

Acknowledgments

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About This Workbook

The Implementing Evidence-Based Practices Project Assertive Community Treatment Workbook was written to provide the leaders of new assertive community treatment programs a tool for orienting practitioners to the principles and practices of assertive community treatment. This workbook is made up of nine modules. Modules 1 through 4 focus on principles, processes, and practices specific to the assertive community treatment approach to service delivery. Modules 5 through 8 provide additional information about additional evidence-based interventions that teams use in working with assertive community treatment consumers and family members: (1) illness management and recovery skills, (2) integrated treatment for dual-diagnoses, (3) supported employment, and (4) family psychoeducation. The content of modules five through eight is taken from materials on these interventions that were developed for the Implementing Evidence-Based Practices Project.

Much of the material used in this workbook was adapted from *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-up* written by Deborah Allness and William Knoedler and published by the National Alliance for the Mentally Ill ACT Technical Assistance Center. This publication, referred to as *The PACT Manual*, is used by The Evaluation Center at the Health Service Research Institute in Boston to illustrate characteristics of a model manual. In preparing the Implementing Evidence-Based Practices materials on assertive community treatment, we consistently found that assertive community programs had used this manual in starting their programs and referred to it often. *The PACT Manual* is a valuable tool, particularly since it was written by people who were involved in the original assertive community treatment program. Groups forming new assertive community treatment programs can obtain a copy from the National Alliance for the Mentally Ill ACT Technical Assistance Center via the internet (<http://www.nami.org/about/PACT.htm>) or by calling (866) 229-6264. The Implementing Evidence-Based Practices Project materials on assertive community treatment are meant as a complement to, but not a replacement for, The PACT Manual.

PLAN A GROUP LEARNING PROCESS

Leaders of new assertive community treatment programs can use the Assertive Community Treatment Workbook to guide a group learning process. The sense of being part of a team and the ability of the team to process information as a group and make sense of it *together* is an essential part of assertive community treatment. For this reason we suggest a group learning process versus simply giving practitioners the workbook to peruse on their own.

PREPARE PROGRAM-SPECIFIC INFORMATION

In addition to the materials in this workbook, team leaders will need to be prepared to provide program staff with information about the specific policies and procedures that pertain to the program being implemented. These include:

- criteria for admitting people to the program
- the limited conditions under which people will be discharged or 'stepped down' to other services
- the assessments team members will complete and the timeframe for completing them
- the criteria upon which the program's fidelity to the assertive community treatment model will be assessed
- the outcomes that will be monitored

PREPARE AGENCY-SPECIFIC INFORMATION

In addition to the areas addressed in this workbook, team leaders will need to develop a plan for training members of new teams about other policies and procedures that may be relevant to the agency in which the team operates. These might include:

- safety- many agencies with existing community-based programs will have materials related to safety. If training in this area is not already available, the team leader will want to plan for training in de-escalation techniques. A local law enforcement agency may also be able to provide training in personal safety and crime prevention strategies.
- emergencies-team members must know the procedures to follow if an emergency occurs while they are in the community
- billing procedures- team members will need to know how to document their activities and bill for services
- vehicles-team members need to understand the policies about the use and maintenance of vehicles
- mandated reporting-team members must know how to report suspected abuse and neglect
- consumers' rights-team members should be aware of State and Federal consumer rights requirements, especially the Americans with Disabilities Act.

The human resource office of the agency in which the new program is operating may know of other program, agency, or state policies the staff need to be aware of.

VISIT AN EXISTING TEAM

We suggest that the staff of new programs visit and observe an experienced assertive community treatment team after they have processed the information in this workbook. Being familiar with the materials in this workbook prior to visiting a team will make the visit more productive. Rather than the hosting team having to take time to explain the basics, they will be able to spend time showing the new program staff how the basics are applied in the 'real world.' To locate a team to visit in your area, contact:

Assertive Community Treatment Association
810 E. Grand River Ave., Suite 102
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email: CheriMSixbey@actassociation.com
<http://www.actassociation.com>

National Alliance for the Mentally Ill
2107 Wilson Blvd, Suite 300
Arlington, VA 22201-3042
(866) 229-6263
ACT@nami.org
<http://www.nami.org/about/PACT.htm>

ARRANGE FOR DIDACTIC TRAINING

After the staff of a new program have reviewed this workbook and visited an experienced team, the program is ready to bring in a trainer. The trainer's job is to help the team take what they have seen and read and put it into practice. The initial training takes 2-3 days. If help with locating a trainer is needed, the Assertive Community Treatment Association and the National Alliance for the Mentally Ill can provide you with names of people experienced in training new teams (see contact information on previous page).

RECRUIT A MENTOR OR CONSULTANT

After the initial 2-3 day training, the team leader and psychiatrist are responsible for assuring that the team follows the assertive community treatment model in their work with consumers. This can be a challenge. What has to happen is that the team leader has to facilitate a team development process, apply what they have just learned about assertive community treatment in their own clinical work with consumers, AND at the same time assure through clinical supervision that team members follow the model.

It is very easy to get off track and do something similar to, but not quite the same as, assertive community treatment. Sometimes this happens because teams believe they are diligently following the assertive community treatment model, but have missed some of the more subtle aspects of it. In other cases, teams do well at the start, but as more consumers are admitted to the program and

there is more pressure on the team, they revert to older, more familiar ways of working. To assure that a new program implements and follows the assertive community treatment model, it is important that new team leaders work with a mentor or consultant throughout the first year of operation. A mentor or consultant can provide ongoing telephone and in person support to help the team leader with this challenging leadership role.

INVITE THE ADVISORY GROUP

The more information members of the team's advisory group have about assertive community treatment, the better they will be able to support the team and its mission. Training is also an opportunity for team members and advisory group members to become familiar with each other. Make sure that the advisory group members and team members are introduced to each other and that team members are familiar with the role of the advisory group.

Principles of Assertive Community Treatment

OBJECTIVES

Familiarize staff and Advisory Group members with the assertive community treatment model.

This chapter explains the history of ACT, the outcomes associated with this model, key components, how assertive community treatment compares to case management, and characteristics of the population who receive ACT services.

Team members will also need to know specific information about the particular program in which they will be working, such as:

- admission criteria for consumers;
- criteria upon which the program's fidelity to the assertive community treatment model will be assessed;
- outcomes upon which the success of the program will be assessed.

Staff and Advisory Group members will understand the potential benefits of assertive community treatment.

Studies that have explored what makes a difference in whether or not practitioners adopt a new treatment approach have found that practitioners are more likely to adopt a practice if it addresses an area in which they feel they need to improve. With assertive community treatment, it may not be so much a matter of an individual practitioner needing to improve, but of radically addressing the way services are organized and delivered. Encourage team members to share experiences where the traditional service delivery system has been inadequate and help them identify aspects of assertive community treatment that address those inadequacies.

Begin to build a 'team'

The ultimate purpose of this chapter is to have staff begin to think and act like a team. A critical component of a well-functioning team is open communication. Working through this chapter creates an opportunity to learn about how team members communicate in a team environment. You will want to have team members discuss their responses to the questions in this workbook in a group format.

Some people have difficulty speaking up in a group. This might be because they are somewhat timid or soft-spoken by nature. Others may feel professionally intimidated by those with more experience or higher degrees. Conversely, some team members will be very self-confident and outspoken and will need to learn to listen openly to what others have to say. One of the leader's roles is to encourage individuals who are more withdrawn to express their views and make sure that more vocal team members give others an opportunity to speak. There will be an opportunity to assess anxiety that team members may feel about working on an assertive community treatment team.

Introduce cross training

This chapter introduces cross training by having people begin to think about the professional knowledge and expertise they have and how it could be of value to other team members.

COMPLEMENTARY ACTIVITIES

Identify communication styles

There are a number of exercises that identify differences in the ways people communicate and work. Often these exercises involve a brief quiz or questionnaire that result in the person being identified as some particular 'type' of communicator or worker. If you do not have an exercise like this on hand, check with your Human Resources Officer. If you are still unable to locate an exercise of this nature, the Myer-Briggs Type Indicator is used for this purpose but requires a person trained in interpretation of it. A number of adaptations of this are available.

The idea behind having your team do an exercise of this nature is to help team members understand their innate differences and to give them a vocabulary for talking about those differences. Ideally, the exercise will include tips on how people with different tendencies can communicate or work more effectively with other 'types.' This can also function as an icebreaker.

Have team members take responsibility for presenting materials to the team

One strategy for using this workbook is to have individuals read the materials and come to a team meeting prepared to respond to the discussion questions. Another option is to divide this workbook into sections, then have the team divide into groups with each group taking responsibility for different sections. Ask each group to plan a presentation of the materials for the larger group. When they have finished, discuss the review questions together.

Write a mission statement or team motto

Part of being familiar with the assertive community treatment model and working as a team is being clear about goals. You might have the group develop a brief mission statement or come up with a one-line motto. Depending on the interests of the group, they might also create a team logo.

Learn about consumers' and family members' perspectives on mental health services

We encourage you to invite a group of 3 to 5 people who have been recipients of mental health services and people who have family members who have been diagnosed with a severe mental illness to participate in a panel discussion. These might include members of the team's Advisory Group, consumers working on the team, or people identified through local consumer or family groups.

Ask panelists who have experienced mental illness to be prepared to discuss the effect of their illness on them as a person. Also ask them to share experiences they had with the mental health system that were helpful and those that were not helpful.

Ask family members participating in the panel to discuss the experience of finding out their family member had a mental illness and how their family member's illness has affected the family. Also, ask them to talk about experiences they have had with the mental health system that were helpful and not helpful.

Have each panelist in turn tell his or her story and then ask the panelists if they would be willing to entertain questions from the team?

PRINCIPLES OF ASSERTIVE COMMUNITY TREATMENT

1. Assertive community treatment is a service delivery model, not a case management program.
2. The primary goal of assertive community treatment is recovery through community treatment and habilitation.
3. ACT is characterized by a:
 - team approach
 - small caseload
 - shared caseload
 - fixed point of responsibility
 - in vivo services
 - time unlimited services
 - flexible service delivery
 - 24/7 crisis availability
4. ACT is for people with the most challenging and persistent problems.
5. Programs that adhere most closely to the ACT model are more likely to get the best outcomes.

HOW DID ACT CHANGE THE WAY SERVICES ARE DELIVERED?

Assertive community treatment (ACT) began when several mental health professionals at the Mendota Mental Health Institute in Madison, Wisconsin realized that many people diagnosed with a severe mental illness were being discharged from inpatient care in stable condition only to return shortly thereafter. At best, revolving door hospitalizations were accepted as inevitable. At worst, people diagnosed with severe mental illness who did not fair well under the existing system of care were labeled as ‘noncompliant,’ ‘treatment resistant,’ or ‘unmotivated,’ and their needs went unmet.

Rather than finding fault with the people who were not benefiting from existing mental health services, the originators of assertive community treatment, Drs. Arnold Marx, Leonard Stein, and Mary Ann Test, took a different approach. They looked at the way mental health services were delivered and created a way to change care so that people diagnosed with a severe mental illness could become integral members of the community.

What they found was that:

- following discharge, the variety and intensity of services to support individuals in their lives outside the hospital decreased dramatically
- services were invariably clinic-based, and admission criteria and rules about continuing to receive services varied
- regardless of an individual’s needs, many programs were available only for a limited period and were of no assistance once a person was discharged
- services were structured in a way that assumed individuals progressed steadily from more to less structured services without consideration for individual differences in the course of recovery
- if a service was not available, no one was responsible for insuring that individuals got the help they needed
- even when a considerable amount of time was spent in the hospital teaching people the skills they needed to live in the community, these skills did not generalize to community living
- problems with shifting skills into the community were exacerbated by the fact that many people diagnosed with a severe mental illness were particularly vulnerable to the stress associated with change and new experiences.

The originators responded by designing a service delivery model in which a team of professionals assumed responsibility for providing the specific mix of services each individual needed at the appropriate frequency and intensity and for as long as necessary, and in which team members were available 24 hours a day, 7 days a week. Services were provided *in vivo*, that is, services were provided in the community in places and situations where problems arise rather than in an office or clinic settings. Interventions were integrated through collaboration among team members. The individual's response was carefully monitored so that the team could quickly adjust interventions to meet changing needs. Rather than brokering services from other providers, team members provided an array of treatment and habilitation support themselves.

WHAT ARE THE BENEFITS OF ASSERTIVE COMMUNITY TREATMENT?

Since the original assertive community treatment (ACT) program began in Madison nearly 30 years ago, programs have been implemented in 35 states and in Canada, England, Sweden, Australia, and Holland. As assertive community treatment spread, researchers carefully studied its effectiveness. Reviews of assertive community treatment research consistently conclude that, compared with other treatments under controlled conditions (e.g., brokered case management, clinical case management), assertive community treatment leads to a greater reduction in psychiatric hospitalization and a higher level of housing stability. Research also shows that, compared to other treatments, assertive community treatment has the same or better effect on quality of life, symptoms, and social functioning. In addition, consumers and family members report greater satisfaction.

While studies consistently show that assertive community treatment is associated with many beneficial outcomes, the Patient Outcomes Research Team (PORT) made up of researchers from the University of Maryland and Johns Hopkins University found that people who might benefit from assertive community treatment often do not receive this intervention. Those findings ultimately lead to the Implementing Evidence-Based Practices Project and the development of materials to help mental health systems implement assertive community treatment programs and other interventions known to be effective for adults diagnosed with serious and persistent mental illness.

WHAT ARE THE 'ACTIVE INGREDIENTS' OF ACT?

One of the unique features of assertive community treatment is that the important characteristics of this intervention have been delineated. The characteristics of assertive community treatment have been translated into program standards to help make certain that programs attempting to replicate assertive community treatment are adhering to the model. An instrument called the Dartmouth

Assertive Community Treatment Scale (DACTS) is available to help teams assess how closely their program is following the Assertive Community Treatment model (See Appendix C). Your team leader will tell you about how your program will use this instrument.

The following briefly describes some of the basic characteristics of assertive community treatment:

Team approach – practitioners with various professional training and general life skills work closely together to blend their knowledge and skills.

Small caseload – a team consists of 10 to 12 staff that serve approximately 100 consumers. This results in a staff to consumer ratio of approximately 1 to 10.

Shared caseload – practitioners do not have individual caseloads; rather the team as a whole is responsible for assuring each consumer is receiving the services he or she needs to live in the community and reach his or her personal goals.

Fixed point of responsibility – rather than sending consumers to a variety of providers for services, the team itself provides the services each consumer needs. If using another provider cannot be avoided (e.g., medical care), the team is responsible for making certain that the consumer receives the services he or she needs.

In vivo services – services are delivered in the places and contexts where they are needed

Time unlimited services – a service is provided as long as needed, not on the basis of predetermined timelines

Flexible service delivery – the team meets daily to discuss how each consumer is doing. The team can quickly adjust the services they are providing to be responsive to changes in consumers' needs.

24/7 Crisis services – services are available 24 hours a day, 7 days a week. Team members often find, however, that they can anticipate and head off crises.

HOW IS ASSERTIVE COMMUNITY TREATMENT DIFFERENT FROM CASE MANAGEMENT?

In an article published in 2001 in the journal *Disease Management and Health Outcomes*, Bond, Drake, Mueser, and Latimer, leading ACT researchers, compared assertive community treatment with case management models (Table 1.1). They write:

Case management has been defined as the “coordination, integration, and allocation of care within limited resources.” ACT is a model of care that provides treatment and rehabilitation in addition to performing case management functions. Although we discuss ACT in the context of case management, it should be noted that ACT is a more comprehensive service model.

The typical goals of case management (e.g., preventing hospitalization, improving quality of life, improving client functioning), as well as some typical case management activities (e.g., service planning, assessment, and advocacy) overlap with those for ACT programs. However, the methods and resources to achieve these ends differ sharply.

Unlike ACT, traditional case managers usually broker services (i.e., link consumers to other service providers) rather than intervening directly. Brokered case managers have individual caseloads, typically averaging about 30 consumers (sometimes more), and far more circumscribed job duties.

ACT also differs conceptually from intensive case management (ICM). One important difference is that ICM has no single origin. Consequently, unlike ACT, ICM has not achieved clear consensus in its essential ingredients. One frequently-mentioned difference between ACT and ICM is that ICM programs do not subscribe to the team approach with shared caseloads and daily team meetings, a difference that has been empirically confirmed in one study.

Table 1.1 A Comparison of Case Management and ACT

Case Management Programs	ACT Service Delivery Model
Caseloads of 30 or more	⇒ Staff to consumer ratio of about 1 to 10
Services ‘brokered’ from other providers	⇒ All services provided directly by team members
Case managers have sole responsibility for people assigned to them	⇒ Team members share responsibility for all individuals
Change in intensity of services means change in providers	⇒ Type and intensity of services can be varied easily
Individuals receive services they need IF the service exists, the person meets eligibility criteria, and there is space in the program	⇒ Team members provide ANY service a person needs
Individuals may be dropped from the caseload if they are ‘noncompliant,’ in jail, or receiving services somewhere else	⇒ Team is responsible for assuring people receive services they need even if they are difficult to engage, get arrested, or are hospitalized
If a case manager quits or goes on vacation, consumers are switched to someone else or do not receive services	⇒ If a team member goes on vacation or quits, service plans are continued by other team members who are known to the consumer
Treatment plans updated monthly or less often	⇒ Team discusses changes in individuals’ status daily and adjusts treatment as needed

HOW IS AN ACT TEAM DIFFERENT FROM OTHER TEAMS?

People from multiple disciplines work together on assertive community treatment teams, but it is not technically a 'multidisciplinary team.' Rather, an assertive community treatment team is what is known as a transdisciplinary team. Table 1.2 on page 19 compares transdisciplinary and multidisciplinary teams.

One way of thinking about a transdisciplinary team is as a vehicle that blends the knowledge and skills of professionals from multiple disciplines with the goals of service users to surpasses the limitations of individual disciplines and service programs. It even transcends the typical provider-consumer relationship. Consumers have a decisive voice in what services they receive and the way they receive them. This model allows providers to deliver a comprehensive and integrated array of services to individuals who have complex needs.

As a transdisciplinary team, assertive community treatment teams are set up around a task - keeping individuals out of the hospital and supporting their recovery from mental illness. This is very different from the way mental health services are usually set up.

Typically, services are set up in a predetermined hierarchy or configuration. The service system then tries to fit the tasks that it is given into that configuration. In contrast, the configuration of ACT services is not predetermined. Instead, ACT teams start with a task - keeping an individual out of the hospital and supporting his or her recovery. The team's resources and services are then configured to accomplish that task. What this means essentially is that rather than trying to fit people into a rigid service system, services are fitted to people's needs.

Several things can go wrong in the more traditional hierarchal system, especially when service users have needs that are as complex as the needs of individuals receiving assertive community treatment services. In traditional service models, services may be delivered sequentially. For instance, one provider at one agency treats the person's mental illness, and after that problem is treated, the person is sent to a substance abuse treatment program or to a vocational program. One of the problems with this 'pass around' approach is that many problems are too pressing to wait for attention, and some problems are of such a protracted nature that the person might never get to the next provider.

Another problem under the usual care system is to provide parallel services. For instance, a mental health professional and a substance abuse treatment provider work with a person at the same time. Ideally, practitioners communicate with each other, but even so they may duplicate efforts or miss information that might be relevant to the other provider or work at cross-purposes.

In a transdisciplinary team, team members work together intimately so that each team member can

draw on every other team member's knowledge, skills, and observations, and a precise combination of carefully crafted, well-integrated services.

Open communication is essential to providing integrated services. Assertive community treatment teams work in shared space to facilitate the informal sharing of information. They have daily meetings where they talk about what is going on with each consumer.

It is difficult to have a transdisciplinary team if some service users are 'yours' and some are 'mine.' That is why members of assertive community treatment teams do not have individual caseloads. Specific consumers may be assigned to mini teams for administrative purposes, where a subgroup of team members works very closely with particular consumers, but the team as a whole is responsible for the success of every consumer.

In order for a transdisciplinary team to function optimally, cross training has to occur. This does not mean that every member of the team prescribes medicine or does physical examinations. Some tasks are governed by licensure and laws. However, many of the things that team members know that are specific to their discipline can be taught to people from other disciplines. Those other people then become extra eyes and ears, can recognize when there is a problem brewing, help deliver or reinforce interventions, and communicate from a broader perspective about what is going on with each consumer.

Cross training occurs while doing comprehensive assessments, during treatment planning, and in daily meetings. On new teams, cross training can be facilitated by having members of different disciplines work together jointly with consumers. By observing the types of questions team members from other specialists are asking and finding out why that information is important, colleagues can begin to understand each other's professional perspectives and skills. Teams can also make opportunities for members from the various disciplines to 'teach' their teammates about their discipline.

Working on a transdisciplinary team can be taxing. It requires flexibility and a willingness to set aside professional turf. On the other hand, working on a transdisciplinary team can be very rewarding. Many professionals who have worked in this model find that it is less stressful because other team members are available to provide expertise and support. They also see the work environment as being enriched, find that problem solving is easier, and they enjoy opportunities to learn from other disciplines. Most of all, professionals find it rewarding to see consumers benefit from a service model that meets their needs and helps them achieve greater independence.

Table 1.2 COMPARISONS of Team Models

	Multidisciplinary	Interdisciplinary	Transdisciplinary
Assessment	Separate assessments by team members	Separate assessments with consultation	Team members conduct comprehensive assessment together
Consumer Participation	Consumers meet with individual team members	Consumers meet with team or team representative	Consumers are active and participating team members
Service Plan Development	Team members develop separate plans for disciplines	Team members share separate plans with each other	Team members and consumers develop plans together
Service Plan Implementation	Team members implement part of plan related to their discipline	Team members implement their section of plan and incorporate other sections where possible	The team is jointly responsible for implementing and monitoring the treatment plan
Lines of Communication	Informal lines	Periodic case-specific team meetings	Regular team meetings with ongoing transfers of information, knowledge and skills shared among team members
Guiding Philosophy	Team member recognizes the importance of contributions from other disciplines	Team members willing and able to develop, share and be responsible for providing services that are part of the total service plan	Team members make a commitment to teach, learn and work together across disciplinary boundaries in all aspects to implement unified services plan
Staff Development	Independent within each discipline	Independent within as well as outside of own discipline	An integral component of working across disciplines and team building

Woodruff, B. & McGonigel, M (1988). Early intervention team approaches: The transdisciplinary model. In J.G. Jordon, J.J. Gallagher, P.L. Hutinger, & M.G. Karnes (Eds). Early childhood special education: Birth to three. Reston, VA: Council for Exceptional Children cited in Nicholson, D., Artz, S., Armitage A., Fagan J., (2000) Working relationships and outcomes in multidisciplinary collaborative practice settings. 29(1), 39-73

HOW DOES AN ACT TEAM RELATE TO OTHER SERVICES?

Quality care is delivered by many capable people in mental health and related systems. It is the case, however, that some consumers need a higher level of resources and a different approach to service delivery. This is a fact - not a criticism of the work of individual mental health professionals.

ACT teams may find that other professionals within the mental health system will be envious of the resources, training, and skills of the team. Teams will need to build relationships with other providers to assure seamless and coordinated care. There will be times when, for instance, hospitalization cannot be avoided or when a consumer who has been stable for an extended period will be 'stepped down.' Team members must work alongside and partner with professionals in other services to assure consumers receive proper and continuous care.

WHO USES ASSERTIVE COMMUNITY TREATMENT SERVICES?

Based on *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up*, published by the National Alliance for the Mentally Ill ACT Technical Assistance Center. Deborah Allness & Bill Knoedler (NAMI). Copyright 1999, Used with permission.

Target Population

Assertive community treatment is designed for consumers characterized as those in the greatest need, estimated to be 20 to 40 percent of persons with severe and persistent mental illness. Criteria for selection include psychiatric disorders (schizophrenia and bipolar illness of a minimum), which severely impair functioning in the community. Impairment is likely in multiple areas (1) inability to perform practical tasks required for basic functioning in the community; (2) inability to be consistently employed or carryout homemaker roles; or (3) inability to maintain a safe living situation. They are also likely to have a history of high service needs (e.g., repeated hospitalizations, a history of substance abuse or criminal justice system involvement, substandard housing or homeless). Some programs will focus exclusively, for example on a criminal justice or homeless population, this will influence the amount of specialized expertise required by the full team.

People are not excluded from receiving services because of severity of illness, disruptiveness in the community or in the hospital, or failure to participate in or respond to traditional mental health services (e.g., outpatient therapy, day treatment). During acute episodes, people are often unable to adequately care for themselves and need intensive services and supports, including hospitalization. Symptoms may completely remit with effective treatment for the majority of consumers, but for others symptoms only partially remit and they experience them continuously. In addition to symptoms, a significant number of people with severe psychiatric conditions have persistent impairments that are the cause of long-term disability and poor community functioning. Impairment, may be present months or years before the onset of recognizable psychiatric symptoms, may worsen during acute symptom episodes, and tend to persist even after symptom remission. Some impairments require a long-term, ongoing, and consistent approach to intervention.

Impairment, even more than symptoms, produces enduring challenges in employment, personal care, and socialization such that living in the community is often difficult, and in some circumstances impossible without extensive and regular assistance from others. Many adults with severe and persistent mental illnesses struggle with day-to-day living tasks such as personal hygiene, cooking, shopping, and managing money. As a result of the impairments associated with severe and persistent mental illnesses, individuals are often single, isolated, and have few non-family relationships and supports. Unemployment or ability to work only part-time or intermittently is another significant issue. Compounding these difficulties are the stigma and rejection that persons with severe and persistent mental illnesses experience from the rest of the community.

As a consequence of problems in daily living, adults with severe and persistent mental illnesses are typically poor and financially dependent on entitlements and other benefits (e.g., Supplemental Security Income, Social Security Disability Insurance, Medicaid, veterans' benefits) and on family. Many persons with severe and persistent mental illnesses cannot afford decent housing, therefore constituting a significant portion of the homeless population in the United States. Further, poverty along with mental illness makes persons more vulnerable to arrest and incarceration, mostly for misdemeanor offenses, and to victimization. Adults with severe and persistent mental illnesses also more often die prematurely from suicide or physical illness, and they frequently become involved in the use and abuse of alcohol or other substances.

WHO ARE 'CONSUMERS IN GREATEST NEED'?

Assertive community treatment programs serve individuals with the greatest need. Consumers in greatest need are individuals who have severe symptoms and impairments that are not effectively remedied by usual treatment or who, for reasons related to their mental illness, resist or avoid involvement with traditional mental health services.

Consumers in greatest need include people who:

- have major symptoms that improve only partially or not at all with medication and other treatments and who, as a result, have severe persistent or intermittent symptoms that create personal suffering and distress (e.g., hallucinating and delusional most hours of the day and, consequently, fearful and isolated)
- have serious disability resulting from mental and behavioral impairments (e.g., evictions because of poor care of residence and disruption of neighbors, job losses secondary to poor concentration and anxiety about co-workers)
- have co-existing substance use disorder, physical illnesses or disabilities (e.g., diabetes, visual impairment) that aggravate psychiatric symptoms and impairments and magnify overall service needs
- appear to 'resist or avoid' involvement in services because:
 - illness changes their beliefs and perceptions (e.g., delusions and hallucinations) so that they have difficulty acknowledging that they have a mental illness and view mental health services as a threat, or as unnecessary
 - other symptoms (e.g., disorganization and confusion of thinking), impairments (e.g., anxiety, social withdrawal, limited attention span), and associated problems (e.g., substance use, sexual inappropriateness) limit their ability to meet the participation expectations of standard psychiatric services
 - some traditional services designed for persons with severe and persistent mental

illnesses (e.g., day treatment programs, group homes) do not easily accommodate individual choice and personal preference

- persons diagnosed with severe and persistent mental illness sometimes view such programs as stigmatizing and limiting, rather than promoting their opportunity to have normal life experiences (e.g., job, home)

Because they do not wish for, or cannot receive consistent help, many of these individuals go without services and persistently experience symptoms, impairment, and are at risk of becoming more refractory to treatment when they do eventually receive it. Consumers in greatest need often have the poorest quality of life and create the greatest social and financial costs of persons with severe and persistent mental illnesses. In particular, these individuals are more likely to frequently use emergency and inpatient medical and psychiatric services, to be homeless or live in substandard housing, to be arrested and incarcerated, or to die prematurely from suicide or physical illness.

Many of these individuals may have already been ordered into treatment involuntarily (e.g., inpatient commitment, probation, or parole expectations) and consequently approach their caregivers with anger and resentment. Providing effective services for these persons requires providers to reach out and:

- make visits in the community, on the street, or in jails, shelters, and impoverished living situations
- to understand substance use
- to listen, support, and provide assistance, even when individuals may have trouble following through (e.g., paying bills)

REVIEW

1. Before Assertive Community Treatment what characteristics of mental health services made it difficult for 'consumers with the greatest need' to get the services they needed. What were these problems?
 - a. Have you ever encountered any of these problems when working with people diagnosed with a severe mental illness? If so, what happened to these people?

 - b. Which aspects of Assertive Community Treatment that might have made a difference? Explain.

2. Why would it be inaccurate to describe ACT as just a case management program?

3. What characteristics of Assertive Community Treatment programs help to facilitate communication between team members?

Important Concepts

OBJECTIVES

Introduce the concept of recovery as the goal of mental health treatment.

The concept of recovery is one that may be new to people. Recovery does not mean cure, but it does mean learning ways to live with an illness so that it is not the driving factor in a person's life.

Provide a framework for understanding the onset and course of mental illness.

This chapter includes an overview of the stress-vulnerability model. This model provides a useful framework for understanding mental illness and factors that influence its onset and course. The stress-vulnerability model also offers a schema for thinking about the objectives of assertive community treatment and the skills that consumers need for their recovery.

COMPLEMENTARY ACTIVITIES

Visit the web pages of the National Empowerment Center

The National Empowerment Center operates a website (www.power2u.org) that has stories and articles written by people who have experienced psychiatric disorders. The articles provide a glimpse of what it is like to be on the receiving end of mental health services, as well as, accounts of personal journeys to recovery. You will find articles to share with your team as well as training materials that can help team members better understand the experience of mental illness.

Read more about recovery

Much of the information on recovery in this chapter comes from a report called *A Review of Recovery Literature* written by Dr. Ruth O. Ralph for the National Technical Assistance Center for State Mental Health Planning (NTAC) and National Association for State Mental Health Program Directors (NASMHPD). You can download this report in its entirety (about 30 pages) from the NASMHPD website – <http://www.nasmhpd.org/ntac/reports/ralphrecovweb.pdf>.

IMPORTANT CONCEPTS

- 1. The ultimate goal of assertive community treatment services is to support consumers in their recovery processes.**
- 2. In a recovery framework, mental health practitioners are called upon to be a source of hope and support for consumers.**
- 3. Mental illness involves two key factors: (1) biological vulnerability that predisposes individuals to mental illness, and (2) stressors.**
- 4. Objectives of assertive community treatment interventions are to reduce the stressors to which a person is exposed, and to change conditions that affect the person's susceptibility to stressors**

IMPORTANT CONCEPTS

This chapter presents two concepts that are important in understanding the goals and objectives of assertive community treatment. One is the concept of recovery. Recovery in the context of severe and persistent mental illness may be new to some team members. Since the ultimate goal of assertive community treatment services is to support the consumer's recovery process, this chapter begins with a discussion of this concept.

The second concept addresses the stress-vulnerability model. This model provides a useful framework for understanding mental illness and factors that influence its onset and course. The stress-vulnerability model also offers a schema for thinking about the objectives of the services that assertive community treatment teams provide and skills that consumers need for their recovery.

RECOVERY

The idea of 'recovery' from severe and persistent mental illness may be new to team members who came of age professionally in an earlier era when the mental health field generally held and communicated low expectation for people with severe and persistent mental illness. 'Recovery' embraces a more hopeful vision for people who experience psychiatric disorders.

In a recovery framework, the expectation is that people who experience severe mental illness can live a life in which mental illness is not the driving factor for their existence. Recovery means more than expecting people to simply 'cope' with mental illness. It also means more than 'maintaining' people with mental illness in the community.

In a recovery framework, mental health practitioners are called upon to be a source of hope, support, and education, and to partner with people on their journey through mental illness and the accompanying social consequences. As Alan McNab describes it, people with mental illness are looking for:

- support and education so they can take responsibility for controlling their symptoms,
- encouragement to set personal goals and work toward them, and
- help getting facts, planning strategies, gathering support, and targeting their efforts.

In a publication prepared for the National Technical Assistance Center for State Mental Health Planning (NTAC) and the National Association for State Mental Health Program Directors (NASMHPD), Dr. Ruth Ralph describes recovery as "a process in which consumers learn to approach daily challenges, overcome disability, learn skills, live independently, and contribute to society."

Helping consumers in the process of recovery is the ultimate goal of assertive community treatment teams.

Consumer Comments on Recovery

The dictionary talks about recovery in terms of regaining something or getting something back. In consumers' comments on recovery, there are themes of regaining:

- hope
- motivation
- self-confidence
- meaning
- independence

It is important for practitioners to convey the belief that consumers can:

- get well and stay well for long periods of time,
- work toward and meet goals, and
- lead happy and productive lives

Consumers who were involved in the development of the Implementing Evidence-Based Practices Project materials described their experience of recovery. These individuals discussed the importance of goals in providing meaning and instilling hope. As one consumer says, "I have to have goals. That's what gives my life meaning. I'm looking to the future."

According to another individual, "It's about motivation." The idea of motivation and how to use it in helping individuals with recovery is discussed in another Resource Kit (Illness Management).

For another consumer, the issue is self-esteem: "Recovery is about having confidence and self-esteem. There are things I'm good at, and I have something positive to offer the world."

Independence is also important: "The most important thing in my recovery is to be as independent as possible. I'm working at that all the time." Team members work with consumers to help them achieve maximum independence in many areas including housing, finances, and medication management. Team members can also help consumers become more independent in their relationship with the mental health system by educating them about mental illness and treatment options and relating to them as partners in the treatment process rather than as the subjects of treatment.

Other Perspectives

We want to be careful to say that we are not suggesting that recovery means that a consumer simply goes back to where he or she was before the onset of illness. For one thing, we are all continuously changing, growing, and learning. Further, being diagnosed with a severe and persistent mental illness is a life-altering experience. For these reasons and others, some consumers prefer to talk about the experience of mental illness in terms other than recovery.

In Dr. Ralph's publication (mentioned earlier in this chapter) a paper written in 1999 by S. Caras called *Reflections on the Recovery Model* and another by K. Cohan and S. Caras written in 1998 called *Transformations* were cited. We include these quotes to give team members a broader view of consumers' thoughts about the experience of mental illness:

"I am not recovered. There is no repeating, regaining, restoring, recapturing, recuperating, retrieving. There was not a convalescence. I am not complete. What I am is changing and growing and integrating and learning to be myself. What there is, is motion, less pain, and a higher portion of time well-lived."

S. Caras, 1999

"Our lives seem not to follow a traditional linear path; our lives appear to be like advancing spirals. We relapse and recuperate, we decide and rebuild, we awaken to life and recover/discover, and then we spiral again. This spiral journey is one of renewal and integration, the dynamic nature of this process leads to what can only be described as transformation. Recovery and rehabilitation imply that someone was once broken and then was fixed. Transformation implies that proverbial making of lemonade after life hands you lemons. It is the lesson, hard learned, of the opportunity available in the midst of crisis that evokes a substantive change within ourselves."

K. Cohan & S. Caras, 1998

Recovery as a Process

Recovery does not mean the same thing as cure. When we use the term recovery in this workbook, it is not meant to imply that a person will never experience psychiatric symptoms again. What we *are* talking about is an ongoing process. Based on a review of the literature on recovery and severe mental illness in the publication by Dr. Ralph this process might be seen as a journey through mental illness to a place where a person has the courage, skills, knowledge, and aspiration to struggle persistently with psychiatric symptoms and the impairments that can limit people from living independent and meaningful lives.

The process of recovery involves consumers' experiencing and processing their feelings about having a mental illness and the consequences of that illness in their lives. Consumers write and speak of experiencing grief, frustration, loneliness, despair, and anger at God, the mental health system, and at society's treatment of people with mental illness.^{1,2}

As you work with people, it is important to allow them to express their feelings about having a mental illness. Anger, grief, frustration, hopelessness, and despair are all normal emotions a person diagnosed with a major illness might be expected to experience. Be careful not to write these feelings off as merely symptoms of mental illness, mood swings, or labile affect.

Listen and validate feelings, without discounting or minimizing their experience. You will want to help people refocus on what they *are* able to do, and ways they can decrease the symptoms they experience, prevent them from recurring, and become involved in meaningful adult activities that interest them.

¹ See "The Wounded Prophet" in *Recovery: The New Force in Mental Health*, published by the Ohio Department of Mental Health.

² See "How I Perceive and Manage My Illness" by E. Leete in *Schizophrenia Bulletin*, Volume 8, 1998.

Conveying Hope

It is easy for a person diagnosed with a severe mental illness to lose hope. The symptoms of psychiatric illness can be very difficult to live with. As a society we have historically sent a clear message that people who experience psychiatric illnesses are less valued members of our society. Even the mental health profession has sent the message, until recently, that the best a person might hope for is to “cope.” While progress is slowly being made to change attitudes and eliminate the stigma associated with mental illness, a person diagnosed with a severe mental illness will still receive many negative messages and it is easy for them to be internalized. Your job involves countering those negative messages by showing the people you work with the same respect and consideration you would any adult and by helping them to envision social roles for themselves other than that of a patient or consumer.

Barbara Julius, who directed the Outreach Program in Charleston, South Carolina for more than a decade remembers her struggle coming to believe in the possibilities for people diagnosed with severe mental illnesses:

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 to decide if we were going to admit someone to our program 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 be in the community. That would be a huge a risk. What about our program’s liability?”

During a consultation with Debbie Allness, a member of the original program for assertive community treatment, 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 cannot, as a team leader or program director, hold the dream of possibility for another person, then you should not be leading an assertive community treatment team. If your thinking is so restricted that you cannot envision people who experience severe and persistent mental illness getting better and you think they will require constant supervision, then why do assertive community treatment?

Your role is not only to help the people who receive your services to see a more hopeful future, but also to help change the attitudes of those around you. Mike Neale, who has helped to develop more than 50 ACT programs for the Veterans Administration talks about the role of assertive community treatment team members in changing attitudes:

[Assertive community treatment] is all about advocacy, all the time. That is the mode you go into when you start doing community-based services. You do not know where, when, and how, but you know you will do it. And you need to. You need to educate everybody; all the stakeholders from yourself, to your client, family members, others out in the community, other providers, providers on your team, providers back in your system, and community members. It is 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 are trying to change perception and behaviors at every level.

STRESS-VULNERABILITY MODEL

The ultimate goal of assertive community treatment is to help individual's reach a point where having a mental illness is not central in their life. In order to help people reach that point, team members need to understand something about the onset and course of mental illness. The stress-vulnerability model provides a framework for thinking about mental illness and a practical schema for conceptualizing the objectives of services.

According to the stress-vulnerability model, an episode of major mental illness such as schizophrenia, schizoaffective disorder, bipolar disorder, or major depression involves two factors: biological vulnerability and stress.

In order for a person to develop a mental illness, he or she must have the biological vulnerability for that particular illness. The illness may then develop spontaneously or when the person is exposed to stress. The illness, triggered by stress, may reoccur periodically. In some individuals with severe disorder, vulnerability appears to increase with repeated episodes of illness. The criteria for admission to assertive community treatment programs makes it particularly likely that consumers who receive ACT services will have had multiple episodes of illness and experience symptoms that may not fully remit.

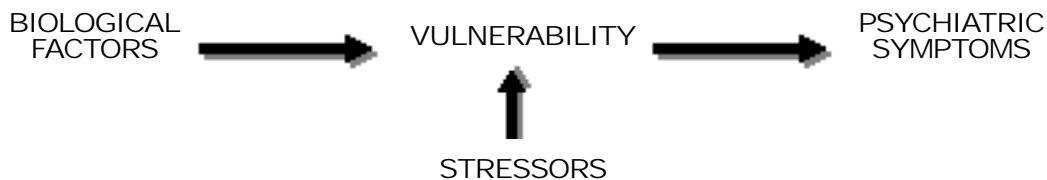


Figure 2.1 Stress-Vulnerability Model

Researchers are not certain of the exact precursors of biological vulnerability. There is research implicating genetics, biochemical agents, and early biological development.

On the other hand, stressors are something with which everyone is familiar. Look at the list of stressors in Table 2.1. You will see that some stressors are major unpleasant life events. These stressors include experiences like losing a loved one, being fired, losing your home, being arrested, and being hospitalized.

Stressors can also be events and experiences that happen to people that are generally considered positive or desirable. For example, being discharged from the hospital, being released from prison, the birth of a new child, a job promotion, an increase in pay, and starting a new relationship are experiences that would generally be considered changes for the better. The key is that they involve *change* and change, even for the better, can be stressful.

Stressors do not always have to be *major* events. Daily hassles such as traffic jams, cranky children, rude people, or deadlines can also be stressful.

There are times when people may be particularly susceptible to stress; when even little things that normally would not bother them are stressful. These may include times when people are hungry, tired, lonely, or not feeling well (Table 2.1).

Table 2.1 Stressors and Susceptibility to Stress

STRESSORS			SUSCEPTIBILITY TO STRESS	
Major ‘Negative’ Events	Major ‘Positive’ Events	Everyday Hassles	Increase Susceptibility	Decrease Susceptibility
Major illness	A new home	Deadlines	Not feeling well	Good health
Hospitalization	Hospital discharge	Rude people	Being tired	Adequate rest
Serious injury	A new baby	Forgetting something important	Being hungry	Adequate nutrition
Victimization	Release from jail	Traffic	Noisy living environment	Adequate financial resources
Losing one’s home	A new relationship	Cranky children	Crowded living environment	Social support
Divorce/separation	Getting married	Paying bills	Social isolation	Opportunities to relax
Having one’s child taken away	Starting a new job	Not receiving a check on time	Negative or pessimistic attitude	Exercise
Arrest/incarceration	A promotion			Positive or optimistic attitude
Losing a job	A pay raise			
Family crises	Giving up addictive drugs		Lack of meaningful stimulation	

Some conditions and circumstances make it *easier* for people to cope with stress, for instance, exercise, proper rest, and good nutrition. Social support, that is having people who will listen and support when things are not going well, can also make it easier for people to cope with stress.

Implications for Intervention

Returning to the basic premise of the stress-vulnerability model, when a person is biologically vulnerable to mental illness and encounters stressors such as those listed in Table 2.1, there is a risk of relapse. It stands to reason then that a person’s odds of experiencing psychiatric symptoms (and chances of reaching a point where his or her life does not center around mental illness) can be favorably altered by interventions that:

- change the person’s biochemistry
- change the person’s risk of being exposed to stressors
- change factors that influence the person’s susceptibility to stressors

Change Biochemistry

One way to alter the stress-vulnerability equation is to alter biological processes. Medications can alter the workings of chemicals within the brain to reduce or eliminate psychiatric symptoms. These medications can have substantial side effects and using them effectively requires a close working relationship between the consumer and his or her doctor.

Drugs and alcohol also affect the chemistry in the brain and can make psychiatric symptoms worse. Effectively addressing psychiatric symptoms means also treating co-occurring drug and alcohol abuse disorders.

Change Person's Risk of Exposure to Stressors

Major negative life experiences such as job loss, arrest, and injury are likely to be common experiences among people in assertive community treatment programs. When people initially enter the program, the team focus will be on helping them through the aftermath of these experiences. To change people's exposure to stressors, it is important to think ahead about what skills, support, and resources people need to prevent such events from recurring. For instance, future evictions might perhaps be avoided by helping the person devise and carry out a plan to pay his or her rent on time or by coaching the person to keep his or her apartment reasonably clean. Perhaps future arrests can be avoided through coordinated interventions that include helping the person occupy his or her time in activities that provide alternatives to using illegal substances.

The comprehensive assessment and psychosocial history timeline can help the team anticipate antecedents of these negative life events. This information can then be used to inform approaches to prevent these stressful events from recurring.

There are some stressors people may *not* want to avoid; for example, a move to a new apartment, discharge from the hospital, or a new job. In these instances, the team will want to think about strategies to make the change less stressful. One approach to managing these positive events is to break them into manageable, 'bite-size' pieces. For instance, the move to the new apartment might begin with the consumer spending part of a day there with people he/she knows. On the next visit, the person's supporters might only stay for part of the time. The next step might be for the consumer to spend time in the apartment alone, eventually working up to spending a night alone in the apartment. Starting a new job might be done in a similar fashion; the consumer might spend increasing amounts of time on the job with the amount of immediate support being gradually reduced until the consumer is comfortable in the situation. These types of interventions, and the need for them, will vary from consumer to consumer.

Not all stressors are major events. Life is full of hassles that can be sources of stress, some may be easier to deal with if they can be anticipated, then plans can be made to either avoid the hassles or strategies can be rehearsed for coping with them. For instance, if traveling to a job during rush hour is intolerably stressful for a person, the team might want to help him or her make plans for leav-

ing for work at a different time to miss the rush. Another alternative might be to rehearse with the person a conversation with his or her job supervisor about starting work at a different time. Team members might also work with a person about learning to recognize signs that he or she is experiencing stress and practicing ways to relax. For instance, the person might decide to try listening to quiet music on a headset when he or she recognizes signs of stress.

Change Factors that Influence Susceptibility to Stress

Table 2.1 also listed factors such as health, nutrition, social support, and attitude that affect a person's susceptibility to stress. One approach to reducing the likelihood of psychiatric symptoms is to focus on assuring that he or she has good physical health, adequate nutrition, and proper rest. Because of the psychiatric symptoms and related cognitive and social impairments people experience, it may be difficult for them to organize and carry out basic activities to care for themselves and their homes. For instance, proper nutrition involves being able to plan what foods to purchase, managing a budget, travel to the store, selecting food, paying for it, bringing it home, and preparing it. Fatigue and disorganized thinking may make it difficult for the person to plan and follow through on the steps involved in purchasing and preparing food. Similarly, good physical health requires, in part, being able to communicate health concerns and follow through on treatments for medical problems. Psychiatric symptoms and associated impairments can make this difficult.

According to Allness & Knoedler, side-by-side help and support are effective in motivating and helping consumers restore activities of adult role functioning. Side-by-side help and support means that team members actively participate with consumers to plan and carry out any or all activities to live independently, work, and socialize.

REVIEW

1. Review the Comprehensive Assessment in Appendix A. The table below lists stressors and hassles that influence a person's susceptibility to stress discussed in this chapter. Identify which of these factors Mr. Jones, the subject of the Comprehensive Assessment in Appendix A, experienced in the year prior to the assessment. Which were present at the time the comprehensive assessment was done?

	Past Year	At time of comprehensive assessment
Illness of injury to self		
Illness or injury of loved one		
Moving		
Poverty		
Discrimination		
Hospitalization/Discharge		
Family crises		
Changes in employment		
New baby		
Arrest or incarceration		
Death of a loved one		
Victimization		
Loss of an important relationship		
Social isolation		
Lack of meaningful stimulation		
Pessimistic environment		
Inadequate rest		
Poor nutrition		
Discrimination		
Conflicts		
Substance abuse		
Giving up or reducing substance use		
Feeling rushed		
Crowded living conditions		
Noisy living conditions		
Not enough privacy at home		
Marriage		

2. Review the treatment plan in Appendix B that was developed for Mr. Jones. The action steps identified in the plan are listed below. Review each action step and decide which of the following the step addresses (there may be more than one response for a step):

- A. change the person's biochemistry
- B. change person's risk of exposure to stressors
- C. change person's susceptibility to stressors
- D. other

Action Step	A, B, C, D
1. See MD every 4-6 weeks for prescriptions, symptom assessment, supportive therapies	
2. Daily contact with Integration Specialist (IS) for symptom assessment and development of coping strategies (e.g., anger management, environmental issues)	
3. Available 24/7 for crisis response and support services	
4. Monthly meeting with Integration Specialist to educate Mr. Jones about relationship between mental health and behaviors and involvement in criminal justice system and developing coping strategies	
5. 1:1 motivational interview 3 x week with substance abuse specialist	
6. Weekly dual diagnosis group at ACT program office	
7. Locate safe affordable housing	
8. Weekly contact for apartment maintenance monitoring – adjusted as needed.	
9. Monthly meeting to review budget and liaison with payee as needed	
10. Monitor food supply, trips to grocery, and education about nutrition	

Core Processes

OBJECTIVES

Describe the relationship between engagement and assessment.

This chapter describes the relationship between assessing an individual's needs and engaging them in treatment. Underlying this relationship is the assumption that services should be centered on consumers' needs *as they perceive them*. The consumers who receive assertive community treatment services are particularly likely to not have benefited substantially from previous mental health treatment. It may take time for people to learn that you are there for them and will not unnecessarily hospitalize or force medications on them, but rather will help them learn how to manage their illness and accomplish what they are interested in.

Understand the principles of comprehensive assessment.

A comprehensive assessment is vitally necessary to developing and implementing a treatment plan that integrates the best thinking and observations of the team and places their skills in the service of the consumer. This chapter emphasizes that the administrative task of completing assessment forms for record keeping purposes and a thorough and meaningful assessment that provides the necessary information for developing consumer-centered interventions are not necessarily the same.

Familiarize team members with the specific assessments they will be responsible for completing.

Review Table 3.1, Elements of a Comprehensive Assessment, on page 42. The elements described in this table are based on a comprehensive assessment laid out in *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up* by Debo-

rah Allness & Bill Knoedler.

You will need to review the assessment forms in *The PACT Manual* and determine what, if anything, is missing. Develop a supplemental form to be used by your team members if needed. You should be prepared to tell your program staff what specific assessments each discipline will be responsible for completing and the timeline for completing the assessment.

Describe how to develop a Psychiatric/social Functioning History Timeline.

The psycho/social timeline covers the period from when an individual first experienced problems to the present. Creating the timeline requires collecting information from the individual, previous treatment providers, and collateral sources such as employers and family. This detailed timeline can help the team identify what has and has not worked effectively in the past for a particular individual as well as events or situations that trigger an exacerbation of symptoms. A copy of the timeline is included in this workbook chapter.

When team members complete a timeline for a person who was actually admitted to the program, they will use original records, interviews, and information from the chronologies contained in the assessments that make up the comprehensive assessment. However, working from a completed comprehensive assessment will give team members an opportunity to understand the steps in completing the timeline and a chance to see how the timeline can be used to look at what has and has not worked in the past.

You might suggest that team members work in small groups to complete the timeline. When they have finished, have them answer the questions in the section titled *Create a Timeline* as a group.

Familiarize team members with the Weekly Consumer Schedule.

There is a Weekly Consumer Schedule that can be printed on 5x8 cards. This card is broken into a.m. and p.m. time blocks for a 7-day period. An alternative approach to the Weekly Consumer Schedule is to use a sheet of paper that has the entire month printed on it for each consumer. The exercise in this workbook uses the 5x8 card. If the team you are training will be using the monthly calendar, consider providing trainees a copy of the calendar to create the Weekly Consumer Schedule.

Team members are instructed to complete a Weekly Consumer Schedule from a treatment plan that was created by an actual ACT team. Use this opportunity to point out strengths and weaknesses of the treatment plan. For instance, does it communicate what the plan is for the individual concerned clearly enough that other practitioners can follow the plan?

Familiarize team members with the Daily Team Schedule.

Creating the Daily Team Schedule involves taking each contact scheduled for each consumer on a given day and assigning team members to make those contacts. In addition to the recurring contacts identified on the Weekly Consumer Schedule cards, the Daily Team Schedule must also address

any additional contacts that need to be made. These might include taking consumer's to medical or social services appointments, going with an individual to meet with a landlord, or following up on a crisis that occurred the previous day.

If the team you are training is using the 5x8 Weekly Consumer Schedule you will need to explain the process the team is to use to let the person doing the scheduling know about these more random appointments. This might be a separate calendar that the scheduler looks at before creating the Daily Team Schedule for a particular day. For example, if during a contact a team member finds out that an individual has a medical appointment on Wednesday of the following week and the team nurse is to accompany the person, the team member who learns about the appointment would note that on a separate calendar. When the Daily Team Schedule is being developed on the following Wednesday, after listing the standing contacts from the 5x8 cards, the scheduler would look at the schedule and see that he or she also needs to include the appointment with the doctor.

If a calendar is being used to record consumers' schedules, the person who learns about the doctor's appointment, would make a note of that appointment on the calendar form for that individual so the scheduler would know about it.

Creating the Daily Team Schedule also involves balancing the contacts that need to be made with the resources that are available. It is also important to block out time for staff to take care of documentation, order meds, develop job leads, attend in-service training, etc. The person creating the Daily Team Schedule will need to know where to find information about which team members are available at which times.

COMPLEMENTARY ACTIVITIES

Familiarize team members with assessments related to other disciplines.

Before discussing this workbook, ask each team member to list up to five things that are included in the assessments members of their discipline typically complete. While they are preparing their lists, write the name of each specialty represented on the team on a dry erase board or flipchart. Identify a specialty (e.g., nursing) and ask members of that specialty to share their list. Write the items under the heading for that specialty. Pick another specialty (e.g., vocational specialist) and ask for their lists. Continue until each specialty has shared its list.

Ask the group if there are any items listed in another specialty area that could be relevant to their specialty. What is it? How might it be relevant? How would they typically find out about this? If an item is listed under more than one specialty, ask people from each specialty what they would do with this information. Is it the same thing or something different?

CORE PROCESSES

1. Following the core processes will make the difference between your team being proactive and reactive.
2. To engage a person in treatment, the team must be working on goals that are important to the consumer.
3. You are beginning a long-term relationship, so take the time up front to really get to know the person.
4. Most information for the comprehensive assessment is collected while working with the consumer to meet her or his initial needs.
5. Psychosocial timelines help team members learn what has and has not helped the person in the past.
6. The treatment plan is translated into a schedule of specific activities that become the schedule of contacts the team will have with the consumer.
7. The team's daily activities are based on the schedule of activities developed for each consumer and any other appointments or situations that call for the team's support.
8. Consumer progress is monitored every day.

There are a series of processes essential to carrying out the clinical work of assertive community treatment programs. They include:

compiling a thorough and comprehensive assessment of the individual's current and past psychiatric and social functioning

constructing a historical timeline depicting the individual's psychiatric and social functioning and prior treatment experiences

developing a treatment plan based on needs and goals articulated by the individual

translating an individual's treatment plan into a schedule of day-to-day activities

developing a schedule each day for team members to carry out the activities that must occur that day

sharing with team members the outcome of the previous day's contacts

ongoing assessment of the effectiveness of interventions

At first, you might think that these processes are too time consuming and burdensome and that there is no way you will ever be able to spare the time for them. That is simply not true. Effective teams that are serving consumers with very complex and demanding needs follow these processes. In fact, it is part of what makes them effective.

You are beginning a *long-term* relationship with a consumer, which gives you the luxury of time. You also have the luxury of teammates that are equally responsible for consumers. If one team member needs to spend time with a person to gather assessment information, or set time aside to obtain clinical records, someone else on the team can free her or him up to take care of those things.

In the long run, it is much more productive to invest time upfront really getting to know a consumer, forming sound detailed plans, and tracking those plans closely than it is to grope along ill-informed and unprepared. If a team does not invest resources to thoroughly sort out the experiences a consumer has had, what he or she hopes to accomplish, and is not diligent in monitoring whether goals are being met, the team will find that they are spending their time managing crises rather than helping consumers make progress.

OVERVIEW OF PROCESSES

Here is how the processes discussed in this chapter flow:

1. A consumer is referred to your assertive community treatment program.
2. The team leader and other staff who may potentially be working closely with the consumer meet with him or her to explain the program and assess the consumer's initial needs.
3. Multiple team members meet with the consumer as the work of meeting the consumer's initial needs begins. During these contacts, team members are gathering information for the comprehensive assessment and timeline.
4. Team members meet at the end of 30 days to pool information (complete the comprehensive assessment and timeline)
5. Based on the comprehensive assessment and timeline, team members plan what they will do. This plan includes specifics about what will be done by whom at what times on what days.
6. A team member meets with the consumer to review and achieve consensus about the plan.
7. The activities in the treatment plan are translated into a weekly schedule of contacts between the consumer and the team.
8. Just prior to the team's daily meeting, a designated team member checks the Weekly Consumer Schedule for each consumer served by the team. He or she writes each scheduled activity for that day in the appropriate time slot. If a particular team member is scheduled to carry out an activity, that person's initials are written next to the activity.
9. Next, the person drafting the daily team schedule checks for appointments that are not part

of the regular activities on the Weekly Consumer Schedules. These might be appointments to apply for benefits, a follow-up on a job lead, or looking at an apartment that has become available – activities that the team provides support for, but which do not occur on a recurring basis. These are also written on the daily team schedule in the appropriate time slot. If there is a particular team member who should attend to the appointment, that person's name is written next to the activity.

10. The person drafting the schedule also checks for crisis situations and consumers who are hospitalized. These are events that the team will respond to, but that are not part of the pre-planned activities or appointments.
11. The team begins going through its Communication Log. A team member calls out each consumer's name in turn. When a consumer's name is called, anyone who had contact with that person in the past 24 hours describes the contact and the outcome *briefly in behavioral terms*. By doing this, the team is engaged in a process of continuously adding to the information they learned when doing the comprehensive assessment and timeline and reassessing the effectiveness of the consumer's treatment plan.
12. If, during the daily team meeting, team members report that a consumer is having a difficulty, the team will strategize about how to address the problem *if the problem can be addressed quickly*. If the problem is more involved and requires extensive discussion, the team will schedule a separate meeting outside of the daily meeting.
13. Once all the scheduled activities, special appointments, and any crisis response for the current day have been noted, the team will make any changes in the schedule that are needed to make certain that all the things that need to happen that day are taken care of. For example, as the consumers are discussed, the team may decide that a team member who was initially scheduled to meet with one consumer is needed more urgently to intervene with another consumer. Someone else will have to step forward to cover the original appointment.

ENGAGEMENT

It is important to understand the relationship between the core ACT processes and engaging people in treatment. It is difficult, if not impossible, to engage someone in a treatment process in any meaningful way unless the provider knows that person's needs and goals and that what is being done is aimed at reaching those goals.

The engagement process never stops. If you want people to stay engaged, you have to continue to help them make progress that is meaningful to *them*. It may take some people a while to realize that you are offering something different than they have received from the mental health system in the past.

Ideally, engaging a person in the process of assertive community treatment starts before he or she is formally admitted to the program. Team members meet with the person and his or her family members or other supporters, they describe the program, find out the person's immediate needs and goals, and perhaps arrange for the person to visit the program. Each time a team member meets with the person, he or she is learning more about the person's immediate needs and what his or her goals are.

As members of the team begin to work with the individual to meet his or her immediate needs, the person is introduced to other members of the team. For instance, if a person needs a place to live, one team member might take the person to locate an apartment, but stop by the office to introduce the person to the program receptionist and other members of the team. The next time the team member meets with that person, he or she might bring someone from a different discipline along to introduce them and then that team member will begin to get to know the person.

There are times when a person who has just been admitted to your program will be experiencing serious psychiatric symptoms. The person's thinking may be very disorganized or he or she may be experiencing delusions. In these instances, the process of introducing the person to multiple members of the team may need to move more slowly so as not to overwhelm the person. You will want to figure out who on your team the person might be most comfortable with and let that person initially be the primary contact person. Until a degree of trust has been established, you may want to involve other team members gradually.

COMPREHENSIVE ASSESSMENT

In a more traditional assessment process, individuals from different specialties often sequentially 'interrogate' consumers to get the information they need to complete assessment forms that are relevant to their specialty (e.g., nurses ask about medical problems, social workers ask about benefits, etc). Assessments seldom include any observations of individuals in their every day environments, and they do not look at much outside of the specific area being assessed.

Although the information obtained by a practitioner from one discipline might be relevant to practitioners from other disciplines, practitioners have to take the initiative to read all the assessments in the individual's chart. Even when practitioners do this, forms are often in a checklist format or use jargon and catch phrases that convey very little about the unique impact of a particular problem on a specific person's life, or factors in the environment that may be exacerbating a problem.

Sometimes assessment information is shared at staffings or treatment planning meetings. Unfortunately, a professional from one discipline may have a piece of information that seemed irrelevant and may not realize it fits with a piece that another team member has. This needs to be shared so the whole picture will be pieced together.

In an assertive community treatment program, services are 'made to order.' To know what services you are going to provide to a particular person and who is going to be involved in delivering them, you have to do a comprehensive assessment. All the team members that are working with that person have to know what was learned in each assessment.

The Comprehensive Assessment Process

The comprehensive assessment is completed after the team has had 30 days to get to know the individual. Individual team members are given primary responsibility for completing particular elements of the assessment. Table 3.1, on page 55, provides an overview of these elements. These are based on assessment forms included in *The PACT Manual*. If your program is using different forms, it is important that you compare your program's forms to the forms in *The PACT Manual* to determine if any elements included in *The PACT Manual* assessment forms are missing from your program forms. This is even more important if for some reason your program is required to use a checklist-type assessment. If you find that elements of this comprehensive assessment are missing from the assessment your program is required to use, you may want to consider creating a supplemental form. If you do not already have a copy of *The PACT Manual* you can obtain one from the National Alliance for the Mentally Ill ACT Technical Assistance Center via their website at www.nami.org/about/PACT.htm or by calling (866) 229-6364.

Assessments are carried out for the most part while team members are working with individuals around their initial needs. Team members with various specialties may schedule a time to meet with an individual to talk about issues related to that specialty. However, whenever anyone on the team is with an individual, they are assessing the individual's symptoms, the effect of those symptoms on the person's everyday activities, the individual's strengths, their preferences, problems in the environment, resources in the environment, and whether a particular treatment, support or service the team is providing is serving its intended purpose. Because of the extensive cross-training that occurs, team members are looking at things not only from the perspective of their own specialty, but are also the 'eyes and ears' of other specialties. For instance, the vocational specialist might provide transportation for a person for grocery shopping and ask about employment goals and past work experiences while he or she is with the person. During that trip, the person might mention in passing that he or she used to have an interest in art. The vocational specialist would mention that during the next daily meeting so the team members who are responsible for assessing the person's leisure interests could follow-up with the person. The team has also learned of an interest that might be used by the person for stress management.

The goal of the comprehensive assessment is for team members to understand the individual's strengths, hopes, and experience with mental illness and mental health services. As individual team members learn about a person, that information is shared in 'real time' with the team. If potentially urgent needs are uncovered - for instance information about a critical medical condition or an extremely unsafe housing situation - those needs are communicated immediately to the team leader.

When all the assessments have been completed, the team leader or a designee takes the information and compiles the comprehensive assessment. The assessment is reviewed by the individuals who contributed to it and is discussed as part of the initial treatment planning meeting. If members of the team later learn something about the individual that is relevant to the assessment, that information is added. An example of a Comprehensive Assessment is included in Appendix A.

Table 3.1 PRINCIPLES OF ASSESSMENT

Start at the first meeting. The assessment process begins during visits with the person and family members or other supporters while the person is being admitted to the program.

Immediate needs first. The initial assessment focuses on basic needs such as safety, food, clothing, shelter, medical needs.

Assess while you work. As the team begins to meet those needs, other assessments are done. Most assessments are done while the team is working with the person on problems that were identified in the initial assessment.

Be sensitive. The assessment process begins with the most critical problems and moves next to assessing information that is not particularly sensitive or personal, and then, as trust develops, information of a more personal nature is solicited (e.g., drug use, sexual activity).

Focus on the needs of the consumer. A critical part of the assessment is finding out what the person's preferences are and what they want to accomplish.

Share what you know. Assessments are not proprietary (e.g., medical assessment may be important to mental health professionals, family assessment may be important to employment specialist).

Look for patterns. Chronological information is collected in each area of assessment and then assembled in a timeline to show the relationship between events and experiences in the person's life.

Table 3.2 Elements of a Comprehensive Assessment

Assessment	Purpose	Person Responsible	Sources of Information	Timeframe
Psychiatric History, Mental Status, & Diagnosis	Ensure accuracy of diagnosis Inform plans that will be made with the consumer for treatment	Psychiatrist	Person receiving services Family Supporters Past treatment records concerning onset, precipitating events, course and effect of illness Past treatment and treatment response Risk behaviors Current mental status	Within 30 days, psychiatrist schedules times to meet with the person. Findings presented at: daily meetings or to the team leader and individual treatment team first treatment planning meeting
Psychiatric History Narrative	Establish timeline of course of illness and treatment response	Psychiatrist	Psychiatrist's interview with person being treated Psychiatric/Social Functioning History Timeline	Started at admission or first interview the person has with the psychiatrist. Completed within the first 30 days
Physical Health	Identify current medical conditions and ensure proper treatment, follow-up, and support Determine health risk factors Determine medical history Determine if there are problems communicating health concerns	Registered nurse	Person being treated. Medical records.	First interview within 72 hours of admission. If the person is experiencing problems concentrating or needs time to get to know the staff to discuss sensitive areas such as sexual issues the assessment may need to be completed over 2 to 3 interviews. Presented at first treatment planning meeting unless there are immediate concerns, in which case the nurse should consult the team psychiatrist and the team leader and present those concerns at the daily meeting.
Use of Drugs and Alcohol	Determine if the person currently has a substance use disorder Determine if the person has a history of substance abuse treatment Develop appropriate treatment interventions to be integrated into the comprehensive treatment plan Establish chronology	Substance Use Specialist	Composite International Diagnostic Interview - Substance Abuse Module (CIDI-SAM) or similar standardized instrument Info is obtained from interviews or discussions with the person that are conducted in the person's home or community settings. Information also collected in the Psychiatric History, Mental Status, and Diagnosis Assessment and the Health Assessment Records from past treatment providers	Assessment begins at admission. It may take several interviews to collect this information since it is sensitive information and requires a sufficient level of rapport and trust between the consumer and mental health professional. Presented at first treatment planning unless there are immediate concerns in which case the substance abuse specialist should consult the team leader, the psychiatrist, and the individual treatment team and present the information at the daily organization staff meeting.

Assessment	Purpose	Person Responsible	Sources of Information	Timeframe
Social Development and Functioning	Assess how illness has interrupted or affected the person's social development. Information is gathered about : childhood, early attachments role in family of origin, adolescent and young adult social development, culture and religious beliefs leisure activity and interests, social skills. involvement in the legal system social and interpersonal issues appropriate for supportive therapy	Mental health professional	Obtained from consumer interview or discussion conducted in the consumer's home or other community settings.	Begins at admission Information may be gathered over several meetings Completed within 30 days. Presented at: daily meeting or to team leader or at the first treatment planning meeting.
Activities of Daily Living (ADL)	Person's current ability to meet basic needs Adequacy and safety of the person's current living situation Current financial resources Effect of symptoms on person's ability to maintain an Independent living situation Person's individual preferences Level of assistance, support, and resources the person needs to reestablish and maintain activities of daily living	Mental health professional	Interviews or discussions with the person Assessment takes place in the person's home or other community settings Interviewer must pay special attention to the consumer's preferences and serve as the consumer's advocate to insure activities of daily living and other services meet the consumer's preferences	An initial ADL plan is completed at admission to identify all immediate services the person may need (e.g., assists with nourishment, circumventing eviction). Information may be gathered over several interviews Comprehensive ADL assessment is completed within 30 days. Presented at the daily meeting or to the team leader, and the individual treatment team, and at the first treatment planning meeting.
Education and Employment	How person is currently structuring his or her time Person's current school or employment status Person's past school and work history (including military service) Affect of symptoms on school and employment Person's vocational/educational interests and preferences Available supports for employment (e.g. transportation) Source of income Education, military and employment chronology	Employment specialist	Information obtained from consumer interviews School records Past employers.	The assessment may be completed over several meetings, leading to an ongoing employment counseling relationship between the consumer and the vocational specialist. Presented at: daily meetings or directly to the team leader, team members working with the person, and at first treatment planning meeting.
Family and Relationships	Allows the team to define with the consumer the contact or relationship ACT will have with the family and significant others Obtain information from consumer's family and significant others about the consumer's mental illness Determine the family's and significant others' level of understanding regarding mental illness Learn family's expectations of ACT services.	Mental health professional	Person being treated Significant others or family members	Begun during the initial meeting with consumer and family or significant others participating in admission. Completed within 30 days of admission Presented at first treatment planning unless there are immediate concerns in which case the mental health professional should consult the team psychiatrist and team leader and present the information at daily meetings.

PSYCHIATRIC/SOCIAL FUNCTIONING HISTORY TIMELINE

The Psychiatric/Social Functioning History Timeline (Figure 3.1, page 59) is used to develop a detailed overview of the significant events in a person's life, the person's experience with mental illness, and his or her treatment history. When the timeline is complete, it provides a picture of how various events are related. It can help you check for gaps in the information you have about a person's life, and if there are inaccuracies or conflicting information in clinical records, this will become apparent.

The timeline can be particularly useful in helping you see how various events in the individual's life are related. For instance, you will be able to see the relationship between various treatments and the individual's symptoms and functioning; events that proceed an increase in symptoms, and when treatments that have initially been effective begin to break down. This information can be extremely valuable in developing a treatment plan.

Information for completing the timeline is obtained only with the person's permission. Written releases may be needed to obtain some of the records that are used to create the timeline. The individual's verbal consent should also be obtained before speaking to family or employers. Potential sources of information include:

- past inpatient and outpatient records for psychiatric and substance abuse treatment including admission and discharge summaries, physician orders, treatment plans, treatment plan reviews, and assessments
- school records or transcripts
- medical treatment records
- arrest records
- interviews with the individual
- interviews with family members and significant others
- interviews with employers
- past treatment providers

The timeline begins at the point a person first started to experience problems relating to mental illness and continues to the present. After the timeline is initially completed, additional information may be added as it becomes available.

Construct a timeline

Use the Comprehensive Assessment in Appendix A to complete a Psychiatric/Social Functioning History Timeline.

Figure 3.1 is a copy of a Psychiatric/Social Functioning History Timeline. The form has been reduced in size in order to present it in this workbook. The actual form is larger and provides much more room in which to record information. You may want to ask your team leader for a copy of the full size form, or take a moment now to copy the headings from the Psychiatric/Social Functioning History Timeline to sheets of paper that you can lay out side by side.

Please note that if you were constructing a timeline on someone being admitted to your program you would be using original records, information obtained from interviews with key informants, and information from the assessments that go into making up the comprehensive assessment. This exercise, however, will help you understand how the timeline is constructed, how it can be used to check the thoroughness and accuracy of the information the team has about an individual, and illustrate how a timeline can be used to detect treatments and other circumstances that have and have not been helpful to the individual.

Step 1. Carefully review the Comprehensive Assessment to determine the earliest date mentioned in the assessment. This is the beginning date for the Timeline. Write the date in the first blank space under the column labeled "Timeline Dates."

Step 2. Decide what increment of time will be represented by each row in the timeline. This could be one or multiple months or years. For instance each row might represent one month, six months, one year, two years. After you decide on the time interval, write the dates covered by each row in the Timeline Dates column. For instance, if you determine that a person first experienced problems in September, 1975 and decide to use a one year time interval, the first row under Timeline Dates would be labeled September, 1975 to August, 1976. The next row would be labeled September, 1976 to August, 1977, etc., until the present. For the example in Appendix A, the final row would be labeled September, 1999, the date the individual was admitted to the ACT program.

Step 3. After you have identified the earliest date in the Comprehensive Assessment in Appendix A and marked the time intervals covered by each row in the Timeline Date column, go back to the beginning of the Comprehensive Assessment. As you read the first section - History of Present Illness - you learn that this individual was admitted to the ACT program on September 29, 1999 and is diagnosed with Schizophrenia, Paranoid Type and also has a co-existing Substance Use Disorder. Note this information under the appropriate headings in the row labeled September, 1999.

Figure 3. 1. Psychiatric/Social Functioning HISTORY Timeline

Client Name: _____ Page: _____

Psychiatric Inpatient/Outpatient Services History								Psychosocial History		
TIMELINE DATES	ADMISSION/ DISCHARGE DATES	INSTITUTION/ PROVIDER	PRESENTING PROBLEM/ LEGAL STATUS	DIAGNOSIS/ SYMPTOMS/ SIGNIFICANT EVENTS (suicide attempts, threats, violent acts, self-neglect)	MEDICATION (Drug name, strength, dosage instructions, dates, response//side effects)	SERVICES RECEIVED	REASONS FOR DISCHARGE/ RECOMMENDATIONS	LIVING SITUATION (Dates, Address/ Type, Reason for leaving, Activities of Daily Living (ADL)(personal hygiene, household activities, house-cleaning, cooking, grocery shopping, laundry, and financial source and money management)	EMPLOYMENT / EDUCATION (Dates held, employer, Position/type Reason for leaving, Other educational activities)	OTHER: Alcohol or drug use treatment, Family relationships, Medical, Other (specify)

From: *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up* by Deborah J. Allness and William H. Knochler (NAMI, 1999).

As you read on, you learn that this individual received treatment from the Smithville State Hospital between from August, 1999 until he was admitted to the ACT program. Prior to being admitted to Smithville, he was serving a sentence for felony assault that began in July, 1988, that he was incarcerated for robbery in 1976, and was incarcerated for assault in 1984. During the incarceration that began in 1984 he was diagnosed with Schizophrenia and treated with Haldol and Sinequan. He had a good response to these medications (see Appendix A).

Make note of these facts and any other information that may be important on the timeline.

Continue reading through the Comprehensive Assessment, noting important dates and events on the timeline.

Step 4. When you have noted all available information on the timeline, answer the following questions:

Is any information missing about a particular period?

Is any of the information conflicting? For example, do records show the individual was incarcerated and working during the same period?

Are there treatments that seem to have worked well in the past?

Are their situations or events that appear to have contributed to the deterioration in this individual's condition in the past?

TREATMENT PLANNING

Practitioners will find that the treatment plans assertive community treatment teams develop tend to be dynamic and more intimately linked to providers' activities than treatment plans developed by practitioners in more traditional settings. The day-to-day contacts between team members and individuals are taken directly from the treatment plan and each day the contacts from the previous day are reviewed. If the team's activities aren't helping the individual meet his or her goals or if a new need arises, the plan can be quickly modified.

Consumer's perception of their needs and goals are an important part of the treatment plan. They help the team understand what might motivate the individual to address illness to treat their goals.

The treatment plan defines the specific issues and problems that will be addressed by the team in both the short (2-3 months) and long term (6 months). The plan also details what specific interventions or services will be provided, by whom, when, for what duration, and where the service will be

provided. These plans are then translated into the Weekly Consumer Schedule.

If treatment plans that are meaningful to the people you are serving, they may let you know in direct or indirect ways. For example, you might notice that an individual is never at home when you go to see him or her, or that the person is having more unscheduled after-hour contacts. Changes in the consumer's responsiveness to the team or changes in the consumer's level of symptoms or functioning should signal the team to ask: What is the team (not the consumer) doing wrong?

- Are we working on the consumer's goal or our goals?
- Are we respecting the consumer's preferences?
- Have the consumer's goals changed?

Treatment plans are formally reviewed at least every six months. However, revisions are made immediately when an individual's service needs increase (e.g., return of symptoms, heavy and dangerous use of substances, pending eviction). On the other hand, when needs decrease (e.g., significant symptom remission, successful integration into a new job), the plan is reviewed with the individual before support and services are decreased.

WEEKLY CONSUMER SCHEDULE

After the treatment plan has been written, the activities described in the treatment plan are translated into a weekly schedule of contacts and activities that will occur between team members and the client. Each individual has a weekly schedule that is filled out in pencil so it can be easily changed. These are kept in a central location and are used to complete the Daily Team Schedule. Some teams use a 5 x 8 card that represents a one-week period. Other teams use a sheet of paper that has all the days in a given month on it.

Here is how a weekly schedule might work:

Paula has recently been admitted to your program. She has two children ages 5 and 7. She was reported to Child Protective Services (CPS) for neglecting her children and is at risk for having her children removed from her care. There is no evidence that the children are in imminent danger and Paula's goal is to prevent her children from being taken from her. Team members facilitated a meeting between Paula and the CPS worker to help Paula understand the specific concerns of CPS. They also want to help Paula take specific steps to take to assure the children are being adequately cared for and prevent them from being placed in CPS custody. After the meeting the goals that were decided on were for Paula to consistently get her children up and ready for school in the morning, consistently provide an evening meal for the children (the school will provide breakfast and lunch), and take care of basic housekeeping like washing dishes and doing laundry. CPS is also requiring Paula to attend parenting skill classes one hour a week for six weeks, however, she says that it is difficult for her to attend to what the instructor is saying.

Paula and the team have agreed that someone from the team will call in the evening to help her plan what clothes need to be laid out for the morning and what other materials the children need to have ready for the next day. In the morning, a team member will call to make sure Paula is awake and remind her to follow the routine she developed for getting the children up, check to see if there are any last minute problems, and offer positive reinforcement for her efforts to get her children off to school on time. Team members will also provide transportation once a week so Paula can buy groceries and will assist with meal planning. Transportation to parenting classes is being provided by CPS, but the team has obtained a copy of the parenting curriculum and will meet with Paula twice a week in her home to review and model the skills taught in the parenting class. A team member will also work with her twice a week to help her with laundry. Paula’s Weekly Consumer Schedule might look like the one in Figure 3.2 on the next page.

Complete a Weekly Schedule

A copy of a completed treatment plan is in Appendix B. Review the plan and make a list of activities that need to happen in order to carry out the plan. Also, note how often the activities are scheduled to occur (e.g., daily, weekly) and any activities that happen on specific days (e.g., every Wednesday). Replicate the Weekly Consumer Schedule form from the example on the following page on a separate sheet of paper. Translate your list of activities into a Weekly Consumer Schedule.

Figure 3.2 Weekly Consumer Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	7:30 phone call to prompt morning routine SALLY 8:30 SALLY 11:00 meal planning for the week./ grocery store MARY	7:30 phone call to prompt morning routine MARY	7:30 phone call to prompt morning routine SALLY	7:30 phone call to prompt morning routine SALLY 8:30 laundry SALLY	7:30 phone call to prompt morning routine SALLY		
PM	7:00 phone call to prompt preparations for the morning GEORGE	7:00 phone call to prompt preparation for the morning – GEORGE	4:00 visit to reinforce & model parenting skills SALLY 7:00 phone call to prompt preparations for the morning GEORGE	7:00 phone call to prompt preparations for the morning MARY	4:00 visit to reinforce & model parenting skills SALLY		7:00 phone call to prompt preparations for the morning MARY

DAILY TEAM SCHEDULE

Each day during the daily team meeting, a member of the team completes the Daily Team Schedule (Figure 3.3, page 66). Many teams hold their team meeting at 10:00 am. This allows team members to take care of early morning contacts as they are coming into the office. Where team meetings are scheduled at 10:00, the Daily Team Schedule will cover the contacts that occur from 11:00 a.m. on the day of the team meeting during which the schedule is developed through 10:00 a.m. the following day.

The team leader begins by going through the Weekly Consumer Schedule for each individual and noting all the activities that are indicated for that particular day. These are written in the appropriate time slot along with the person responsible for the contact. Next, the person checks for other appointments that have been scheduled. These are appointments such as doctor visits, job interviews, appointments with Social Security, or other meetings that are not part of the recurring schedule of contacts. Teams that use a monthly calendar for each individual's schedule might note these types of appointments directly on the individual's calendar. Teams using a 5x8 card system will have a separate calendar where these appointments are noted.

The team leader also checks a calendar on which team members note when they will be unavailable to see consumers. A team member might be unavailable because he or she is sick or taking vacation. A team member might also be unavailable at a particular time because he or she is scheduled to take part in a treatment planning meeting, or has time blocked off to attend required professional training, or is scheduled to be working on developing job leads, ordering medications, or taking care of other discipline-specific necessities. Time will also be blocked off for charting and documentation.

After noting the routinely scheduled contacts from the Weekly Consumer Schedules, special appointments, and staff availability, a tentative Daily Team Schedule is drafted. During the team meeting, a team member might report a crisis that developed the previous evening that requires the team to make an unscheduled visit to a consumer. The Team Schedule is adjusted to accommodate this visit. It is also likely that during the meeting, a team member may decide they need to contact a consumer to follow-up on something that one of their team mates mentioned. These contacts are also worked into the schedule. At the same time, the person developing the schedule is also listening for team members to mention appointments that were made for consumers. When these are mentioned, the scheduler checks to see that these have been noted on the appointment calendar.

As soon as the meeting ends, the person who filled out the Daily Team Schedule immediately makes copies for everyone on the team. Team members keep these with them throughout the day. To protect the confidentiality of consumers, only the consumer's initials are used on the daily team schedule (See Figure 3.3).

In developing the Daily Team Schedule, teams that are covering extensive geographic areas will also want to take into consideration where, geographically, team members are going to be throughout the day. In areas where there is extensive distances for team members to cover, the team will want to consider having a person that is scheduled to be in a particular area cover other contacts that need to be taken care of in that area on a particular day. A team using this approach, however, must be careful to vary the people covering different areas so that the program does not become a case management program where staff are assigned to a limited geographic area and individuals are deprived of the benefit of working with multiple team members.

In Figure 3.3 the activities that were written on the Consumer Schedule for Paula, whom we met earlier, have been transferred to the team schedule beginning with the team meeting on Wednesday at 10 a.m. The initials PJ are used in preparing the schedule to protect her identity. The Team Schedule covers the period from 10 a.m. on Wednesday morning up until 10 a.m. Thursday morning. The person who is doing the schedule has penciled in the Wednesday afternoon appointment to work on parenting skills, the 7:00 p.m. phone call, the morning phone call for the next day, and laundry for the next day. The call that was made on Wednesday morning occurred before the team meeting so it was included on the schedule for the previous day.

DAILY TEAM MEETING

There will be times when a lot of things are going on and everyone on the team is very busy. Your team may be tempted to forego the daily team meeting, but do not succumb to this temptation. The daily team meeting is a vital activity for ACT programs.

Figure 3.3 Daily Team Schedule

Date WEDNESDAY February 9

On Call and Vehicle Status O/C _____ 4613 Chvy 4614 Chvy 4615 Chvy 4616 Chvy Century Truck	5-6p
11-12	6-8p 7:00 P.J. – Phone call, George
12-1	Date: THURSDAY, February 10 <u>Acute Clients and Clients Hospitalized:</u> 1. 2. 3. 4
1-2	On Call and Vehicle Status O/C 4613 Focus 4614 Focus 4615 Focus 4616 Focus Century Truck
2-3	7-8a 7:30 P.J. – Phone call, Sally
3-4	8-9a 8:30 P.J. – Housekeeping, Sally
4-5 P.J. Parenting –Sally	9-10a
Issues or Events for the Following Day:	

The daily team meeting is the vehicle through which the open communication that is so critical to the assertive community treatment process occurs. The daily meeting is the place where all team members are kept current on what is happening with each individual who is receiving services from the team. If a crisis is brewing, the team can talk about how best to respond. Perhaps the team will decide to talk to the individual about having someone drop by more often. If an individual is having trouble getting

access to a resource, the team can quickly decide another course of action. If an individual is doing well, team members also hear about that and can provide reinforcement.

The team meeting is structured around the Daily Communication Log. The log might simply be a 3-ring binder that has an index tab for each consumer followed by several sheets of notebook paper. The team leader who is responsible for the Communication Log states the first individual'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.

If a problem was noted during the contact, and that problem can be dealt with by a quick suggestion, a team member might offer that suggestion. If there is a more complicated problem or if there needs to be a more thorough discussion of the team's response to a situation, the team members who are the primary contacts for the individual might decide to schedule a review of the treatment plan.

A focused team can move through a caseload of approximately 100 people in about 45 minutes.

OTHER MEETINGS

In addition to the daily team meeting to review consumer's progress, the team also meets once a month to handle administrative issues and issues related to team development. During this meeting, the team leader might deal with administrative housekeeping issues. It is also during this time, that the team leader will share information on consumer outcomes or model fidelity (see Appendix C). However, this is also the time for team members to work on issues of team dynamics.

What would you do?

Harold

Harold was a teacher who experienced his first episode of schizophrenia in his late thirties. He was well-known in the community. During the course of his illness, Harold burned down two homes that he owned. He is tall and solidly built and his father was frightened by his temper on several occasions. His father did not know what to do with him. Harold was ultimately sent to the State Hospital where he lived for several years. He had several passes during his hospitalization, but a crisis occurred during each one. Even while taking medication, he experiences severe paranoia and persecutory hallucinations. He was very much a loner.

You visit him several times at the State Hospital in anticipation of his admission to your program. He has money from the sale of a home that he owned and could probably afford to buy a condo or rent an apartment in any of several modest neighborhoods. He has chosen, however, to move to an apartment complex in a high crime area. His father is at a loss because he does not know how to help him. He loves and cares for him, but is afraid of his temper. In the first few weeks that Harold is out of the hospital, he is victimized - his apartment is broken into twice. When you call him, he does not answer the phone. When you go by his apartment, he yells at you to go away.

Describe how you might engage Harold in treatment.

How one team responded:

Harold did not want a lot of help and he did not want a lot of company. We were delighted when he would open the door just a crack when we went by to see him. Because of the paranoia Harold experienced, the team decided that having a lot of different people going to his home might make Harold uncomfortable. We sent a nurse to visit on a regular basis. She kept up her contact with Harold and introduced him to the doctor who visited with Harold at his apartment. Harold was agreeable to letting the doctor continue to administer the psychotropic injections he had been receiving in the hospital. Occasionally, other team members would accompany the nurse for a brief visit. We deliberately limited the number of people who had contact with him and let him get familiar with us very slowly.

Harold had no obvious desires. His father really loved him, but did not know what to do for him. After months, Harold agreed to have dinner with his father on Sundays. While talking with his father, we learned that, as a child, Harold loved to play tennis. By luck there was a public court near his home and we were able to arrange for him to play tennis there with another consumer served by the team. Harold and the other consumer played tennis once a week for years.

Lucy

Lucy is a 54-year old woman who had been referred to your program. She was acutely psychotic when she was last seen. She has been picked up by the local police many times because of complaints from area residents. A typical complaint would be someone in the community calling the police to complain about a woman camping in their back yard or eating out of their garbage cans. She has moved from state-to-state for much of the last decade. You know the general area where she was last seen. After weeks of looking for her, a member of your team locates her.

Describe how you might engage Lucy in treatment.

How one team responded:

It took us weeks to locate Lucy. Once we found her, we just kept visiting and talking to her. I would go see her and say, “Hey...this is Barbara. Is everything okay today?” or “Hey, this is Mary. She is a nurse. Is there anything we can do to make you more comfortable?” We just would not give up hope.

We continued our visits and one day when we asked if she needed anything she said, “My feet hurt.” We offered to bring her some shoes. “What size shoes do you wear?” we asked. The next time we visited her we brought her shoes. Each time after that we would bring her small treats and items to make her feel more comfortable. She saw that we were not there to admit her to the hospital. We wanted to know what she needed and to help her.

One day she asked, “Where’s my daughter? My daughter don’t talk to me any more.” We asked her if it would be okay for us to call her daughter and she agreed. The daughter was apprehensive when we called and did not want to “take on” her mother again. The daughter said she was burned out and had her own family to care for. We met with her, described the program to her, and assured her that we would be responsible for her mother’s clinical care. After that she agreed to go with us on a visit and we were able to get Lucy to come out of the bushes she had been living in. Eventually, Lucy agreed to take medication. We were lucky because Lucy is one of those people who responds well to medication. She found a good housing situation near her family. The team helped her keep up with her home, and she began to go to church, look up old friends, and crochet, which she loved. Lucy had been labeled one of the most difficult people in the city because of her extensive involvement with the police. Because we were consistent in visiting her and willing to go at her pace and respect her need to feel safe, Lucy experienced a successful outcome.

ACT Service Components

OBJECTIVES

Anticipate areas in which team members will work with consumers.

This chapter discusses the major ACT service components: treatment, habilitation, and support; team members address the needs of consumers in the areas of: medication support, psychosocial treatment, community living skills, health promotion, family involvement, housing assistance, and employment. Services that the team provides in these areas should not be thought of as discrete, disconnected services, but rather as part of the larger, coordinated intervention of the team.

Identify areas where cross training is needed.

Different members of the team will have different levels of expertise with regard to these areas of services, depending partly on their professional training, but also their life and work experiences. As the team reviews these materials together, the team leader will be able to get a sense of the areas in which cross training is most needed. The leader can then begin to arrange times when information is formally presented to the team. He/she can also begin to consider how to potentially group team members to work together with consumers during the first few weeks of the program so that individuals who have the most to teach each other have opportunities to work together in the field.

Learn more about assertive community treatment services.

Various treatment, rehabilitation, and support services are discussed in detail in *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up* (NAMI, 1999). Much of the material in this workbook was adapted with permission from this manual (see chapters 7-10) available from the National Alliance for the Mentally Ill ACT Technical Assistance Center (on-line at www.nami.org/about/PACT.htm or by calling (866) 229-6263.

OVERVIEW

Treatment, Habilitation, and Support

It is important for team members to understand that providing services is not simply doing things for consumers. Rather, the ACT team works closely with consumers to teach them how to develop and carry out strategies for reducing the negative effects of their mental illness and associated impairments in cognitive and social functioning. This includes overcoming problems resulting from past experiences, as well as minimizing the risk of further acute episodes of illness.

The services delivered by ACT teams should not be thought of as discrete, disconnected services but rather as parts of an integrated intervention. Services provided by teams target problems and address objectives in multiple areas of a consumer's life (see Figure 4.1 next page).

Figure 4.1 – ACT Service Components

Medication Support

- Educate about medications
- Order medications from pharmacy
- Deliver medications to clients
- Organize medications
- Monitor adherence and side effects
- Use of medications*

Psychosocial Treatment

- A problem-oriented approach
 - to counseling/psychotherapy
- Managing illness*
- Crisis intervention – 24/7 availability
- Dual disorders treatment*
- Care coordination
 - (e.g., hospital with community)

Community Living Skills

- Hygiene
- Nutrition
- Purchase and care of clothing
- Use of transportation
- Housekeeping
- Money management
- Social relationships, and leisure activities

Health Promotion

- Preventative health education
- Medical screening
- Schedule health maintenance visits
- Liaison for acute medical care
- Reproductive counseling

Family Involvement

- Collaboration with families
- Lessening consumers' overreliance on family
- Crisis management
- Assistance to consumers with children
- Psychoeducation and family support
- Actively engage family members in
 - the consumer's recovery

Housing Assistance

- Find suitable shelter
- Support housing once established

Employment

- Provide support in finding work
- Liaison with and education of employers
- Job coach
- Supported employment*

*See separate Implementation Resource Kits specific to these services for more information, as described briefly in Appendices D - I of this workbook.

MEDICATION SUPPORT

Medications are one of the important tools that consumers use to reduce or eliminate the symptoms of mental illness that make it difficult for them to handle everyday activities or engage in major life roles. Medications may also help prolong the period between episodes of illness.

Not all people diagnosed with a psychiatric disorder benefit to the same extent from medications and some people will decide they do not want to take medications. If a person decides not to take medications, the team continues to work with him or her in other areas. It may be helpful to talk with people who are considering discontinuing medications about previous experiences when they stopped taking medications and plan with them ahead of time what they would like to have happen should their symptoms get worse. If people experience an exacerbation of symptoms when not taking medications, team members can work with them to assess out the relationship between not taking medications and experiencing acute psychiatric symptoms and also, to weigh the relative costs of taking medications versus experiencing symptoms.

Formal training in “Medication Management Approaches in Psychiatry Implementation Resource Kit” is recommended for one or more team members. These concepts and skills are introduced in Appendix D on Page 103 of this workbook.

Educate about medications

The team provides consumers and families education about how medications work and their role in the treatment of symptoms. Education occurs over time, in verbal and written forms and in language geared to the client and family. A major theme is discussing the purpose of the medications a consumer is taking.

Order medications from pharmacy

Sometimes people have more prescriptions to fill than their insurance will cover. Team members may be able to work with local pharmacies to arrange for the person to get two months worth of a prescription at once and stagger the ordering of medications. They can also work with pharmacies about packaging pills so that they are easier to take.

Deliver medications to clients

When consumers are having difficulty taking medications as prescribed having a team member stop by their apartment and giving medications to them can be extremely helpful, even twice a day if needed. This contact may be very brief or also a chance to check-in about other needs. For other consumers, a telephone call is sufficient.

Organize medications

When individuals have been prescribed multiple medications, it can be particularly difficult for them to organize their medications so that the right dose of the right medication is taken at the right time. The team psychiatrist can help by simplifying medication regimens; that is by prescribing the fewest medications taken the least number of times that effectively control symptoms with minimal side effects. Until a simplified regimen has been worked out, team members can help people organize their medications in special containers that hold individual doses.

Monitor medical compliance and side effects

Some people may not wish to take medications because of side effects. Team members should carefully monitor medication adherence side effects and facilitate communication between the individual and the team psychiatrist so that medications can be adjusted quickly when needed. Team members will also need to work closely with individuals and the team psychiatrist to develop strategies to help individuals relieve minor side effects.

Use of medications

For detailed information about medication strategies the reader is referred to the Medication Management Approaches in Psychiatry Implementation Resource Kit. For a brief introduction see Appendix D.

PSYCHOSOCIAL TREATMENT

A problem-oriented approach to counseling/psychotherapy

Counseling/psychotherapy in assertive community treatment follows a problem-oriented and supportive approach. It is integrated into the continuous work of all team members in contact with the consumer. The consumer's goals as laid out in the treatment plan are the focus and are thus an integral part of the treatment, habilitation and support provided by the team.

Managing illness

Teaching illness management and recovery skills is a method of systematically assisting consumers to recognize the symptoms of mental illness that they experience and to use strategies that they choose and rehearse to minimize the effects of those symptoms. It also includes teaching consumers to recognize factors that 'trigger' episodes of symptoms, and to develop and practice specific steps to prevent these episodes. Problem-solving, goal-setting, and stress management skills are an integral part of illness management. These concepts and skills are introduced in Appendix E; formal training with the Illness Management Kit is recommended for one or more team members.

Formal training in "The Illness Management and Recovery Implementation Resource Kit" is recommended for one or more team members. These concepts and skills are introduced in Appendix E on of this workbook.

Crisis intervention – 24/7 availability

Assertive community treatment teams can respond in various ways to acute situations and may be able to prevent the need for a consumer to be hospitalized. When a consumer has acute needs, the team must quickly assess the situation and come up with a short-term treatment plan. This plan usually addresses:

- safety and protection of the consumer or others
- emotional support
- structuring of the consumer's time and activity
- treatment of specific symptoms (e.g., pharmacological)
- evaluation of symptoms in a controlled environment
- relief from demands and stress
- detoxification
- evaluation and treatment of a coexisting medical problems

In responding to these needs, the team might:

- increase the frequency of contact with the consumer
- arrange for others in the consumer's support system to provide support and supervision
- change medications to treat symptoms and distress
- manipulate the environment to limit stressors
- lessen work and social demands through direct intervention with employers and others
- limit substance use that is exacerbating or causing the situation, such as more frequent supports and prompts, or a temporary change of residence.

Around the clock availability of the ACT team allows a quick response to a crisis. Knowledge that the team will see or talk with a consumer whenever necessary is very reassuring to the consumers and family members. Crisis visits are more frequent in the early stages of involvement in ACT. Once it is clear that such support is truly forthcoming, the number of crises usually diminishes and can often be handled by telephone.

Dual disorders treatment

Rather than sending people with co-occurring substance abuse problems to a separate program for substance abuse treatment, interventions targeting substance abuse are delivered by the assertive community treatment team. The team provides both individual and group interventions.

When a consumer is suspected or known to have a substance abuse or dependency disorder, one of the team's substance abuse specialists is assigned to work with the person. The substance abuse specialist has primary responsibility for assessing the person's substance use disorder and planning treatment. The substance abuse specialist collaborates extensively with other members of the team in carrying out these interventions.

The use of outside providers for substance abuse treatment is highly selective. An instance where an outside provider might be used is for detoxification or when residential services are warranted. When outside services are used, the team refers consumers to those programs that are adapted specifically to consumers with dual disorders.

Integrated treatment for substance abuse and mental disorders is introduced briefly in Appendix F; formal training with the Integrated Dual Disorder Treatment Implementation Resource Kit is recommended for one or more team members.

Care coordination (e.g., hospital with community)

One of the outcomes of assertive community treatment is reducing hospitalization. That does not mean that consumers are never hospitalized. There will be times when inpatient care will be indicated, but remember, the team is the primary point of responsibility. Even when a consumer is in the hospital, the ACT team is still responsible for care, in the case of hospitalization that means making certain the inpatient staff have critical information for treatment needs.

You may be able to address problems that lead to hospitalization by increasing the number of contacts you are having with a person, but there will still be times when hospitalization is necessary. You are going to try to do that before a problem becomes a crisis. You are also going to keep the consumer's community resources in place if you can -- for instance, keep their housing.

Acute psychiatric hospitalization. Although the team has the ability to quickly respond to changes in a consumer's status, there will still be times when inpatient care is appropriate. When a consumer is admitted to an inpatient setting, the team's role is to make the transition from outpatient to inpatient status, and back again, as smooth as possible and to facilitate collaboration between the team and the inpatient staff.

Formal training in "Integrated Dual Disorder Treatment Implementation Resource Kit" is recommended for one or more team members. These concepts and skills are introduced in Appendix F of this workbook.

***The PACT Manual* suggests that short-term psychiatric inpatient treatment may be appropriate for people who:**

- are suicidal or homicidal or their behavior is of such intensity that they are likely to commit a suicidal or homicidal act soon and the risk cannot be immediately reduced through assertive community treatment crisis interventions;
- are experiencing symptoms (e.g., confusion, disorganized thinking) that are causing serious neglect of self-care and risk of physical harm and the risk cannot be immediately reduced through assertive community treatment crisis interventions;
- are experiencing mixed acute symptoms of mental illness and drug intoxication such that intensive, supervised medical care is required to reduce the effect of the substance abuse so that acute symptoms of mental illness can subside;
- are in need of medication changes or adjustment, and because of concern for significant medical complications, side effects, or exacerbation of symptoms during this change, need the safety and supervision of an inpatient unit;
- require medical workups or medical treatment for serious conditions (e.g., bacterial pneumonia, poorly controlled diabetes), when the necessary medical procedures and treatments can reasonably be completed only on an inpatient basis; and
- present severe symptoms at a time when the team already has a large number of acute and subacute consumers who require very intensive services and the team therefore cannot responsibly provide services in the community for another person with high needs.

According to *The PACT Manual*, longer term hospitalization is appropriate for consumers who have such severe symptoms and accompanying poor functioning that they are often at risk of harm to others or themselves or cannot carry out basic survival tasks (e.g., nutrition, shelter, clothing, healthcare, protections from harm) despite very intense daily team efforts and repeated short-term psychiatric hospitalizations over an extended period of time.

When inpatient care is needed, the assertive community treatment team collaborates with inpatient staff to facilitate rapid development of a treatment plan and provide continuity in treatment to the greatest extent possible.

Admission to the unit. There will be times when consumers will seek emergency admissions on their own or they may be taken to the hospital by family or emergency personnel (i.e., EMS, police), but in most cases the assertive community treatment team will usually initiate inpatient admissions. When the team is involved in the admission process, team members can provide emotional support to the consumer and share information with the inpatient staff that facilitates their understanding of the consumer's history, current status, and create a smoother transition between outpatient and inpatient care.

It is difficult to admit consumers unless funding for the hospitalization is assured ahead of time, though in true emergencies hospitalization will proceed even if this is not guaranteed. Where the consumer has insurance (e.g., Medicare or Medicaid, funding may not be a problem, though increasingly payors require preadmission and concurrent review). Where preadmission assessment is required, staff usually must present information and negotiate with a screening or gatekeeper agency that has authority to provide funding. When this agency is closely managing local funding and using very tight criteria for hospitalization, this negotiation can be a difficult process demanding patience and skill.

After the funding for the admission has been approved, a team member calls the attending psychiatrist of the inpatient unit to request admission and explains the details of the case. The team member also informs a nurse on the unit.

When the inpatient unit has approved the admission, a team member accompanies the consumer to the unit, helps him or her through the admission process, assists the inpatient staff in establishing communication with the consumer, and settles the consumer into the unit. This team member should bring a copy of the current treatment plan and a list of current medications with their dosages and side effects.

Key tasks during hospitalization. The team stays actively involved with consumers who are hospitalized. Someone on the team who has worked closely with the consumer visits the consumer at least once a day (assuming geography permits). These visits are to assess the consumer's status and progress, implement parts of the treatment plan (with the agreement of the inpatient staff), make recommendations to the inpatient staff, and provide support and advocacy for the consumers.

There are a number of practical 'rules of conduct' the team follows in working with hospitalized consumers and the inpatient staff:

- Inform the staff of your presence on the unit, ask them about the status of the consumer, and tell them the purpose for your visit. Introduce yourself to staff that you do not know.
- After seeing the consumer, communicate any noteworthy information back to the inpatient staff (e.g., the consumer seems to be in distress or losing control and needing monitoring and support).
- Respectfully suggest changes the inpatient staff can make in their approach with the consumer (e.g., avoid giving detailed information and direction to a consumer who is processing information poorly, give side effect medication to a consumer, limit visit of friends or relatives who are disturbing a consumer). Team members should also present their observations to the team's psychiatrist so he or she can use these observations in conferring with the inpatient psychiatrist.
- Model interpersonal approaches to the consumer that the team has found helpful in the past (e.g., being supportive to a consumer who is feeling irritable or hostile, eliciting information regarding psychotic symptoms from a nondisclosive consumer, being directive with an anxious and scattered consumer).

The team psychiatrist should regularly (i.e., once or twice a week) confer with the inpatient psychiatrist to relay his or her, and other team members' observations and recommendations.

Most inpatient units organize their collective observations and formulate treatment plans for consumers in staffing meetings. Usually, an initial staffing is held within the first few days of admission, with others scheduled as needed or at regular intervals thereafter. The consumer often attends part of the meeting. Team staff should respectfully but assertively ask to be involved in these meetings, starting with the first one soon after admission. Inpatient staff are usually quite receptive to this involvement and will learn to plan and rely on it.

Most consumers will usually remain continuously on the inpatient unit over the first one to two days of admission to allow for assessment and treatment of presenting symptoms. Thereafter, it is useful for most consumers (unless suicidal or very easily distressed) to continue to be involved with their life and treatment in the community, even on a daily basis.

When not clinically counter-indicated, passes for consumers to go on visits into the community might be part of the overall treatment plan that is developed with the inpatient staff. Passes allow consumers to stay involved in normal activities (i.e., handling tasks like paying bills or retuning to work); in social and supportive relationships (e.g., visit with family and friends, contact with the team); and in personally satisfying activities (e.g., going for a walk, shopping while in the hospital). Overnight or weekend passes provide a method for the consumer and team to assess consumer improvement and readiness for discharge.

Discharge planning and return to the community. Some consumers will only be hospitalized for a short time and will need very little change in the treatment plan guiding the assertive community treatment team's interventions in anticipation of discharge. In other cases, markedly different interventions may be needed at discharge. Passes can be used to test new interventions prior to consumer discharge.

Long-term hospitalization. A few consumers will require long-term (i.e., 3 months or more) hospitalization. These admissions are usually involuntary and preceded by an appropriate legal process. Continuity of care (i.e., continued team participation) is as important for these consumers as for consumers hospitalized on acute units.

The team usually initiates the legal or other proceedings leading to the commitment, usually after an extended period of unsuccessful treatment in the community.

Relying heavily on the strength of its teaming capacity, team members approach the consumer hospitalized long-term with the same commitment, energy, and community orientation as they do any other consumer; at the same time they support and assist the inpatient staff to provide optimal treatment. This means visiting the consumer at least weekly to assess progress and status, develop-

ing treatment plans in collaboration with the inpatient staff, attending regular staffing, and involving the consumer in regular treatment and rehabilitations activities in the community as part of the treatment plan (i.e., work, socialization, etc).

Discharge planning should be underway long before discharge. Outpatient treatment and rehabilitation activities should have been an ongoing part of the treatment plan and are increased in intensity as the consumer moves closer to discharge. In fact, readiness is determined by the consumer's ability to handle increased expectations in the community. Necessary resources (particularly housing) may have to be secured and the consumer introduced to them (e.g., overnights, extended visits). The outpatient plan is usually an intense and structured one and anticipates the need for at least once-per-day contacts, including supervision and assistance in the area of medications, self-care and care of residence, finances, socialization and support, and daily productive activity.

COMMUNITY LIVING SKILLS

Hygiene, nutrition, purchase and care of clothing, use of transportation

This set of community skills needs to be approached with the same sensitivity as other foci on skills development or redevelopment. When a consumer can make a request for change in any of these areas a direct approach to working on them will be much easier. To the extent that such goals are clearly incorporated in the treatment plan agreed to by the consumer, there is a basis for addressing each with tact over time. For other consumers awareness of problems in any of these areas and/or a desire to change may not be present. Limited performance may be related to old struggles with family or others, or stigma about mental illness and serious questions about whether change would result in greater acceptance by others, which also may not be a goal. Work on the above community skills may have to be tied into related goals and seen as a step toward them. For example, good hygiene and reasonable attire may be necessary to obtain and keep a job and good nutrition necessary to have the energy to engage in social and leisure activities. Reasonable housekeeping, also a health issue, is necessary for keeping an apartment. Team members can assist through concrete assistance (e.g., shopping for groceries, clothes), education (e.g., apartment cleaning), encouragement and reminders.

The goals of community living skills are to (*The PACT Manual*, pp. 93):

- Guarantee that each client's basic needs are being met
- Continually assess each client's Activities of Daily Living (ADL) functioning to ensure he or she gets the help needed to live with quality in community settings
- Help clients upgrade their quality of life (e.g., move to nicer living arrangements, increase possessions)
- Provide continuous, ongoing ADL services which meet client needs and preferences so that they can manage ADL functions as autonomously as possible

Housekeeping

Respect should be given to consumer's housekeeping styles and preferences. If you do not think so, just imagine for a moment one of your teammates coming into your home and imposing his or her standards and methods. There is however, some minimal level of housekeeping that is necessary to assure basic hygiene – putting food away, washing dishes, taking the trash out, etc. There is also a practical aspect of organizing things to make them easier to find. Finally, housekeeping rituals can help bring a sense of structure to a person's day and a degree of order to their environment.

If consumers need help organizing and planning housekeeping tasks, team members might work with them on defining a list of tasks. It is worth the effort to discuss how often the task will be done. For example, does making the bed mean every morning, some time during the day, more often than not, or when the mood strikes. Does washing dishes mean when there are not any more clean ones, before going to bed, or immediately after meals. Does it include drying and putting them away? This is particularly important because multiple people are working with the consumer and the plan needs to be consistent to avoid confusion.

Whatever decisions are made, the team will need to make certain that the consumer has basic information (i.e., what day does the trash get picked up, what dumpster does it get put in) and that he or she has the needed equipment/tools (trash bags, dish soap, broom).

Money management

Some consumers will manage their own money but may need assistance from the team in other ways. Examples include setting up a checking account, developing a system for paying bills on time or assisting them with obtaining entitlements. The latter effort usually involves going with the consumer to apply for benefits, and assisting with documentation and completion of forms. For other consumers, a task for the team may be to help prevent consumers from being taken advantage of financially (e.g., mail or TV scams) and then advocating for them to obtain a release from such commitments.

The assertive community treatment program has the capacity to directly handle consumer funds to promptly pay monthly bills and distribute cash (e.g., for groceries, laundry, spending) in amounts determined by each person's budget. The purpose of this system is to assist consumers in money management and to provide the consumer with frequent access to cash when budgeting or financial management is a problem. For example, if a consumer's monthly spending money is gone in the first week of the month and no more is available for that month, the consumer suffers high stress, which is counterproductive to his or her treatment. The team works with the consumer to come up with a plan to allocate the spending money. The team holds the spending money and takes responsibility to set up smaller amounts of money that the consumer receives more frequently (e.g., daily, three times a week).

The program may manage consumer services money and individual consumer funds including disability benefit payments such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) under the supervision of a payee or financial guardian.

Consumer services money. Consumer services money comes from funds allocated in the program budget to provide direct financial grants or loans to consumers when disability benefits have not started, a benefits check is delayed, or the first check from a new job is insufficient to cover expenses. Lack of immediate financial resources keeps many persons on inpatient units longer than their psychiatric treatment requires and contributes to homelessness among person with severe and persistent mental illness. Consumer services money can also be used for emergencies, rent, security deposits, food, clothing, recreation, and transportation costs.

Individual consumer funds. Individual consumer funds consist of entitlements (e.g., SSI, SSDI, VA pensions and benefits) consumer wages, grants, and family supports. When a consumer has a protective payee appointed by Social Security or a financial guardian designated by the court, the team works with the consumer and the financial guardian or protective payee to make sure 'the beneficiary's day-to-day needs are met' and that records are kept showing how the money was used.

The team leader and the program assistant may manage and operate a system (in compliance with Social Security requirements) to:

- dispense money to consumer from individual consumer accounts in accordance with the consumer's monthly budget
- maintain an account with a local bank for deposits and withdrawals of consumer money
- document all cash transactions with receipts signed by the consumer upon receiving cash and return these receipts to the payee or guardian to document the consumer's receipt of the money or keep the receipts to document payment of consumer services money
- communicate regularly with financial guardians and protective payees of consumers to coordinate individual consumer budgets between the program and the guardian or payee
- receive money from guardians or payees and maintain records of receipt and current balances for each consumer.

Social relationships and leisure activities

[adapted from *The PACT Manual* (pp. 101-104)]

When a person has a severe and persistent mental illness, the onset of mental illness, acute episodes of symptoms, hospitalizations, and ongoing impairments can interfere with social development – forming relationships, making friends, getting married, getting and giving emotional support, and relating as adults with families, employers, and landlords. The assertive community treatment team provides a broad array of services to assist consumers to:

- develop, restore, and maintain social and interpersonal relationships
- engage in social and leisure-time activities
- develop their social network

Social competence and social skills. According to *The PACT Manual*, the nature and quality of a consumer's social and sexual relationships prior to onset of illness such as, social involvement with friends from adolescence through early adulthood, whether the consumer dated, had relationships, or married is often correlated with social competence. Consumers who achieved milestones before becoming ill will generally be more socially competent than those who did not since they have been exposed to these adult life experiences. This is what being socially competent means – to meet adult interpersonal goals.

Social skills, on the other hand, refer to the abilities needed for effective interpersonal performance. Consumers with severe mental illness often lack social skills because of the symptoms of mental illness, the iatrogenic effects of institutionalization, insufficient learning opportunities and appropriate role models during childhood and adolescences.

The difference between social competence and social skills is best portrayed by the following two consumer examples:

Example 1 – Jerome had developed social skills before the onset of mental illness when he was 20 years old and attending a community college. He was a good student, played sports, and had friendships in high school. His mental illness is episodic with almost complete recovery between episodes. He has been able to reestablish his relationships because treatment was provided immediately to lessen symptoms and continuously to minimize and prevent recurrent acute episodes. The team provides treatment and support to Jerome during episodes and the periods of recovery after the episodes. The team then provides rehabilitation services long term to help him to reestablish or renegotiate the relationships that have been disrupted by these episodes as well as to initiate new friendships and social relationships. For example, the team met with Jerome and his longtime

friends and roommate to provide support for Jerome to talk about and resolve issues that resulted between them during the last episode. The team provided both ongoing supportive therapy and side-by-side assistance to help reinvolve Jerome in existing relationships and to pursue leisure-time activities. This treatment and rehabilitation process is continuous as Jerome experience fluctuations in his symptoms.

Example 2 – Marcia has few social skills. Her only interpersonal relationships are with her family. The onset of her mental illness occurred gradually in her middle to late teens, disrupting her normal social development and producing impairments in social functioning. She has had great difficulty in making a full recovery between episodes because of persistent symptoms and functional difficulties. Additionally, it was traumatic for her and her family when acute episodes disrupted her participation in high school formative relationships; normal family functioning also was altered because of her symptoms and impairments and because of her involvement in mental health services (Psychiatric hospitals can be frightening and stigmatizing places for young people and their families).

Marcia experiences significant social anxiety, is withdrawn, and has idiosyncratic characteristics in her dress (e.g., at all times wearing a red bandanna over her hair). She needs significant long-term help from the team to improve her social competence and skills, pursue and establish a social niche with one or two relationships with others (e.g., other people, consumers, volunteers, and family) and participate consistently in leisure-time activities. The team provides a combination of social stimulation and involvement for Marcia through one-to-one activities with staff (e.g., social recreation contacts) and groups (e.g. social recreation activities) to pursue consistent and regular leisure-time activities. The team also provides gradual teaching of social skills (e.g., ‘small talk,’ assertiveness) to increase her social competence and comfort.

Goals of social, interpersonal relationships, and leisure-time services. Services for social and interpersonal relationships and leisure-time enjoyment include:

- assessing the consumer’s social and interpersonal functioning, social development, culture, social skills, and interests
- developing an individualized plan with rehabilitation interventions to establish, reestablish, and maintain relationships and increase social skills and comfort in social situations.
- receiving individualized services in normal social situations (e.g., a neighborhood coffee shop, the break room at work) in the community in which the consumer normally interacts with people
- identifying and overcoming stressors, behaviors, and environmental issues, which affect and diminish quality of interpersonal relationships

- reducing the stress of unstructured time – evening, weekends, and holidays – and fostering normal social routines
- planning, participating in, and handling holidays, family, and other social obligations with less stress and greater competence

Features of social, interpersonal relationships, and leisure-time services.

Individualization. The team's activities to enhance consumers' social and interpersonal relationships and enjoyment are individualized to the needs and goals of each consumer. For example, the team reviews plans for a holiday individually with each consumer prior to the holiday and helps each person to work out how he or she will spend that day. If the person usually spends the holiday with family, the plan might include assisting the person to call the family to make arrangements. In addition, the team will problem solve and provide side-by-side coaching and assistance to help the person determine how long to visit, the best means of transportation, what to wear, and strategies to manage interpersonal interactions with family. Team members may meet with the consumer and his or her family prior to the holiday to problem solve and plan ways to make it an enjoyable time for both.

Active provision of social activities and interpersonal support. The team helps consumers develop, restore, and maintain social and interpersonal relationships, to engage in social and leisure-time activities, and to increase their social network by first providing social and interpersonal support to consumers. The team works out how to establish an understanding and trusting relationship with each consumer and then provides it. Each team member plans an important role for each consumer as an unwavering social support and a role model who maintains the appropriate balance between professional interpersonal boundaries and adequate compassionate support. This modeling occurs in all contacts between consumers and team members.

Moratorium and support during recovery. The team helps consumers in social and interpersonal relationships over time in a gradual step-by-step fashion. Continuous services in this area allow consumers the time to restore social functioning. Consumers may delay having to function in some social situations until they feel better, and they are provided adequate support and assistance to practice in real-life social situations as opportunities arise.

Reconciliation and renegotiation of relationships. The team evaluated with each consumer what relationships in his or her life have been affected or disrupted by mental illness and develops and implements strategies or interventions with the consumer to reconcile or renegotiate these relationships. The stigma that goes with mental illness as well as the lack of help from traditional service providers in this area often prevents consumers from directly dealing with disruptions in interpersonal relationships.

Through problem-solving, role-playing, and modeling, the consumer make goals and plans approaches for reconciliation or renegotiating relationships. Intervention also may include team

members working with the consumer and the friend or family member in an intermediary role or supporting the consumer in meeting with the individual to either get closure or reestablish the relationship on mutual terms. It is a tragedy when consumers have been separated from parents, brothers, sisters, and even children because of their mental illness. It also is a serious shortcoming when mental health providers assume that a family wants nothing to do with a consumer without making an effort to find out if this is really the case.

Restoring balance in relationships. Helping consumers restore a sense of personal well being can be difficult because mental illness has rendered them so vulnerable and highly dependent on relationships and services just to survive. The asymmetrical quality of helping relationships, especially if help is provided in a patronizing or authoritarian manner, can cause consumers to feel controlled and demoralized. To help consumers make their relationships more symmetrical, the team directly assists consumer to move from the primarily receiving position in relationships to that of an equal participant (e.g., giving and taking). This is accomplished through cognitive-behavioral approaches including assertiveness training and all one to-one rehabilitation services provided by team members (e.g., redirecting a question to the consumer that the landlord directed to the team member; drawing the consumer into a social conversations; practicing before an interaction with an employer how the consumer prefers to respond to anticipated feedback; assisting a consumer to shop for a present to have something to take to a parent's birthday party).

HEALTH PROMOTION

All consumers need access to high quality preventive and health maintenance care. Some consumers who receive assertive community treatment services have serious health concerns. You will find consumers with HIV, hepatitis, diabetes, and any number of significant health problems. One of the challenges for the team, especially when consumers are experiencing acute psychiatric symptoms, is to keep a pulse on the consumer's medical conditions, and their response to treatment for such conditions.

Preventative health education

Good basic health practices—daily hygiene, adequate food, proper rest – can make is easier for people to deal with stressors. The problem is that psychiatric symptoms and associated impairments directly and indirectly create challenges to good basic health practices. One indirect challenge is that many people with severe and persistent mental illness have limited incomes. Supplies for daily hygiene like soap, shampoo, and toothpaste can be a luxury when income is extremely limited. Hygiene items can be purchased with consumer funds in the team budget if necessary, however, the team should be able to find community agencies that will donate these items. Daily hygiene should be monitored by the team since marked changes may signal a change in the person's clinical status.

The team also needs to monitor whether a consumer is getting proper rest. As with changes in hygiene, changes in sleeping patterns can also indicate a change in symptoms. Alternately, difficulty

going to sleep, as well as difficulty staying awake, may indicate the need for an adjustment in the consumer's medication regimen.

Along with encouraging good basic health practices, the team also provides education on the prevention of certain communicable diseases including HIV and sexually transmitted diseases. This education is particularly important for consumers engaged in high-risk behaviors.

Psychiatric medications and medications prescribed for physical illnesses can interact in ways that alter the effects of the medication or lead to serious health problems. Consumers need to be educated about the medications they are taking and possible interactions. It may also be advisable for the team psychiatrist to communicate directly with medical providers (with the consumer's permission) in order to work out the best medications to safely address both the consumer's mental health and physical health needs.

Medical screening

Screening for medical concerns begins during the initial intake. The team makes certain that any health needs that have been identified are followed up (e.g., eye exams and opticians, if needed; periodic testing for HIV is essential for people with risk factors; mammograms for women in accordance with age guidelines). This might involve helping consumers schedule an appointment with their medical provider, providing transportation, and even helping the consumer practice explaining his or her health concern to the medical provider.

Schedule health maintenance visits

Identifying a regular primary care provider is often a first, insuring regular follow up comes next. Dental needs are often neglected and require attention.

Liaison for acute medical care

Acute medical care refers to emergency or inpatient treatment. Consumers may be anxious about a medical crisis or being in a medical environment, thus, another focus is team support. Involvement of the team corresponds to some extent to the guidance provided previously for a psychiatric hospital admission, i.e., insuring that there is financial coverage for medical care, facilitating an admission, communicating with medical providers, ensuring that the consumer understands and recommends his/her choices, and then supporting discharge after care.

Reproductive counseling

Consumers will vary in their knowledge of safer practices and birth control. This is important to assess whether or not consumers say they are sexually active. Team nurses, or other well informed staff, counsel consumers on the approaches to birth control.

When a pregnancy (planned or not planned) occurs, team involvement is usually very important. The team must adapt the consumer's psychiatric treatment so that it meets the needs of the pregnancy and delivery; they ensure the provision of prenatal care and maintain communication with hospital staff both during and after delivery.

FAMILY INVOLVEMENT

Historically, people with severe and persistent mental illnesses have received most of their support and care in the community from family members, particularly parents and siblings. These family responsibilities have, in fact, grown in recent years with the decreased use of hospitalization and increased emphasis on outpatient treatment for this population.

Families provide significant amounts of care and support to their relatives with severe and persistent mental illness. Family member roles can become distorted. For example a mother's role may have become intertwined with that of nurse or social worker. When a family member has a severe and persistent mental illness, it can be difficult for a family to just be a family.

Many consumers have little or no contact with their family and may say they have none. This may be due to moving away or family termination of contact.

Further, many consumers have children. Their ability to parent can be compromised by their mental illness. Women consumers, as their opportunities for community living and relationships expand, become pregnant and have children, with perhaps as many as one-third giving birth by age 30. The team delivers a range of services to help consumers fulfill their parenting role responsibilities.

Collaboration with families

For consumers with family desiring contact with the ACT team.

At the point of admission, the assertive community treatment team involves the consumer and family members in a collaboration to free the family of some of the provider roles they have taken on.

Initiation of the collaboration process involves:

- meeting with the consumer and family members to learn about the person's developmental and illness history, current symptoms, functional status, and the consumer-family relationship (e.g., typical ways of coping with and helping the consumer, relationship stresses, conflicts, and family strengths)
- basic information about the assertive community treatment model is presented and an initial plan is developed that specifies what the team, consumer, and family member will do
- subsequent meetings and phone calls are scheduled to exchange information and ideas

Family meetings can occur at the consumer's residence, the family home, or the assertive community treatment office. Family meetings usually involve the consumer but he or she can choose not to attend. The psychiatrist participates in most meetings with family members and is readily available to assist them with crises and other problem-causing situations.

Lessening Consumers' Overreliance on Family

Soon after admission, the team uses a practical problem-solving approach to assess the consumer's reliance on the family and the stress this may have produced for both the consumer and family member. Assertive community treatment teams use two approaches to reduce the responsibility of the family:

First, team members take over many of the practical functions (e.g., shopping, laundry, money management, medication administration) that family members perform and then help the consumer to carry out these tasks on his or her own.

Second, since teams can easily increase the intensity of the contacts they have with the consumer, they can even provide intensive support to help consumers gradually move out of the family home into their own residences.

Crisis management

When the family is actively engaged with the ACT team, family members are likely to take advantage of the 24/7 availability for crisis intervention. Prior work with the family about their experience with types of crises that arise and that they have handled previously, is helpful because such information can be used to develop a plan if similar crises should arise.

Assistance to Consumers with Children

A significant number of women with severe and persistent mental illnesses give birth to children before and after developing mental illness. The needs of these women are complex and demand that the team alter services to address both the needs of the mother and children. The team assists consumers with the range of activities related to pregnancy and parenting, including:

- arranging prenatal, physical, and practical care
- soliciting and using appropriate social services agencies
- facilitating admission to the hospital and effective communication with hospital staff during the birth process and immediate neonatal period
- supporting neonatal, infant, and childhood parenting at home
- changing psychiatric treatment, particularly psychotropic medications, to match the needs of pregnancy, and delivery
- educating the consumer about birth control

All activities involve the participation of partners and other individuals in the consumer's support network. The team also supports consumers in fulfilling parenting responsibilities and coordinating services for the child. Though the team's primary obligation is to the consumers, the team works with consumers to help them meet parenting roles and responsibilities. The team does not directly provide physical or psychological care for children, but assists consumers and their families to plan for and obtain necessary services (e.g., parenting training, child care, respite care) for them. Team

members help consumers relate to the systems (e.g., schools, social services, mental health professions) that provide services to children by being available to meet with the agencies, consumers, and children, reviewing agency recommendations with consumers and establishing plans to carry them out. Over time, staff often function as extended family and friend to consumers and their children.

Another role of the assertive community treatment team is maintaining the mother-child relationship. A single woman with severe and persistent mental illness often has difficulty effectively and safely raising her child. Even with intensive assistance by the team, other family members, and social services agencies, mothers are sometimes forced to surrender this responsibility to others (e.g., family members, foster parents, adoptive parents). Sometimes this happens voluntarily; at other times, in spite of her protests, the mother is forced by the court to relinquish custody. This is a painful situation for the consumer who suffers a great loss and a blow to self-esteem and confidence. Though the welfare of the child is primary, the team supports the mother's desire and need to maintain a connection with her child and to continue in some way to participate in parenting. Where this is not harmful to the child and is potentially to his or her benefit, the team advocates with the court and social services for the consumers continued contact and helps establish a visitation plan, which may include supervised visits with team members, family members, or social services staff. When the consumer is doing poorly or not adhering to the treatment, the team is responsible to report this to social services, which may lead to suspension of visits. Some consumers learn to ask staff or others to help with their child during rough times, even to the point of suggesting themselves more limited contact with their children until they feel better.

Psychoeducation and family support

The team provides increasing amounts of education, including explanations and discussion of various aspects of mental illness (i.e., etiology, symptoms, functional problems, course, treatment). Efforts are made to help families learn new attitudes toward themselves and the consumer, such as not blaming themselves or being overly critical of the consumer. Some families are immediately receptive to a very structured, cognitively-oriented approach, whereas others prefer a much more gradual and informal process. See Appendix G on Family Psychoeducation for introduction; formal training for at least one team member in the Family Psychoeducation Implementation Resource Kit is recommended

Actively engage family members in the consumer's recovery Relationships between family members and a relative who has a mental illness may have been severed or greatly damaged. The family may be hesitant to become reinvolved. In such cases the team, with the consumer's consent, attempts to make contact with family members to obtain and give information. Attempts are made to help families gradually reconnect in a way that respects the distance they have established. When

Formal training in "Family Psychoeducation Implementation Resource Kit" is recommended for one or more team members. These concepts and skills are introduced in Appendix G of this workbook.

relatives become aware of the consumer's improvements and the team's comprehensive service delivery, they often reconsider contact and wish to have more.

HOUSING ASSISTANCE

The type of housing a consumer lives in may be influenced by his or her financial situation. The team can provide support 24-hours a day if needed for a person to live independently, but being able to afford safe, independent housing is a challenge to be addressed. Being knowledgeable about public housing is a first step, since the public housing environment may not be safe or manageable for ACT consumers, it is important to identify subsidized housing (especially Section 8) options.

Many consumers have very limited incomes (e.g., SSI, SSDI, wages from part-time work). Consumer services funds from the assertive community treatment program budget are often needed to cover many of the upfront costs for housing (i.e., security deposits, first month's rent, etc).

In addition to the financial barriers to obtaining safe affordable housing that people encounter, some people served by the assertive community treatment program will run into difficulty because they have a poor rental history with multiple evictions, poor credit, or criminal records.

It is very important for team members to get to know people in the community who own or manage low cost and subsidized housing and to introduce them to the program. People may be willing to take risks on consumers with marginal rental/credit histories if they know that the program is providing support around payment of rent and monitoring upkeep of the residence.

Find suitable shelter

The PACT Manual suggests that working with a consumer to find housing begins by meeting with the consumer to learn about his or her housing needs and housing history:

- Where has the consumer been living?
- How often has the person moved?
- What did the person like/dislike about past situations?
- What type of living situation does the consumer want and need?

Team members schedule regular appointments with each consumer to plan and look for a place to live. Consumers are involved in each step of the process including:

- Discussions of important considerations in choosing housing (security deposit, rent, utilities, accessibility to transportation, laundry, stores, safety, personal preferences, acuity of symptoms).

- Looking for leads in the paper or by contacting property owners that are known to the team or consumer.
- Driving by to check out the location of rentals.
- Coaching and rehearsing with consumers how to best present themselves on the phone or in face-to-face contacts with property owners.
- If appropriate and necessary, accompanying the consumer to meet the landlord.
- Secure leases and ensure client payment of rent

Support housing once established

Shared housing. In order to make housing costs more affordable, some consumers may share an apartment or house. Living with another person who may have different habits and preferences can be difficult and the team will want to help consumers who are sharing housing develop skills and routines for solving the problems that may arise. The team will want to facilitate meetings between potential roommates to help them clarify practical issues such as:

- how the rent and utilities will be split
- how cooking and cleaning will be handled
- preferences for social activities within the apartment

The team may want to discourage situations where more than 2 or 3 consumers share a dwelling as several consumers living together may take on the attributes of a group home rather than independent housing.

Safety. Despite your most creative and diligent efforts to help consumers obtain safe housing, some consumers will live in housing that is in questionable repair or in areas in which there is a relatively high level of crime.

When it comes to the safety of the property, your team will need to be prepared to help consumers hold property owners to meeting at least minimum legal standards for safe housing. That is, gas should not leak from appliances, electric wiring should not be exposed, toilets should flush, floors should not have holes in them, faucets should turn on and off, etc. Municipal authorities may be able to assist you, if needed, in pressuring property owners to bring housing up to code.

There will be instances in which consumers will be living in housing in areas in which there is an abundance of drug activity and other types of crime. Consumers can be easy prey for people who are looking for a place to sell drugs or someone to carry drugs for them. They may also be easy marks for people who would hustle them out of their money or personal property. A secure, locked building and regular phone or face-to-face support and coaching might assist the consumer in not permitting entry to those who might take advantage of him or her. Your local law enforcement agency can also provide tips in crime prevention strategies. You will want to take advantage of this

training and work with consumers on developing and practicing specific things they can do to protect themselves and their property.

The more difficult situation is when the consumer is using drugs and has contact with people who are selling drugs. In such instances, part of the substance use treatment plan might include a change in residence or involving the person in alternative activities.

Neighbors. Sometimes neighbors may be anxious about living in close proximity to someone with a severe mental illness. This may have nothing to do with anything that the consumer does. It may simply come from the neighbor's stereotyped misperceptions about people with mental illness. It may be helpful for the consumer to make an effort to meet some of his or her neighbors and even possibly put the fact that he or she has an illness in the open as a way of educating people about what people with mental illness are really like. The consumer might also choose to have a neighbor or two meet members of the team and give them information about how to contact the team.

Help purchase and repair household items. Consumers may need assistance with purchasing household items at a reasonable price. They may also need some instruction for simple repairs (unclogging a sink) or how to get help if the power goes out or telephone is disconnected.

Develop relationships with landlords. An ongoing relationship with landlords is essential not only to obtain housing originally, but to trouble shoot problems (e.g., safety issues above, failure to pay rent).

EMPLOYMENT

Assertive community treatment emphasizes work and vocational expectations for all consumers, while accepting individual differences in capacity and interest in competitive employment. As Allness and Knoedler describe it, the "focus is on promoting growth rather than stability (even for those individuals with serious impairments) and maximizing normalization rather than minimizing stress."

The team's employment specialists are responsible for providing the majority of employment services. They are also responsible for directing and teaching other team members to participate in carrying out individual consumer employment plans.

Persons with severe mental illnesses rarely lose jobs because they do not have the skills for the job. More often, jobs are lost because mental illness and related symptoms and behavior effect job performance. For this reason, the assessment process includes a careful review, not only of the consumer's education and past work experience, but also of the specific behaviors or other issues that have been problematic on the job.

Provide support in finding work

Initially, many consumers indicate that they do not want to work or that they are unable to work. In addition, because staff cannot predict how well a person is going to do in employment, they may be hesitant to help consumers find jobs. To overcome both consumer and staff resistance or apprehension, it is critical for the employment specialist and all the team members to work together to encourage, support, and provide consumers with opportunities to try work.

The team promotes consumer interest and motivation to work by:

- talking about work, stimulating thinking about work, and raising expectations to work in individual and group, and formal and informal interactions with consumers
- finding work opportunities for consumer to boost their confidence help them realize they can work, and to determine their work interests and competencies
- gain confidence that they can maintain a job
- successfully meet expectations that go with work
- feel a sense of accomplishment and belonging

Direct Placement in Competitive Jobs. Experience with assertive community treatment has demonstrated that consumers with severe and persistent mental illness can work competitively if they are provided sufficient help to get a job and continued support to retain it. Assertive community treatment employment services are based on the direct placement model in which the employment specialist works directly with individual consumers to find and sustain, as quickly as possible, competitive work in the community.

Job sites are developed individually for each consumer based on the specifications identified in the vocational assessment (e.g., consumer preferences and skills, type of job, environmental adaptations, availability of ongoing work supports).

To make an appropriate job and consumer match, the employment specialist, with other team members, uses the want ads, friends, personal contacts, and the yellow pages to locate jobs and meet employers. In fact, the employment specialist may go as far as proposing to an employer a job which fits both a particular consumer's needs and goals, and with those of the work setting. Appendix H is a set of Job Support Checklists called "Planning for Success." It offers several lists of questions with many tips on getting and keeping a job.

Liaison with and education of employers

One of the first tasks of an employment specialist is to identify opportunities for consumers in the employment market. To do so involves meeting with potential employers, eliciting their interest in identifying positions for adults with psychiatric disability and then ensuring availability of the ACT team for consultation and support.

Job coach

Job coaching involves significant on the job contact with ACT consumers to help them settle in and to problem solve and trouble shoot. If it is not possible to get the consumer to the job, it is sometimes necessary for the team member to do the job – a big incentive to insure that the consumer is on the job.

Supported employment

Supported employment is an evidence-based approach to obtaining and maintaining work for consumers with severe mental illness. It has been effectively utilized with ACT consumers. See introduction in Appendix I.

Formal training in “Supported Employment Implementation Resource Kit” is recommended for one or more team members. These concepts and skills are introduced in Appendix I of this workbook.

Appendix A

Sample Comprehensive Assessment - Mr. Jones

Client Name: Mr. Jones

Date of Evaluation: 09/30/99

Reason for admission (chief complaint) as stated by client, family and/or referring agency:

“The Sheriff’s Department injected me with germ warfare causing these sores.”

History of present illness:

Mr. Jones is a forty-eight year old, White male who was referred to the Smithville Assertive Community Treatment team (SACT) for after-care following his release from Smithville State Hospital due to his diagnosis of Schizophrenia, Paranoid type. He has significant functional impairments. He has a high use of acute psychiatric hospitalizations, persistent recurring symptoms, a coexisting substance use disorder, and a recent history of involvement with the criminal justice system.

Previous Smithville State Hospital records indicate that he was released from a maximum-security forensic unit (release date 8/27/99) after being found incompetent to stand trial for alleged felony assault. He was transferred to Smithville State Hospital for treatment and released on 09/29/99.

Mr. Jones was admitted to Smithville State Hospital Forensic Unit in July 1988 after facing charges of aggravated assault. Jones states that, while on the forensic unit, he made suicidal gestures, such as, slashing his neck with a razor blade due to auditory hallucinations. He reported attempting to commit suicide five or six times in jail by slicing his arms with sharp instruments, sticking pins into electrical outlets, overdosing on pills, jumping off things, and setting himself on fire.

The client’s first encounter with the legal system occurred in 1975, when he shot a friend in self-defense. After that time, he began to drink heavily and use street drugs. He served time in the Mississippi Department of Correction in 1976 for robbery and again in 1984 for aggravated assault. While in prison for aggravated assault, he was diagnosed with Schizophrenia and placed on Haldol and Sinequan. He reported a good response to Haldol and was described as quiet and cooperative. He is afraid of what might happen if he goes to prison again, and believes that the Mississippi syndicate has a contract out on him for \$10,000.

The Smithville Police Department records from 6/8/98 indicate that Jones was threatening to cut people with a knife at his apartment. He was found to have three outstanding warrants. Police noticed a strong odor of alcohol. Jones attacked the officers. He was not affected by pepper mace. After being handcuffed, Jones stated that the police were going to burn in a volcano and that he was going to light the fire.

Correctional Medical Services notes from August 1998 indicate Jones was treated with Haldol for Schizophrenia, but had been refusing medications. He is described as acutely “decompensated.” He constantly talks about Jesus and devils. He complains about vampires. He refused antibiotics for his impetigo.

A letter from Dr. Hidalgo (who saw Jones 10/98) describes Jones as “extremely labile and frequently quite hostile.” He was loud and demanding. He had improved after a recent hospitalization during which he received Haldol, but again decompensated. He was religiously preoccupied and delusional.

A court order from 11/9/98 indicates that a jury found him incompetent to stand trial and he was subsequently committed to Smithville State Hospital.

A report from Smithville County Jail indicates that Jones was treated with Haldol and Cogentin for paranoid schizophrenia that is complicated by “non-compliance.” The jail indicates that Jones is “very unpredictable and goes through mood swings. He exhibits paranoia and is delusional at times. He thinks that he is Christ and will accuse others of being the devil. He picks hair out of his head and beard and has little round areas of pink skin where he no longer has any hair. He can be aggressive and a couple of days ago, he tried to hit a nurse with his fist. He does not like to wear clothes.”

Service system records indicate numerous previous psychiatric hospitalizations, including five admissions to the State Hospital and fourteen to Morgan Medical Center. He has been offered outpatient treatment since 1992. Other past diagnosis includes Psychotic D/O, NOS; Organic Hallucinosi; Adjustment Disorder and Undifferentiated Schizophrenia.

He states “I was charged with murder in 1976, but all I did was pull the trigger.” He reports that he has AIDS (a delusion) and stomach viruses from drinking out of toilets. He has 19 past admissions but only four of them longer than two weeks. When asked about substance abuse, he states “I can’t get them enough.” He has numerous self-inflicted scars on his arms. He reports that he hears voices and is Jesus Christ. He believes that he has bugs crawling inside and outside of his body. He also believes that staff have tried to kill him in the past.

He is difficult to interview and gives rambling statements. He reports that he is a victim of a conspiracy involving Satan and the Smithville County Sheriff’s Department to infect him with germ warfare. He states that he hears voices of the devil and the Holy Spirit. He reports that this occurs all of the time and that he is not bothered by these experiences. He states that the voice says “stick ice picks in my eye and I’m going to eat you in the microwave.” When asked to elaborate on these symptoms, he became agitated, hostile, and threatening. He will not discuss any other psychotic symptoms. He denies any symptoms of depression but reports two previous suicide attempts by

cutting his forearm. He states that he has not been suicidal in many years. He denies any symptoms of mania, panic attacks, or memory impairment. Recently he reports that he is doing poorly, which he attributes to being infected with germ warfare.

Treatment goals and individual strengths as stated by the client:

Jones states that his goals are as follows:

- “Find a doctor that can get rid of these germs that the Smithville County Sheriff’s Department injected me with.”
- “Get me some money so that I don’t have to eat out of trash cans and sell drugs for food.”
- “I want to stay out of jail and the hospital because people are out to get me there. A man can’t live his whole life that way.”

Jones states that his strengths are as follows:

- “I know that I can survive on the streets because no one is going to mess with me.”
- “I’m a smart man.”
- “People like me.”

History of past mental/psychiatric illness:

Smithville County Jail (1975) Shot a friend in self-defense. Shortly thereafter, he began drinking heavily and using street drugs. His sister reports that Jones was “never quite right as a child and had lots of problems in school and at home.” She reports that he used to draw funny pictures on everything – “they looked evil.” She feels that his first divorce triggered an increase in ETOH use and led him to the situation where he was arrested after killing his friend. She states that he “went down hill from there.”

Department of Corrections (1976-1983) Convicted of armed robbery. Jones spent two months in the Skyview Unit (Psychiatric Unit) and received the diagnosis of Psychotic D/O, NOS during this incarceration. Reports indicate that he would be fighting with “spirits” and was saying that the “devil was coming to get him.” Doctors tried him on Thorazine, which helped to clear up the hallucinations but he experienced a reaction to the medication and was transferred to the medical unit. Reports indicate that he was not restarted on another antipsychotic following this episode.

During his time in the community, Jones married again and later divorced. He says that his ex-wife just did not understand him and refused to believe that the “devil would kill them one day.” He stated that they would stay barricaded for days in their apartment to stay safe. He feels that this led to their divorce.

Department of Corrections (1984-1988) Convicted of aggravated assault. First diagnosed as having schizophrenia. Reports indicate that Jones had a serious suicide attempt while incarcerated. He was being tormented by voices, which he believed to be the devil telling him that the Mississippi

syndicate was coming to cut off both his hands and gouge out his eyes. He self inflicted deep cuts across his jugular veins. He was treated with Haldol and Sinequan. This reportedly helped to alleviate some of the symptoms and decreased the aggressive acts.

Smithville State Hospital (4/14/88-7/1/88) Charged with aggravated assault and unauthorized use of a motor vehicle. During his stay, he received Haldol-D injections, Ativan, and Cogentin. The forensic psychiatrist felt that he was not actively psychotic at the time of the aggravated assault and that he was able to understand court proceedings. He was discharged as competent to stand trial and then convicted of both charges and incarcerated. Jones reports that he was high on "crack" cocaine at the time of the murder and that the scene was related to a drug deal.

Department of Corrections (7/2/88-2/1/92) During this period, Jones was incarcerated at the Skyward Psychiatric facility. It is reported that he exhibited "fixed" delusions the entire time he was there, related to the devil trying to kill him. His hallucinations decrease with an "adequate" dose of Haldol-D. His aggressive behaviors decreased as well although he continued to be confrontational with staff as well as other inmates. Staff reports that he suffered several injuries related to retaliation from inmates. He did not actively participate in Substance Abuse Treatment and continued to deny problems in this area.

Mireston County MHMR (2/7/92-11/1/93) It is reported that Jones showed up for one after-care appointment, received an injection and did not show up for any other appointments.

Mireston County Jail (1993) Felony assault of a police officer. Jones reportedly resisted arrest when being questioned in a "drug-related" situation. The report indicates that he was verbally aggressive stating "that the devil would not receive him tonight and that the police would die for helping the devil." He reportedly caused extensive injury to one officer requiring several days of hospitalization (i.e. a broken wrist and bruising to the face). Charges were dropped and he was released.

Hospitalizations 11/4/93-5/24/98:

Morgan Medical Center (11/4/93-11/19/93)

Morgan Medical Center (11/26/93-12/5/93)

Morgan Medical Center (2/4/94-2/15/94)

Morgan Medical Center (8/20/94-8/29/94)

Morgan Medical Center (11/1/94-11/5/94)

Morgan Medical Center (1/12/95-5/4/95)

Morgan Medical Center (6/28/95-7/6/95)

Morgan Medical Center (8/21/95-8/28/95)

Smithville State Hospital (8/28/95-9/8/95)

Morgan Medical Center (3/1/96-3/5/96)

Morgan Medical Center (7/19/96-7/30/96)

Smithville State Hospital (10/4/96-12/1/96)

Smithville State Hospital (12/13/96-2/8/97)

Morgan Medical Center (5/17/98-5/24/98)

In the review of the hospitalizations at Morgan Medical Center and Smithville State Hospital listed above, a significant pattern is noted. Symptoms include Jones verbalizing that, "Vampires from England attack him and he believes he is Jesus." He is irritable and threatening and believes that Morgan Medical Center barbeques people. Medications that were tried were Zyprexa, Risperdol, Seroquel, and Haldol. It appears that when he was released, there was never any follow-up and housing was an on-going issue. Notes from the hospital indicate repeatedly that he was "non-compliant" with his medications and follow-up. In speaking with the Salvation Army, it was reported that Jones was released to their charity but could only spend three days at a time there per their policy/procedure. The Smithville County Sheriff's Department reports many "criminal trespass" arrests during this time as well.

It appears that Jones's symptoms are never adequately treated and that trials on the new-generation antipsychotics are short with no supervision upon release from the hospital. In assessing Jones, due to his symptomatology, he is not organized enough to take his oral medications independently or meet his basic needs. His survival techniques included rotating through the hospital, jail, and temporary shelters. His interactions with others were apparently threatening, entitled, and frustrating.

Smithville County Jail (6/8/98-11/19/98) While in jail, he was prescribed Haldol-D and oral plus cogentin. He refused the injection. It was reported by staff that he was "arrogant, and believing the devil is in him."

Smithville State Hospital (11/20/98-8/27/99) Committed to Maximum Security Unit after being found incompetent to stand trial for the alleged offense of Assault Causing Bodily Injury/Assault to a Public Servant. It was reported that Jones continued throughout his hospitalization to maintain psychotic symptoms with delusions and hallucinations. He was also described as easily agitated, impulsive, potentially explosive, and unpredictable. He was described as treatment resistant. It was recommended to the court that he would not likely become competent within the near future. His medications included Gabapentin 900mg bid; Ativan 1mg bid; and Risperidone 5mg bid.

Smithville State Hospital (8/27/99-9/29/99) Transferred from Smithville State Hospital after the felony charges were dropped for further treatment. Reports indicate that Jones was aggressive and easily agitated towards staff. He was verbally loud and escalated easily. He was also engaging in self-talk and laughter significant for auditory hallucinations.

Mental Status Exam:

The patient was lucid, oriented, coherent, and alert. He was groomed casually and appropriately with good hygiene. His hair and beard were appropriately trimmed. His mood was labile. Initially his mood was mildly elevated, but he was accommodating and patronizing. However, he showed ease of agitation without apparent provocation, especially when upset. He was easily frustrated. During the interview he became angry and this escalated to cursing with loud, shouting speech. At the end of the interview, he stalked angrily out of the room, cursing as he went and slammed the door. His speech was loud, rapid, continuous, and pressured. He acted demanding, irrational, and was easily confused. His thought processes were disorganized and he could not be engaged in meaningful or substantive conversation in areas related to his mental illness or his offenses. He was preoccupied with his delusional thoughts. These delusions included religious, satanic, and paranoid themes. For example, he said "Satan attacked me in jail and said he was going to stick an ice pick in my eyes and cut me with a chainsaw. He made me cut my jugular vein... I hear the Holy Spirit. Once it's in you, it stays with you... I'm not going to talk about hearing the angels. I know not to... This is a conspiracy." Jones admitted to racing thoughts. He was paranoid, explosive, and unpredictable. He was not threatening to self, and not felt to be suicidal. He was hallucinatory, and admitted to hearing angels. His memory was difficult to assess due to his active psychosis. His eye contact was fair. His psychomotor activity was increased with his agitation. He said, "Taking them pills or not taking them pills, I feel the same way."

Diagnosis (SCID completed):

Axis I: 295.30 Schizophrenia Paranoid Type Polysubstance Dependence
Axis II: 301.7 Antisocial Personality Disorder with Borderline features
Axis III History of Exposure to Hepatitis A, B, and C, as validated by laboratory studies
Esophageal Reflux
Non-Tuberculosis Mycobacterium
Axis IV A, B, C, E, H, I
Axis V 30

Recommendations for Treatment Plan:

The overall psychiatric rehabilitation goal is for Jones to function more independently in the community and cope more effectively with stressors without resorting to the use of chemical substances that will cause him to have further conflicts with the law.

It is recommended that Jones see the ACT psychiatrist a minimum of every month to monitor symptoms, side effects, and medications. Psychoeducation will be provided by his primary advo-

cate on a weekly basis during med training in order to enable Jones to communicate the need for medication changes. Medications will be monitored daily with continuous monitoring of suicidal/homicidal ideation. Collaboration with the local law enforcement agencies to ensure the safety of the community and staff is maintained. Assertive attempts will be made to change the pattern of hospitalizations/jail/homelessness and to treat symptoms with a new-generation antipsychotic medication.

PART 2: PHYSICAL HEALTH

Current Doctor: Mississippi Family Practice, Smithville

Past Medical History:

Records show that he has no major health problems. History of exposure to Hepatitis A, B, and C, as validated by laboratory studies; esophageal reflux; non-Tuberculosis Mycobacterium

Surgical History:

Records show he has no previous surgery.

Substance Abuse History:

The patient reports past use of cocaine, marijuana, LSD, alcohol, and other sedatives.

Other Significant Social Factors:

Sexual: Heterosexual

Current Medications:

Haldol and Cogentin

Allergies:

None

Family History:

He denies knowledge of any major health problems with family members. Contact with family should be made to verify. He reports that both his mother and father have died and that he has nine sisters who refuse to have contact with him. He states that he has three children but does not know where they are living.

Height: 6'2" Weight: 155 Blood Pressure: 120/70

Significant Occupational Exposure:

None

Travel History:

US only

Prosthetic Devices:

None

Review of Systems:

Special Senses: Vision, hearing, taste, and smell are preserved.

Neuromuscular: Denies any history of head concussion, seizure disorder, or paralysis.

Cardiorespiratory: denies any history of chest pain, cardiac arrhythmia, palpitations, bronchitis or pneumonia.

Gastrointestinal: Denies any history of dysphagia, peptic ulcer disease, hematemesis, or melena. Does report a history of esophogial reflux.

Genitourinary: Denies any history of kidney stones or kidney infection.

Gynecologic/Menstrual: N/A

Endocrine: Denies any history of diabetes.

Fractures: Denies any history of fractures.

At physical examination, this patient is alert, active, somewhat cooperative, delusional.

Appearance and Nutrition: He appears to be malnourished and underweight.

Skin: There are multiple sores on face, neck, and extremities, which are self-inflicted traumatic sores; there is a tattoo on right arm; there is no evidence of major scars.

Head: Normalcephalic; face is symmetrical; scalp is normal except for some sores that are also self-inflicted

Eyes: Conjunctivae are pink; scerae are white; pupils are equal, round, they react to light and accommodation; there is no ptosis; there is no nystagmus; the extrocular movements are normal; vision is 20/20 both eyes without glasses.

Ears: External ear canals are clean, tympanic membranes are normal; able to hear conversational voices and the vibrating fork.

Nose: In the midline; no obstruction.

Mouth: Oral mucosa is moist, throat is clear

Neck: No enlarged thyroid; no vein engorgement; no palpable lymph nodes; range of motion of the C-spine is normal.

Chest: Lungs are clear.

Breasts: No masses felt.

Heart: Regular.

Vascular system: In upper and lower extremities, all pulses are present; there is no evidence of varicose veins.

Lymphatic system: There is no evidence of lymphedema or enlarged lymph nodes in groin, axillae or supraclavicular areas.

Abdomen: Soft; nontender; no masses felt.

Genitalia: Of a male.

Anus/rectum: The patient declined to be checked.

Pelvic: not applicable.

Trunk and extremities: Range of motion of all joints in upper and lower extremities is normal.

Neurological exam: Alert and oriented; uncooperative and delusional.

Cranial Nerves: Pupils are equal, round, they react to light and accommodation; there is no ptosis; there is no nystagmus; the extraocular movements are normal; facial muscles are symmetrical without weakness; tongue is in the midline with normal movement and the deglutition mechanism is preserved.

Motor system: In upper and lower extremities, good muscle strength and development; fine and gross manipulation and grip strength are normal; gait in terms of speed, stability, and safety is normal.

Sensory system: Vibration, pain and temperature can be felt.

Cerebellar: Finger to nose and tandem gait are normal; Romberg is negative. Reflexes in upper and lower extremities are brisk and symmetrical; no abnormal reflexes found.

Personal Routine:

Oral Hygiene: Jones reports that he brushes his teeth when he has a toothbrush and toothpaste. His transitory history has affected this area.

Shampoo/Bathing: Jones reports that when he has access to facilities, he enjoys being clean and bathes daily.

Sleep: "I don't keep track of time except when the sun rises and the sun sets."

Sexual: Jones reports that he is currently sexually active and prefers "many different" women. He states that he uses a condom each time because he reports that he is HIV positive. (Tests do not confirm this.) He reports that "he learned his lesson" when he had Chlamydia and "practices safe sex

now." He denies a history of sexual abuse.

Substance Use: Jones reports that he smokes at least a pack of cigarettes a day and more if he can get them. He reports that he has smoked since he was fourteen and has no complaints of shortness of breath or persistent cough. He states that he drinks 1-2 caffeinated drinks. He states that he drinks alcohol on a daily basis if available and prefers beer. He reports that he enjoys using marijuana and "crack" cocaine and will use it daily if he can access it. He feels that he needs the alcohol and drugs to survive but states he "can cut down when he needs to."

Recommendations:

On-going monitoring

Follow-up with MMB in re: Esophageal Reflux, Non-TB Mycobacterium, and sores on head/face.

Dental Appointment

PART 3- USE OF DRUGS OR ALCOHOL

(SCID Completed)

Records and self-report indicate an extensive history of Substance Abuse involving the following:

Alcohol: Jones reports that he uses this substance daily if it is available. He has used within the past 48 hours. Use began at the age of 12.

Heroin: Jones reports that following the shooting of his friend in 1975 that he tried Heroin several times. He has not used this substance since that time.

Sedatives: Jones reports that he has used Dalmane and Seconal after doctors at SMITHVILLE STATE HOSPITAL prescribed it for him. He states that he did not like the effects but that they had a "high street value."

Tranquilizers: He reports using Ativan, Valium, and Xanax. Again he reports that he did not like the effects but that these drugs he was able to sell on the streets.

Amphetamines: He reports using prescribed Cylert.

Cocaine: Jones reports he would use "crack" cocaine on a daily basis if it were available. He began using this drug in 1988 and has used this consistently when in the community and even times when he has been incarcerated. He reports he has snorted, smoked, and injected. This is his drug of choice.

Hallucinogens: Jones reports that he has used LSD, PCP, and MDMA. He has not used these since he has been incarcerated. He stated that he enjoyed the "Ecstasy" and would use this drug again if it were offered to him.

Marijuana: Jones reports that he has used this in the past 48 hours. He states that he started using this drug when he was 12. He states that it was readily available because other family members used it.

Withdrawal Symptoms: Jones reports that he has experienced flu-like symptoms, gets sick to his stomach, gets confused and possibly experiences visual and tactile hallucinations when forced to quit using the substances of his choice.

Use Patterns: Jones reports that he usually uses in the morning with others when he is tense or scared. He feels that he has to use more than he used to and has been unable to hold a job because of his use. ("No one will hire a user.") He knows that even though use causes his symptoms to increase, he wants to continue to use because that is all he knows. He knows that if he is using daily, he is not able to function as he should but that it helps him to forget and it stops the voices of the devil. He states that he will not be killed if he does not hear them (the voices).

Problems Related to Substance Use and Level of Impairment:

Physical-Jones has received a doctor's warning more than once to quit using substances.

Cognitive-Jones reports experiencing blackouts, memory problems, and confusion due to use.

Affective-No reports of depression following use but reports do indicate an increase in "manic" type symptoms.

Tolerance-An increased dose is required to get the desired effect.

Felt need-Jones reports a strong desire to use to feel "normal."

Interpersonal problems-He knows that many relationships have focused around use and who has access to the drugs. He reports that he has never had a relationship with someone who did not need to trade something for drugs. He acknowledges that when he has committed all of his alleged crimes, he either has been "drug-seeking" or has owed someone.

Aggression-he becomes homicidal when using and experiencing acute symptoms.

Vocational-Has not worked since he was 23.

Legal-Multiple arrests related to use.

Financial-"Most of my money is spent paying back people that I owe."

Treatment and Abstinence History: Jones reports that he has never been treated for alcohol or drug addiction and is only abstinent when he is incarcerated or in the hospital.

Family Substance Abuse Assessment: Jones's sister reports that many of his sisters have suffered severe consequences due to substance use including incarceration, interpersonal problems. She also reports that Jones' father was 'drunk' all the time

Motivation/Confidence Rating: Due to the severity of dependence and lifestyle/familial pattern, Jones is not motivated to quit using at this time but is able to verbalize the impact that the use has on his illness.

His history shows repeated disturbances of functioning seemingly precipitated by relatively small amounts of alcohol or drug use.

Assessment Summary: Jones meets the diagnostic criteria for Polysubstance Dependence. Even though he has experienced extreme consequences due to his use, this has had little impact. This is a learned behavioral pattern of dealing with stressors and has been modeled by family members as a coping strategy.

It is recommended that staff work with Jones on developing coping strategies to deal with his stressors/symptoms and to work on environmental changes. It will be of the utmost importance to develop a non-judgmental therapeutic relationship with Jones to help him make better choices.

PART 4: EDUCATION AND EMPLOYMENT

Current Daily Structure: Jones reports that he usually spends his day wandering the streets. When he is incarcerated, "my day is planned for me." He states that he has a hard time doing things because "People are watching me and the devil will come for me if I am out too long."

Education History: Jones graduated from Ball High School in Smithville. He states that he does not have many memories from school. He states that he did not have many friends and struggled in school. People thought I "was weird." His sister reports bizarre behavior and that he was always drawing evil pictures. She reports that classmates were scared of him because of his constant talk about "the dark side."

Jones is able to read and write but states that he finds it difficult to concentrate to complete something.

Military History: He is a non-veteran.

Employment History: Jones reports that the only job that he has ever worked was construction. The last time that he worked was in 1975.

Recommendations: Jones states that he does not want to work at this time. Staff needs to identify his interests and work with him on "adult role functioning" that is not related to drug use.

PART 5: SOCIAL DEVELOPMENT AND FUNCTIONING

Jones and his sister report that he was born and raised in Mudville, Mississippi. He has nine siblings all of whom are sisters. He is in the middle of the birth order. He feels that he was left to "raise

himself." He states that his dad was "drunk" all the time and that his mother would cry. He stated that his father was in jail several times and that his mother had to live on welfare. He states that his father beat his mother and the children. He states that he does not have any good memories from childhood and that he never had any friends. He graduated from Mudville High School. He states that he liked being alone except when he needed to "satisfy his manly urges." He states that he and his friends drank beer and smoked pot on a regular basis. That was the only thing we had to do.

He states that the only friends he has now are people who owe him. He feels it is not "worth it" to be in a relationship. He has been married two times and divorced. His first wife divorced him after he was caught messing around on her and beating her because she was possessed by the devil. His second wife divorced him, he feels, because she would not believe him when he told her the devil would kill them and would barricade them in the apartment for days at a time. He has three children with whom he has no contact.

Culture and Religious Beliefs: Both of Jones's parents are of African-American descent. When he is asked where he was raised, he states that he was raised overseas. (His sister reports that this is inaccurate.) Jones reports that he is discriminated against by the "white" people and that the KKK is out to get him and that the Mississippi syndicate will track him down and kill him. When asked about religion, he stated that he is Jesus Christ and verbalized how the angels and devils are beneath him when he is all-powerful. Many of his delusional thoughts are fixated around his belief that he is persecuted because of his race and the belief that he is Jesus.

Leisure Activities: Jones reports that it is difficult for him to concentrate for long periods so he spends his time walking. He states that he does not watch TV because that is "the way that they gather information on you." He reports that he will go to a bar to "find him a woman."

Social Skills: Jones feels that if you behave in a threatening manner, you will get what you want. He reports that he gets into fights all the time and the police are always called to handle things. He states that people "piss him off" all the time and that he really does not like anyone. He has multiple arrests related to his aggressive responses.

Legal Involvement: See Part 1 of this assessment

Recommendations: Due to the majority of his adult life being spent in institutions, extreme paranoia, and his delusional thought processes, Jones does not have the skills to function/interact independently in a community in a successful manner. Staff will need to help him develop coping strategies in-vivo. Due to the negative symptoms related to his illness, Jones is not able to identify "healthy" leisure choices. Staff will help him to identify interests and then help him pursue these choices during weekly 1:1.

Living Arrangements: Jones is currently homeless. He states that he wants to live by himself in Smithville. He reports that when he is not in the hospital or in jail, he has lived on the streets or has gotten “dive” apartments, staying no longer than a month before being evicted. Prior landlords report that evictions occur due to “aggressive” threats to other tenants, poor upkeep of the apartment, and alleged drug trafficking.

Eating Habits/Food Preparation: Due to his extensive history institutionalization, Jones has not been required to prepare his own meals. When he has been homeless, he reports that he will eat whatever he can get. He would like to eat three meals a day with “lots of meat.” He states that he is not able to cook well but can make things like sandwiches and that he can bar-b-que. He feels that he will need assistance in learning these skills. It has been noted that he has been able to trade food items for beer and drugs.

Grocery Shopping: During contacts at the store, Jones is unable to complete the task due to his paranoia and unable to prepare a list due to his disorganized thoughts.

Diet and Exercise: He has a history of being malnourished due to lack of access to nutritional foods and due to his beliefs that food is poisoned and then not eating. Treatment of paranoid symptoms and monitoring of his eating habits and weight will be of the utmost importance.

Grooming: Jones reports that he wants to take daily bathes. He states that he has to take them frequently at times “because there are bugs crawling out of my skin and I have to get them off.” He has infected sores on his skin due to continuous picking at his scalp and face. He requires verbal prompting to remember to use all the grooming items such as shampoo and soap.

Laundry: Jones does not know how to use the laundromat facilities and needs physical prompts and reminders to complete the task. He does not like to spend his money doing laundry. He is limited in his clothing and staff will need to assist him in purchasing new clothes.

Money Management: Jones’s current monthly income is his SSI check of \$509. In the past, when he has received the check himself, he would spend the entire amount in one week primarily on drugs and then present himself in the ER for admission to the psychiatric unit. His payee will now be Guardians Are Us to ensure that his check is spent on his basic needs. He will complete a monthly budget with staff assistance.

Housing: Jones will be responsible for housekeeping tasks where he lives. He reports that he has a hard time keeping places clean because he cannot organize well. He states that he cannot get motivated and at least he is not living in a dumpster.

Recommendations: Due to the severity of Jones's symptoms (i.e. paranoia, avolition, poor concentration) and extensive time spent in an institutional setting, he will require extensive support in all areas of ADLs. Jones reports that he would like to stay in one apartment for six months without being evicted. He feels that he will need daily supports to do this in the areas of housekeeping, money management, and apartment maintenance. He also will require on-going monitoring of his diet to assure that he is eating properly.

Appendix B

Sample Treatment Plan

ACT Treatment Plan

Name: Mr. Jones

SSN: 123-45-67	Tx Plan Date: 1/0/21/99	Review Date: 4/21/00
Primary Treatment Team: Sally Shue, MA (IS) Fred Fowler (Substance Abuse Specialist) Jane Johnston (Employment Specialist) Nancy Norton, RN Mike Mathews, MD	Discharge Criterion: 1. No significant major psychotic or affective symptoms for two years, and 2. No major role dysfunction in areas of work, socialization, and self-care for one year under conditions of minimal treatment.	
DSM IV Diagnoses	Axis I / Axis IV	
Axis I 295.30 Schizophrenia, Paranoid Type 304.80 Polysubstance Dependence	Psychosocial Stressors: Rejection by family Inadequate social support Unemployed Inadequate housing/unsafe neighborhood Multiple arrests/convictions Hostile relationships w/others	
Axis II 301.7 Antisocial Personality Disorder w/Borderline Features	Severity: 3 - Moderate	
Axis III History of exposure to Hepatitis A, B, & C as validated by laboratory studies; Esophageal reflux Non-tuberculosis mycobacterium	Axis V Current GAF: 30 Highest GAF past year: 30	
Strengths 1. Survival skills developed while living on the streets 2. High school diploma 3. Desire for more stability in his life 4. Engaging personality		

<p>Focus Area #1</p> <p>Jones experiences:</p> <ol style="list-style-type: none"> (1) persistent delusional thoughts of a religious, satanic, and paranoid theme (i.e., "The Smithville Co. Sheriff's Department injected me with germ warfare." "The devil is trying to kill me") (2) persistent auditory hallucinations (Satan or the Holy Spirit are talking to him) which, at times, command him to harm others or himself - Mr. Jones has a history of suicide attempts and two felony arrests for murder; (3) periods of unpredictable agitation, leading to cursing with loud shouting speech and implicit threats to others; (4) when acute, hallucinations and delusions increase with an increase in impulsive acts (often leading to misdemeanor arrests); (5) symptoms become worse with the use of alcohol and illegal substances. 	<p>Goal Trial of new generation medication (Risperdal) to better control psychiatric symptoms while minimizing side-effects. Mr. Jones will take medications consistently as prescribed to allow for an adequate trial or communicate a need for a change 90% of the time through 10/00 as measured by staff observation and document in progress notes.</p> <p>Goal - Through 4/00, Mr. Jones will have no incidents of unplanned hospitalization as measured by staff, community, and crisis report.</p>
<p>Plan</p> <ol style="list-style-type: none"> (1) Mike Mathews, M.D. to see q 4-6 weeks for medication prescriptions, Sx assessment, and supportive therapies. (2) Daily 1:1 with Integration Specialist (IS) for symptom assessment, medication education (3) Weekly 1:1 with IS, for psychoeducation, Sx assessment, and development of coping strategies (e.g., anger management, environmental issues) (3) ACT team to be available 24/7 for crisis response and support services.. 	<p>Goal - Through 10/00, Mr. Jones will have no arrests or physical altercations as measured by self, staff, community and police reports.</p>
<p>Focus Area #2</p> <p>History of involvement with the criminal justice system including three felony convictions, multiple arrests, and hospitalizations</p>	<p>Goal - Through 10/00, Mr. Jones will revisit his timeline on a monthly basis during 1:1 to identify pattern and develop pre-crisis copin strategies as monitored by staff report.</p>
<p>Plan</p> <ol style="list-style-type: none"> (1) IS, to meet monthly with Mr. Jones for 1:1 on the relationship between his mental health and behaviors and involvement in the criminal justice system and develop coping strategies. (2) IS, and Substance Abuse specialist to interact with law enforcement officials to provide education about MI and function as liaison, PRN 	<p>Goal - Mr. Jones will understand the connection between substance use, increase in psychiatric symptoms, and arrest as evidenced by being able to verbalize the relationship to staff on three of more different occasions prior to 4/00.</p>
<p>Focus Area #3</p> <p>Extensive history of substance abuse which contributes to an increase in psychotic symptoms and possible suicidal/homicidal risk (see Need Area #1). History of burglaries to obtain money to purchase substances (see Need Area #2). Predominantly ETOH and "crack" cocaine use, but inclusive of LSD, PCP, MDMA, marijuana, amphetamines, tranquilizers, and sedatives. Most recent use was ETOH and "crack" cocaine. Substances are often used to "drown out the voices so I don't have to hurt anyone."</p>	<p>Goal - Mr. Jones will understand the dangers of combining alcohol and other illegal substances with his prescribed psychiatric medications as evidenced by being able to verbalize the dangers on three or more different occasions prior to 4/00.</p>
<p>Plan</p> <ol style="list-style-type: none"> (1) 1:1 motivational interview 3 x week - Substance Abuse Specialist (2) Weekly dual-diagnosis group at ACT program office – Substance Abuse Specialist 	<p>Goal - By 1/00, Mr. Jones will identify one or more factors he personally views as benefits from reducing or eliminating the use of alcohol or other substances.</p>

<p>Focus Area #4 Inability to conduct activities of daily living without consistent prompts and assists (i.e., living arrangements, money management, nutrition, housekeeping and grooming/hygiene) as directly related to Focus Area #1 symptomatology including paranoia, impulsive agitation, and poor interpersonal social skills</p>	<p>Goal - Mr. Jones will maintain his residence in a safe environment for three consecutive months by 10/00 as monitored by self, staff, and apartment manager.</p>
<p>Plan (1) IS and Substance abuse specialist to work with Mr. Jones on locating affordable safe housing. (2) Weekly 1:1 with IS for apartment maintenance monitoring. Based on need, interaction by staff will be titrated from side-by-side assistance to verbal prompts) (3) IS to meet monthly with Mr. Jones to review budget and to liaison with his payee on PRN basis. (4) Weekly monitoring of food supply/trips to grocery store and education about nutrition.</p>	<p>Goal - Mr. Jones will complete and adhere to a monthly budget to ensure that his basic needs are met for 6 months without need for supplementation as monitored by self, staff report, and payee report by 10/00.</p>
<p>Focus Area #5 Care and management of medical and dental needs is complicated by Mr. Jones' difficulties to recognize the need for intervention and to follow through with medical recommendations due to Focus Area #1.</p>	<p>Goal - F/U re: esophageal reflux, non-TB mycobacterium, and sores on head/face</p>
<p>Plan (1) Nurse to schedule dental appointment and accompany Mr. Jones. (2) Nurse to schedule appointment with MFP to address medical needs.</p>	<p>Goal - dental appointment</p>
<p>Goal - ongoing monitoring</p>	

Appendix C

Dartmouth Assertive Community Treatment Scale

Source: Bond, G.R., Drake, R.E., Mueser, K.T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness. *Disease Management & Health Outcomes*, 9: 141-159.

Dartmouth Assertive Community Treatment Scale

Part 1. Human Resources, Structure & Composition

CRITERION		RATINGS / ANCHORS					SCORE 1 thru 5
H1	SMALL CASELOAD: client/provider ratio of 10:1.	50 clients/clinician or more.	35 - 49	21 - 34	10 clients/clinician or fewer	11 - 20	
H2	TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.	Fewer than 10% clients with multiple staff contacts in reporting week. Program service-planning for each client usually occurs once/month or less frequently.	10 - 36%.	37 - 63%.	90% or more clients show contact with > 1 staff member in 1 week.	64 - 89%.	
H3	PROGRAM MEETING: Program meets frequently to plan and review services for each client.	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.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.	At least twice/week but less often than 4 times/week.	
H4	PRACTICING TEAM LEADER: Supervisor of front line clinicians 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 provides services at least 50% time.	Supervisor normally provides services between 25% and 50% time.	
H5	CONTINUITY OF STAFFING: program maintains same staffing over time.	Greater than 80% turnover in 2 years.	60-80% turnover in 2 years.	40-59% turnover in 2 years.	Less than 20% turnover in 2 years.	20-39% turnover in 2 years.	
H6	STAFF CAPACITY: Program operates at full staffing.	Program has operated at less than 50% of staffing in past 12 months.	50-64%	65-79%	Program has operated at 95% or more of full staffing in past 12 months.	80-94%	
H7	PSYCHIATRIST ON STAFF: there is at least one full-time psychiatrist per 100 clients assigned to work with the program.	Program for 100 clients has less than .10 FTE regular psychiatrist.	.10-.39 FTE per 100 clients.	.40-.69 FTE per 100 clients.	At least one full-time psychiatrist is assigned directly to a 100-client program.	.70-.99 FTE per 100 clients.	
H8	NURSE ON STAFF: there are at least two full-time nurses assigned to work with a 100-client program.	Program for 100 clients has less than .20 FTE regular nurse.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	Two full-time nurses or more are members of a 100-client program.	1.40-1.99 FTE per 100 clients.	
H9	SUBSTANCE ABUSE SPECIALIST ON STAFF: a 100-client program includes at least two staff members with 1 year of training or clinical experience in substance abuse treatment.	Program has less than .20 FTE S/A expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	Two FTEs or more with 1 year S/A training or supervised S/A experience.	1.40-1.99 FTE per 100 clients.	
H10	VOCATIONAL SPECIALIST ON STAFF: the program includes at least one staff member with =1 year training/experience in vocational rehabilitation and support.	Program has less than .20 FTE vocational expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	Two FTEs or more with 1 year voc. rehab. training or supervised VR experience.	1.40-1.99 FTE per 100 clients.	
H11	PROGRAM SIZE: program is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage.	Program has fewer than 2.5 FTE staff.	2.5 - 4.9 FTE	5.0 - 7.4 FTE	Program has at least 10 FTE staff.	7.5 - 9.9	

Part 2. Organizational Boundaries

CRITERION	RATINGS / ANCHORS					SCORE 1 thru 5
O1 EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Program has no set criteria and takes all types of cases as determined outside the program.	Program has a generally defined admission process is dominated by organizational convenience.	The program makes an effort to seek and select a defined set of clients but accepts most referrals.	The program actively recruits a defined population and all cases comply with explicit admission criteria.	Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	
O2 INTAKE RATE: Program takes clients in at a low rate to maintain a stable service environment.	Highest monthly intake rate in the last 6 months = greater than 15 clients/month.	13 - 15	10 - 12	Highest monthly intake rate in the last 6 months no greater than 6 clients/month.	7 - 9	
O3 FULL RESPONSIBILITY FOR TREATMENT SERVICES: in addition to case management and psychiatric services, program directly provides counseling / psychotherapy, housing support, substance abuse treatment, employment, and rehabilitative services.	Program provides no more than case management and psychiatric services.	Program provides one of five additional services and refers externally for others.	Program provides two of five additional services and refers externally for others.	Program provides all five of these services to clients.	Program provides three or four of five additional services and refers externally for others.	
O4 RESPONSIBILITY FOR CRISIS SERVICES: program has 24-hour responsibility for covering psychiatric crises.	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for program clients.	Program is available by telephone, predominantly in consulting role.	Program provides 24-hour coverage.	Program provides emergency service backup: e.g., program is called, makes decision about need for direct program involvement.	
O5 RESPONSIBILITY FOR HOSPITAL ADMISSIONS: program is involved in hospital admissions.	Program has no involvement in fewer than 5% decisions to hospitalize.	5 - 34% of admissions are initiated through the program.	35 - 64% of admissions are initiated through the program.	95% or more admissions are initiated through the program.	65 - 94% of admissions are initiated through the program.	
O6 RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: program is involved in planning for hospital discharges.	Program has involvement in fewer than 5% of hospital discharges.	5 - 34% of program client discharges are done in cooperation with the program.	35 - 64% of program client discharges are done in cooperation with the program.	95% or more discharges are planned jointly with the program	65 - 94% of program client discharges are done in cooperation with the program.	
O7 TIME-UNLIMITED SERVICES: Program never closes cases but remains the point of contact for all clients as needed.	More than 90% of clients are expected to be discharged within 1 year.	From 38-90% of clients are expected to be discharged within 1 year.	From 18-37% of clients are expected to be discharged within 1 year.	All clients are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.	From 5-17% of clients are expected to be discharged within 1 year.	

Part 3. Nature of Services

CRITERION	RATINGS / ANCHORS					SCORE 1 thru 5
	Less than 20% time in community.	20 - 39%.	40 - 59%.	60 - 79%.	80% of total service time in community	
S1 IN-VIVO SERVICES: program works to monitor status, develop community living skills in vivo rather than in office.	Less than 20% time in community.	20 - 39%.	40 - 59%.	60 - 79%.	80% of total service time in community	60 - 79%.
S2 NO DROPOUT POLICY: program engages and retains clients at mutually satisfactory level.	Less than 50% of the caseload is retained over a 12-month period.	50- 64%.	65 - 79%.	80 - 94%.	95% or more of caseload is retained over a 12-month period.	80 - 94%.
S3 ASSERTIVE ENGAGEMENT MECHANISMS: as part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g., representative payees, probation/parole, OP commitment) as indicated.	Program passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms.	Program makes initial attempts to engage but generally focuses efforts on most motivated clients.	Program attempts outreach and uses legal mechanisms only as convenient.	Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.	Program usually has plan for engagement and uses most of the mechanisms that are available.	
S4 INTENSITY OF SERVICE: high total amount of service time as needed.	Average of less than 15 min/week or less per client.	15 - 49 minutes / week.	50 - 84 minutes / week.	Average of 2 hours/ week or more per client.	85 - 119 minutes / week.	
S5 FREQUENCY OF CONTACT: high number of service contacts as needed.	Average of less than 1 contact / week or fewer per client.	1 - 2 / week.	2 - 3 / week.	Average of 4 or more contacts / week per client.	3 - 4 / week.	
S6 WORK WITH SUPPORT SYSTEM: with or without client present, program provides support and skills for client's support network: family, landlords, employers.	Less than .5 contact per month per client with support system.	.5-1 contact per month per client with support system in the community.	1-2 contact per month per client with support system in the community.	Four or more contacts per month per client with support system in the community.	2-3 contacts per months per client with support system in the community.	
S7 INDIVIDUALIZED SUBSTANCE ABUSE TREATMENT: one or more members of the program provide direct treatment and substance abuse treatment for clients with substance use disorders.	Clients with substance use disorders average fewer than 3 minutes / week in substance abuse treatment.	From 3 to 9 minutes / week.	From 10 to 16 minutes / week.	Clients with substance use disorders spend 24 minutes / week or more in substance abuse treatment.	From 17 to 23 minutes / week.	
S8 DUAL DISORDER TREATMENT GROUPS: program uses group modalities as a treatment strategy for people with substance use disorders.	Fewer than 5% of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.	5 - 19%	20 - 34%	50% or more of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.	35 - 49%	
S9 DUAL DISORDERS (DD) MODEL: program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	Program fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Program uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for persuasion of clients in denial or who don't fit AA.	Program uses mixed model: e.g., DD principles in treatment plans; refers clients to persuasion groups; uses hospitalization for rehab.; refers to AA, NA.	Program fully based in DD treatment principles, with treatment provided by program staff.	Program uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; no hospitalization for rehab. nor detox except for medical necessity; refers out some s/a treatment.	
S10 ROLE OF CONSUMERS ON TREATMENT TEAM: Consumers are involved as members of the team providing direct services.	Consumers have no involvement in service provision in relation to the program.	Consumer(s) fill consumer-specific service roles with respect to program (e.g., self-help).	Consumer(s) formally assist in provision of direct services (e.g., co-lead groups).	Consumer(s) are employed as clinicians (e.g., case managers) with full professional status.	Consumer(s) work in case management roles with reduced responsibility.	

Appendix D

Medication Management Approaches in Psychiatry Implementation Resource Kit Pamphlet:

Information for Practitioners and Clinical Supervisors

(Draft Evaluation Edition)

Medication Management Approaches in Psychiatry

Implementation Resource Kit



DRAFT VERSION

2003

Information for Practitioners and Clinical Supervisors

Medications are a part of recovery for most people diagnosed with severe mental illnesses. This brochure contains information about the Evidence-Based Practice (EBP) specifically involving the systematic use of medications as a part of the treatment for schizophrenia. This practice is termed Medication Management Approaches in Psychiatry or MedMAP. In the near future, we hope to expand this approach to include the pharmacological treatments for other mental illnesses.

MedMAP is designed to involve consumers, family members and supporters, practitioners, program leaders, and the public mental health authority in a united effort to practice medication prescribing in the interest of recovery of the consumer. MedMAP provides guidelines and algorithms that were developed using research and evidence to help the agencies, practitioners and consumers achieve the best possible recovery outcomes.

The following questions and answers address some of the common concerns regarding MedMAP and the use of medications in the treatment of schizophrenia.

What are Medication Management Approaches in Psychiatry (MedMAP)?

Evidence-based medicine is a mixture of clinical research, expert consensus, and practitioner expertise. MedMAP uses evidence-based medicine to guide medication decisions. All fields of medicine use evidence-based medicine. For example, practice guidelines derived from scientific evidence have been created and are being used to treat a myriad of disease states including diabetes and asthma.^{1,2}

Why is there a need for evidence-based medicine?

Studies show that actual practice patterns in health care systems often differ substantially from evidence-based recommendations based on the current evidence.^{3,4} Clearly a greater standardization of care is needed. Moreover, since many consumers move between treatment settings and receive medications from several different prescribers over the course of their lives, a system to create consistency in their treatment is highly desirable. Evidence-based practice guidelines and algorithms have demonstrated their ability to improve outcomes in the areas of depression, cancer pain management, and the intra-operative use of anesthetic drugs.^{5,6,7} MedMAP was designed specifically to address medication management for persons diagnosed with schizophrenia.

What is the goal of MedMAP in the treatment of schizophrenia?

The goal of MedMAP in the treatment of schizophrenia is to improve care through the optimal use of medications. Medication use can be optimized through implementation of the following principles:

- (1) utilization of a systematic approach to medication management
- (2) objective assessment of the symptoms that the medications are supposed to affect
- (3) clear, concise documentation of the treatments and their outcomes
- (4) efforts to enhance medication adherence through consumer education and involvement in medication decisions.

The remainder of this document will address the tenets of MedMAP.

Why is a systematic approach to medication management important and why is it difficult to achieve?

Thorough, evidence-based medication management helps practitioners determine the best treatments for consumers in an efficient fashion, thereby reducing pain, suffering, and the costs of inadequate treatment. Since all clinicians want the best for the individuals they treat, what factors contribute to the non-systematic use of medications? One factor is that different treatment settings have different goals of medication management, a reality that results in variable prioritization of medication choice. Another factor is the variation that exists across practitioners in terms of selection, dosing, and duration of treatment. Finally, the combination of inadequate documentation and incomplete consumer recall can make it impossible to determine which treatments have been tried and what effects they had. The recent proliferation of treatment guidelines and algorithms in psychiatry is testimony to the perceived need for greater standardization of care.

Why are objective assessments of symptoms important in the treatment of schizophrenia and why are clinicians sometimes opposed to them?

While chronic illnesses such as diabetes and hypertension lend themselves to quantitative outcome measurements, in schizophrenia, quantification of outcomes has historically been reserved for the research arena. Recently, the advent of managed care has required that clinicians provide evidence of treatment effectiveness in order to justify cost. Another reason that objective, reproducible symptom measurement is important in the treatment of schizophrenia is that individuals with schizophrenia often receive treatment from many different providers in a multiplicity of settings. The chronic nature of schizophrenia necessitates effective communication between prescribers and objective measures of clinical status are an integral part of this dialogue.

One reason that clinicians are opposed to incorporating objective ratings into their practices is the belief that objective ratings are more time consuming than global assessments. Another is the view that objective ratings do not capture the depth and extent of an individual's illness but instead reduce the consumer to numbers and values. However, assessments of consumer satisfaction indicate that most consumers welcome having the outcomes of their medication treatment identified and measured. Moreover, brief rating scales have been developed that are reliable and efficient to use.

Why is documentation such an important part of MedMAP and what are some impediments to good documentation?

Thorough documentation includes information about dose and duration of medications used and the response to treatment. Good documentation of the medication history is the key to identifying the most effective treatment for a consumer, but the system can prevent the flow of information.

For example, charts are often organized chronologically and by department (laboratory, radiology, etc) so that clinicians have to go through multiple sections in order to find the data that they need to make a decision. Another impediment to the careful documentation of medication trials is the fact that required institutional forms often prioritize insurance and legal issues over information necessary for medication management.

What can facilitate consumer adherence to a treatment plan?

Selection of the “best” medications is of little value if they are not taken as prescribed. Consumers and family members need to know about their medications and be comfortable with them. The practitioner and the consumer should decide on the treatment plan together because consumers who are part of the decision-making process are often more motivated to see the plan through. (see section on Shared Decision-Making: MedMAP Practitioner Resource Manual)

How can MedMap enhance risk management practices?

Prescribers who incorporate the four principles of MedMAP into their practices can reduce the numbers and types of challenges to their medication selections and monitoring. First, treatment decisions (medication selection, dosing strategies and treatment duration) that are supported by evidence-based recommendations carry the weight of expert consensus and the medical literature. Second, the adoption of reproducible symptom measurements allows prescribers to quantify severity in an objective manner that uses a common language to substantiate treatment decisions. Third, concise and consistent documentation of medication treatments and their outcomes is critically helpful in dealing with regulatory agencies and with potential litigants. Finally, shared decision-making is vital to promoting a therapeutic alliance. The presence of a positive therapeutic alliance has been found to be the single most important factor in avoiding lawsuits when, as will inevitably happen in the practice of medicine, undesirable outcomes occur.

References

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Internet Resources

The following websites contain information about algorithm, guideline and expert consensus approaches to medication management.

Texas Medication Algorithm Project/Texas Implementation of Medication Algorithms TMAP/TIMA

TMAP began in 1996 as collaborative research effort in the state of Texas to develop, implement and evaluate medication algorithm-driven treatment. The medication management in TMAP consists of evidence-based, consensually agreed upon medication treatment algorithms, clinical and technical support to implement, patient and family education programs, and documentation of patient care and outcomes.

TIMA is the ongoing statewide implementation phase of TMAP occurring in the Texas Mental Health and Mental Retardation facilities.

<http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TIMA.html>

<http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TMAPtoc.html>

Ohio Medication Algorithm Project: Optimizing Recovery Through Best Practices

<http://www.bstpractice.com/OMAP.htm>

Psychopharmacology Algorithm Project at the Harvard Medical School Department of Psychiatry

<http://mhc.com/Algorithms/>

The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations

<http://www.ahcpr.gov/clinic/schzrec.htm>

Expert Consensus Guidelines: Treatment of Schizophrenia

http://www.psychguides.com/gl-treatment_of_schizophrenia_1999.html

Training contacts and consultants for the Evidence-Based Practice of Medication Management Approaches in Psychiatry:

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Other Evidence-based Practices in this Series:

Illness Management & Recovery

Integrated Dual Disorders Treatment

Assertive Community Treatment (ACT)

Family Psychoeducation

Supported Employment

<http://www.mentalhealthpractices.org>

Appendix E

Illness Management and Recovery Program Implementation Resource Kit Pamphlet:

Information for Practitioners and Clinical Supervisors

(Draft Evaluation Edition)

Illness Management & Recovery

Implementation Resource Kit



DRAFT VERSION
2003

Information for Practitioners and Clinical Supervisors

What is the Illness Management and Recovery Program?

The Illness Management and Recovery Program consists of a series of weekly sessions in which mental health practitioners help people who have experienced psychiatric symptoms develop personal strategies for coping with mental illness and moving forward in their lives. The program can be provided in individual or group formats and generally lasts between 3 to 6 months.

With the permission of the person who has experienced psychiatric symptoms, family members and other supporters may be asked to read the educational handouts, attend some sessions, and help the person develop and implement plans for coping with symptoms, reducing relapses, and pursuing recovery goals.

How do practitioners benefit from the Illness Management and Recovery Program?

Practitioners benefit by:

- ▶ Learning a comprehensive, step-by-step approach to helping people gain skills in managing mental illness
- ▶ Saving time by receiving ready-to-use materials for conducting sessions
- ▶ Gaining skills in using motivational strategies, cognitive behavioral strategies, and educational strategies
- ▶ Experiencing increased job satisfaction from seeing improved outcomes, such as people reducing relapses and hospitalizations and making progress in their goals for recovery

How does the program compare to what is currently offered at community mental health centers?

This program pulls together the main components of effective illness management programs and provides a comprehensive, structured, step-by-step approach. It provides materials that have a recovery orientation and are user friendly both for practitioners and for persons who have experienced psychiatric symptoms. The program also heavily emphasizes helping people put knowledge into practice in their every day life.

What will people learn in the Illness Management and Recovery Program?

The following subjects are covered in educational handouts:

1. Recovery Strategies
2. Practical Facts About Mental Illness
3. The Stress-Vulnerability Model and Treatment Strategies
4. Building Social Support
5. Reducing Relapses
6. Using Medication Effectively
7. Coping with Stress
8. Coping with Problems and Symptoms
9. Getting Your Needs Met in the Mental Health System

What resource materials do practitioners receive as part of the Illness Management and Recovery Program?

- ▶ A Practitioners' Guide, with practical tips for teaching people about mental illness and helping them develop strategies for each of the 9 topic areas
- ▶ Educational handouts, checklists, and planning sheets for each of the 9 topic areas
- ▶ A short introductory video
- ▶ Informational brochures
- ▶ A fidelity scale to measure whether the program is being implemented as designed
- ▶ Outcome measures to assess whether the program is having a positive impact on participants

How can you find out more about the Illness Management and Recovery Program?

Visit our website: www.mentalhealthpractices.org.

Appendix F

Co-Occurring Disorders: Integrated Dual Disorder Treatment
Implementation Resource Kit Pamphlet:
Information for Practitioners and Clinical Supervisors
(Draft Evaluation Edition)

Co-Occurring Disorders: Integrated Dual Disorders Treatment

Implementation Resource Kit



DRAFT VERSION
2003

Information for Practitioners and Clinical Supervisors

What is meant by “dual disorders”?

This refers to the presence of both a severe mental illness and substance use disorder.

What is effective treatment?

Integrated dual disorders treatment has been shown to work effectively for both disorders. People with dual disorders have a better chance of recovery from both disorders when their mental health practitioners provide combined mental health and substance abuse treatments.

Why is information about integrated treatment for dual disorders important to mental health practitioners?

Dual disorders are common.

More than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).

Dual disorders lead to poor outcomes.

People with dual disorders are at high risk for many additional problems such as symptomatic relapses, hospitalizations, financial problems, family problems, homelessness, suicide, violence, sexual and physical victimization, incarceration, serious medical illnesses, such as HIV and hepatitis B and C, and early death.

Referral to separate substance abuse services is not effective treatment.

Sending people with dual disorders to substance abuse treatment programs or to self-help groups such as AA, without offering substance abuse treatment in the mental health setting, is not an effective approach.

What are the basic components of integrated dual disorders treatment?

Providing effective integrated dual disorders treatment involves the following:

Knowledge about alcohol and drug use, as well as mental illnesses

Clinicians know the effects of alcohol and drugs and their interactions with mental illness.

Integrated services

Clinicians provide services for both mental illness and substance use at the same time.

Stage-wise treatment

People go through a process over time to recover and different services are helpful at different stages of recovery.

Assessment

Consumers collaborate with clinicians to develop an individualized treatment plan for both substance use disorder and mental illness.

Motivational treatment

Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery. This is important for consumers who are demoralized and not ready for substance abuse treatment.

Substance abuse counseling

Substance abuse counseling helps people with dual disorders to develop the skills and find the supports needed to pursue recovery from substance use disorder.

How does one get effective training and information?

Learning dual disorders treatment skills requires knowledge, training, supervision, and practice.

Order an Integrated Dual Disorders Treatment Implementation Resource Kit.

This provides you information, training materials, annotated bibliography, and references to other training resources.

Explore implementation and training centers.

Since practitioners learn in different ways, implementation and training centers offer readings, workbooks, training videos, courses, job shadowing, supervision, and consultation.

Learn from consumers.

Many consumers will be in recovery from their substance abuse. Ask them what their recovery process was like, and what treatments were helpful. Read consumer writings about the dual disorder recovery process.

Attend AA, Al-Anon, or other self-help group meetings.

Many self-help meetings are open to nonmembers. You can learn about the process of recovery by attending these meetings.

Identify or hire an expert for your team.

One experienced team member can help others learn about integrated dual disorders treatment.

Visit an integrated dual disorders treatment team.

Arrange to visit and job shadow a program with a team that has experience providing integrated dual disorders treatment. Check the mentalhealthpractices.org website for a listing of available sites nationwide.

Co-lead a dual disorders group.

One way to learn skills while you are helping people work on their recovery process is to co-lead a group with an experienced dual disorders clinician.

Get supervision.

The proven way that clinicians acquire new skills is by working with people with dual disorders and discussing their work with an experienced supervisor. If you cannot get supervision in your agency, you may be able to obtain off-site supervision or consultation through a training center.

For more information:

Information about integrated dual disorders treatment, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.

The Integrated Dual Disorders Treatment Implementation Resource Kit contains an annotated bibliography in the User's Guide and copies of research articles.

Appendix G

Family Psychoeducation Implementation Resource
Kit Pamphlet:

Information for Practitioners and Clinical Supervisors

(Draft Evaluation Edition)

Family Psychoeducation

Implementation Resource Kit



EVIDENCE-BASED PRACTICES
Shaping Mental Health Services Toward Recovery

DRAFT VERSION
2003

Information for Practitioners and Clinical Supervisors

Who benefits from Family Psychoeducation?

People diagnosed with schizophrenia or schizoaffective disorder and their families have shown the most benefit from family psychoeducation. There simply needs to be an interest in improving family relationships while learning what to do about the symptoms of mental illness.

Recently, family psychoeducation has been shown to be helpful for people with bipolar disorder, major depression, obsessive compulsive disorder, and borderline personality disorder.

Family is defined as anyone committed to the care and support of the person with mental illness and does not have to be a blood relative. In fact, consumers often ask a close friend or neighbor to be their support person in the group.

What is family psychoeducation?

It is an elaboration of models developed by Carol Anderson, Ian Falloon, Michael Goldstein and William McFarlane.

For multi-family groups, practitioners invite 5 to 6 consumers and their families to participate in a psychoeducation group for at least six months. Additional meeting time promotes improved outcomes. Meetings are held every other week. The format is structured and pragmatic to assist people with developing skills for handling problems posed by mental illness. Over time, practitioners, family members, and consumers form a partnership as they work toward recovery. Consumers and their supporters may decide to meet as a single family rather than in the multi-family group format.

Family psychoeducation involves:

- ▶ joining (developing an alliance)
- ▶ on-going education about the illness
- ▶ problem-solving
- ▶ creating social supports
- ▶ developing coping skills

Why should practitioners consider family psychoeducation?

Family psychoeducation builds on the family's important role in the recovery process of people with mental illness. This approach is for practitioners who want to see markedly better outcomes for consumers by involving their families or support people. Family psychoeducation can be used in a single or multi-family format. It does not replace medication.

What are the benefits of family psychoeducation?

- ▶ improved clinical outcomes, community functioning, and satisfaction for consumers
- ▶ diminished interpersonal strain and stress within families
- ▶ higher rates of employment and recovery
- ▶ reduced need for crisis intervention and hospitalization over time
- ▶ improved cost-benefit ratio

The American Psychiatric Association cites family psychoeducation, used in conjunction with medication, as one of the most effective ways to help in the recovery process for schizophrenia. Research has shown that there is a significant reduction in relapse rates and unemployment when family intervention, multi-family groups, and medication are used concurrently.

Who provides family psychoeducation?

A family psychoeducation practitioner can be a social worker, nurse, doctor, occupational therapist, employment specialist, or case manager.

What skills will I gain?

Many practitioners find their work with families helps them to develop their own knowledge and professional skills. They mention:

- ▶ improved understanding of the effect of illness on family relationships
- ▶ improved understanding of consumer and family perspectives

- ▶ improved ability to shift perspectives from leader to partner
- ▶ more effective family, cognitive, and behavioral therapy skills

Why work with families?

According to the World Fellowship for Schizophrenia and Allied Disorders, there are multiple reasons:

- ▶ to achieve the best possible outcome for the consumer through collaborative treatment and recovery
- ▶ to ease suffering among family members by supporting their efforts to foster their loved one's recovery
- ▶ to listen to families and treat them as equal partners
- ▶ to provide relevant information for consumers and families at appropriate times
- ▶ to provide training for the family in structured problem-solving techniques
- ▶ to pay attention to the social, as well as the clinical needs, of the consumer and family
- ▶ to explore family members' expectations and assess a family's strengths and difficulties
- ▶ to encourage clear communication among family members

Practitioner experience:

"The patient is much better – more active, more aware of his illness, and exerts more control over recognizing [early warning signs] and getting help early on."

-L.B. (multi-family therapist)

"The family is ... more knowledgeable and more hopeful."

-R.L. (single family therapist)

For more information

Information about family psychoeducation, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.

Appendix H

Supported Employment Implementation Resource Kit
Workbook Materials:

Planning for Success - Job Support Checklists

(Draft Evaluation Edition)

Planning For Success: Starting The Job, Employment

Specialist Checklist

First Day Worries

- Does she know it is natural to have worries about the first day of a new job?
- Does she have a plan for managing any worries that come up the night before?
- What will she do if she cannot sleep the night before?
- Would she benefit from you meeting her for breakfast on the morning before work starts?
- Would a phone call before work be helpful?
- Are her family or friends informed about her starting work?
- Would it be useful to check with her family if they have questions about her first day?
- Does she know how to contact you on the first day if she needs to?
- Is there another team member available to her on the first day if you are not?
- Does she know whom she can ask questions of at work?
- Is there anyone she can call after her first day of work?

Family and friends

- Are his friends and family aware of his job plans?
- Have you discussed the value of positive support with his support system?
- Do his family and friends know how to contact you if necessary?
- Have you discussed releases of information with the consumer to speak with family and friends?
- Are his family and friends aware of your role and the ways you may be of assistance as the employment specialist?
- What is his or her plan for childcare during working hours?

Workday Schedule

- What is her schedule for going to bed before workdays?
- Does this allow for adequate sleep?
- How will she awaken on time for work?
- What are the tasks she needs to do before going to work?
- Has she planned for eating before going to work?
- Has she allowed enough time to get these things done?
- Has she practiced this plan to see how well it works?
- What will she do if she gets behind schedule getting to work?

- Does she have the means to contact you or her employer from home?
- What is her plan for taking medications on workdays?
- Has the psychiatrist or nurse reviewed this plan?
- How will she take medications at work if she needs to?
- What is her plan for food or drinks for breaks or lunchtime?

Public Transportation

- Is she aware of the public transportation routes?
- Does she know where to get on and off the public transportation?
- Does she have a copy of the schedule and stops?
- Has she practiced using this transportation?
- Does she need you to accompany her?
- What is her plan for transportation fares?
- Does she need a transportation pass?
- What is her plan for getting back home?
- What will happen if she is late getting out of work?
- Does she know whom to call if she has transportation problems?

Private Transportation

- Who will be providing private transportation?
- Does he know where he will be picked up?
- Does he know what time he will be picked up?
- Will he be driving? If so, has he driven the route?
- Does he know where to park if driving?
- What will he do if his ride is not there on time?
- Does he know whom to call if he has transportation problems?
- Does he know where he will be picked up after work?
- Does he know what time he will be picked up after work?
- What will he do if his ride home from work is not there?

Getting Ready for Work

- What are her grooming habits?
- Are they appropriate for the job?
- Does she have what she needs for grooming (toiletries, facilities, etc.)?
- Has she allowed enough time for hygiene and grooming?
- What will she wear the first day at work?
- Is this clothing appropriate for the job?
- What is her plan for having clean clothes for workdays?
- What is the quality of her nutritional habits?
- Will she eat enough of the right foods to last for her workday?

Arriving at Work

- Is he aware what time he should arrive at work?
- Where will he enter the work site?
- Whom does he report to on the first day?
- Does he need you to meet him at work when he starts?
- Is there anyone at work who will be showing him around?
- How will he introduce himself to his coworkers?
- Would it be helpful for you to role-play with him regarding introductions?
- What is he expecting for the first day?
- Does he understand what his work duties will be?
- What is his understanding of breaks at work?
- How long do they last and when can he take them?
- When and how will he eat lunch at work?
- What is the workplace policy on smoking?
- Can he manage his smoking to fit with their policy?
- Whom will he ask if he has questions upon arriving?

Planning For Success: Doing A Job Over Time, Employment Specialist Checklist

Wages and Benefits

(Income, Insurance, Housing)

- Have you reviewed all the benefits (income, insurance, and housing) she is currently receiving?
- Has she participated in developing a benefits plan?
- Does she understand how her work income will effect her benefits?
- Have all the work incentive plans been explored?
- Who will report her earnings to the appropriate programs or agencies?
- Has she signed a release of information for these if needed?
- Have her family and friends been informed of the benefits counseling and plan?
- Have the rest of the treatment team been informed of this plan?
- Do her family and friends know how to contact you with benefits questions?
- Would it be helpful for you to call her family regarding the benefits plan?
- Does she understand when she will be paid?
- What is her plan for when she receives her first check?
- Does she have a bank account or place to cash her check?
- Does she need you to help her when she receives her first check?

Disclosure of Mental Illness

- Have you reviewed the idea of disclosure of a mental illness with him?
- Is he aware of the pros and cons of disclosing a mental illness?
- Have you discussed the best ways and reasons for disclosure?
- If he wants to disclose his mental illness, how will you help?
- What is the plan for when and how to disclose?
- Are you and he aware of the ADA and how it relates to disclosure and accommodation?
- Is he aware of the pros and cons of telling coworkers about his mental illness?
- Has he signed a release of information for you to discuss his mental illness with his employer if he needs you to?
- Are his family and friends aware of the disclosure plan?

Accommodations and Support

- Are there parts of the job that need modification in order for her to be successful?
- Have you and she discussed how to ask for these modifications or accommodations?
- What is the plan for requesting modifications or accommodations?
- Does she need you to be present when she does this?
- Would it be helpful to role-play this in advance?
- Is she aware of the supports available to her by you and the rest of the team?
- What is the plan for meeting with her and her employer?
- Does she understand she can ask for your assistance in such a meeting?
- What is her understanding of how to contact you during workdays?
- Does the employer know how to contact you?
- Is the employer aware of the ways you can be supportive to him and the consumer?

Work Tasks

- What is his understanding of his duties at work?
- Is this consistent with your understanding of the job?
- Are there any job duties he is unsure about?
- How will he go about asking for help with these?
- Does he need your assistance in asking for help?
- How will he receive feedback about how he is doing at work?
- How does he usually respond to criticism or praise?
- Does he need your assistance in discussing how he is doing at work?
- If he has a strong response to criticism, have you discussed this with his employer?
- Would it be helpful to role-play how to discuss his job performance with his boss?

Social Skills

- What is the quality of her social skills?
- How comfortably and effectively is she communicating with her boss?
- How can you be helpful in this area?
- Is she content with her relationships with her coworkers?
- Does she participate in conversations at breaks or lunch?
- Are there people at her work site that intimidate or worry her?
- Has she spoken with anyone about this?

- Would it be helpful to discuss any coworker concerns with her boss?
- How can you be of support to her regarding working relationships?
- Are there specific skills teaching available through her treatment team?
- How will she deal with friends who visit her at work? Is there a workplace policy?

Family Support

- How involved is his family in supporting his work efforts?
- Does he feel he is receiving positive support from his family?
- Has he shared his work experiences with his family?
- Are there any family members he calls to share good things about work?
- How can you be of assistance in helping him to explain the value of this to his family?
- Are they aware of how you can be of assistance to them and the consumer?

Money Management

- What is the quality of his money management skills?
- How well has he done with meeting his needs with money in the past?
- What is his plan for managing his paychecks?
- Does he have a budget?
- Does he need assistance in adjusting or developing a budget for his wages?
- If she abuses substances, how will having new money effect this issue?
- Does the client have a plan to address the urges that can come with money?

Planning For Success: Avoiding A Crisis, Employment Specialist Checklist

The Person

- What types of mental illness does he experience?
- What does the treatment team notice about warning signs of increased symptoms?
- How might this show up at work?
- What does the treatment describe as his history of alcohol or substance use?
- What work-related problems might occur with alcohol or substance use?
- Does he sometimes stop or change his medications without the knowledge of the treatment team?
- How will the treatment team keep you informed of any medication changes?
- When he experiences increased symptoms, does he tell people or isolate?
- Is there anyone on the treatment team with whom he works best when in crisis?
- What has been helpful in managing crises recently according to his treatment team?
- What other crisis causes, strategies, or ideas does the treatment team have regarding the consumer?
- How does he usually react to increased stress?
- How does he usually react to changes in his routine?
- Does he have strong reactions to certain people (e.g., women, older men, etc.)?

The Work Environment

- Are there situations at work that have become bothersome to her that may grow into a crisis?
- Are there coworker relationships that are bothering her?
- How can you be of assistance in helping her address either of these?
- Is it useful for her employer to notify you in advance of any upcoming work changes?
- Has she, or will she, experience changes in
 - Routine
 - Coworkers
 - Boss
 - Job duties
 - Job location
 - Job schedule
- What have been successful ways for her to manage change in the past?
- How will she contact you if she feels a crisis coming at work?

- Can her employer contact you if she is having a crisis at work?
- Who is the back-up person if you are not available for a work crisis?
- Has she signed a release of information for you to communicate with her employer in case of a work crisis?
- What is the plan for working with the treatment team in evaluating and helping to manage a crisis?
- What types of emergency services are available in case of a work crisis?

The Personal Environment

- Has she, or will she, experience stress or changes in
 - Using alcohol or drugs
 - Interpersonal conflicts
 - Medications
 - Her living situation
 - Seasons or difficult times of the year
 - Family members, friends or pets
 - Members of her treatment team
- How does she handle increased personal stress?
- Does she use her support network or her treatment team?
- Does she know she can contact you if it will impact her work performance?
- Does she know how to contact emergency services in her area?
- What is the plan for working with the treatment team regarding personal stress or changes?
- Do you have a signed release of information to communicate with her family?
- Does her family know how and when they can contact you?

Planning For Success: Leaving The Job, Employment Specialist Checklist

Leaving

- What are his reasons for wanting to leave his job?
- How long has he been thinking about leaving?
- Has he attempted to discuss these reasons with his employer?
- How can you be of assistance if he wants to discuss his reasons with his employer?
- Are there modifications or changes at work that would change his mind about leaving?
- If possible, would a break from work help with his reasons for leaving?
- Have you discussed the pros and cons of leaving his job?
- Is he making an informed decision about leaving or staying?
- Is he aware that leaving is his decision to make, not yours?
- What length of notice does the employer expect before he leaves?
- Does he understand the benefits of giving an appropriate notice?
- Will he want to use this employer as a reference in the future?
- If he leaves, does his current position fit the desires of another consumer?
- Does he have another job to go to, as it is often easier to find a job if you are already employed?
- Have his family and friends been informed of his decision to leave?
- Has the treatment team been informed of his decision to leave?
- What is the plan for notifying benefits programs or agencies?
- How can you be helpful to him so that he may leave his job successfully?

Working Again

- Does he know how to get a reference from his employer?
- What has he learned about working from the job he is leaving?
- What, if anything, would he do differently in his next job?
- What is his plan for working again in the future?
- Is this a realistic plan?
- Have you done a reassessment of his job skills and preferences based on the job he is leaving?
- What are the pros and cons of his future work plan?
- Have his family and friends been informed of the new work plan?
- Has the treatment team been informed of the new work plan?
- How can you be of assistance in developing and sharing his new work plan?

Appendix I

Supported Employment Implementation Resource
Kit Pamphlet:

Information for Practitioners and Clinical Supervisors

(Draft Evaluation Edition)

Supported Employment

Implementation Resource Kit



DRAFT VERSION
2003

Information for Practitioners and Clinical Supervisors

People with mental illness have many talents and abilities that are often overlooked, including the ability and motivation to work. Work has become an important part of the recovery process for many consumers. Research has shown that:

- ▶ 70% of adults with a severe mental illness desire work.
- ▶ 60% or more of adults with mental illness can be successful at working when using supported employment.

The following section answers some common questions regarding supported employment.

What are the principles of supported employment?

Supported employment is based on six principles.

- ▶ Eligibility is based on consumer choice. No one is excluded who wants to participate.
- ▶ Supported employment is integrated with treatment. Employment specialists coordinate plans with the treatment team: the case manager, therapist, psychiatrist, etc.
- ▶ Competitive employment is the goal. The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- ▶ Job search starts soon after a consumer expresses interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like prevocational work units, transitional employment, or sheltered workshops).

- ▶ Follow-along supports are continuous. Individualized supports to maintain employment continue as long as consumers want the assistance.
- ▶ Consumer preferences are important. Choices and decisions about work and support are individualized based on the person's preferences, strengths, experiences.

Work is stressful. Will consumers experience increased symptoms if they obtain a competitive job?

Generally speaking, people who work do not experience symptoms at any higher rate than people who do not work. In fact, for many consumers, symptoms improve through the planned, purposeful activity of work. In supported employment, the assessment of an individual's strengths, coping strategies, and symptoms helps identify a good job and work environment for each person. It should also be remembered that not working is also stressful, often more stressful than working.

Case managers are already overworked. How will they have time to support this employment effort?

The work of employment specialists provides an additional resource for case managers and consumers in supporting consumer goals. Over time, consumers depend less on case managers and the mental health system as they progress in their recovery process.

How will colleagues be convinced that supported employment works?

Everyone will need education and training on how to carry out their part in supporting a consumer's efforts to work. Managers and supervisors help practitioners follow the principles and practices of supported employment in their daily work. More and more, practitioners who have seen how people grow when they are working have become convinced that work can be part of the recovery process.

The people I work with are too disabled to hold jobs. What does supported employment have to offer people with the most severe disabilities?

The evidence shows that even people with the most severe mental illnesses can work. In supported employment, job selection is tailored to individuals. An important part of the recovery process is hope. Supported employment provides all consumers a chance to succeed at employment. For some people, the opportunity to work a few hours a week is a symbol of hope.

If consumers start going to work, will they still be able to attend groups and activities and keep appointments with doctors and practitioners?

Agencies have restructured their resource allocations, programming, and scheduling as more consumers work. While most consumers are not taking full-time jobs, some may need evening appointments.

What is the role of psychiatrists in supported employment?

In supported employment, employment specialists work closely with the treatment team to support the goals of consumers. As clinical leaders, psychiatrists convey positive messages about work to consumers, family members, and the whole team. Psychiatrists make treatment recommendations based in part on how a person is functioning at work.

Limited resources are available to pay for needed case managers. Employment specialists seem like a luxury. How can an agency afford employment specialist positions?

Agencies continually make decisions about how to use their limited resources. As more consumers express a desire to work, providing supported employment is becoming an increasing priority. Leaders of numerous agencies and systems have established ways to fund supported employment programs. Some agencies, for example, have converted day program staff to employment specialists. In some states, the public mental health authority has worked out mechanisms with the Division of Vocational Rehabilitation and Medicaid office. Available financing mechanisms for such services vary from state to state and agency to agency.

How many employment specialists are needed for a program?

Employment specialists can manage caseloads of 20 to 25 people. While some case managers learn to support a consumer's work efforts, many consumers benefit most from employment specialists who are solely devoted to supported employment, in addition to their case managers.

How can we make time to talk about vocational issues when we have crises that need our attention?

Programs that have implemented evidence-based supported employment find that fewer crises occur because people are interested in developing their lives in the community and managing their illness more independently. Comprehensive and coordinated planning that occurs with supported employment leads to fewer crises, less chaos, and more structure.

What elements of supported employment are most critical?

Currently, some of the elements of supported employment have more supporting evidence than others. The following components are predictive of better employment outcomes:

- ▶ focus on competitive employment
- ▶ rapid job searches
- ▶ jobs tailored to individuals
- ▶ time-unlimited follow-along supports
- ▶ integration of supported employment and mental health services
- ▶ zero exclusion criteria (that is, no one is screened out because they are not ready)

How will we know which consumers are ready for supported employment?

Research has suggested that even people who are assumed unlikely to succeed in employment can improve their employment outcomes with the help of supported employment. When an agency develops a culture of work and encourages people to consider employment options, the number of people who go to work increases. Giving people the choice to decide whether or not to participate in supported employment is consistent with the recovery philosophy. Many consumers in agencies with supported employment programs identify themselves as wanting to work in competitive jobs.

Why should mental health agencies provide supported employment when consumers can access services at the Division of Vocational Rehabilitation?

The evidence shows that consumers achieve better employment outcomes with the support of programs that integrate employment support services and mental health treatment. Increasingly, mental health agencies are working closely with the Division of Vocational Rehabilitation to establish higher quality supported employment programs with demonstrated effectiveness for people with severe mental illness.

For more information:

Supported employment services are provided by numerous agencies across the country. If you are interested in knowing more about these services, contact staff at your local mental health or vocational agency.

Information about supported employment, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.

The Supported Employment Implementation Resource Kit contains copies of research articles and an annotated bibliography in the User's Guide. Some of these materials are referenced on the website: www.mentalhealthpractices.org.