Mid-America (HHS Region 7)
MHTTC Mental Health Technology Transfer Center Network
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Implementing Assertive Community Treatment in Kansas: Orientation to ACT

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The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

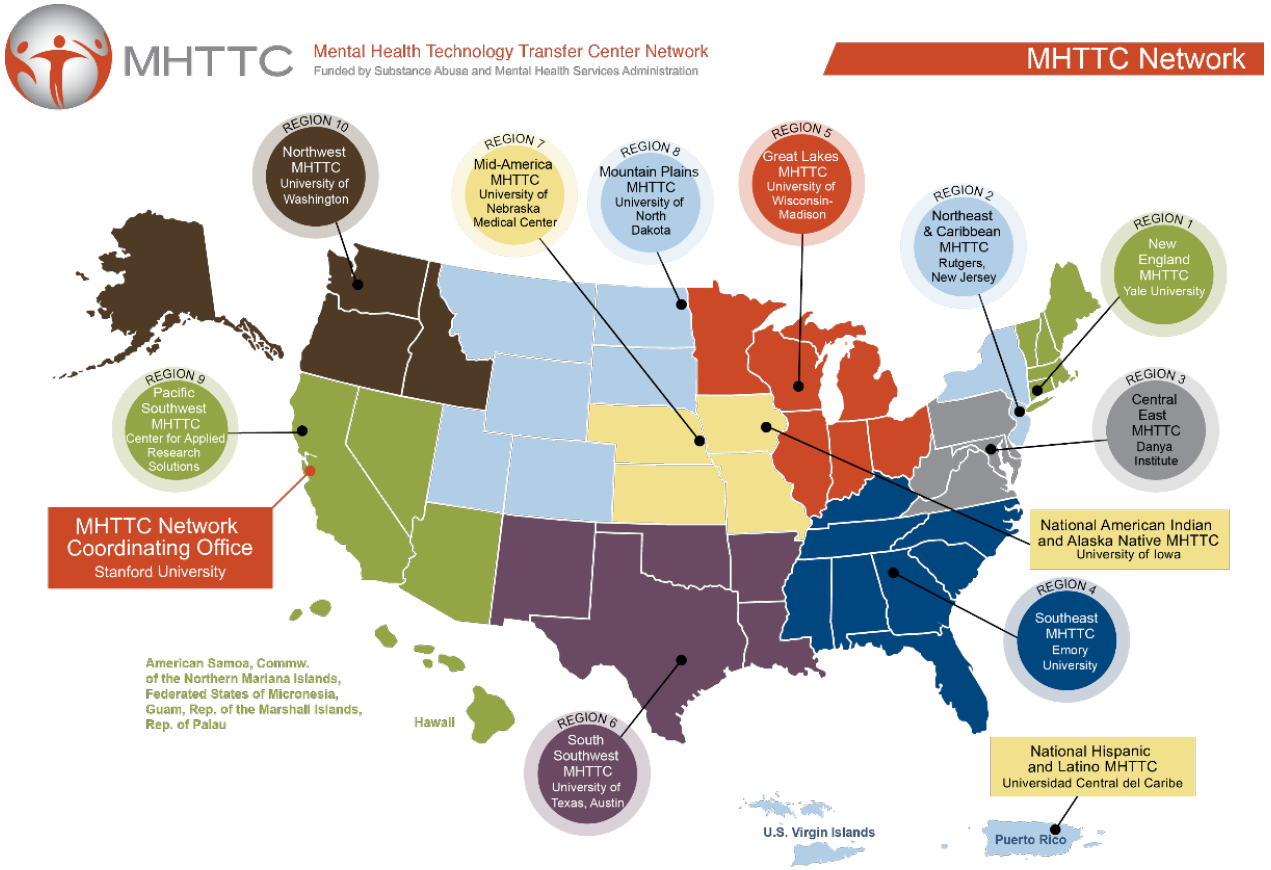
- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered/ trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Mid-America Mental Health Technology Transfer Center

Established to increase utilization of evidence-based mental health practices.

- Missouri, Iowa, Nebraska, and Kansas.
- Free training and technical assistance.
- SAMHSA grant awarded to the Behavioral Health Education Center of Nebraska at University of Nebraska Medical Center.
  (5 years, $3.7 million, grant number: H79SM081769)



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I, Mogens Bill Baerentzen attest that I have no financial, personal, or professional conflicts of interest in this training titled Permanent Supportive Housing: Fidelity Assessor Training.

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Deinstitutionalization

Since the deinstitutionalization of persons with mental illness, beginning in the 1950's fewer people with serious mental illness are living in hospitals, nursing homes and assisted living facilities; in fact, most are living in the community independently or with formal supports. The role of families has increased as access to long-term inpatient care has reduced.

- From 1955 to 1983 there was a 75.3% reduction in the state-hospital population (Goldman, Adams, & Taube, 1983).
- 558,239 inpatient psychiatric beds in 1955 for a population of 164.3 million (Bureau of the Census, 1956).
- 51,413 inpatient psychiatric beds in 2004 for a population of 269.4 million (Torrey, Entsminger, Geller, Stanley, & Jaffe, 2007).

Serious Mental Illness and QOL

Persons with severe and persistent mental illness are at risk of not living a fully satisfying life.

- Difficulties forming social connections (Bellack, Morison, Wixted & Mueser, 1990),
- sexual dysfunction (Bobes et al., 2003; Wesby, Bullmore, Earle, & Heavey, 1996),
- impaired functioning (Bellack & Mueser, 1993),
- lower work readiness skills (Lysaker, Bell, Milstein, Bryson, Shestopal, & Goutlet, 1993), and
- impaired cognitive abilities (Braff, 1993).

Low life satisfaction for persons with severe and persistent mental illness are directly related to

- poverty (Cohen, 1993),
- homelessness (Lehman, Kernen, DeForge, & Dixon, 1995),
- mental health stigma (Corrigan, 2004),
- impaired family relations and friendships,
- access to health care and community services (Brown, Cosgrove, & DeSelm, 1997).

SMI and Health

Serious mental illness is associated with 20-year lower life expectancy (Thornicroft, 2011) and increased rates of many chronic lifestyle related illnesses (Jones et al., 2014). Persons with a severe and persistent mental illness are more likely to be
obese (Cook et al., 2016),

to smoke cigarettes (Bartlem et al., 2015),

to use alcohol and illicit drugs (Regier et al., 1990),

to eat unhealthy (Christensen & Somers, 1996; Kilbourne et al, 2007),

to be physically inactive (Bartlem et al., 2015),

have other negative health practices, such as

poor adherence with treatment (Lehner et al., 2007), and

adverse health related side effects from psychotropic medication (Blanchard and Samaras, 2014; Dipasquale et al., 2013; Jerome et al., 2009; Cooper et al., 2012).

In a multi-national study, Parletta, Aljeesh, & Baune (2016) found that persons with mental illness compared to a normative sample eat less healthy food, more unhealthy foods, have more sleep problems and higher alcohol consumption.

Support for Recovery

- The transition from hospital to community created a significant concern about how to help persons with serious mental illness live meaningful lives (Gudeman, Miles, & Shore, 1984).
  - how to support people in housing, and
  - how to improve the quality of their lives.

Recovery, 1/3

Historically, mental illnesses was believed to be caused by societal stressors. Consequently, families were often blamed for the ill of their loved ones and excluded from any treatment process and care (Corrigan, 2016).

Contemporary mental healthcare is founded on beliefs that biological, psychological and social factors all contribute to a person's mental illness. Also, and more importantly, the same factors contribute to their well being and recovery. Consequently, families are more likely to be viewed as a resource to include in the treatment process (Alverson, Alverson & Drake, 2000; Hatfield, 1994).

Recovery, 2/3

Since the deinstitutionalization we have been concerned about helping persons with a serious mental illness live meaningful lives (Gudeman, Miles, & Shore, 1984).

There is a positive correlation between independence and quality of life.

- In a study that compared the quality of life among people in hospital settings and different levels of independent living, quality of life increased as independence increased (Anderson & Lewis, 2000).
- Several studies have found that the quality of life for persons with serious mental illness is higher in community-based housing compared to hospital settings (Barry & Crosby, 1996; Lehman, Possidente, & Hawker, 1986; Shepard, Muijen, Dean, & Cooney, 1996).

Recovery, 3/3

We know how to better help persons:

- find employment (Bond, Drake, & Becker, 2008),
- be stable in housing (Blanch, Carling, & Ridgway, 1988; Culhane, Metraux, and Hadley, 2002),
- form meaningful social relationships (Bellack, Mueser, Gingerich, & Agresta, 2004).

Similarly, our understanding of how to help persons with serious mental illness with their symptoms has steadily increased (Bandelow et al., 2011; Goodwin, 2009; Komossa et al., 2010).

What is ACT

- Developed in 1970’s – 1980’s.
- ACT is an evidence-based practice to help persons with SMI who would otherwise be best served in an institution.
- Highest level of community-based care for persons with SMI.
- A model to deliver best care (psychiatry and psychiatric rehabilitation).

The evidence behind ACT

- Validity of **ACT Fidelity Assessment**: Discriminant and Predictive, 1998.
- Studies have found ACT associated with reduction in psychiatric hospitalization, increased housing stability, increase QOL, decrease in symptoms, increased functioning, and greater life satisfaction.

ACT and Housing

- Persons who are homeless or unstable in housing fare well in ACT programs.
  - ACT reduces homelessness.
  - Rehabilitation services, incl social, coping and independent living skills training, are best provided in an individual's home.
- Higher levels of residential care are not needed when individual’s have access to ACT.

Principles of ACT

- Team approach
- Community outreach
- Small caseload
- Time-unlimited services
- Shared caseload
- Flexible delivery of services
- Comprehensive program
- 24/7 crisis service

The ACT team

- Inter-professional/multi-disciplinary
- Rehabilitation staff
- Nursing staff
- Substance use specialist
- Psychiatrist
- Team leader
- Peer-support specialist
- Employment specialist

Assertive Outreach

- Staff go to where persons with mental illness are. Including at their home, work and family.
- Persons with SMI best learn in the environment where they live.
- Some services, incl. psychiatry and group services are often provided at program location.

Case load size

- Small caseload size compared to other best practices.
- 10:1 staff to consumer ratio.
- 10-12 professionals on the team.

Time unlimited

- Some persons need indefinite services to maintain community level of care.
- Others can transfer to other supports over time.
- Decisions regarding termination are individualized.

Shared caseload

- The team share a caseload.
- The team share in treatment planning.
- The team share in assessment.
- The team rotate to see clients.
- The team is responsible for consumer outcomes.

Flexibility

- The team meets daily.
- The team plans services daily.
- The team adjust services to meet changes in needs.

One-stop shop

- A comprehensive team to meet the totality of client behavioral health needs.
- Includes med management, nursing care, rehabilitation (incl. vocational and independent living), and psycho-therapy.
- Primary care and dentistry are brokered.

24/7 crisis line

- The team is available 24 hours per day and 7 days per week.
- Year round.
- Some crises are avoidable.

Fidelity - Adherence to the model

- Well defined
- Reflect client goals
- Be consistent with societal goals
- Demonstrate effectiveness
- Yield durable outcomes
- Produce minimal side effects
- Have reasonable costs
- Adaptable to diverse communities and client subgroups
- Relatively easy to implement

Eligibility

- SMI.
- Functional impairments.
- Hx of inability to manage illness in lower levels of care.

Human Resources

- Team approach
- Program meeting
- Practicing ACT/PSH leader
- Psychotherapist
- Peer-support specialist
- Psychiatrist
- Nurse
- Substance use specialist
- Vocational specialist
- Rehabilitation staff

Organizational Boundaries

- Explicit admission criteria
- Time unlimited service
- Intake rate
- Responsibility of tx services
- Crisis services
- Hospital admission
- Hospital discharge

Nature of Services

- Community based services
- No dropout policy
- Assertive engagement
- Intensity of service
- Frequency of contact
- Work with informal support
- Individualized substance use treatment
- Co-occurring disorders group
- Dual Disorders model
- Role of consumer

References

Alverson, H., Alverson, M. & Drake, R.E. (2000). An Ethnographic Study of the Longitudinal Course of Substance Abuse Among People with Severe Mental Illness. Community Ment Health J, 36, 557–569. https://doi.org/10.1023/A:1001930101541

Anderson, R. L., & Lewis, D. A. (2000). Quality of life of persons with severe mental illness living in an intermediate care facility. Journal of Clinical Psychology, 56, 575–581. doi:10.1002/(SICI)1097-4679(200004)56:4<575::AID-JCLP11>3.0.CO;2-S

Bandelow, B., Sher, L., Bunevicius, R., Hollander, E., Kasper, S., Zohar, J. (2012). Guidelines for the pharmacological treatment of anxiety disorders, obsessive–compulsive disorder and posttraumatic stress disorder in primary care. International Journal of Psychiatry in Clinical Practice, 16(2), 77–84. doi:10.3109/13651501.2012.667114

Bartlem, K. M., Bowman, J. A., Bailey, J. M., Freund, M., Wye, P. M., Lecathelinais, C., … Wiggers, J. H. (2015). Chronic disease health risk behaviours amongst people with a mental illness. Australian & New Zealand Journal of Psychiatry, 49(8), 731–741. doi:10.1177/0004867415569798

Barry, M. M., & Crosby, C. (1996). Quality of life as an evaluative measure in assessing the impact of community care on people with long-term psychiatric disorders. The British Journal of Psychiatry, 168(2), 210–216. doi:10.1192/bjp.168.2.210

Bellack, A. S., Morrison, R. L., Wixted, J. T., & Mueser, K. T. (1990). An analysis of social competence in schizophrenia. The British Journal of Psychiatry, 156(6), 809–818. doi:10.1192/bjp.156.6.809

References

Bellack, A. S., & Mueser, K. T. (1993). Psychosocial treatment for schizophrenia. Schizophrenia Bulletin, 19(2), 317–336. doi:10.1093/schbul/19.2.317

Bellack, A.S, Mueser, K.T., Gingerich, S., & Agresta, J. (2004). Social skills training for schizophrenia. NY: The Guilford Press.

Blanch, A. K., Carling, P. J., & Ridgway, P. (1988). Normal housing with specialized supports: A psychiatric rehabilitation approach to living in the community. Rehabilitation Psychology, 33(1), 47–55. doi:10.1037/h0091686

Blanchard, E., & Samaras, K. (2014). Double jeopardy: Diabetes and severe mental illness. Addressing the special needs of this vulnerable group. Diabetes Management, 4(4), 339–353. doi:10.2217/dmt.14.24

Bobes, J., Garc A-Portilla, M.P., Rejas, J., Hernandez, G., Garcia-Garcia, M., Rico-Villademoros, F., & Porras, A. (2003). Frequency of sexual dysfunction and other reproductive side-effects in patients with schizophrenia treated with risperidone, olanzapine, quetiapine, or haloperidol: The results of the EIRE Study. Journal of Sex & Marital Therapy, 29(2), 125–147. doi:10.1080/713847170

Bond, G. R., Drake, R. E., & Becker, D. R. (2008). An update on randomized controlled trials of evidence-based supported employment. Psychiatric Rehabilitation Journal, 31(4), 280–290. doi:10.2975/31.4.2008.280.290

References

Braff, D. L. (1993). Information processing and attention dysfunctions in schizophrenia. Schizophrenia Bulletin, 19(2), 233–259. doi:10.1093/schbul/19.2.233

Brown, C., Cosgrove, N., & DeSelm, T. (1997). Barriers interfering with life satisfaction for individuals with severe mental illness. Psychiatric Rehabilitation Journal, 20(3), 67–71. doi:10.1037/h0095360

Christensen, L. & Somers, S. (1996). Comparison of nutrient intake among depressed and nondepressed individuals. International Journal of Eating Disorders, 20(1), 105-109. doi:10.1002/(SICI)1098-108X(199607)20:1<105::AID-EAT12>3.0.CO;2-3

Cohen, C. I. (1993). Poverty and the course of schizophrenia: Implications for research and policy. Psychiatric Services, 44(10), 951–958. doi:10.1176/ps.44.10.951

Cooper, J., Mancuso, S. G., Borland, R., Slade, T., Galletly, C., & Castle, D. (2012). Tobacco smoking among people living with a psychotic illness: The second Australian survey of psychosis. Australian & New Zealand Journal of Psychiatry, 46(9), 851–863. doi:10.1177/0004867412449876

Corrigan, P.W., Mueser, K.T., Bonds, G.R., Drake, R.E., & Solomon, P. (2008). Principles and Practice of Psychiatric Rehabilitation. The Guilford Press, New York.Corrigan, P.W. (2016). Principles and Practice of Psychiatric Rehabilitation. The Guilford Press: NY

References

Culhane, D.P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. Housing Policy Debate, 13, 107-163.

Dipasquale, S., Pariante, C. M., Dazzan, P., Aguglia, E., McGuire, P., & Mondelli, V. (2013). The dietary pattern of patients with schizophrenia: A systematic review. Journal of Psychiatric Research, 47(2), 197–207. doi:10.1016/j.jpsychires.2012.10.005

Goodwin, G.M., & Consensus Group of British Association for Psychopharmacology. (2009). Evidence-based guidelines for treating bipolar disorder: Revised second edition – recommendations from the British Association for Psychopharmacology. Psychopharm, 23(4), 346-388.doi:10.1177/0269881109102919

Gudeman, J.E., Miles, F., & Shore, M.F. (1984). Beyond deinstitutionalization: A new class of facilities for the mentally ill. The New England Journal of Medicine, 311(13), 832–836. doi:10.1056/nejm198409273111306

Hatfield A. (1987). Coping and Adaptation: A conceptual framework for understanding families. In A. Hatfield & H. Lefley (Ed's), Families of the mentally ill. New York: Guilford Press

Jerome, G. J., Rohm, D.Y., Dalcin, A., Charleston, J., Anthony, C., Hayes, J., & Daumit, G. L. (2009). Physical activity levels of persons with mental illness attending psychiatric rehabilitation programs. Schizophrenia Research, 108(1-3), 252–257. doi:10.1016/j.schres.2008.12.006

Refences

Komossa, K., Rummel-Kluge, C., Hunger, H., Schmid, F., Schwarz, S., Duggan, L., Leucht, S. (2010). Olanzapine versus other atypical antipsychotics for schizophrenia. Cochrane Database of Systematic Reviews. doi:10.1002/14651858.cd006654.pub2

Kilbourne, A. M., Rofey, D. L., McCarthy, J. F., Post, E. P., Welsh, D., & Blow, F. C. (2007). Nutrition and exercise behavior among patients with bipolar disorder. Bipolar Disorders, 9(5), 443–452. doi:10.1111/j.1399-5618.2007.00386.x

Lehner, R. K., Dopke, C. A., Cohen, K., Edstrom, K., Maslar, M., Slagg, N. B., & Yohanna, D. (2007). Outpatient treatment adherence and serious mental illness: A review of interventions. American Journal of Psychiatric Rehabilitation, 10(4), 245–274. doi:10.1080/15487760601166324

Lehman, A.F., Kernen, E., DeForge, B.R. & Dixon, L. (1995). Effects of homelessness and the quality of life of persons with severe mental illness. Psychiatric Services, 46(9), 922–926. doi:10.1176/ps.46.9.922

Lehman, A. F., Possidente, S., & Hawker, F. (1986). The quality of life of chronic patients in a state hospital and in community residences. Psychiatric Services, 37(9), 901–907. doi:10.1176/ps.37.9.901

Lysaker, P., Bell, M., Bryson, G., Shestopal, A., & Goutlet, J.G. (1993). Work capacity in schizophrenia. Hospital and Community Psychiatry, 44(3), 278–280. doi:10.1176/ps.44.3.278

References

Parletta, N., Aljeesh, Y., & Baune, B. T. (2016). Health Behaviors, Knowledge, Life Satisfaction, and Wellbeing in People with Mental Illness across Four Countries and Comparisons with Normative Sample. Frontiers in Psychiatry, 7(145), 1-8. doi:10.3389/fpsyt.2016.00145

Regier D.A., Farmer M.E., Rae D.S., Locke B.Z., Keith S.J., Judd, L.L., & Goodwin, F.K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study. Journal of American Medical Association, 264(19), 2511–2518. doi:10.1001/jama.264.19.2511

Shepherd, G., Muijen, M., Dean, R., & Cooney, M. (1996). Residential care in hospital and in the community--quality of care and quality of life. The British Journal of Psychiatry, 168(4), 448–456. doi:10.1192/bjp.168.4.448

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