

Telecare Service Category: Assertive Community Treatment



ASSERTIVE COMMUNITY TREATMENT (ACT) DEFINITION

Assertive Community Treatment (ACT) is a community-based alternative to inpatient hospitalization for individuals with serious mental illness who do not respond well to less intensive services. These individuals are often heavy utilizers of emergency psychiatric services and report significant dissatisfaction with the quality of their lives. Developed in Madison, Wisconsin by Stein and Test in the 1970s, the ACT model is built on the belief that people with serious mental illness can achieve better results while living in the community, rather than in a hospital setting, when they receive highly supportive, individualized mental health services. The original Stein/Test model is known as the Program for Assertive Community Treatment (PACT). Results on PACT were published in 1980. Since then, there have been hundreds of replications and dozens of research evaluations on its effectiveness. ACT has been widely implemented nationally with enthusiasm. It is appealing because it offers a clearly defined model that is research-proven to provide consistent outcomes. It appeals to most consumers because of its member-centered approach, to families because it is effective and inclusive, and to customers because it helps manage clinical and fiscal risk while supporting recovery.

PRINCIPLES AND STRUCTURE: ACT programs are successful because of specific structures and processes, many of which are identified by Suzan Phillips, et al, in the Principles of ACT (see box). Other essential factors include the use of multidisciplinary teams to meet the complex needs of members. When a member is confronted with a particular challenge (e.g. housing needs, entitlements, substance use), they can be assisted by the staff member that has the most relevant skills. The most effective team size is one that is large enough so needed disciplines/skills are included and 24/7 coverage is possible, but small enough so that each staff person is familiar with each member. The conventional staffing ratio is 1:10. Richer staffing ratios are used in rural settings and with members presenting complex challenges. As members require fewer services and supports, less intensive ratios are needed.

RESULTS OF RESEARCH: ACT has been studied more extensively than any other community mental health treatment approach. Research has demonstrated the effectiveness of ACT in decreasing the use of acute psychiatric hospitalization, with higher levels of housing stability and member and family satisfaction. There is evidence that with additional focused resources, positive outcomes can be achieved in the areas of homelessness, jail/arrests, employment, and substance use.

STANDARDS: Two organizations have published standards for ACT services, which Telecare uses to define the types of ACT programs it provides. In 1998, the Substance Abuse and Mental Health Services Administration (SAMHSA) published PACT standards based on replication of the Madison model. The National Alliance for the Mentally Ill (NAMI) has championed these standards. In 1999, the Rehabilitation Accreditation Commission (CARF) published ACT standards that included input from ACT programs nationally. These standards and research findings noted above define the three ACT models Telecare provides, which are described on the back of this brochure.

THE PRINCIPLES OF ACT

By Suzan Phillips, et al, "Moving Assertive Community Treatment Into Standard Practice" Psychiatric Services; June 2001

1. Services are targeted to a specified group of individuals with severe mental illness.
2. Rather than brokering services, treatment, support, and rehabilitation services are provided directly by the ACT team.
3. Team members share responsibility for the individuals served by the team.
4. The staff-to-consumer ratio is small (approximately 1 to 10).
5. The range of treatment and services is comprehensive and flexible.
6. Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings.
7. There is no arbitrary time limit on receiving services.
8. Treatment and support services are individualized.
9. Services are available on a 24-hour basis.
10. The team is assertive in engaging individuals in treatment and monitoring their progress.



SERVICE COMPARISON

WHAT IS RECOVERY?

Recovery is the awakening of hopes and dreams. The recovery process involves gaining the knowledge to reclaim one's power and achieve one's desires by learning to make choices that bring strength rather than harm. Recovery involves living a meaningful life with the capacity to love and be loved.

RECOVERY-CENTERED ACT:

Each individual's recovery process is unique. ACT is a treatment structure that effectively assists individuals to achieve better results while living in the community. When the two are combined in the context of recovery, the opportunity for a synergistic effect occurs. ACT was not originally conceived to support member recovery. The foundation of ACT programs was laid in the 1970s when services previously provided in institutions were moved into the community. Even today remnants of these institutional origins can be found in ACT program structure and processes, including assessments and interventions. Telecare believes that there are opportunities for further improvement by restructuring the remaining traditional elements of ACT. Telecare describes its ACT models as Recovery-Centered, reflecting the program design principle that each structural and process consideration must maximally support member recovery. The model not only recognizes the uniqueness of each individual, but has developed assessments and interventions to give maximal expression to that uniqueness to better enhance members' personal power and motivation in support of their recovery process.

TRADITIONAL COMMUNITY M.H. SERVICES	STANDARD ACT APPROACH	TELCARE RECOVERY-CENTERED APPROACH
<p>Community services vary greatly, from very client-centered to more traditional. The more traditional services have the following characteristics:</p>	<p>SAMHSA's PACT standards and CARF's ACT standards have the following characteristics:</p>	<p>All Telecare ACT models are Recovery-Centered and expand upon the standard ACT/PACT models. All aspects of our ACT programs, including structure, assessments and interventions, are designed to support a member in his/her personal process of recovery. Telecare Recovery-Centered ACT models have the following characteristics:</p>
PROGRAM PURPOSE		
<p>Goals: Reduce symptoms, control risk and adverse consequences, and increase daily living skills.</p>	<p>Goals: To support members recovery and "assist consumers to live satisfactory, hopeful and contributing lives in the community" (Test). Provide supports when skills are not yet present.</p>	<p>Goal: To support members recovery and growth beyond illness, supporting the recovery of life roles and hope for a meaningful life. Use objective clinical information to work with clients to develop choice-making skills that reduce harm, including clinical risks, and increase personal strengths. Provide supports when skills are not yet present.</p>
FOUNDATION		
<p>Provider-centered. Emphasis on compliance and control. Services are provided by separate agencies and practitioners without effective coordination.</p>	<p>Member-centered. Emphasis is on providing services and supports necessary to help member live successfully in the community.</p>	<p>Member-centered. Built on a Recovery-Centered philosophy with a Harm Reduction, Strengths Enhancing emphasis. Skill acquisition is a central tenet. An integrated client information collection- and feedback-process supports all aspects of the program.</p>
FOCUS OF MEMBER/STAFF RELATIONSHIP		
<p>Professional relationships with clients. Provide services according to professional assessment of client's needs.</p>	<p>Member-centered partnership. Plans are based on each member's identified desires. Staff support member's life goals and chosen path of recovery, building sustained relationships with members over time.</p>	<p>Staff are engaged in and supportive of each member's personal process of recovery. Staff assist members to accept responsibility for and control of their lives, using assessments and interventions designed for that purpose. Staff assist members to develop life goals based on an objective understanding of their personal strengths and choice-making skills.</p>
CLIENT EXPERIENCE		
<p>Clients' experiences vary greatly depending upon the complexity of their needs and the qualities of their primary provider. Too often they experience a sense of powerlessness and loss of control of their lives. Involuntary treatment is common.</p>	<p>Members experience significant support from staff. Services are brought to them in their environment and are available 24-hours every day. Members establish their own goals.</p>	<p>Members have personal responsibility in their own recovery process and are empowered through their own choices and the support of staff. They actively participate in initial assessments, develop life goals and identify goals where they would like program assistance. They participate in developing their medication plan. When members make choices that result in harm, it is an opportune time for a conversation about using the results of those choices as feedback in making better choices.</p>

SERVICE COMPARISON

TRADITIONAL COMMUNITY M.H. SERVICES

STANDARD ACT/PACT

TELECARE RECOVERY-CENTERED APPROACH

STAFF EXPERIENCE

Many staff experience frustration from relationships with clients that are often time-limited and narrow in scope. Many staff are distressed at seeing clients struggling in poorly integrated systems with many barriers to accessing services.

While the work is demanding, it is very rewarding. The team environment is supportive and lowers risk of staff burnout. Staff have meaningful relationships with members over time and see members' successes.

While the work is demanding, the opportunity for personal growth is engaging. Staff choose this environment because of the focus on recovery and empowerment. Members cannot be empowered unless staff are empowered. The team is a learning environment where staff and members learn from each other.

CLIENT INFORMATION SYSTEM

Outcome information generally is not available.

The amount of outcome information collected varies. Programs involved in research generally collect more, however, information collected is often not integrated into the program's structure and processes. Information is not used as a part of the intervention process.

Member data collection is embedded into the assessment and intervention process. This unique approach uses the same data for multiple purposes, enhancing its accuracy and meaningfulness. It is shared and used in decision-making with members, in strategic interactions, and in the evaluation of program effectiveness over time. Members, staff, program management, corporate management and Telecare customers all review and work from the same data.

ASSESSMENT PROCESS

Traditional domains of assessment are similar to, but less comprehensive than those identified by SAMHSA.

Assessments usually have traditional base. Examples from SAMHSA standards include: 1) psychiatric symptomology & mental status with DSM IV Diagnosis; 2) psychiatric history including adherence to and response to treatment; 3) medical, dental, and other health needs; 4) extent and effect of drugs or alcohol use; 5) housing situation and activities of daily living; 6) vocational and educational functioning; 7) extent and effect of criminal justice involvement; 8) social functioning; 9) recent life events.

The assessment process balances the need to obtain essential program information with the need to engage members in the process of change. The assessment is conducted in a conversational style and acts as the beginning of the intervention. Together, staff and members assess: 1) cultural beliefs about mental illness; 2) current amount of harm and personal strengths; 3) member's level of engagement in the process of change; 4) risks of danger to the member or others; 5) problems following medication plan; 6) member's plan for staff assistance with crisis; 7) use of drugs and alcohol; 8) spiritual needs; 9) member's natural supports; 10) a psychiatric assessment including factors that enhance likelihood of following medication plan. Members receive validation by telling "their story their way." A summary of the assessment is given to the member.

INTERVENTIONS

Interventions take place in facility/office. Interventions include medication management, therapy, case management. Some specialty programs (e.g. Day Treatment) provide structured programs with money management, shopping, cooking, etc.

Interventions take place in member's territory and focus on challenges in that environment. Interventions include the treatment, rehabilitation and the supportive services a member needs, e.g. assistance meeting daily living needs, housing, financial, physical health and dental care; personal & psychological well-being; work, education, social relationships & recreation; support & education to family, significant others, and community members.

All interventions support the member's process of recovery. The conversational assessment process is an intervention. A *Guided Planning Dialogue* helps the member define his/her desires in life, develop choice-making skills, understand the harm or personal strengths that result from these choices, understand the role of substance use, address his/her thoughts and beliefs about medication, and participate in the development of his/her own medication plan. Psychiatric rehabilitation helps the member develop life skills or identify needed supports. Cognitive counseling teaches the member how to examine and reshape the beliefs or assumptions that he/she holds that are untrue and limiting. Family education is also a foundation of the Recovery-Centered approach.

OUTCOMES TRACKED

Outcome information generally is not available.

In general, outcome information includes Psychiatric Hospital Admissions and Days; Housing Stability; Member & Family Satisfaction. Other programs may have additional measures.

Telecare can track and report on changes in the amount of Risk, Harm, Engagement, Strengths, Spirituality, Cultural Factors, Supports, Problems Following Medication Plan, and Substance Use over time. Standard measures of acute psychiatric hospital and emergency services use, housing stability, and member and family satisfaction can also be reported.

TELECARE DELIVERS THE FOLLOWING:

Telecare's Recovery-centered ACT programs have three levels of intensity that expand on the standards developed by SAMHSA and CARF. Telecare can vary its programs to meet specific consumer and customer needs. All Telecare ACT programs are CARF accredited.

Recovery-Centered CARF ACT:

CARF ACT programs are based on CARF's ACT standards. This level is more flexible than PACT. It can be adapted to program purpose, member characteristics, and/or available funding, while maintaining the critical elements of ACT services.

Telecare's Recovery-Centered CARF ACT programs typically conform to the following standards:

- Staffing ratio of 1:8-15
- Majority of staff are professionals, including psychiatrist and nursing as necessary to meet member needs
- Specific hours of operation include evenings, weekends and nights
- Crisis assessment and intervention available 24-hours-a-day, seven-days-a-week

Recovery-Centered Enhanced CARF ACT:

CARF ACT programs can also be enhanced to serve and achieve desired outcomes with specialty populations with high degrees of complexity. The literature has demonstrated that ACT programs can achieve these ends when a program has a defined purpose with targeted outcomes and focused interventions. Telecare can deliver enhancements in staff, skills and structure to achieve this.

Telecare provides Recovery-Centered Enhanced CARF ACT programs for specific rehabilitation goals such as employment or education, or for individuals who:

- Are homeless
- Are involved in the legal system
- Use substances
- Are older adults with complex problems
- Are high utilizers of 24-hour facilities

Recovery-Centered PACT:

PACT programs adhere to the PACT standards supported by NAMI. These standards are based on the extensively researched Madison model. PACT has the most specifically defined requirements for structure and processes.

Telecare provides Recovery-Centered PACT programs that conform to the following standards:

- Staffing ratios of 1:10
- 80% of staff are professionals, including psychiatrist and at least 3 RNs per team, as well as employment and peer specialists
- Specific hours of operation include a minimum of 12 hours per week-day and 8 hours per weekend day
- Crisis assessment and intervention are available 24-hours-a-day, seven-days-a-week

GENERAL INFORMATION:

For more information about Telecare's Recovery-Centered ACT services, please contact Ross Peterson, Vice President of Development, at (800) 977-7471.

POPULATIONS SERVED: ACT serves individuals with serious mental illness who do not respond to less intensive services, and can be customized to address the needs of other populations with complex needs.

NUMBER OF MEMBERS: 50 to 120 members (large numbers of members may require more than one team).

LENGTH OF SERVICE: Traditionally provided for as long as member wants services. There is evidence in the literature that criteria can be established for members who are likely to live successfully without support of ACT.

SETTINGS: Community

STAFFING: NAMI has specific staffing standards for PACT model. CARF has staffing guidelines.

RESULTS: See Alameda STRIDES Survey.

FUNDING SOURCES: Medicaid Rehab Option, County and Local Authority.

START-UP TIME: Services can commence 90-120 days from a negotiated contract.

