FM115

ASSERTIVE COMMUNITY TREATMENT (ACT)

PROGRAM SUMMARY

The Assertive Community Treatment (ACT) model of care evolved out of the work of Arnold Marx, M.D., Leonard Stein, and Mary Ann Test, Ph.D., in the late 1960's. Stein indicated that the purpose of ACT 'is to maintain regular and frequent contact *in order to* monitor the clinical condition *in order to* provide effective treatment and rehabilitation' (Burns & Firn 2002).

The program commenced in early 2002 as a pilot program in collaboration with Medical Benefits Fund (MBF) of Australia, and gained approval from the Minister, Department of Health and Aging, as an Outreach Service in November 2002. A variety of Private Health Insurance Providers now offer financial support for patients with appropriate levels of cover to be able to access this type of service.

Assertive Community Treatment complements the specialist mental health services provided by the treating psychiatrist and the Toowong Private Hospital; and effectively substitutes for acute hospital admissions with frequency of contact varying dependent on the clinical need of the patient. This includes the capacity for visits no less than 3 per week, or multiple daily contacts for individuals who have a high level of need. The service is available seven days per week and is accessible beyond normal business.

The program provides outreach clinical treatment, support and facilitation of links to other health and social support agencies for people who have a history of recurrent or prolonged acute inpatient admissions or people who exhibit the potential for multiple admissions, based on assessment and clinical profile.

The staffing profile includes the treating psychiatrist, registered nurses and/or a member of allied health. The program maintains a staff to patient ratio of one full-time equivalent for between 6-8 patients, in addition to the treating psychiatrist. Each patient is assigned a key worker responsible for ensuring comprehensive assessment, care and review by themselves or by the whole team.

A full range of services is provided to the target group on an outreach basis, including ongoing assessment, individual treatment planning, treatment, unplanned responsive interventions, medication administration and management, and the facilitation and coordination of access to other health and community support agencies. Contact is assertive as it is not dependent upon the person maintaining appointments. Services are delivered as an 'in vivo service' that is predominately in the community rather than at the hospital. The staff will work collaboratively with the individual in relation to identifying and meeting their treatment and support needs. They will also work collaboratively with family and carers, treating general practitioners, other components

of the hospital services, and other community health and support agencies involved in the individual's treatment.

This multidisciplinary approach enables the service to provide frequent contact with the individual, and provide the discipline specific expertise in treatment where required. Contact arrangements are flexible, with both a planned and unplanned capacity. Frequency of contact varies with the capacity for multiple daily contacts for individuals who have a high level of need. The intensity of contact may vary from several times per week to one or more times daily, seven days per week. This intervention is responsive and proactive to ensure early intervention in a crisis and continuing treatment and care for the target group to prevent readmission or continuing prolonged admissions.

PURPOSE

- To provide intensive acute treatment and support in the community that reduces the likelihood of a person's need for prolonged or recurrent mental health acute inpatient services.
- To provide bio-psycho-social treatment responses with particular reference to the circumstances surrounding previous relapses or the potential for prolonged admission.
- To provide best practice treatment interventions that ensure improved clinical outcomes and continuity of care, including instances of inpatient admissions.
- To provide a flexible and responsive service that meets the needs of the individual patient and their carer/s.
- To actively involve the patient and their carers (i.e. family/spouse) in the care planning, management and review processes.
- To provide direct assistance with practical problems of living, including the teaching of basic living skills.

EXPECTED OUTCOMES ARISING FROM THE PROVISION OF CARE

- Reduce the frequency of hospital admissions and/or the length of extended hospital admissions by providing safe intensive community based treatment and support services.
- Improve patient functioning including social, occupational and independent living skills, by providing treatment, support, education and advocacy to both the patient and their carer/s.
- Improve the levels of adjustment and well being by providing high quality psychological and psychiatric treatment.
- Directly assist patient in symptom management in the community – skills learnt in the community can be better applied in the community.
- Reduce dropout from treatment and non-compliance by providing an assertive outreach approach, effective case management and continuity of care.
- Assist and encourage patients in accessing other community health and support services, and to provide consultation, education and support to those services, in order to facilitate effective system-wide case management and patient support in the community.

TARGET POPULATION

The Program target population is:

- Patients who have had frequent admissions (short and extended acute admissions) and/or
- Patients who exhibit the potential for multiple admissions, based on assessment and clinical profile; and/or
- Patients who are at high risk of admission who can be suitably managed in a community setting.

REFERRALS

Referral to the Program will be directly from treating psychiatrists who are members of the Toowong Private Hospital's Medical Council.

PATIENT CONSENT

Patients who are willing to participate in the Program will be required to give their consent. Patients can choose to withdraw consent and will be referred to alternative treatment options for ongoing treatment if required.

ADMISSION/DISCHARGE CRITERIA

ADMISSION

MANDATORY REQUIREMENTS

1. Resides within the service catchment area for most of a 6 month period
2. Has a major psychiatric condition where the primary diagnosis is not intellectual impairment of drug dependence/abuse
3. Has had prolonged, frequent, or multiple inpatient admissions to hospital OR; based on assessment and clinical profile, exhibits the potential for multiple and/or prolonged inpatient admissions
4. Assessed a being NOT at high risk of self-harm and NOT requiring a safe environment with a higher level of clinical supervision and monitoring.
5. Is NOT a nursing home type patient.
6. Referred by a psychiatrist
7. Patient consents to ACT Program service involvement

SCORING CRITERIA

1. Requires constant clinical input that is more than twice weekly face to face contact.
2. Unstable accommodation
3. Inadequate support systems
4. Poor living skills
5. Unable to benefit from existing services because of;
   a. Inability to independently access them.
   b. Lack of/poor insight
   c. Lack of motivation
   d. Inability to organise self
   e. Physical limitations

To be considered for ACT Program services the patient must meet all the mandatory requirements and score a total of 16/35 points or higher.

DISCHARGE

A person will be discharged from the Assertive Community Treatment Program if the person:

1. No longer requires constant clinical input that is more than twice weekly face to face contact.
2. Is admitted to a psychiatric facility (including Toowong Private Hospital) for inpatient treatment of an acute psychiatric episode or no longer resides in catchment area.
3. Withdraws consent to participate in the Assertive Community Treatment Program.
4. Is no longer financially covered by their Health Insurance Fund.

A person who is discharged from the Assertive Community Treatment Program as a result of an acute psychiatric episode may be readmitted to the Program following assessment including the eligibility criteria.

EVALUATION OF CONSUMERS PROGRESS

The progress of individual patients will be evaluated at three monthly intervals during their admission to the Program and at discharge. The Program evaluation process will incorporate a number of qualitative rating scales to evaluate individual consumer progress/outcomes. This will include as the standard suite, the Health of the Nation Outcome Scale (HoNOS) and the MHQ 14.

Other measures that could be considered are the GAFS, DASS 21, LSP20, MADRS, BPRS and QIDS.

A patient satisfaction survey will be sent to patients every 90 days and when discharged from the Program.

References

1. Burns, T & Firn, M 2002, Assertive Outreach in Mental Health a manual for practitioners, Oxford University Press, Oxford, New York
2. Assertive Community Treatment Association, Assertive Community Treatment Association, Copyright © 2001-2013. Last Revised: Jan 28, 2013, viewed 2 September 2013 http://www.actassociation.org/actModel/