

**B.C.'s Mental Health Reform**

**ASSERTIVE  
COMMUNITY  
TREATMENT**

**BEST PRACTICES**



**BRITISH  
COLUMBIA**

Ministry of Health and  
Ministry Responsible for Seniors

This report is one of seven mental health best practices reports. The reports reflect the efforts of 44 industry representatives who formed the best practices working groups. Following literature reviews and consultation, they documented what they collectively recognized as services and strategies that produce positive health outcomes for individuals.

The Ministry of Health is grateful for the expertise and diligence these mental health consumers, family members and service providers brought to the work.

The reports on Best Practices for B.C.'s Mental Health Reform are:

- Housing
- Assertive Community Treatment
- Crisis Response/Emergency Services
- Inpatient/Outpatient Services
- Consumer Involvement and Initiatives
- Family Support and Involvement
- Psychosocial Rehabilitation and Recovery

**B.C.'s MENTAL HEALTH REFORM  
BEST PRACTICES FOR  
ASSERTIVE COMMUNITY TREATMENT**

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**BEST PRACTICES WORKING GROUP**  
**ASSERTIVE COMMUNITY TREATMENT**

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**Important note**

The principles of psychosocial rehabilitation form the philosophical foundation for all best practices in mental health. These principles emphasize both consumer involvement in developing and realizing personal care and life goals, and treatment and supports that help consumers manage their symptoms and build on their strengths.

## EXECUTIVE SUMMARY

Assertive Community Treatment (ACT) is a service delivery model that provides flexible, comprehensive services to individuals with multiple and complex needs. ACT is distinct from all other models of case management in its key components, which include a low staff-to-consumer ratio, a team approach, consumer-directed delivery of care, assertive outreach and continuous services. This model is defined as a best practice because controlled research studies have linked this approach to positive client outcomes. Controlled research is lacking that compares other models of case management and identifies what aspects are most effective; however, all models share the functions of assessment, planning, linking and monitoring.

The target population for ACT is individuals with serious and persistent mental illness, and accompanying functional disabilities, who are intensive users of the health care system. Because of the high costs and intensity of services, ACT is intended for a small percentage of the population of individuals with a serious mental illness.

The outcomes of ACT will benefit individuals living with serious mental illness, their family members and the community. Consistent with research evidence, it is expected that ACT will decrease hospital utilization, improve individuals' level of functioning and decrease caregiver burden.

# 1. ASSERTIVE COMMUNITY TREATMENT GUIDELINES FOR BRITISH COLUMBIA

## 1.1 Purpose

- To provide policy direction for planning and delivering Assertive Community Treatment (ACT) services to consumers who are dealing with a serious and persistent mental illness.
- To ensure that ACT teams are established within a framework consistent with best practices.

## 1.2 Case management and ACT

Case management was developed in the 1970s as a method of service delivery for people with severe mental illness who are living in the community. It was a response to the fragmented care and increased hospital readmission rates for these individuals. Various models of case management have been established as needs emerged; common to all models are the functions of assessment, planning, linking and monitoring.

There is a lack of clear distinction among most models and, in practice, case management is often eclectic, is practiced at different levels of intensity and combines elements from several different models. This lack of uniformity in implementing different elements creates difficulties in comparing outcomes across models. For most models of case management, there is no supporting research evidence that a generic case-management approach provides superior outcomes to traditional (i.e., office based) services; in fact, some studies report that case management is less effective in decreasing hospitalization rates. Assertive Community Treatment (ACT), however, has been the most researched model of case management. This model is distinct from other models in its key components and research evidence has shown it to be effective in multiple studies with a variety of populations. ACT has been defined as a “best practice” because the process has been clearly linked to positive client outcomes.

### Definitions of case management

The following definitions describe the key features and purposes of the variety of case management approaches described in the literature:

- **Brokerage**
  - **Expanded broker or generalist model:** Coordination and referral of a client to services.
- **Clinical case management**
  - **Rehabilitation model:** Developing skills for daily living in order to attain personal goals and enhance community tenure; based on a functional assessment and rehabilitation plans.
  - **Personal strengths:** Emphasis on developing a partnership between case manager and consumer, focusing on strengths rather than disabilities.
  - **Intensive case management:** Small caseloads and high intensity input, including intensive contact and proactive outreach; caseloads are not shared.
- **Full support model or Assertive Community Treatment (ACT)**
  - Focuses on reduction and management of symptoms through skill teaching, clinical management and support; case management is provided by a team, and support is provided in the community where the client lives. Other names for this model are Training in Community Living (TCL) and Program in Assertive Community Treatment (PACT). The Chicago-Bridge model of Assertive Community, referred to as Assertive Case Management (ACM) is a variation of PACT.

#### **Other terms for case management practices**

Other terms are often used to refer to case management practices. These terms may be unique to a particular health region or program, or they may be commonly used in many communities:

- **Outreach:** Interacting with clients in the community, outside an office; often refers to service provided at the client's location.
- **Bridging:** Providing a transitional service, linking clients to community services from a hospital; may also refer to linking one community to another.
- **Hospital admission diversion:** Intensive case management services provided for a short period during a crisis, in order to avoid or prevent hospitalization; the service is provided for the duration of the crisis and is not indefinite.
- **Community living support:** Outreach services are provided in the community, usually by a contracted agency, as an adjunct to case management provided by the mental health centre. The services are also provided to individuals who live in supported housing.
- **Forensic liaison outreach:** Outreach services provided to individuals who require transition services between the criminal justice system, forensic clinics and mental health services.

## 2. ASSERTIVE COMMUNITY TREATMENT

### 2.1 Benchmarks

Assertive Community Treatment (ACT) is an expensive alternative to other forms of community care; therefore, it should be targeted to the most appropriate clients: intensive users of the system served by inpatient care and forensic services. The 1998 mental health plan addresses the two per cent of the population who have serious and persistent mental illness, with accompanying functional disabilities. The plan supports intensive or assertive community treatment for only a portion of the most seriously mentally ill, *up to 8,200 clients*.

This number represents approximately 0.2 per cent of the adult (over age 19) population of British Columbia, but it does not reflect community-service utilization by individuals or the population distribution of intensive system users. It cannot be assumed that there is equal distribution throughout the province; in fact, a greater proportion of individuals with serious mental illness are accessing acute hospital and community mental health services in the Lower Mainland.

#### *Recommendations*

1. ACT should be provided for those individuals who have a serious and persistent mental illness with accompanying functional disabilities and who are intensive users of the health care system. The important criterion for deciding who should access the ACT service is who has the greatest need and most frequent use of other services.
2. Resource allocation for ACT should reflect the service needs of intensive system users in each health region. In the absence of a standardized measure from the Ministry of Health of utilization, each region should identify the number of individuals who are intensive users of the system of care, including community agencies, acute care hospitals, Riverview or other tertiary hospitals, jails and forensic services.

## **2.2 Goal**

- To enable individuals with serious mental illness to live independent and self-sufficient lives in the community by receiving treatment in their own environment and appropriate to their needs.

## **2.3 Objectives**

- To reduce the need for hospitalization and improve community tenure.
- To improve the quality of life, health and safety for the consumer and family, as well as the community.

## **2.4 Outcomes**

- Decrease in use of hospital bed days as a result of fewer/shorter hospital admissions.
- Increase in level of functioning in activities of daily living, social, recreational and employment activities.
- Increase in families' satisfaction with their relatives' care and reduced burden of care.
- Improved Global Assessment of Functioning (GAF) scores, reflecting a decrease in symptom severity and fewer acute episodes of illness.
- Decrease in demand on emergency, acute care, forensic and transitional housing services.

### 3. PRINCIPLES OF ASSERTIVE COMMUNITY TREATMENT

The following principles should guide the development of all ACT teams:

- An ACT team is a group of professionals who work together to deliver mental health services to a group of consumers.
- Consumer needs direct the delivery of care.
- Consumers and assertive case managers work in partnership.
- ACT case managers assertively and flexibly provide outreach to consumers, rather than expecting consumers to come to the services.
- ACT service is targeted to the population most in need.
- ACT services are designed to prevent hospitalization and help consumers live successfully in community settings.

## 4. SERVICE COMPONENTS

ACT is a service delivery model that encompasses a continuum of flexible, comprehensive interventions to coordinate all the multiple and diverse needs of clients. Services are delivered by a mobile mental health team that provides treatment, rehabilitation and support services enabling consumers to live successfully in the community. Services are available continuously and over the long term, as long as the consumer needs them, even when this is lifelong.

A number of service components of the ACT model are vitally important to successful implementation:

- a low staff-to-consumer ratio (1 staff for 10 consumers)
- use of team approach/shared case loads
- consumer-directed delivery of care
- assertive outreach
- continuous services.

Component	Objective	Standard
Low staff-to-consumer ratio	Provide intensive contact with consumers to reduce their need for hospitalization and reliance on other crisis services.	A ratio of 10 clients for each staff member on the ACT team. An average of three or more contacts per week per client.
Team approach	Improve continuity of services to consumers. Prevent staff burn-out.	Caseloads shared among all team members and rotated on a weekly basis. Daily meetings held by staff to discuss issues, problems and plans.
Consumer-directed delivery of care	Meet consumer defined needs.	Care/treatment plans are individualized to the consumers and focus on strengths rather than pathologies or deficits.
Assertive outreach	Deliver services at the consumer's location in the community (i.e., home, restaurant, park, etc.)	80 per cent of care is provided in the community, outside the office.
Continuous services	Provide availability of a range of services at all times.	Consumer access to services 24 hrs/day, seven days/week. Services available on a long-term basis, rather than being time-limited.

*Recommendations*

3. The ACT model will include five key components for each consumer receiving the service: a low staff-to-consumer ratio, a team approach, consumer-directed delivery of care, assertive outreach and continuous services. Fidelity of the ACT model will be dependent on all five components being present at the same time for all consumers who are receiving the service.
4. Funding for ACT teams should be based on adherence of the teams to a fidelity scale that measures the degree of conformity in implementing the five key components of the model.

## **5. LOW STAFF-TO-CONSUMER RATIO**

A staff-to-consumer ratio of 1:10 is one of the basic tenets of ACT. The ability to have contact with consumers on average three times a week or more, during a particularly difficult period, is important to providing continuity of treatment and reducing hospitalizations. The highly individualized nature of treatment means that crises can be averted before hospitalizations are necessary.

## 6. USE OF TEAM APPROACH/SHARED CASELOAD

All members of the team share the responsibility for the total consumer caseload. In this model, every team member gets to know every consumer and every consumer gets to know every team member. Sharing responsibility among the team members yields benefits for both consumers and staff. The consumer gets to know and work with all members of the team; the departure of one team member does not create a gap in service for the consumer. It also allows for a variety of approaches that may be better suited to the consumer. For the ACT case manager, the-shared caseload approach has been very effective in preventing burnout; staff morale is higher and turnover is lower.

### 6.1 Staffing

An ACT team should have a minimum of three and not more than six staff members. It is recognized that ACT teams in rural areas, for example, and in other unique situations may have some flexibility in team size. The team may include nurses, social workers, occupational therapists, health care workers, recreational therapists and psychiatrists. In addition, teams should consider the inclusion of peer support workers as members of the team. Evidence suggests that peer support workers may contribute to better outcomes in service delivery with particular emphasis on social network building and peer support. The peer support worker's involvement can have a significant effect on the consumer's quality of life and may also have a positive effect on the attitudes and actions of other members of the team.

Staffing Mix	Nurses	Other Professionals (Social Work, Occupational Therapy)	Psychiatry	Other (Health Care, Peer Support)	Clerical Support
URBAN	Minimum of 2 per team	Minimum of 1 per team	0.5 for every 6 FTE team members	1 for every 6 additional team members	0.5 for every 6 FTE team members
RURAL	Minimum of 2 (may be working in different communities)	May include professional supports available in the community	0.5 for every 6 FTE team members	Undetermined; team may have a wide variety of other supports	0.5 for every 6 FTE team members

## **6.2 Role of ACT staff**

- Team case management
- Home/street visits
- Engagement and assessment
- Coordination of/access to resources
- Brokerage, mediation and advocacy in seeking services
- Health and life skills teaching
- Crisis management and interventions
- Administering and monitoring medication
- Symptom assessment/management, supportive therapy
- Rehabilitation and vocational services
- Education, support and consultation to consumers, their families and other major caregivers.

## **6.3 Staff training**

ACT team members must be qualified and possess the necessary skill set to provide treatment in community settings. Training in the principles of psychosocial rehabilitation is essential because the ACT approach is a form of active treatment combined with psychosocial support. Staff should make it a mission to reduce consumer recidivism and be willing to do “whatever it takes” to prevent a hospitalization. They must be passionate about caring for these individuals who suffer from a severe and persistent mental illness, be flexible and adaptable and value a client-directed practice.

## **7. CONSUMER DIRECTED DELIVERY OF CARE**

Traditional health care delivery matches consumers with existing programs. The ACT model adapts the program to the consumer. Services and interventions are designed on a highly individualized basis to meet the current needs and preferences of each consumer.

As a result of the many and varied factors that affect people's lives, the intensity of any particular individual's service needs may vary over time. The ACT model is designed to accommodate that variability with low staff-to-consumer ratio and highly individualized treatment plans. ACT case managers have the flexibility to meet consumer needs.

## 8. ASSERTIVE OUTREACH

Being an ACT team is about taking a “*can-do*” attitude—i.e., doing whatever needs to be done to help the person with mental illness meet their individual goals and service needs. In this way, the team works to adapt the environment and themselves to meet the consumer’s needs, rather than requiring the consumer to conform to the treatment program. Motivation and engagement of the consumer, as well as retention of the client over time, are key to successful outcomes for the consumer and the ACT model.

Eighty per cent of the total services provided for consumers are delivered in the community. The ACT team office is seen as a home base for staff, rather than a primary treatment site.

Providing services in the environment of the consumer’s choice enables the team to assess the consumer’s needs in the real world and to provide support and teaching in daily living skills. Assertive outreach is the key to engaging clients who do not connect with traditional office or institution-based approaches. Innovative approaches should be developed and implemented on an individual basis to motivate and engage consumers.

## **9. CONTINUOUS SERVICES**

ACT teams should be part of a continuum of services for people with serious mental illness. Case management and crisis services are available in many regions; and ACT teams should build on this expertise, not replace it. In some areas, given their geographical access and clinical resources, an ACT team may arrange after-hours coverage with a crisis response service that consumers have already developed a relationship with. In regions where crisis services are not available, ACT team members should be on call.

Another important feature is the long-term nature of these services. Services are delivered on a continuous, rather than a limited, basis. Evidence shows that consumers who do well while engaged in ACT may relapse after discharge.

## 10. ADMISSION CRITERIA

Individuals who have multiple problems and are intensive users of hospital and community services require a model of health care delivery that provides continuity. In order to assist in identifying these individuals, the following criteria can be used as a checklist:

### 10.1 Age

Client is over the age of 19 years.

### 10.2 Nature of illness

Client has a severe and persistent mental illness that seriously impairs functioning in a community setting. Priority should be given to individuals diagnosed with:

- schizophrenia
- mood disorder
- other Axis (e.g., personality disorders).

*Note: Individuals with a primary diagnosis of a substance-abuse disorder or mental handicap are not appropriate.*

### 10.3 Functional impairments

Clients with significant functional impairments as demonstrated by at least three out of the six following conditions:

1. Unable to consistently perform a range of practical daily living tasks or persistent or recurrent failure to perform daily living tasks without significant support or assistance, for example:
  - maintaining personal hygiene
  - meeting personal nutritional needs (meal planning, shopping)
  - budgeting and managing personal business affairs
  - other.

2. Unable to maintain a safe, stable living situation, for example:
  - homeless
  - repeated evictions
  - residing in substandard housing.
3. Has inappropriate social behavior, for example:
  - demand for intervention by community agencies
  - demand for intervention by police.
4. Needs help with personal effectiveness, for example:
  - assertiveness
  - problem solving
  - stress management
  - social skills.
5. Unable to be consistently employed, for example:
  - unemployed
  - shelter work
  - poor work history.
6. Lacks a support system, for example:
  - unable to develop a support system
  - unable to maintain a support system.

#### **10.4 Indicators of need**

Individuals with one or more of the following problems, which are indicators of continuous intensive needs for service:

- intensive use of acute care psychiatric hospitals (two or more admissions per year)
- frequent use of psychiatric emergency services
- admissions to Riverview Hospital or another tertiary psychiatric facility
- high risk or recent history of criminal justice involvement
- non-compliance with treatment:
  - refuses traditional office-based follow up services
  - has poor linkages to existing services

residing in an inpatient bed or a residential facility, but clinically assessed as able to live in an independent living situation if intensive services are provided or requiring a residential or institutional placement if more intensive services are not available determined to be at risk for (re)hospitalization without intensive services.

#### **10.5 Substance abuse**

Co-existing, exacerbating substance abuse disorder of significant duration.

## 11. DISCHARGE CRITERIA

Discharges by the ACT team occur when consumers and program staff mutually agree to the termination of services. This occurs when consumers:

- **Move outside the geographic area.** In such cases, the team arranges for transfer. The ACT team ensures continuity of service with the receiving region. The team maintains contact with the consumer until this service transfer is arranged.
- **Maintain a defined level of functioning** in all major role areas (i.e., social, self-care) for at least two years. This determination is to be made by both the consumer and the ACT team.
- **Request discharge,** despite the ACT team's best efforts to develop a treatment plan acceptable to them.

## 12. ASSESSMENT TOOLS

A wide variety of assessment tools are available to determine suitability for ACT, to evaluate outcomes and to measure the fidelity of model implementation. They include:

- Admission Screening Criteria
- Global Assessment of Functioning (GAF)
- Discharge Screening Criteria
- Consumer Satisfaction
- Caregiver Satisfaction
- Hospital Utilization Data
- Contact Sampling Logs
- Fidelity Scale

## **13. EXAMPLES OF BEST PRACTICES**

### **13.1 The United States and Canada**

Stein and Test developed the Program for Assertive Community Treatment (PACT) in Madison, Wisconsin, in the early 1970s. The program was initially conceived as an alternative to acute hospital admissions, but soon it was widely applied as a means of caring for patients in the community. The PACT program was replicated in many jurisdictions (e.g., the Threshold/Bridge Assertive Case Management Program in Chicago has replicated the PACT model in the inner city and rural areas). More than 30 states in the USA have initiated statewide implementation of ACT. NAMI (the National Alliance for the Mentally Ill) has recognized ACT as the most effective service delivery model for community treatment of people with a serious mental illness.

Many provinces in Canada are in the process of establishing guidelines and standards for ACT, including Ontario, Quebec and New Brunswick.

### **13.2 British Columbia Examples of ACT**

#### **Lower Mainland Assertive Case Management**

In 1988, the Riverview/Fraser Valley Assertive Outreach Program Research Project was implemented under the direction of Dr. John Higenbottam. This two-year project in two Lower-Mainland mental health centres (Surrey and New Westminster) served an experimental group of 60 clients identified as being at high risk for rehospitalization and 60 individuals who were assigned to a control condition. The program was based on the Threshold/Bridge Assertive Case Management model. At the conclusion of the research project in 1991, additional Assertive Case Management (ACM) teams were established in Delta, Langley, Maple Ridge, North Shore, Port Coquitlam and Surrey.

#### **Vancouver Assertive Community Treatment**

In 1995, Greater Vancouver Mental Health Services, in partnership with local hospitals, established an ACT team with the mandate of serving intensive users of hospital and emergency services. This included individuals who had mental health/physical/substance abuse problems. The program, modeled after the PACT program in Wisconsin, was recently reshaped to focus on individuals with a serious mental illness.

## **Forensic Services**

### ***Inter-Ministerial Project***

The Inter-Ministerial Project (IMP) was established in 1987 as a joint venture between the Ministry of Attorney General, Greater Vancouver Mental Health Services and Forensic Services. The target population includes people who have a history of involvement in the criminal justice and mental health systems and are living in Vancouver. The IMP program is based on an ACT model with a team approach, low staff-to-client ratio and assertive outreach. Clients are engaged prior to leaving a correctional facility and are discharged from the program when they are hospitalized or incarcerated for a period of three months or more, when they are deemed capable of maintaining themselves in the community or when they withdraw from the program.

### ***Forensic Assertive Case Management***

The forensic model of service delivery may be viewed as a hybrid of ACT, similar to a rural model of ACT. Case managers from the Kamloops Forensic Outpatient Clinic travel to see clients throughout the Thompson, Okanagan and Kootenays, wherever the client resides. Clients are referred from the courts and BC Review Board as NCR-MD (Not Criminally Responsible due to Mental Disorder) or unfit. The case managers work as part of a team of professionals in each region and assist in coordinating and providing the necessary resources to help the client function successfully in the community. The team includes members from mental health centres, family and related community agency staff providing services to the clients.

The recent addition of the Forensic Liaison Workers (FLW) will assist in the streamlining of the process involved in the disposition of cases of people with mental disorders who come into conflict with the law, with a major focus of their role being on the diversion of appropriate cases and subsequent case management of appropriate clients. As with the Forensic Case Managers, the FLWs will have large areas to cover and will need to use a similar network of agency and professionals to ensure the principles of assertive outreach and frequent contact for clients are upheld.

## **14. IMPLEMENTATION**

### **14.1 Linkages**

When implementing ACT, it is important to maintain ongoing linkages with existing services. This ensures that duplication is minimal and that consumers get access to the array of services that are available. Not all services can be provided directly by the ACT program; therefore, strong linkages and service coordination are vital (i.e., with emergency services, general hospitals, tertiary facilities, rehabilitation services, housing and other community services). From a consumer's perspective, it is essential that a network of services collaborate to provide as seamless a continuum as possible.

### **14.2 Solutions to systemic barriers to Assertive Community Treatment**

#### **Rural communities**

ACT may be implemented in small and/or rural communities by modifying the makeup of the treatment team and the frequency of contacts with the client. A small community without sufficient population or budget to support three ACT team members may hire one staff member who then works closely with other community service providers, family members or landlords for each client. The "team" may differ for each client; however, the important features of a team approach, low staff-to-client ratio and assertive outreach can still be maintained. In addition, as a result of greater travel distances in rural communities, the number of contacts may be modified.

With a suggested staff-to-consumer ratio of 1:10, and the significant level and intensity of services required by this treatment model, a critical mass of consumers must be involved to make this approach viable. Adjustments would be necessary, therefore, to apply this model to rural settings where less than 10 consumers would be eligible for the ACT approach. The same level of direct service delivery may be difficult; travel distances may necessitate a lower case load and community members, along with other local community services, may need to be incorporated into the treatment plan. In some areas of the province, however, this approach may not be possible because there are not enough consumers who meet the admission criteria.

Adjustments to the approach may also be necessary to enable specialized teams to be formed to assist populations with special needs: for example, the psychogeriatric population, the homeless and socially isolated, the dually diagnosed (substance misuse and a major mental disorder), offenders with a mental disorder and other hard to serve populations.

*Recommendations*

5. ACT may be implemented in small and/or rural communities by modifying the makeup of the treatment team and the frequency of contacts with the client. The “team” may differ for every client; however, the important features of a team approach, low staff-to-consumer ratio and assertive outreach must still be maintained.
  
6. With a suggested staff-to-consumer ratio of 1:10, and the significant level and intensity of services required by this treatment model, a critical mass of consumers must be involved to make this approach viable.

### **14.3 Costs**

Integral to the success of ACT is additional funding for unique issues:

- **Client contact funds**—approximately \$15 to \$18 per month per client. This is especially important for engaging new clients; but it can also be used for emergency cleaning supplies, food, etc. It is important that the case manager maintain control of the budget and not present the funds to the client as an entitlement.
- **Travel and car expenses**—including business insurance, increased mileage reimbursement and car detailing.
- **Electronic communications**—Cell phones are necessary for safety reasons, crises or emergencies. Laptop computers are recommended in rural communities for obtaining information or doing reports. This can be realized from savings on office equipment and supports.

*Recommendation*

7. Additional funding, beyond staffing costs, should be provided to ensure the success of ACT. This includes client contact funds, additional travel and car expense budgets and cellular telephones.

#### **14.4 Staff training**

On-the-job training with an established ACT team is an important means of learning the role and functions of the team. There are, however, few established teams in the province and those that do exist are primarily in the Lower Mainland. Riverview Hospital, in partnership with Douglas College, has developed a training program for ACT that includes a classroom component and a field placement with established ACT teams. The possibility of mobilizing this training should be explored. Another option would be for communities that have no previously established ACT service to approach communities that do have ACT about a two-week mentorship of their new ACT employees.

##### *Recommendations*

8. Staff in newly-established ACT teams should receive training from existing teams or through the Douglas College training program developed in partnership with Riverview Hospital.
  
9. If there is a critical demand in rural areas for ACT training, the Ministry of Health should explore the possibility of the Douglas College program providing an outreach service.

#### **14.5 Evaluation**

The effectiveness of ACT as an approach to caring for people with severe mental illness has been validated by numerous studies. The Cochrane review of ACT surveyed randomized controlled trials that compared ACT to standard community care, hospital-based rehabilitation and case management. Its conclusions supported the effectiveness of ACT in reducing hospitalizations, maintaining contact with services and improving social functioning and quality of life. The research evidence suggests, however, that the whole ACT model should be practiced, rather than selected elements only.

ACT should be evaluated as a best practice approach according to the implementation of key components that have been validated by research. These include:

- team approach/shared responsibility
- accountability of the team for all the care required
- in-vivo service
- assertive outreach
- low staff-to-consumer ratios (1:10)
- 24-hour emergency availability.

Health regions can report on the completeness of ACT implementation by using a standardized checklist. Variations may exist between rural and urban areas or across different populations; however, the quality of care can be measured in all situations using the following dimensions:

- accessibility for target population receiving service
- utility/value for hospital/service use
- satisfaction of client/family/caregiver
- safety of client/service provider
- affordability for the client
- efficiency of all available resources networked in care.

A standardized checklist can be developed to define ACT implementation. Regions would then use common dimensions to report on the quality of care provided after implementation of ACT.

#### **14.6 Team size in urban communities**

As teams grow in size, the frequency of contact for each worker with each group of 10 clients decreases. At a certain size, the relationship between case manager and client is weakened by diminished intensity of contact. Therefore, once urban communities reach the optimum size of six team members, a second team should be established, using some of the experienced team members of the first team. In this way, both teams will have experienced and new workers and clients will maintain more intensive contact with all case managers.

#### **14.7 Special populations**

ACT is a client-centred approach that can be effective across all ages and cultures. In addition, special populations, such as offenders with a mental disorder and medically-compromised clients, are equally well served by the model. The important criteria for deciding who should access the service are based on who has the greatest need and most frequent use of other services.

## SUMMARY OF RECOMMENDATIONS

1. ACT should be provided for individuals who have a serious and persistent mental illness with accompanying functional disabilities and are intensive users of the health-care system. The important criteria for deciding who should access the ACT service are based on who has the highest need and greatest use of other services.
2. Resource allocation for ACT should reflect the service needs of intensive system users in each health region. In the absence of a standardized measure of utilization from the Ministry of Health, each health region should identify the number of individuals who are intensive users of the system of care, including community agencies, emergency services, acute-care hospitals, Riverview or other tertiary hospitals, jails and forensic services.
3. The ACT model will include five key components for each consumer receiving the service: a low staff-to-consumer ratio, a team approach, consumer-directed delivery of care, assertive outreach and continuous services. Fidelity of the ACT model will be dependent on all five components being present at the same time for all consumers who are receiving the service.
4. Funding for ACT teams should be based on adherence of the teams to a fidelity scale that measures the degree of conformity in implementing the five key components of the model.
5. ACT may be implemented in small and/or rural communities by modifying the makeup of the treatment team and the frequency of contacts with the client. The “team” may differ for each client; however, the important features of a team approach, low staff-to-client ratio and assertive outreach must still be maintained.
6. With a suggested staff-to-consumer ratio of 1:10, and the significant level and intensity of services required by this treatment model, the involvement of a critical mass of consumers is necessary to make this approach viable.
7. Additional funding, beyond staffing costs, should be provided to ensure the success of ACT. This includes client contact funds, additional travel and car expense budgets and cellular telephones.
8. Staff in newly-established ACT teams should receive training from existing teams or through the Douglas College training program developed in partnership with Riverview Hospital.

9. If there is a critical demand in rural areas for ACT training, the Ministry of Health should explore the possibility of the Douglas College program providing an outreach service.

## GLOSSARY

**accountability.** The management team is responsible for defining expected outcomes and performance measures, a plan for monitoring service delivery and activity reporting structure. The Ministry of Health is responsible for the expenditure of public funds.

**accreditation.** External, formal review of an agency's performance and adherence to standards of delivering care services. Certification by a national organization whose business is the evaluation of compliance by service organizations (such as hospitals) with pre-set standards of care and/or service.

**acute care** (also referred to as secondary level care). Diagnostic and therapeutic health care (in medical disciplines, including psychiatry) provided by health care professionals, usually in a hospital setting and for a short duration.

**acute psychiatry (inpatient).** Assessment, diagnosis, treatment, stabilization and short-term rehabilitation of people with serious mental illnesses admitted voluntarily or involuntarily to a hospital psychiatric unit, which often entails emergency psychiatric care.

**adult.** Person 19 years of age or older.

**advocacy.** The act of informing and supporting people so they can make the best decisions possible for themselves or an act or acts undertaken on behalf of others when they are unable to act on their own.

**ALOS.** Average length of stay.

**Assertive Community Treatment (ACT).** An alternative to other forms of community care which, because of its comparative expense, should be targeted to the most appropriate clients (i.e., frequent users of the system, including inpatient care and forensic services). The 1998 mental health plan addresses the two per cent of the population with serious and persistent mental illness, with accompanying functional disabilities. The plan supports intensive or assertive community treatment for only a portion of the most seriously mentally ill, up to 8,200 clients.

**best practices in mental health.** Descriptions of what can be done to facilitate change for the better in mental health policies, practices and initiatives. Factors that facilitate change include clearly articulated conceptual bases, wide stakeholder involvement, political vision and will, infrastructure supports, the reallocation of funds and personnel from institutions to community, partnerships beyond health, reduction in stigma, enthusiastic leaders, skilled staff and the Canadian Mental Health Association National Framework for Support.

**biopsychosocial approach/model.** Services that take into account the biological, psychological and social needs of an individual. Involves multidisciplinary care teams, including physicians, nurses, pharmacists, social workers, occupational therapists, dietitians and psychologists.

**case management.** The coordination of a consumer's health care, housing, employment, training and/or rehabilitation services, usually by one person (the case manager) operating in a team environment who liaises with all others providing services to the consumer. Case management provides active outreach, coordination of personalized care plans and monitoring of mental health status.

**clinical practices guidelines.** Systematically developed statements to assist practitioners in decisions about appropriate health care for clients in specific clinical circumstances.

**community resource base concept.** This concept "assumes the perspective of the person in the centre: the consumer who is actually living and coping with a mental health problem. The majority of consumers now live most of their lives in the community and are influenced by a wide range of factors. These factors include housing, education, work, income, mental health services, consumer groups and organizations, family and friends and generic community services and groups.

**consumers.** People who use mental health services.

**crisis stabilization program.** Provides community-based, short-term treatment and stabilization services for individuals in psychosocial and psychiatric crises as an alternative to hospitalization. During the client's stay, a thorough assessment is completed, intensive brief crisis intervention services are provided and an immediate action plan for community re-integration is implemented.

**decompensate.** The psychotic symptoms return or the person's ability to function is disrupted.

**designated facility.** A hospital or provincial mental health facility that may admit involuntary patients under the *Mental Health Act*.

**determinants of health.** Factors that influence and determine health status. These include social, economic and physical environments, health services, biological influences and health behaviors and skills.

**DSM-IV.** *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* The American Psychiatric Association's classification tool to assist care practitioners in classifying mental disorders based on symptoms.

**dual diagnoses.** Commonly used to describe the condition of people who have a mental illness and either a mental handicap or substance misuse issues.

**ECT.** Electroconvulsive therapy.

**emergency accommodation.** Facilities that offer short-term emergency accommodation in a supportive environment for people with marked behavioral and social problems associated with mental illness who have no other immediate housing options available to them, but who do not require care in a hospital or intensively staffed facility.

**empowerment.** The capacity of choice. Includes the ability to define, analyze and act on problems one experiences in relation to others and in one's environmental living conditions. As a process, describes the means through which internal feelings of powerlessness are transformed and group actions initiated to change the conditions that create or reinforce inequalities in power.

**epidemiology.** Prevalence of a disease in a particular community at a particular time.

**etiology.** Pertaining to the science of the causes of disease.

**evidence-based decision making.** A process that takes facts, data and evidence into account. It is an essential part of effective and accountable planning, action and evaluation.

**family care home.** Care provided in approved homes to one or two adults with a serious and persistent mental illness who are unable to live independently. This category of care is not subject to licensing under the provincial *Community Care Facilities Act*.

**forensic.** Forensic Psychiatric Services provides assessment, diagnosis, treatment, detention and supervision of people with mental illness who are involved with the criminal justice system.

**FTE (full-time equivalent).** FTE is the unit used to describe a full-time position. For example, two half-time positions equal one FTE.

**functional impairment.** An individual's reduced ability to perform usual daily activities. A number of measurements exist to gauge a person's level of functioning (and level of functional impairment). The global assessment of functioning (an aspect of assessment that is part of the ASP *DSM-IV*) is one such tool.

**governance.** The authority to operate a health care program. Governing bodies, such as boards of directors or trustees, generally define the vision, mission and values of an organization and set goals, objectives and priorities for its operation.

**guidelines.** A suggestion or set of suggestions that guides or directs action. The purpose of a guideline is to provide additional information that assists service providers to comply with policy. Guidelines may be suggestions on how to carry out or implement policy. Whereas health authorities and services providers must comply with Ministry policy, they do not have to comply with guidelines.

**health authorities.** Public bodies mandated under the *Health Authorities Act* to govern, manage and deliver health services in a defined geographic area. Refers to either Regional Health Boards (RHBs) or Community Health Councils (CHCs). Community Health Service Societies (CHSSs) are included here, although they do not have status under the act and derive their authority from their constitution and bylaws, established pursuant to the *Society Act*.

RHBs govern the delivery of all health services within a designated region.

CHCs govern the delivery of acute and continuing care-based services, such as hospitals and intermediate care facilities, in areas of the province where there are no RHBs.

CHSSs govern the delivery of services that are broadly regional in nature—public health, community health care nursing, community rehabilitation, case management, health services for community living and adult mental health services—in areas of the province where there are no RHBs. Collectively, the CHSSs and the CHCs within a region govern the delivery of all health services in the region.

**health status.** A group or community's status of health, evaluated by means of universal epidemiological indicators, such as the rates of illness and death, life expectancy and potential years of life lost, and compared with other populations.

**integration.** Organization of service entities along a continuum, ranging from cooperation between agencies to full amalgamation of governance, management and service delivery structures, in order to ensure that the client's needs are met in a coherent, unified, holistic and efficient manner.

**mandate.** The scope of an organization's responsibility.

***Mental Health Act.*** British Columbia's *Mental Health Act* was proclaimed in 1964. Its purpose is to ensure "...the treatment of the mentally disordered who need protection and care..." The main focus of the *Mental Health Act* is to provide authority, criteria and procedures for involuntary admission and treatment. The act also provides protection to ensure that these provisions are applied in an appropriate and lawful manner.

**mental health crisis.** An acute disturbance of thinking, mood, behavior or social relationship that requires an immediate intervention; which involves an element of unpredictability that is usually accompanied by a lack of response to social controls; and may be defined as such by the client, the family, or other members of the community, including family physicians or police.

**multiaxial assessment.** An assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict the outcome. There are five axis included in *DSM-IV*:

- Axis I Clinical Disorders
- Axis II Personality Disorders
- Axis III General Medical Conditions
- Axis IV Psychosocial and Environmental Problems
- Axis V Global Assessment of Functioning

**operating budget.** The amount of funding necessary to pay for the cost of running an organization.

**organic brain syndrome.** A psychological or behavioral abnormality associated with a temporary or permanent dysfunction of the brain caused by disease processes, strokes or accidents.

**outreach.** Services are taken to the consumer (e.g., at home, at work, in a facility) rather than requiring the consumer to attend a clinic or hospital.

**partnership model in mental health.** Services provided through individual care planning, carried out in a partnership among the Ministry of Health, service providers, local governments, family members, other unpaid caregivers and consumers, to meet the needs of consumers and in the context of all the roles and functions of all parts of the mental health system.

**psychosocial rehabilitation.** Psychiatric rehabilitation services designed to assist a person with a serious mental illness in effectively managing the illness and compensating for the functional deficits associated with the illness. People who receive psychosocial rehabilitation services are significantly more likely to be able to return to work or school or to resume a participating role in the community. The range of psychosocial services may include rehabilitation, case management, residential treatment and support, crisis services, social services, housing, vocational rehabilitation, substance abuse treatment, peer support and family support.

**psychotropic drug.** Any medication that has a primary effect on the central nervous system, with the intention of improving moods or thinking. The term “typical” psychotropic drug refers to relatively old products. The term “atypical” refers to psychotropic drugs that are relatively new and designed to treat a wider range of symptoms with fewer side effects.

**primary care.** Preventive, diagnostic and therapeutic health care provided by general practitioners and other health care professionals. The first level of care normally accessed by clients and patients. Primary care may include referral to more specialized levels of care, e.g., secondary (hospital or specialist care). Family doctors are often referred to as “primary care physicians.”

**quality assurance (QA).** An ongoing program to ensure that standards of service delivery are being met.

**residential care.** Provided in community-based, licensed facilities that are staffed to provide full-time care, supervision and psychosocial rehabilitation for people whose social and/or mental functioning prevents them from living more independently. These facilities average 13 residents and are regulated by the *Community Care Facility Act* and the Adult Care Regulations. The facilities are subject to program standards, guidelines, policies and procedures.

**residential care for specialized needs.** Augmented resources provided to community care settings to respond to the complex care needs of people with severe neuro-psychiatric disorders and very challenging behaviors.

**residential program/services.** An organized program enabling clients to have the best possible quality of life, while remaining or becoming integrated into the community. Residential services may be provided in rural or urban areas, in houses, apartments, townhouses or other culturally appropriate settings.

**respite.** Temporary, short-term care, designed to give relief or support to a family caregiver who has responsibility for the ongoing care and supervision of a family member with a serious mental illness. Respite can be provided inside or outside the home.

**secondary level care.** (See *acute care*)

**serious mental illness.** Generally, illnesses such as schizophrenia, manic depression and bipolar disorder represent the most serious mental illness. It is acknowledged, however, that there are others for whom medical risk and level of impairment, regardless of diagnosis, defines their mental illness as “serious.”

**stakeholders.** Representatives of the British Columbia mental health care community of interest (e.g., consumers, families, professionals, unions, health authorities).

**standard.** An established, measurable, achievable and understandable statement that describes a desired level of performance against which actual performance can be compared. Used by service providers to attain and maintain quality of care or service delivery, they state what consumers and the public can expect from a service. While a policy tells service providers what to do, a standard is a tool that allows a service provider to measure, monitor and compare actual performance against a benchmark.

**supported education.** An effective means of helping individuals with psychiatric disabilities to achieve success in accessing and pursuing educational opportunities of their choice.

**supported housing.** A variety of living arrangements (usually self-contained living units) for people with a serious and persistent mental illness who are able to live independently with the assistance of a range of support services and the provision of a housing subsidy.

**tertiary care.** The care of people with serious, complex and/or rare mental disorders who, by reason of severe psychotic behavior or the need for specialized staff or facilities, cannot be managed by the resources available at the primary and secondary levels of care in the province. It also includes specialized services such as child and adolescent, psychogeriatric, alcohol/substance abuse and forensic mental health services.

Tertiary mental health care includes specialized intensive acute-care assessment and short-term treatment programs and both short-term (episodic) and long-term institutional care for severe chronic cases. It excludes long-term care that does not require daily access to the special clinical resources that are available only within the tertiary care programs.

**utilization data.** The information required to compare observed use of resources with recognized standards for use.

**utilization management.** Process by which agencies decide on the efficient use of care resources, comparing the observed use of resources with recognized standards of appropriate, timely and cost-effective utilization. The objective is to ensure that the right services are provided to the intended consumers, when they most need them, at the lowest cost consistent with high-quality care.

**values.** The beliefs of an organization that underlie its principles and actions and form the basis for planning and operating services.

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