

**ACT Model:
Uniting Evidence-Based
Treatment with
Comprehensive Client-
Centered Services for Severe
Mental Illness**

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What is Evidenced – Based Practice?

- **Basing practice on scientific evidence rather than folklore or loose bodies of knowledge**
- **Use of mental and behavioral health interventions for which research has provided evidence of effectiveness of treatment for specific problems**

Challenges

- **Gap between what we know about effective treatment and services being offered**
- **Practices validated by research are not widely offered in routine mental health practices**
- **Evidence alone does not strongly influence practice; also need consumer demand and administrative incentives**
- **There is a need to facilitate widespread adoption of evidenced based practice in mental health so individuals with mental illness can benefit from services known to work**

NAMI (National Alliance for the Mentally Ill) grassroots efforts to promote the evidenced based model of Assertive Community Treatment (ACT)

- **Sponsoring a practice manual for replication by the experts**
- **Engaging media**
- **Working with providers**
- **Engaging policy makers**
- **Providing education to consumers and their families**

What is ACT Model?

ACT (Assertive Community Treatment) is identified by Substance Abuse and Mental Health Services Administration (SAMHSA) as:

- Evidenced based practice
- Consistently demonstrates positive outcomes
- Essential treatment option

Background

- For most severe mental illness for those ill-served by fragmented office-based mental health models
- Evolved out of work of Arnold Marx, MD, Leonard Stein, MD and Mary Ann Test, Ph.D. in late 1960's
- Gains made in psychiatric hospitals were often lost when clients returned to community
- Implemented multidisciplinary, around the clock staffing to provide intensive services in client's home/community
- Utilized in US, Canada, and England and other countries

Admission Criteria

- Severe mental illness (schizophrenia/other psychotic disorders, bipolar disorder)
- Serious impairment daily living skills, employment and/or ability to maintain housing

Other Indicators:

- High use of psychiatric hospitals
- Severe symptoms
- Coexisting substance use disorder
- Risk of or recent criminal justice involvement
- In residential setting but able to live independently with intensive services

Goals

- **Lessen/eliminate debilitating symptoms**
- **Minimize/prevent recurrent acute episodes**
- **Meet needs/enhance quality of life**
- **Enhance ability to live independently**
- **Develop/support educational, vocational opportunities**

ACT Model Characteristics

- **Multidisciplinary team (psychiatry, rehabilitation specialists, social work, nursing, substance abuse treatment, vocational specialists, peer support specialists)**
- **Mobil team brings services to where the client needs them (home/community/work)- at least 75% services are delivered in community**
- **Services available 7 days per week/24 hours per day**
- **ACT is responsible to help clients meet their needs in all aspects of community living: focus is on the whole person not just the mental illness**
- **Small caseloads allow for intensive treatment (from 2-5 times/day)**

Characteristics (continued)

- Team adapts environment /selves to meet clients needs rather than having client adapt to rigid structure of a treatment program
- Services are continuous, long term, based upon individual progress rather than time-limited
- Services titrated to meet client's changing needs (decreased or increased as needed)
- Collaboration and client empowerment embraced, clients are listened to, respected, supported in directing own treatment plan and services
- Team Approach: clients are served by a team that meets daily to address needs

Services

- **Individual Supportive therapy**
- **Comprehensive assessment/history timeline of significant events in client's life, experiences with mental illness and treatment history**
- **Illness management and recovery skills**
- **Psychopharmacological treatment**
- **Mobil crisis interventions**

Services (continued)

- **Substance abuse treatment**
- **Skill teaching (independent living skills, social skills, structuring time)**
- **Supported employment/education**
- **Education for and collaboration with family members**
- **Advocacy with legal issues, housing, money-management and transportation**
- **Assistance with medical, dental care**

Overview of Research/Endorsements of ACT

- **ACT: most aggressively studied model of case management**
- **Superiority to other models of case management is well documented**

PACT Clients had:

- 12 of 65 ACT clients hospitalized vs. 58 of 65 in usual care
- Shorter hospital stays than control group
- More time in independent living
- Less time unemployed
- More earned income
- More positive social relationships
- Less symptoms
- Expressed greater satisfaction with life

(Stein & Test (1980) and Weisbrod, Test, & Stein (1980))

Longitudinal study found PACT clients had:

- Less time in hospitals/nursing homes/penal settings/homelessness
- More time in employment
- Greater success with independent living
- Less subjective distress
- More satisfaction with life
- Similar levels of suicidality
- Similar ability maintaining social relationships

(Test, Knoedler, Allness, Kameshima, Burkes & Rounds, 1994)

Most Prominent Effects of ACT

- **Significantly reducing time spent in hospital**
- **Improving housing stability and independent living**
- **Moderate improvement in psychiatric symptoms and quality of life**

In addition ACT associated with:

- **Higher rates of client satisfaction**
- **Team approach of ACT improves continuity of treatment over time**

(Muester, Bond, & Drake, 2001)

ACT demonstrated greater ability to engage and retain clients

- 20% of usual care clients never successfully connected with the provider compared to 2% of ACT clients**
- Usual care clients more than twice as likely to drop out due to dissatisfaction**
- ACT teams retained 68% of their clients vs. 43% of usual care clients**

(Herinckx, Kinney, et al, 1997)

ACT Model and Homelessness Study:

- **20-30% of homeless individuals have severe mental illness**
- **ACT significantly reduced homelessness vs. standard case management models**
- **ACT showed significant improvements in psychiatric symptom severity in homeless mentally ill**

(Coldwell, Bender, 2007)

Importance of Fidelity to the Model

Studies show that high fidelity ACT programs have superior outcomes over low fidelity programs

High (versus low) fidelity programs have:

- **Higher rates of retention in services**
- **Fewer hospitalizations**
- **Greater reductions in alcohol and drug use**
- **Higher rates of remission for dual disorders**

Endorsed By

- **The Agency for Health Care Research and Quality along with the National Institute of Health (1998)**
- **Mental Health: A Report of the Surgeon General (1999)**
- **The Presidents New Freedom Commission Final Report (July 2003)**
- **National Alliance for the Mentally Ill: promotes ACT model throughout the country.**

Applying ACT in a Local Program

Villa Hope Community Support Program (CSP):

- Serves individuals with severe mental illness
- Maintains fidelity to the ACT Model
- Referred clients with most intensive needs
- History of high rates of psychiatric hospitalization prior to admission
- Hospital rates drop substantially after admission

Percentage of clients that have had NO hospitalizations

2000=84%	2004=87%	2007=80%
2001=84%	2005=80%	2008=85%
2003=86%	2006=84%	2009=90%

- 36 of 57 clients have had no hospitalizations since their admission
- 11 of the 36 have had no hospitalizations for 10-14 years.

Villa Hope CSP staff identifies likely reasons ACT works so well compared to usual outpatient treatment

- **Over 90% of services in client's home/community**
- **Collaboration with clients to address their goals/interests builds good rapport**
- **A lot of client /staff interaction to proactively meet changing needs**
- **Daily staff meetings allows extensive, on-going planning**
- **Psychiatrist appointments every 6 weeks and emergency appointments**

Villa Hope CSP continued

- Clients can be seen up to 16 times per week
- Able to coordinate a wide variety of services ranging from assisting to keep benefits to finding dental care results in greater consumer satisfaction
- Many clients have such extensive health needs that they were unable to navigate standard outpatient care without our intensive services
- Utilize Diversion Facility/CSP psychiatrist visits daily
- Recovery oriented, strength based, respectful collaboration and the utilization of the power of belief in clients abilities to address their goals

*It's a crusade for possibility,
opportunity, hope and
recovery in the face of
difficulty, stigma and despair*

– Michael Neale, PhD

*(started an ACT program for
veterans)*