision and team processes and should elicit feedback.

Selecting a location for your ACT program

Think about two key things when you decide where the program will be physically located:

- the need for the program to be readily accessible to consumers and team members, and
- the need for a workspace that is laid out in a way that facilitates communication.

Accessibility

Members of the ACT team spend most of their workday in the community, returning to the office intermittently between appointments to get messages and to consult with other team members.

Selecting the location of your ACT office

- **a convenient, central location** that allows the team members to easily reach the neighborhoods where consumers live.

- **parking areas** near the office for program and personal vehicles so that team members and consumers can easily and safely come and go.

- **available times** allowing the building to be open during all hours that the team works, including evenings, weekends, and holidays.

- **accessibility** so that consumers and their families must be able to 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).

- a directly accessible **reception area;**
- **large meeting and work room** with:
  - ❏ a conference table and chairs;
  - ❏ several telephones;
  - ❏ treatment records;
  - ❏ storage space for treatment records; and
  - ❏ storage space for each team member.
- **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** that can also serve as office space for the ACT leader and the psychiatrist or as interviewing or quiet work space for all team members.
- **space to temporarily store consumers' possessions,** as well as for purchased and donated clothing, furniture, and household supplies for consumers.
- **space for office machines** (e.g., copy machine, fax machine) and for storing office supplies.

Office layout

ACT team members should share a common work area rather than having individual offices. This allows a free flow of conversation and an opportunity to informally exchange information and ideas.

You will also need a room in which substance abuse treatment groups can be held. This room must allow for privacy.

Reviewing your ACT program budget and revenue sources

It is important for you to understand the program budget and revenue sources so that you can actively participate in the budgeting process, make informed management decisions, and understand where collateral revenue sources are most needed. If you will be involved in actual budget preparation, you may find it useful to review the budget simulation information in *Financing ACT* in the *Tips for Mental Health Authorities* section.

Transportation is a practical as well as an economic issue in starting an ACT team. We suggest that you deal with it up front.

ACT teams see consumers in community settings and provide them with transportation when necessary because most consumers do not have cars. Many consumers may have difficulty using public transportation, if it exists in their areas.

You must decide whether it is more economical to buy or lease vehicles for team members or whether team members should use their own vehicles and be reimbursed for mileage and additional liability coverage. Agencies that have provided only clinic-based services may also need to develop written policies and procedures about transportation. Travel and transportation costs that may be included in your ACT budget include vehicle lease or purchase, travel reimbursement, and parking and liability insurance for personal vehicles.

You should understand how programs generate revenue. In some mental health systems, ACT programs receive a fixed rate for each consumer that the team serves. In other systems, teams are reimbursed based only on the specific services provided during any given encounter with consumers. In that case, you should be familiar with which team members can capture billing for what services. You will also need to know the billing process and billing codes.

What your budget must include

- 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;

- 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;

- team members education and training; and

- consultation.

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

You must be aware of and avoid the fact that the mission and work of programs over time are defined by the funding that comes into the program. You must know the principles of ACT and be vigilant that funding opportunities support the model rather than shape and corrode it.

Developing a training plan

Developing an ACT team is a complex undertaking. Recruiting and retaining team members who know the ACT model or how to treat consumers can be difficult. Agencies that have successfully implemented ACT indicate that offering one-time training for team members is not enough. You should assess the knowledge level of key stakeholders (see *Evaluating Your Program* in this KIT) and develop a training plan.

The training plan should include:

- basic training for key stakeholders, including consumers, families, mental health authorities, and team members from key community organizations;

- basic training for team members at all levels across the agency;

- intensive training for ACT team members; and

- basic training for selected ACT team members on complementary EBPs.

Team members who implement evidence-based practices are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agency-wide staff develop a basic understanding of ACT. This training will help your ACT team's work.

See *Using Multimedia to Introduce Your EBP* in this KIT for materials to support this basic training. Once trained, ACT team members will be able to use these materials to conduct routine community workshops and in-service seminars.

In addition to the multimedia training tools, the ACT KIT includes *Training Frontline Staff*, which gives team members in-depth information about the ACT model and skills for providing ACT services. ACT leaders may facilitate a four-part structured group training.

Once team members have a basic understanding of the model, we recommend that they visit an existing, well-functioning, high-fidelity ACT team to observe how team members work with consumers and how they interact with one another.

In addition to in-depth training on ACT, we suggest that you have at least one team member attend a basic training in other evidence-based practices. They can then cross-train other team members.

During the first 1 to 2 years of a new team's existence, many agencies have found it helpful to work together with an external trainer or consultant. Establishing the initial processes that must be in place to provide quality services requires great attention to detail. Consultants and ACT leaders often work together over the 2 years of implementation to ensure that the ACT program is structured appropriately. They work together to integrate EBP principles into the agency's policies and tailor ACT program procedures to meet local needs.

Once the program has been launched, it is important that you do not allow teams to revert to older and more familiar, more comfortable ways of doing things. External trainers or consultants who are experienced in running ACT programs can provide ongoing technical assistance, side-by-side supervision, and periodic booster training sessions.

This type of assistance, along with ongoing evaluation of fidelity and outcomes, has been found to be critical in reducing the chance that team members will revert to old, more familiar ways of operating.

Two places where you might identify a mentor are:

Assertive Community Treatment Association
810 East Grand River Avenue, Suite 102
Brighton, MI 48116
(810) 227-1859
www.actassociation.org

National Alliance on Mental Illness
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
(800) 950-NAMI
www.nami.org

Building Your Program

Voices of Experience

Voices of Experience is a series of three interviews with administrators and ACT leaders who have experience implementing ACT. The interviews contain information that will help you implement ACT and anticipate some of the practical challenges associated with developing and leading ACT teams.

Interview 1

Michael Neale, Ph.D.
Veterans Administration

It is very important from the beginning to have a sense that ACT 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 ACT, and a piece of ACT in all of these revolutions.

Congratulations! You're the ACT leader

Many of the ACT 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 ACT leader."

So, now you have to learn to be part administrator and part practitioner. In our system, we expect half of the ACT 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 team members; 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

ACT 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 ACT 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 ACT. As part of their training, team members visit a mentor site. The legacy of ACT is that we've all made a pilgrimage either to Madison (where ACT 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 ACT 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 whom they can learn from. It is important to have consulting, technical assistance, and side-by-side support to help ACT leaders through the process of developing a program. Otherwise, the tendency is for new ACT leaders to see the ACT program through the eyes of a traditional treatment provider. While traditional programs have value, ACT 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 ACT services. You want to make sure programs target the people who most need their services because these services are relatively expensive and not everyone needs services that are this intensive.

Our monitoring in the VA also looks at who provides the services—are there in fact the team member resources available that are supposed to be there? We look at what services are provided, how the team members organize 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 the veterans still in the program, those who have 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 ACT 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: team members get pulled away, positions don't get filled, or all of a sudden you have double the caseload you're supposed to have. This undermines the fundamental principles 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 Community Mental Health Centers (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 ACT program in Madison, Wisconsin. Once the first ACT 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 ACT were put into a standardized checklist that evolved into the ACT Fidelity Scale. 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 team members, 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 team members, 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 practitioners to take care of everything, but certainly leaders should be able to spend an hour or two to see what their team members and consumers are doing.

I also encourage people to set up structures for information flow, whether its e-mail 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 team member's 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, a psychologist, and a rehab worker." You're looking for communication and relationship skills, and the ability to deal with legal and housing issues. 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 team members' 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 is 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 an ACT 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 ACT 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 not 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 e-mail. 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 "pigeonholing" people when they do an assessment. It's partly because that's how we work as humans. We categorize things and pigeonhole 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 ACT. 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 that 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 in 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 team members. The team members know 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 ACT 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 who's 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. You're 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 ACT 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 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 ACT 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 ACT 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 ACT, 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, and 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.

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 ACT. The grant allowed Charleston to start two new, separate ACT 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 the 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 team members and creating the infrastructure to support the new program. The mental health center staffed their team by re-deploying and re-training existing team members, 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 team members 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 team members 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 an ACT leader or program director, hold the dream of possibility for another person, then you shouldn't be leading an ACT team. If you can't envision people who experience a serious mental illnesses "getting better" and you think they'll require constant supervision, then why do ACT?

Admitting and assessing new consumers

As the process of finding consumer candidates began, we used a printout from the state hospital that 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 team members 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, team members 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 team members 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 practitioner 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, team members 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 ACT 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 team members 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 team members 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, and 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 team members 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 team members 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 team 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 any way.

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 to.

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 an ACT leader has to do is have the consumer bond with the team and program rather than with individual team members. Many people who receive ACT 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 3 months to be seen by the doctor for a medication check. Team members, 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 team members 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 ACT leader tends to set the general tone for team members' 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 team members 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 team members care about and value the consumers as individuals.

Relationships are very important to the success of this program. Team members 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 ACT program, there's much broader involvement in the sense that team members 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 calls are 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 team members 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 team members knew the consumer and their surroundings well, the backup person would go with them. If a team members 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 an ACT 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 bouncing 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, would lead 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 inhalant sprays 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 with consumers to think about ways of changing those patterns.

One of the most important things team members, 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. Every day 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 serious 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 also other medications that consumers frequently took 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 team members 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 1 year to 3 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 didn't 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 (e.g., 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 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 team members arrived, the police would do a couple of "drive-throughs" to scatter the drug dealers. Then the team members would drive up, do what they needed to do and leave. If team members 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 ACT leader to help the team members 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 ACT leader helps the team focus on the positive by pointing out progress. For instance, it might seem to the team members 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, stayed within their budget for the week, or only called after hours five times in a week instead of 50 times. For team members that want to see a quick fix, this is the wrong job.

Dawn Petersen, MS, Gulf Coast Treatment Center

Teaching versus doing

ACT 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.

ACT 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 ACT 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 things a new ACT leader needs to understand are the tools of ACT. 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 ACT 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 ACT leaders sometimes have a problem grasping is the way ACT 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 make 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, 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 team member is going to do and the 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 toward 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; 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, using a behavioral approach, what has happened with each person in the past 24 hours. You do it in short concrete statements. 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 three-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 team member's 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, for the dual diagnosis group, and for standing administrative obligations like program director meetings. The person putting together the daily schedule knows if there's a special appointment or if a team member's person is not going to be available.

We're very respectful of the times team members 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 team members 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 team members' 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 team members

ACT 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. An ACT leader is very involved with team members and consumers. Typically, at least 50% of the leader's time should be spent in direct services and supervising team members. The best way to supervise team members is to go with them on consumer contacts.

Red tape

One of the things an ACT leader has to do is break down barriers so that his or her team members 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 ACT 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 an ACT 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 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 ACT model. I use it as the team's "treatment plan." I don't think you can ever be a perfect ACT team; 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 toward 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.

Once a quarter, our team meets 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 then ever before, what are we doing differently? 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 is that the key to safety, and what is different about ACT, is the thorough, detailed, assessment that is done on each individual.

This is actually a safer place to be than an 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, etc. 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; it's 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. We've also found that when you get involved with someone clinically you cannot be involved with their finances; 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.

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services