Supporting Evidence-Based and Promising Practices:
Assertive Community Treatment Fidelity and Rural Considerations

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Outline for Today

- Overview of ACT
- Challenges of rural ACT
- Adapting ACT for rural implementation
- Critical components of ACT

Assertive Community Treatment (ACT)

- Community-based program for adults with serious (and persistent) mental illness
- Focus on independent living, employment and community tenure with assertive outreach
- “Team” staff approach
- Designated as an EBP

Research Support

- Effective at reducing hospital use and increasing community tenure[1]
- Many practice guidelines endorse it as an evidence-based practice for the treatment of schizophrenia[2]
- Improvements in stable housing, symptom management, and quality of life[1]
- Especially effective and cost-effective for clients who returned repeatedly to psychiatric hospitals[3]
- Extensions to homeless clients with SMI aimed at reducing homelessness are also generally effective, especially when integrated with evidence-based housing models[4]

[1]Bond, G.R., Drake, R.E., Mueser, K.T. & Latimer, E. (2001). Assertive Community Treatment for people with Severe Mental Illness: Critical Ingredients and Impact on Patients. Dis-Manage-Health-Outcomes, 9, 141-159. https://doi.org/10.2165/00115677-200109030-00003.
[2]Dixon LB, Dickerson F, Bellack AS, et al. (2010). The 2009 Schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophr Bull, 36*, 48–70. doi: 10.1093/schbul/sbp115.
[3]Dieterich M, Irving CB, Park B, et al. (2010). Intensive case management for people with severe mental illness. *Cochrane Database Syst Rev, 10,* 1-248. doi: 10.1002/14651858.CD007906.pub2.
[4]Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis. *American Journal of Public Health*, *94*(4), 651–656.

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ACT Guidelines

- Small Caseload (consumer/provider ratio of 1:10)
- Community-Based Services
- Team Approach
- Frequent Program Meetings
- Practicing Team Leader (direct services)
- Full Staffing with Continuity
- Psychiatrist (1 FTE per 100 consumers)

ACT Guidelines, Cont'd…

- Minimum of 2 Nurses per 100 Consumers
- Minimum of 2 Substance Abuse Staff per 100 Consumers
- Minimum of 2 Vocational Staff per 100 Consumers
- Program Size: Sufficient to consistently provide the necessary staffing diversity and coverage

More About Staffing…

- Psychiatrist (can be part-time)
- Team Leader
- Nurse(s)
- Peer Staff
- Specialists: Vocational & Substance Abuse
- Social Workers/Counselors (Masters level)
- Paraprofessionals – Community Partners

ACT Treatment Responsibilities

- Full Responsibility for Individualized Treatment Services – case management, psychiatric services, counseling, housing support, substance abuse treatment, and employment/rehabilitation services
- Community-Based Services
- Crisis Services (24/7)
- Hospital Admissions
- Hospital Discharge Planning – Continuity of Care
- Time Unlimited/Indefinite Services

Anticipated ACT Outcomes

- Increased Independent Living – decreased homelessness
- Improved Employment Status
- Decreased Substance Use
- Decreased Hospitalization Days
- Enhanced Quality of Life, Increased Socialization, Reduced Symptom Severity/Distress
- Targeted Programs may Decrease Incarceration Days
- Increased Staff Morale and Retention

Dartmouth Assertive Community Treatment Scale (DACTS)

ACT Fidelity Scale

Human resources: Structure and composition

Criterion	Ratings / Anchors				
	1	2	3	4	5
H1 Small caseload: Consumer/ provider ratio = 10:1	50 consumers/team member or more	35 – 49	21 – 34	11 – 20	10 consumers/team member or fewer
H2 Team approach: Provider group functions as team rather than as individual ACT team members; ACT team members know and work with all consumers	Less than 10% consumers with multiple team face-to-face contacts in reporting 2-week period	10 – 36%	37 – 63%	64 – 89%	90% or more consumers have face-to-face contact with >1 staff member in 2 weeks
H3 Program meeting: Meets often to plan and review services for each consumer	Service-planning for each consumer usually 1x/month or less	At least 2x/month but less often than 1x/week	At least 1x/week but less than 2x/week	At least 2x/week but less than 4x/ week	Meets at least 4 days/ week and reviews each consumer each time, even if only briefly
H4 Practicing ACT leader: Supervisor of Frontline ACT team members provides direct services	Supervisor provides no services	Supervisor provides services on rare occasions as backup	Supervisor provides services routinely as backup or less than 25% of the time	Supervisor normally provides services between 25% and 50% time	Supervisor provides services at least 50% time
H5 Continuity of staffing: Keeps same staffing over time	Greater than 80% turnover in 2 years	60 – 80% turnover in 2 years	40 – 59% turnover in 2 years	20 – 39% turnover in 2 years	Less than 20% turnover in 2 years
H6 Staff capacity: Operates at full staffing	Operated at less than 50% staffing in past 12 months	50 – 64%	65 – 79%	80 – 94%	Operated at 95% or more of full staffing in past 12 months
H7 Psychiatrist on team: At least 1 full-time psychiatrist for 100 consumers works with program	Less than .10 FTE regular psychiatrist for 100 consumers	.10 – .39 FTE for 100 consumers	.40 – .69 FTE for 100 consumers	.70 – .99 FTE for 100 consumers	At least 1 full-time psychiatrist assigned directly to 100- consumer program
H8 Nurse on team: At least 2 full-time nurses assigned for a 100-consumer program	Less than .20 FTE regular nurse for 100 consumers	.20 – .79 FTE for 100 consumers	.80 – 1.39 FTE for 100 consumers	1.40 – 1.99 FTE for 100 consumers	2 full-time nurses or more are members for 100-consumer program

Challenge: Translating Research into Practice

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Challenge: Translating Research into Practice, Cont'd…

- What's different in small/rural counties?
  - Workforce and Staffing
  - Number of Persons with SMI/SPMI – lack of "economies of scale"
  - Geography and Travel (time/distance)
  - Smaller Resource Pools

What are Rural Folks Doing?

Identifying and implementing the core components of an EBP, such as ACT, in a rural area can result in good clinical outcomes for rural consumers.

ACT in South Dakota

Lewis & Clark Behavioral Health Services, Inc.

Behavior Management Systems BMS Cares.org

CACS Building Better Tomorrows

Southeastern Directions for Life

Community Counseling Services
Providing personal counseling and services to South East South Dakota

Northeastern Mental Health Center

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Adapting ACT for Rural Implementation

- Workforce and Staffing
  - Availability of specific clinicians
  - Level of staffing necessary for small teams
    - 24/7 coverage with small teams
  - Shared staffing with other programs and agencies

South Dakota

Fully staffed team important, but difficult. Refer consumers to other resources, such as substance abuse specialists.

Michigan

Teams usually average about 6-7 staff

Implementing ACT for Rural Implementation

- Number of persons with SMI/SPMI
  - Size of Teams

South Dakota

Size of program is usually around 50 consumers

Colorado

Rural team may only have 25 consumers enrolled at one time

Adapting ACT for Rural Implementation

- Geography and Travel

Colorado

Fewer number of contacts, duration is longer

Adapting ACT for Rural Implementation

- Smaller Resource Pools
  - Lack of an economy of scale
  - Benefits of collaborating and sharing resources more visible
  - Consumers better known to smaller communities

South Dakota

Collaboration with local partners – consumers known to everyone

Colorado ACT Scale

COLORADO ASSERTIVE COMMUNITY TREATMENT FIDELITY SCALE (CO-ACT)

CATEGORY How well does the program meet the criteria for the component?	1 Does not meet criteria.	2 Most of the criteria are not met most of the time.	3 Some of the criteria are met, but it is not consistent.	4 Meets most of the criteria most of the time.	5 Meets and exceeds criteria all the time.
(H1) TEAM APPROACH: Small Case Load: Client: staff ratio should be no greater than 12:1, and ideally 10:1 or less	35-40 Clients/clinician or more.	25-35	15-25	11-15	10 clients/clinician or fewer.
(H1-CO) TEAM APPROACH: Team size of at least three FTE members.	Has not been above the 3 FTE requirement during the FY.	Has had 3 FTE for less the 6 months but more than 2 months.	Is below 3 FTE requirement for more than a month.	Has dropped below the 3 FTE requirement for less than 2 weeks during FY.	Always has at least 3 FTE team members, even during employee transitions.
(H2-CO) TEAM APPROACH: Shared case loads for both treatment planning and treatment provision – Provider group functions as team rather than as individual practitioners: clinicians know and work with all clients.	Fewer than 10% of clients with multiple staff face-to-face contacts in reporting quarterly period.	10-36%	37-63%	64-89%	90% or more clients have routine face tot face contact with more than 1 staff during a quarter.
(H3) TEAM APPROACH: Daily team meetings attended by all members.	Program service planning for each client usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least twice/week but less often than 4 times/week.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.
(H4) PRACTICING TEAM LEADER: ACT team has a designated team leader/coordinator who provides direct services and whose responsibilities are limited to the ACT team.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup, and/or has other responsibilities.	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25-50% of the time.	Supervisor provides services at least 50% of the time.
(H6-10-CO) The ACT team is multi-disciplinary (e.g., mental health counselors, social workers, vocational counselors, substance abuse counselors, Housing specialist, Payee specialist).	Team is strictly comprised of mental health professionals.		Team has 1.5 FTE mental health and .5 CAC or Voc.		Team has one FTE mental health clinician and either one FTE CAC or Vocational Counselor.
(H7) PSYCHIATRIST On Staff:	No direct psychiatrist responsible to the Team.	Less than 0.15 FTE psychiatrist available to staff.	0.20 FTE per 40 clients or 0.15 FTE per 25 clients: available to staff bi-weekly.	0.20 FTE per 40 clients or 0.15 FTE per 25 clients: available to staff weekly.	0.25 FTE per 40 clients or 0.2 FTE per 25 clients: available to staff weekly.
(H8) REGISTERED NURSE IS ON STAFF (preferably full-time).	Program for 40 clients has less than .1 FTE regular nurse.	.1-.4 FTE per 40 clients.	.4-.7 FTE per 40 clients.	.7-.9 FTE per 40 clients who attends ½ of staff meetings.	1 FTE RN for 40 clients who attends all staff meetings.

Critical Components of ACT

Critical Components of ACT

- South Dakota Perspective
  - Team Approach
  - Communication
  - Community-Based Services
  - Assertive Consumer Engagement
  - Tailored Individual Treatment

South Dakota

SD plans to continue its IMPACT program and to evaluate programs using a modified SD-specific quality improvement scale.

Critical Components of ACT

- Michigan Perspective
  - Team Approach
  - Frequent Client Contact
  - Assertive Consumer Engagement/Intense Program
  - Tailored Individualized Treatment
  - Community-Based Services

Critical Components of ACT

- Colorado Perspective
  - Multidisciplinary Team
  - Low Caseload
  - Community-Based Services
  - Frequent Client Contact

Critical Components of ACT

- Research Perspective
  - Meta-analysis – relationship between ACT fidelity and reduction of hospital use used two broad indices to find critical ingredients:
    - Staffing: e.g., low client-staff ratio, optimal team size, and inclusion of psychiatrist and nurse in the team
    - Organization: e.g., ACT team provides care directly, rather than brokering, daily team meeting, and 24-hour access.[1]

[1]Burns, T., Catty, J., Dash, M., Roberts, C., Lockwood, A., & Marshall, M. (2007). Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ : British Medical Journal*, *335*(7615), 336. http://doi.org/10.1136/bmj.39251.599259.55.

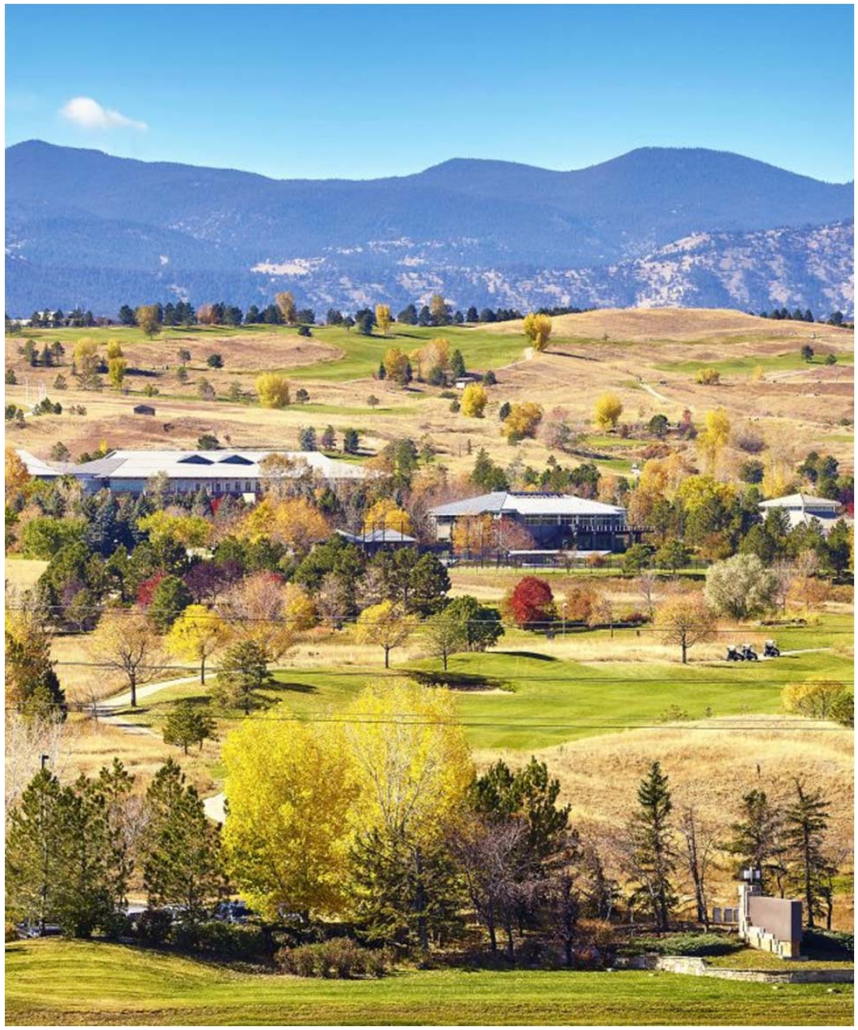
Critical Components of ACT

- Results:
  - *Organization* predicted significant reductions in hospital use, while *staffing* did not.
  - This study provided empirical support for the organizational components of ACT, but cast doubt on the necessity of multidisciplinary staffing standards.[1]
- Multidisciplinary Concept:
  - Now transformed into team members' need to learn new competencies continuously as evidence-based practices emerge.[2]

[1]Burns, T., Catty, J., Dash, M., Roberts, C., Lockwood, A., & Marshall, M. (2007). Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ : British Medical Journal*, *335*(7615), 336. http://doi.org/10.1136/bmj.39251.599259.55.

[2]Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. *World Psychiatry*, *14*(2), 240–242. http://doi.org/10.1002/wps.20234.

Fidelity – Rural Considerations



- What is absolute and what is not?
- What modifications impact program outcomes?
- Monitoring fidelity versus/and outcomes.
- When is the program no longer ACT?

"Finding the proper balance between adaptation and retention of important features remains a fundamental challenge."[1]

[1]Fekete, D. M., Bond, G. R., McDonel, E. C., Salyers, M., Chen, A., & Miller, L. (1998). Rural assertive community treatment: A field experiment. *Psychiatric Rehabilitation Journal, 21*(4), 371-379. http://dx.doi.org/10.1037/h0095286.

ACT is an Investment

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Thank You

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