Iowa's Center of Excellence for Behavioral Health

Evidence-Based Practices in Behavioral Health Summit

Assertive Community Treatment 101

Victoria Tann, MD

September 29, 2023

Learn. Support. Advance.

Assertive Community Treatment 101

9/29/23

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I have no disclosures.

Buck Ennis

FATAL NEGLECT

Homeless New Yorkers with serious mental illness keep falling through the cracks despite billions in spending

Kaufman, M. (2022, September 19). Fatal Neglect. *Crain's New York Business* .

Agenda

Article review – real life example

Intro to ACT

- History
- What we do
- Who does it and how

ACT in Iowa

ACT throughout the World

Challenges in ACT

What Does the Future Hold?

History of ACT

De-Institutionalization

-After World War II, England and the United States began to move away from the asylum and towards "community care".

5 Creepy Asylums Iowa That Are Still Standing And Still Disturbing (onlyinyourstate.com)

Novella, Jan 2010

De-Institutionalization

- Population decrease within state and country run mental hospitals in the United States
  - **From 553,979 in 1953 to 61,722 in 1996**
- 120 mental health hospitals closed in this time frame

Novella, Jan 2010

In the Beginning

- Providers in Wisconsin noted the "revolving door" phenomenon and wanted to do something about it

Elf,2003

"Considering precisely the high number of manifest and latent functions fulfilled by the old psychiatric hospitals—foremost, acute inpatient treatment and custody for long-stay patients, but also physical assessment and treatment, provision of occupation and vocational rehabilitation, shelter, nutrition, basic income or clothing, provision of day and outpatient services, etc., it is not wondering that the development of alternative services could often not be performed in the same range and timing with which the old system was being dismantled [64]. Rather, in most of the cases it followed an uneven and problematic course requiring periodical adjustments."

- Novella, Jan 2010

"We contend that current community treatments do not effectively address certain factors that are required by patients. The absence of one or more of these factors leads to a tenuous community adjustment that keeps patients on the brink of rehospitalization. These requirements, which are derived from our clinical experience and the literature are as follows..."

1. Material resources
2. Coping skills to meet the demands of the community
3. Motivation to persevere and remain involved with life
4. **Freedom from pathologically dependent relationships**
5. Support and education with community members who are involved with patients.
6. A supportive system that **ASSERTIVELY** helps the patients with the previous 5.

- Stein and Test, 1980

In the Beginning – Stein and Test 1980

"TCL" - Training in Community Living* (*+medication*)

Experimental group/
TCL Group

65 people

14 months

Control group (no TCL)

65 people

Results

- Participants receiving TCL care spent very little time in institutions (ANY institution)
  - 58 participants in the control group were admitted with **RE**admission rate of 58% compared to only 6% in TCL group

Results

- TCL participants spent more time in supported employment
- Rates of competitive employment were equal between the two groups but TCL participants made more money

Results

- Participants in TCL group had more "contact with trusted friends" and were more likely to belong to social groups and have attended a group within the last month

Results

-TCL participants had higher confidence, decreased symptom burden. More likely to take medications as prescribed.

Results

- <u>When TCL STOPPED:</u>
  - Hospitalizations increased
  - Sheltered employment dropped from 22-28% to less than 8%
  - TCL group maintained higher attendance at groups but lost their gains in contact with trusted friends
  - Greater satisfaction with life disappeared
  - TCL group continued to have better outcomes with taking medication as prescribed

Conclusions

- Traditional community programming for some people is insufficient inappropriate or both.
- **When community programming is inadequate, the hospital becomes the main locus of treatment**
- Treatment must be **"ongoing rather than time limited"**

Conclusions

" Our study suggests to us that this ongoing treatment program must be organized so that it can provide a flexible system of delivery that gives the patient only ***what he needs when he needs it and where he needs it***"

- Stein and Test, 1980

Conclusions

- How do you bill for this?
- People who NEED to be in the hospital should not be denied care

Thus, Assertive Community Treatment was born……

What is ACT?

Assertive Community Treatment is:

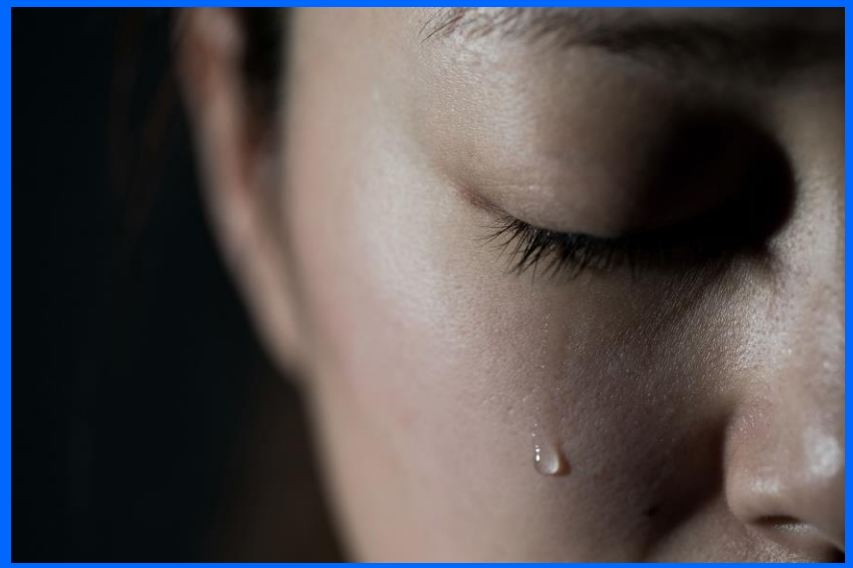
An interdisciplinary team proving care in the community to people living with severe and persistent mental illness whose needs were not met with traditional approaches

ACT Team Staff Include:

- Team leader/manager
- Social workers
- Therapists
- Psychiatrists or psychiatric ARNPs/PAs
- Addiction specialists
- Occupational therapists
- Job coaches
- Nurses
- Peer supports

Participants of ACT Teams

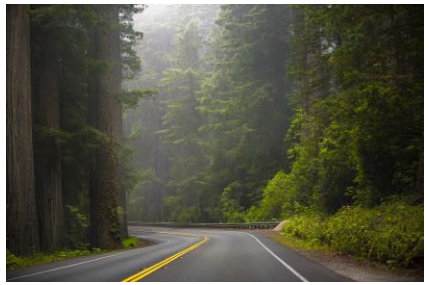
- Primary diagnosis is
  - Schizophrenia
  - Schizoaffective Disorder
  - Bipolar Affective Disorder
  - Severe Major Depressive Disorder

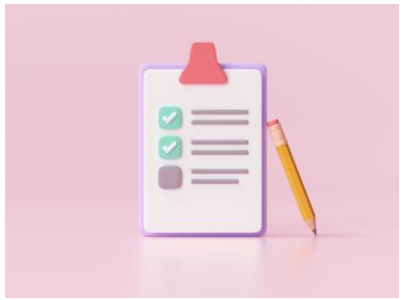


Day to Day Activities

- Daily meeting
  - Shift manager and team leader help to run
  - Discuss all participants
  - Organize schedule (any acute needs?)
- Someone is on call 24/7 if a need or crisis arises with a participant
- Seeing participants in the community
- Treatment planning (6-month review of how participant is doing, participant is involved in their plan)
- Staff generally share most roles evenly
  - Only nurses will do certain aspects of medication administration
  - All staff can ask about medication side effects, follow up with whether a client is taking medication, etc

Some Examples of Visits





Individual Treatment Teams

- Each participant has a case manager assigned specifically to them.
- Smaller group of staff who work more closely with the participant
- Aids in improving continuity of care
- Supportive environment for staff

Admission Process (IMPACT at UIHC)

- Qualifying diagnosis
- Be within our geographical area
- Have the appropriate insurance
- High cost treatment failure:
  - 2 or more admissions in the preceding 24 months (or)
  - More than 3 weeks of hospitalization in the preceding 12 months (or)
  - More than 3 months in residential care in the preceding 12 months (or)
  - Decompensation (or high risk of it) with traditional treatment modalities due to not engaging in treatment as prescribed or severe stress (homelessness

Admission (?) Meeting

- Meeting arranged by current provider, ACT team leader
- Attended by potential participant and their important supports, current provider, new provider, team leader
- Obtain participant perspective
- Explain ACT
- Obtain releases
- Agree on weekly schedule and start date
- Review emergency procedures

Comprehensive Assessments

- Detailed assessments about various aspects of the participants life
- Completed by assigned case manager and individual treatment team
- Completed within the first 30 days

Comprehensive Assessments

- Physical health
- Drug and alcohol use
- Social development and functioning
- Activities of daily living
- Education and employment
- Family relationships-
- Psychiatric/social functioning
- Time intensive… but yields great returns!

Comprehensive Assessment

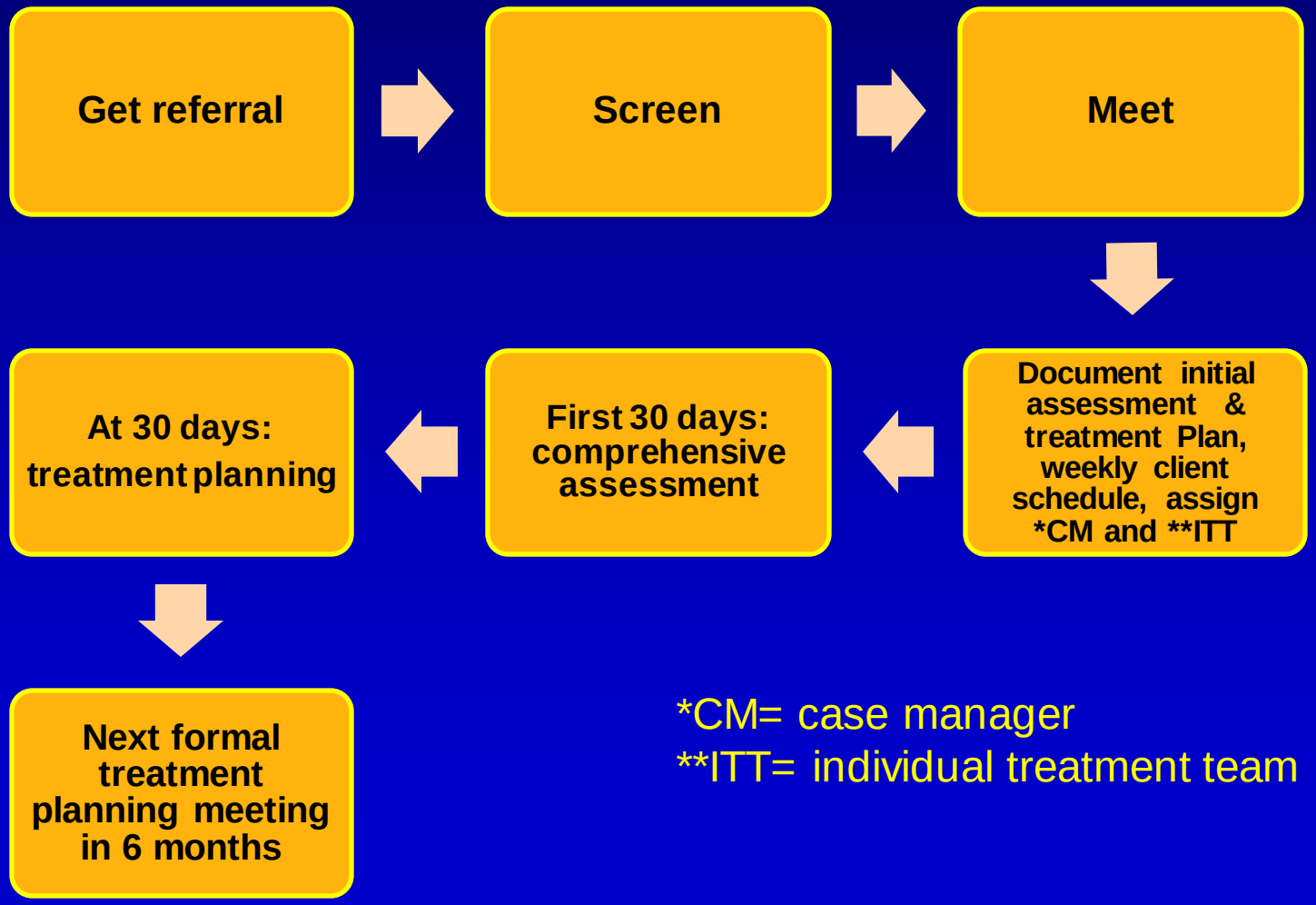
Comprehensive assessment

Individualized Treatment Planning

Goal is *"client centered"* approach to care of each participant

Admission

Overview of the process



*CM= case manager

**ITT= individual treatment team

Discharge From ACT

- Client moves outside of geographic area
- Client may request discharge
- Client has become increasingly stable and self-sufficient and/or needs can be met with a lower level of care
- Traditionally, there was no time limit on ACT services*

Who Monitors ACT Teams/How?

- Individuals can become trained to assess ACT teams using specialized, validated scales
  - Dartmouth ACT Fidelity Scale (DACTS)
  - Periodic review
  - Shows strengths and weaknesses of a team

What Clients Like Best about ACT

(McGrew et al., 1996. N=165)

- **Helping relationship 21%**
- **Attributes of staff 20%**
- **Availability of staff 18%**
- **Nonspecific help 17%**
- **Someone to talk to 14%**
- **Recreation 11%**
- **Problem-solving 9%**

- Home visits 6%
- Medical care 4%
- Intensity of service 4%
- Money management 4%
- Housing 3%
- Shared caseloads 3%
- Transportation 2%

What Clients Like Least About ACT?

Response category	Responses	%
Disliked nothing or said something positive	84	44
Services not frequent enough	12	6
Staff not available	12	6
Program intrusive	11	6
Too confining	8	4
Overemphasis on medications	8	4
Not enough financial support	6	3
Program or office not convenient	6	3
Time-limited services	5	3
Team not understanding enough	5	3
Not enough social or recreational activities	5	3
Negative treatment effects	3	2
Failure to keep appointments or inconsistency	3	2
Too critical	3	2
Fosters dependency or is stigmatizing	2	1
General dislike of mental health system	2	1
Fear that the team might not be able to prevent hospitalization	2	1
Home visits	2	1
Frequency of service is too high	2	1
Generally dissatisfied with assertive community treatment	2	1
Other	6	3

[a] The number of responses is greater than 182 because some responses fell into more than one category.

McGrew, 2002

Criticisms of ACT

- Coercive
- Intrusive
- Too much "agency control"

Table 2

Team-level data distributions for agency control practices and consumer caseload, practitioner, and program characteristics[a]

Variable	Median	M	SD	Minimum to maximum	Percentile 25th	Percentile 75th
Agency control practice[b]						
Involuntary outpatient commitment	16.0	20.6	17.9	0–65.0	4.5	35.0
Representative payee	45.0	47.1	18.1	10.0–96.0	33.0	57.5
Intensive medication monitoring	38.5	41.6	18.6	13.0–78.0	26.0	52.3
Agency-supervised housing	16.0	18.9	18.0	0–71.0	5.5	28.0
Consumer caseload characteristic[b]						
Schizophrenia spectrum diagnosis	75.0	76.9	13.9	53.0–100.0		
Recent hospitalization history	14.0	13.6	7.9	2.0–35.0		
Active substance use	24.0	25.9	11.2	2.0–47.0		
Practitioner characteristic						
Pessimistic attitudes[c]	3.2	3.2	.2	2.7–3.6		
Education[d]	5.3	5.3	.7	3.7–7.0		
Program characteristic						
Assertive community treatment fidelity[e]	4.3	4.1	.5	2.9–4.7		
Quality of basic clinical services[f]	3.2	3.0	.9	1.0–4.3		

[a] Twenty-three assertive community treatment teams were surveyed. Some measures had data available for only 22 teams.

[b] Percentage of caseload meeting criteria

[c] As measured by the pessimistic attitudes scale. Possible scores range from 1 to 5, with higher scores reflecting more pessimistic attitudes.

[d] Possible scores range from 1 to 9, with higher scores reflecting higher education: 1, less than 12 years; 2, high school; 3, some college; 4, associate's degree; 5, bachelor's degree; 6, bachelor's degree and some graduate school; 7, master's degree; 8, master's degree and some doctoral work; 9, doctoral degree.

[e] As measured by the Dartmouth Assertive Community Treatment Scale. Possible scores range from 1 to 5, with higher scores reflecting higher levels of fidelity.

[f] As measured by three items from the General Organizational Index. Possible scores range from 1 to 5, with higher scores reflecting greater quality of basic clinical services (for example, treatment planning).

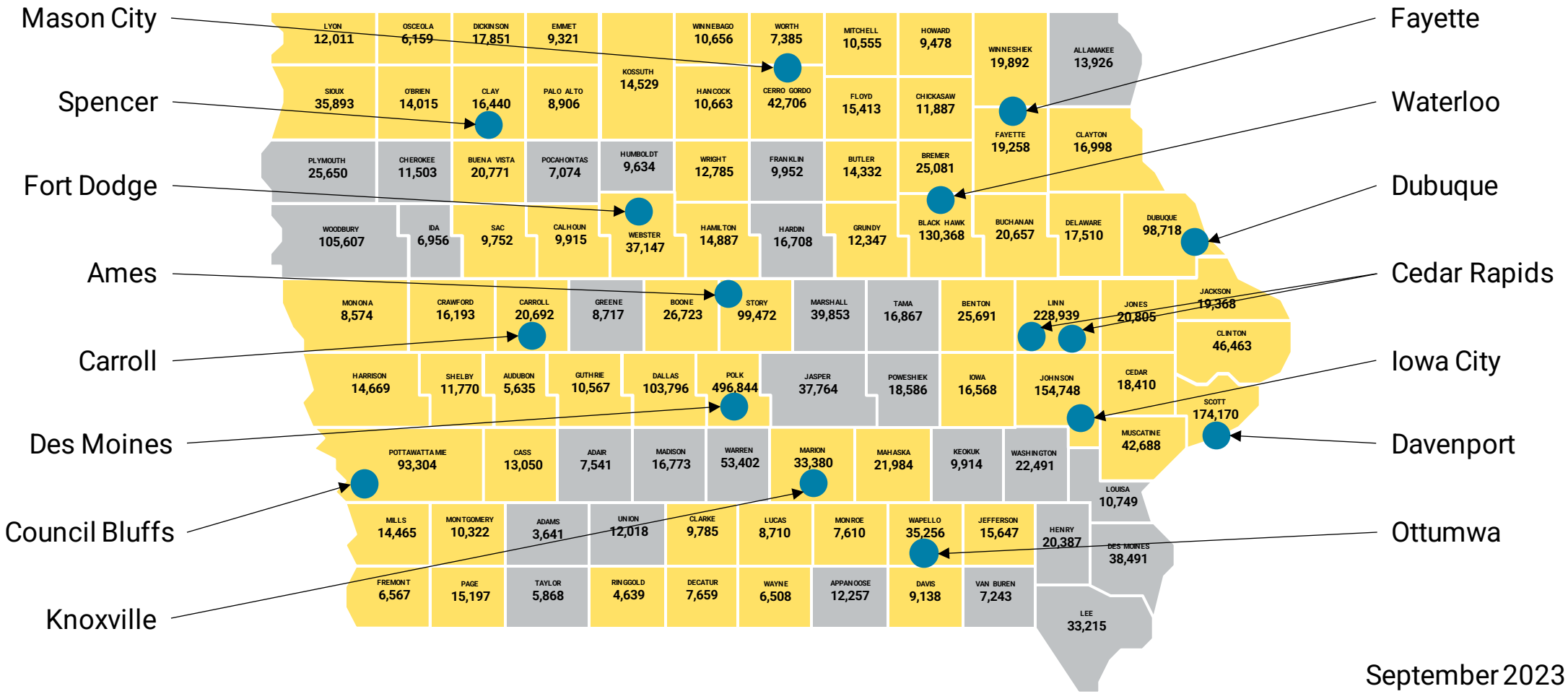
Moser et al, 2009

ACT in IOWA

ACT Teams in Iowa

Iowa Total Population: 3,193,079

2021 County Population Data

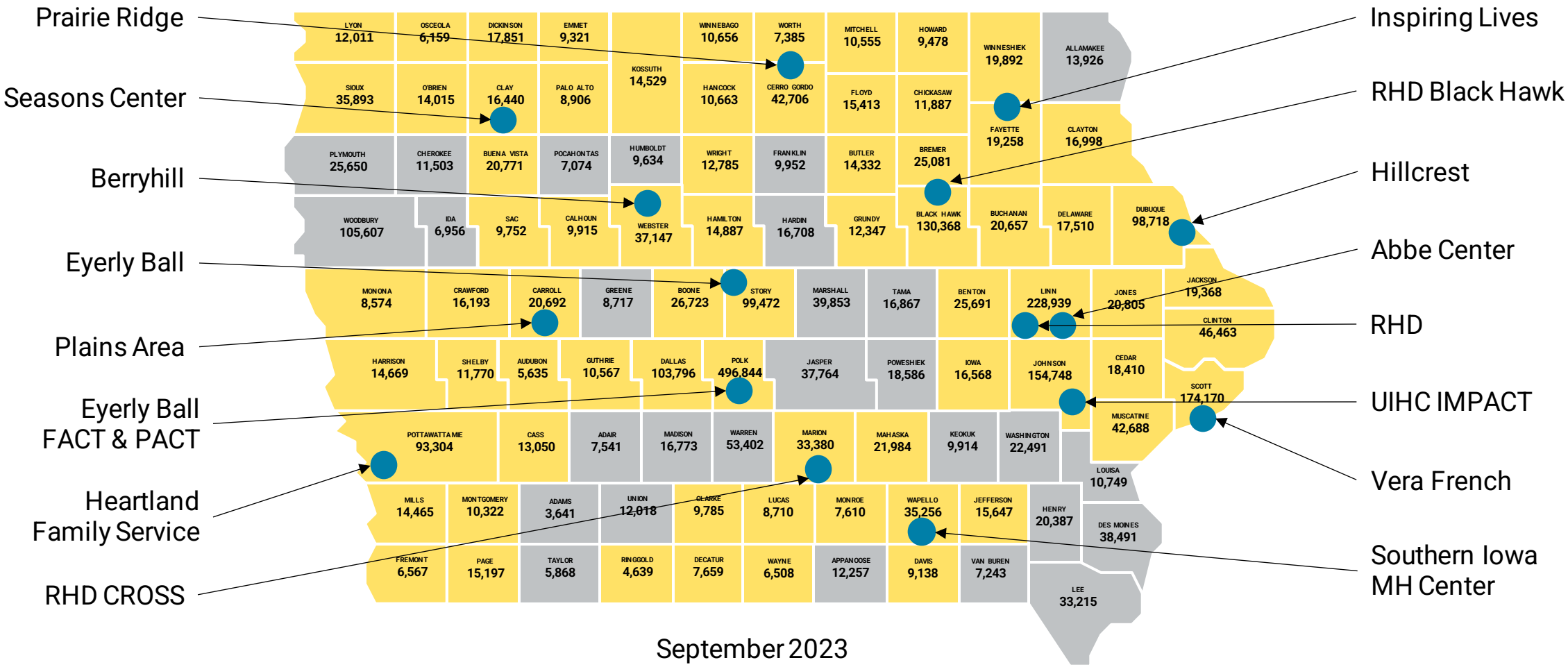


September 2023

ACT Teams in Iowa

Iowa Total Population: 3,193,079

2021 County Population Data



September 2023

Evolution, Future Directions, and (New) Challenges in ACT

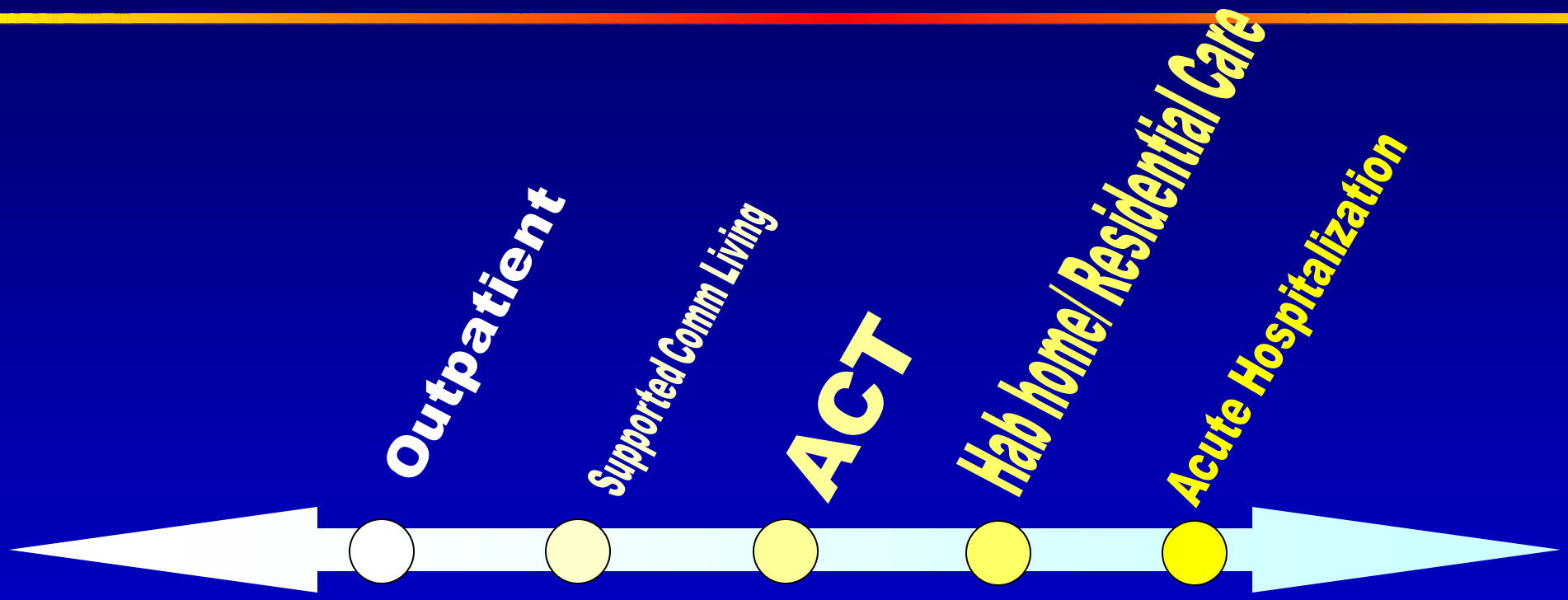
Challenges in ACT

- Dual Diagnosis
- Housing
- Complicated referrals
- Emotional effects
- Staff for the teams
- Stagnant reimbursement rates
- Staff and client safety
- Medically ill participants
- Whom to admit?

To Admit or Not to Admit?

ACT Overview

ACT in the Continuum of Care



Dual Diagnosis

- Clients with SMI and substance use are **less engaged** in treatment compared to people who do not use substances
- High rates of substance use in people with serious mental illness
- Are we seeing it more?
- Recent conference in Vancouver, "triple diagnosis" of SMI, substance use, and brain injury
- Safety

Pettersen et al, 2014

Dual Diagnosis Data

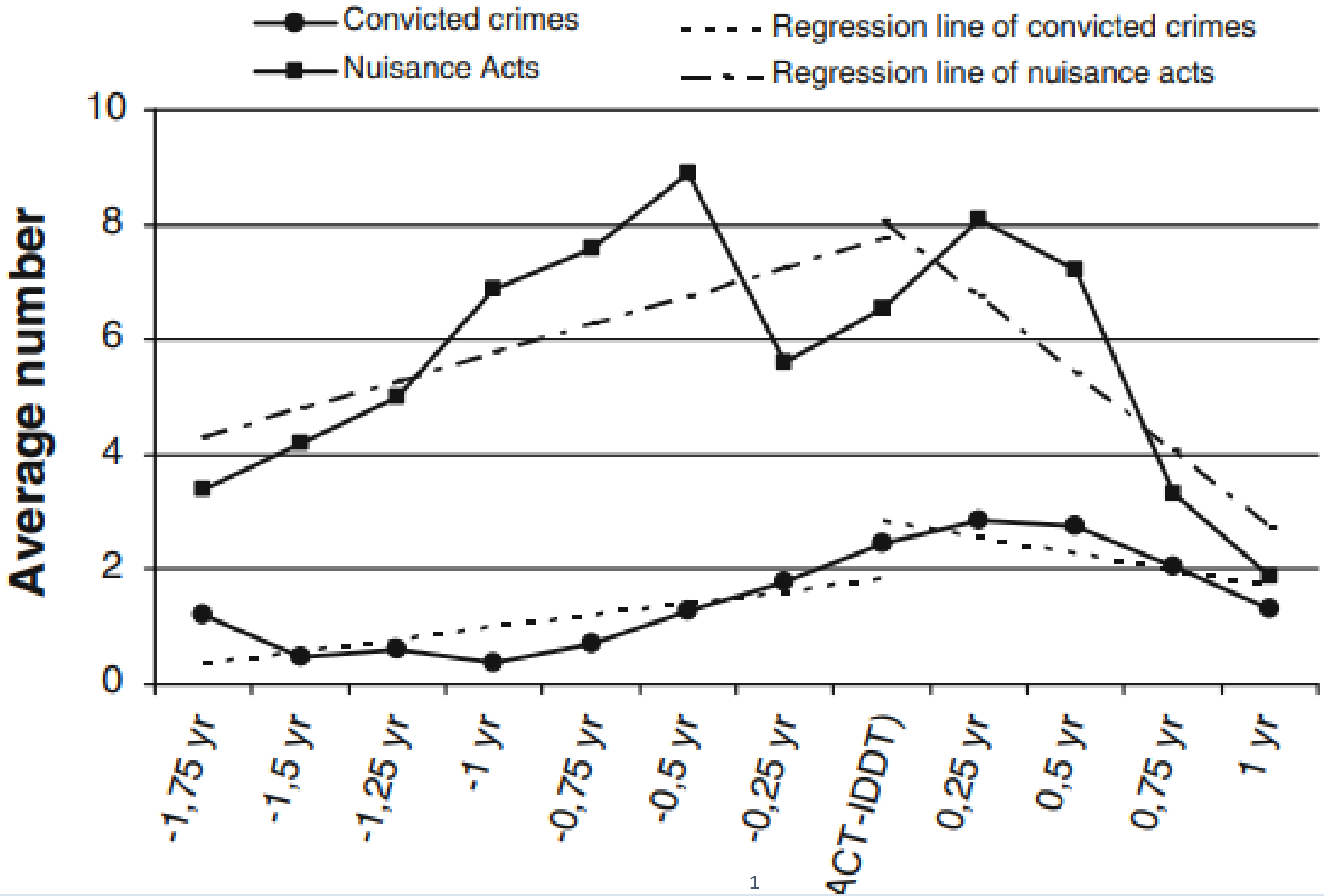
- ACT engages participants better than regular care: those who used substances are less engaged in ACT but also MORE engaged in their treatment compared with regular care
- Admission
  - Trust building, offers of help
- Retainment
  - Feeling "chosen", potential for improvement, ACT as a safety net, personal responsibility to engage in treatment

Pettersen et al, 2014

Dual Diagnosis Data

- Data looking at ACT treatment alone has not shown significant improvement in substance use
- Some small differences have been noted in more sustained remission of substance use in ACT teams with a substance specialist and providing transportation to support groups
- ACT + integrated dual diagnosis treatment decreased nuisance acts and convictions in repeat offenders with dual diagnosis

Drake et al, 2020, Staring, A.B.P. et al, Fries and Rosen, 2011



Staring, A.B.P. et al

Key Values of ACT – Then and Now

THEN

-assertive outreach

-holistic approach

-multidisciplinary team

-direct services model/integration of services

-low client/staff ratio (10 clients for every staff)

-24/7 coverage

-Long term care

Organization (ACT team providing the care rather than brokering out to other services, daily meeting, 24-hour access)

NOW

- Should ACT be time limited?
- Multidisciplinary – but encourage team members to learn new skills/competencies
- ACT doesn't work everywhere
- Focus on recovery
- Shared decision making
- Outcome based supervision
- Strengths based treatment planning
- Use of generic community resources

Bond and Drake, 2015

Housing First

- 1990s model started in New York prioritizing housing *before* treatment
- Iowa City has 2 housing first locations
- Housing first programs reduce time spent in the hospital and ER visits
- One study on housing insecure individuals with severe and persistent mental illness showed improvement in secure housing status, health service usage and quality of life score

Dunt, et al, 2021

Shelter House to provide 36 single adult housing units at The 501 Project

The building will follow a Housing First model to provide housing for single adults experiencing chronic homelessness.

Kate Heston

Steve Schornhorst, the construction manager on the Shelter House's board, helps build some walls for The 501 Project at a volunteer build before the ceremony on Thursday.

Dunlap, N. (n.d.). *Shelter House to provide 36 single adult housing units at The 501 Project*. The Daily Iowan. Retrieved September 20, 2023, from https://dailyiowan.com/2021/06/17/shelter-house-to-provide-36-single-adult-housing-units-at-the-501-project/#:~:text=Shelter%20House%20is%20building%20a%20second%20Housing%20First

Housing First + ACT: A Canadian Study

- **74%** of Housing First participants had stable housing compared to only **41%** of people in the treatment as usual group
- Housing first participants had rapid improvement and more community engagement, better quality of life over first year (later attenuated)
- Both groups improved related to ER visits, days hospitalized, arrests
- Program paid for itself (96% of the cost)

Arbury et, al 2016

Global Assertive Community Treatment Association (GACTA)

Where is ACT?

United States

Australia

UK

Japan

Canada

Singapore

China

Argentina?

South Africa?

Partnership with AOT?

Types of ACT

- Forensic ACT (FACT)
- "Flexible" ACT (also called FACT)
- ACT for geriatric participants
- ACT for adolescents
- ACT for individuals experiencing homelessness

Thank You!

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SCAN ME

SESSION SURVEY

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