Assertive Community Treatment:

Beyond The Basics: Team Start Up

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IMPACT
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Beyond the basics

Overview

- Brief recap of ACT
- 10 steps for ACT start up
  - With an emphasis on putting together the team and daily operations
- Lessons learned
Beyond the basics

Caveat

- This webinar is not intended to constitute your entire “training” for ACT start up.
- Simply provides a next layer of detail into the process of starting ACT
- A great start!
Beyond the basics
Overview

- The key resource for information on ACT start up:
  
  A Manual for ACT Start – Up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illness. Allness and Knoedler. 2003
  
  - Job descriptions
  - Assessment forms
  - Appendix 8 National Program Standards for ACT teams
  - During webinar – refer to this reference as “ACT manual”

- Today’s webinar primarily uses information from the ACT manual (above), also articles (listed) and clinical experience
Beyond the basics
Overview of ACT

- Focus on the people who are the most seriously mentally ill that current system is failing.

- Multi-disciplinary Team
  - (doctors, nurses, social workers, therapists, vocational specialist, substance abuse specialists, etc)

- Continuous, Responsible, Accountable, Comprehensive Care.

- Team provides treatment at home, in the community.
Beyond the Basics
Team Start Up

1. Understand what ACT is.
2. Bring together a planning group.
4. Find the money.
5. *Create the team*
6. *Train the team*
7. *Start the ACT*
8. Collect the data
9. Use the data
10. It’s all about the relation

* today’s focus
# 1 Understand ACT

- Easy in theory, harder in practice.
  - Understanding will come in stages

- As you develop ACT, you realize this is quite different than traditional models.
  - Staffing, supervision, transport, etc

- As you practice ACT, you get an even deeper understanding of ACT.
  - Philosophical/ethical dimensions
# 2 Bring together a Planning Group

- Iowa is doing this!

- Key Clinicians and Key Administrators

- All levels of the public mental health system affected by ACT
  - Hospitals, County Government, County Assistance, Community Mental Health Center, etc

- Need an identified local champion to lead the charge
# 3 Conduct Needs Assessment

UIHC example: 1995

- ~100 Bed Tertiary UI Psychiatric Hospital:

- High Cost, Fragmented Care with Poor Clinical Outcomes.
  - 1/3 inpatients from Iowa City, all with Serious Mental Illness.
  - Frequent Readmissions.
  - Waiting list for inpatient care across State.

- County of 100,000 = 100 may need ACT.

- Benchmark with model program in Wisconsin.

- Collaboration and education with managed care organizations, health plans.
# 4 Find the money

- In Iowa, mechanism for start-up money has varied:
  - Institution: Costs savings to hospital, e.g. University of Iowa
  - Managed care company/state collaboration (Magellan), e.g. Cedar Rapids, Des Moines
  - County/Magellan shared cost: Cost savings by avoidance of RCF, e.g. Fort Dodge team

- Examples from other states: Block grant from state, reinvestment from closures of state facilities, grants, other
# 5 Create the Team

- ...experienced, full time clinicians...
  - Team Leader
  - Psychiatrist
  - Mental Health Professionals (80% of team)
    - Nurses
    - Vocational specialist
    - Substance abuse specialist
    - Occupational therapist
    - Social Work
  - Bachelors in related field/experience
  - Peer counselor
  - Program assistant
# 5 Create the Team

**Team leader**

- **A key hire!**
  - Provides clinical supervision, administrative leadership, and also a practicing clinician on the team ~ monitors all aspects of team operations
  - Masters degree in nursing, social work, psych rehab, psychology, related
  - In conjunction with the psychiatrist, make decisions on admissions and provides clinical supervision to assure clients receive appropriate care/support
  - Team leader and psychiatrist set the tone, “team culture”
# 5 Create the team

**Psychiatrist**

- Need psychiatrist willing to jump in:
  - Comfortable in outreach setting.
  - Comfortable with serious mental illness.
  - Comfortable with changing schedule
  - Comfortable with team care.

- Psychiatrist → Minimum 16 hours per week for every 50 clients
  - No psychiatrist? Nurse practitioner or PA with psychiatrist supervision.
# 5 Create the team  
Mental Health Professionals

- Professional degrees in core discipline
  - Nursing*, social work, rehab counseling, psychology, occupational therapy, substance abuse specialist*, vocational specialist
  - Case management, treatment, rehabilitation, support services
  - Collaborative, flexible, good teachers

- Need at least 2-3 FTE nurses, depending on team size
  - Medication monitoring and set up, assessing physical health needs, etc

* Required per ACT manual
# 5 Create the team

**Peer Specialist**

- Recipient of mental health services
- Expertise and consultation to team
- Can be in any of the staffing positions with appropriate credentials
# 5 Create the team

Remaining staff

- Bachelors level and paraprofessional mental health workers
- Experience with people with serious mental illness, related training
- Rehabilitation and support
# 5 Create the team

Example of staffing

<table>
<thead>
<tr>
<th>Position</th>
<th>Smaller team</th>
<th>Larger team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Leader</td>
<td>1 FTE</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Min 16 hours/50 clients</td>
<td>Min 16 hours/50 clients</td>
</tr>
<tr>
<td>Nurse</td>
<td>At least 2 FTE</td>
<td>At least 3 FTE</td>
</tr>
<tr>
<td>Masters level</td>
<td>2 FTE</td>
<td>4 FTE</td>
</tr>
<tr>
<td>Other level</td>
<td>1.5-2.5 FTE</td>
<td>1-3 FTE</td>
</tr>
<tr>
<td>Peer specialist</td>
<td>1 FTE</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Program assistant</td>
<td>1 FTE</td>
<td>1 FTE</td>
</tr>
</tbody>
</table>

Chart adapted from the ACT manual
# 5 Create the team
Team size, ratio, caseload

- Need to cover all shifts, and on call, account for sick time, vacation, vacancies etc
  - Minimum 6 to 8 FTE
  - Greater than 10 to 12 FTE → split into 2 teams
# 5 Create the team

**Team size, ratio, caseload**

- 8-10 clients per 1 staff
  - Lower ratio for rural or high service needs

- “Overall” ratio
  - Individual staff will have differing size of caseload depending on intensity of service need for clients
# 6 Train the team

- First, get everybody on board with the fundamentals:
  - “Active ingredients” of ACT
  - Client centered approach, Integrated dual disorders treatment, motivational interviewing, supported employment, medication management, medical comorbidities
  - Daily operations- the nuts and bolts
  - Visits to existing team
  - Emphasis on fidelity: DACTS- Dartmouth ACT scale

- Consultation Eg: On site consultation every month x first year
# 7 Start the ACT

**Hours of operation**

- **Smaller team**
  - Daytime hours eg: 8am to 5pm Mon-Friday
  - Weekend/holiday face to face visits for clients who need it eg: 8am to noon
  - On call evening, weekends, holidays

- **Larger team**
  - As above, also evening shift.
# 7 Start the ACT

## Daily team meeting

- **“The Art” of the daily team meeting:**
  - Review of all clients in 60 minutes
  - Sets the tone for the team culture

- Develop daily schedule (based on treatment plan)

- Team leader, shift manager roles

- “You are being paid to have an opinion!”

- Accountability, problem solving, support
# 7 Start the ACT

**Admission**

- **Admission meeting**
  - Review information re: eligibility, develop initial treatment plan, releases signed, exchange contact information
  - Team leader assigns primary case manager and intensive treatment team or “mini team”

- **Comprehensive assessment (first 30 days)**
  - Seven components: Psychiatric history/diagnosis, physical health, substance abuse, education/employment, social history, activities of daily living, family structure/relationships
# 7 Start the ACT

**Treatment Planning**

- In ACT, treatment planning is... useful!
  - Informs the weekly client schedule
- Every six months
- Directs the focus of the daily visits
- “What gets paid attention to, gets paid attention to”
- Need multidisciplinary input
# 7 Start the ACT

Visits – treatment, support, rehabilitation

- **Treatment**
  - Medication management, therapy and problem solving, substance abuse treatment

- **Support**
  - Medical/dental care, legal, benefits, housing, money, transport

- **Rehabilitation**
  - Structure time, employment, activities of daily living, relationships, leisure time
Team assists in all aspects

- Admission- collaboration with ER, inpatient staff, notify family
- Assessment- visits on unit, passes off unit, help determine readiness for d/c
- Discharge planning- attend d/c meetings, plan transport home and getting settled
# 7 Start the ACT

Discharge from ACT

- Client and staff agree can function in the absence of assistance from team without significant relapse; have met goals for d/c
- Needs higher level of care
- Move outside geographic area
- Decline services despite best efforts of team
# 8 Collect the Data

**Outcomes**

- **Outcomes Measures**
  - Hospital/RCF days
  - Homeless days
  - Incarceration
  - Employment status

- **Other**
  - Eg: Framingham scores (IMPACT)
# 8 Collect the Data

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
<th>Chg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>4.8</td>
<td>1.0</td>
<td>-79%</td>
</tr>
<tr>
<td>RCF/MHI</td>
<td>13.1</td>
<td>0.8</td>
<td>-94%</td>
</tr>
<tr>
<td>Homeless</td>
<td>2.3</td>
<td>0.6</td>
<td>-75%</td>
</tr>
<tr>
<td>Incarcerated</td>
<td>2.4</td>
<td>0.5</td>
<td>-79%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>83%</td>
<td>55%</td>
<td>-34%</td>
</tr>
<tr>
<td>Abusing substances</td>
<td>25%</td>
<td>21%</td>
<td>-16%</td>
</tr>
</tbody>
</table>

* Paid for by the Iowa Department of Human Services through its contract with Magellan Health Services for Iowa Plan for Behavioral Health Community Reinvestment funding
# 9 Use the data

- Quality Improvement
  - *Cardiovascular risk reduction*
  - *More attention to diet/exercise/medication effects*
  - *Low rates of employment -> brush up on supported employment principles, more networking*

- Team Morale

- Helps convince others to start ACT
# 10 It’s all about the relationship

- The most critical ingredient for success in ACT operations… is the relationship
  - Engaging with the people receiving care in ACT
  - Supporting your colleagues in day to day work
  - Assisting families to cope with the challenges and heartache of struggling loved ones
  - Being available for landlords, employers to problem solve
  - Collegial relationships with administrators, funders
Lessons Learned

- Team Factors
- Clinical Issues
- Administrative Issues
Lessons learned: Team Factors

- *Team Leader is a KEY HIRE*

- *Salaries needs to be competitive*

- *Experience with Chronic Mental Illness*
  - Bio-Psycho-Social Understanding
  - “80 % of ACT is Medications” then the next “80 % of ACT is Rehabilitation”

- *Motivation, Stamina, team work, continuity, flexible*
Lessons learned: Team Factors

- ACT: decreased clinician burn out
  - Shared responsibility
  - Increased knowledge
  - Clarity of job roles
  - Support, camaraderie
  - Making a difference
    - (Boyer, Bond 1999)
Lessons learned: Clinical Issues

- Outcomes pointed out that some people do worse in ACT:
  - Primary Diagnosis of Substance Abuse, Head Injury, Personality Disorders did worse.
  - At time of referral: examine factors for high utilization – what is primary?
  - Comprehensive assessment (including medical record review) at time of admission is VITAL and pays BIG dividends
Lessons learned: Clinical Issues

- Substance Abuse is very common among our clients
  - Alcohol, Marijuana are favorites.
  - Need a different approach than the mainstream 12 Step Program.
  - Treat mental illness while still using.
  - Motivational interviewing approach is key
  - Harm reduction!
  - Don’t be preoccupied with sobriety
  - Take the long term view
Lessons learned: Clinical Issues

- The Right Medication is Vital:
  - High risk / high reward medication usage, eg clozapine
  - Daily involvement with nurses, psychiatrist
  - Non-adherence with medications -->
    - More discussion, increase visits, blood levels.
Lessons learned: Clinical Issues

- Take the long view
  - Client centered treatment planning
  - “First things first” then, what are the top several priorities?
  - Try something different!
- Startled by what people can accomplish
  - Optimism and hope
Lessons learned: Administrative Issues

- ACT is not a money maker.
  - Excellent clinical outcomes, saves system money, high levels of satisfaction.

- To do it right, enough money needs to be available for:
  - Training and on-going consultation
  - Start up costs.
  - Enough staff to follow the model’s level of care intensity, provide 24 hour on call.
Lessons learned: Administrative Issues

- Fidelity to the ACT Model predicts success
  (Mancini 2009)

- Dartmouth Assertive Community Treatment fidelity scale (DACTS) (Teague 1998)
  - Team organization and staffing most important factors
Beyond the basics

Conclusions

- The ACT model operates differently from traditional treatment
- Start up require attention to these differences … and is worth the effort!
- … You are doing great work for a great cause!
The PACT model of community-based treatment for persons with severe and persistent mental illnesses. 1998 Allness, Knoedler

A Manual for ACT Start-Up. 2003 Allness, Knoedler

Iowa Consortium for Mental Health:
http://www.medicine.uiowa.edu/ICMH/act/

Toolkit for ACT: SAMHSA
http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345
ACT

Resources


- Mancini A, Moser L, et al. Assertive Community Treatment: Facilitators and Barriers to Implementation in Routine Mental Health Settings. Psychiatric Services 2009; (60):2

- Bond GR, Drake RE. The critical ingredients of assertive community treatment. World Psychiatry. 2015; 14:2.


