



EVIDENCE-BASED
PRACTICES

KIT

Knowledge Informing Transformation

Training Frontline Staff

Assertive Community Treatment



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov



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Training Frontline Staff

This workbook will help ACT leaders teach their ACT team members about the principles, processes, and skills necessary to deliver effective ACT services. It covers:

- the basic elements of ACT,
- the theory behind the ACT model,
- the core processes that ACT teams follow, and
- the types of services that ACT team members provide.

Use this workbook as both a training manual for group sessions and a basic desk reference.

Assertive Community Treatment

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Assertive Community Treatment KIT that includes a DVD, CD-ROM, and seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP

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Training Frontline Staff

How Program Leaders Should Use This Workbook

Training Frontline Staff introduces ACT team members to the basic principles and skills they need to deliver effective Assertive Community Treatment (ACT) services. Use this workbook with the **Introductory Video** (English and Spanish versions) and **Practice Demonstration Video** on the DVD in this KIT.

Since being part of a team and learning how to process information together is an essential part of ACT, we recommend that you conduct group sessions rather than simply giving ACT team members the workbook to read on their own. To make the content easy to manage, we divided the training into four modules:

1. *Basic Elements of Assertive Community Treatment,*
2. *Recovery and the Stress-vulnerability Model*
3. *Core Processes of Assertive Community Treatment, and*
4. *Service Areas of Assertive Community Treatment.*

The ultimate purpose of this workbook 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 these modules as a group creates an opportunity to learn about how team members communicate in a team environment.

To complete this four-session training, you should:

- Arrange for your ACT team members to meet once a week for 4 weeks. You will cover one module each week.
- In this workbook, on the page before each module, you'll find Notes to the *facilitator* and *program leader*. Review them to prepare for the training in each module. The notes also include suggestions for additional exercises you should consider to supplement the material in the module.
- Copy and distribute the module's reading materials to the team members before the session so that they can read them beforehand. You'll find each module on the KIT's CD-ROM.
- Copy the exercises for each module so that you can distribute them during each session. You'll find them also on the CD-ROM.
- For each session, ask a different team member to facilitate.
- Begin each training session by showing the corresponding segment of the **Practice Demonstration Video**.
- Discuss the information in the video and workbook.
- Complete the suggested exercises for that module.



Prepare program-specific information

In addition to the materials in this workbook, prepare to give ACT team members information about ACT policies and procedures. These include the:

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

Prepare agency-specific information

You should also develop a plan to train 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 about safety. If training in this area is not already available, plan for training in de-escalation techniques. You might also seek a local law enforcement agency 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 must know how to document their activities and bill for services.
- **Vehicles:** Team members must understand the policies about using and maintaining vehicles.

- **Mandated reporting:** Team members must know how to report suspected abuse and neglect.
- **Consumers' rights:** Team members should be aware of the State and Federal consumer rights requirements, especially the Americans with Disabilities Act.
- **Other policies and procedures:** Consult your agency's human resource office to learn of other program, agency, or State policies that the staff should know.

Visit an existing team

After your ACT team completes this workbook, we suggest that new ACT team members observe an experienced ACT team. Being familiar with these materials before visiting a team will make the visit more productive. Rather than having to take time to explain the basics, the host team will be able to show the new ACT team members how to apply the basics in a real-world setting.

To find a team to visit in your area, contact:

Assertive Community Treatment Association

810 East Grand River Avenue, Suite 102
Brighton, MI 48116
(810) 227-1859

www.actassociation.org

National Alliance on Mental Illness

2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
(800) 950-NAMI

www.nami.org

Arrange for didactic training

After using this workbook and visiting an experienced team, you will be ready for a trainer who will help team members practice what they have seen and read. Some ACT leaders choose to hire an external trainer to introduce ACT principles, processes, and skills. The initial training should take 2 to 3 days.

Recruit a consultant

After the initial 2- to 3-day training, you, along with the ACT psychiatrist, are responsible for ensuring that the team follows the ACT model in their work with consumers. This task can be challenging. You must facilitate a team development process, apply what the team members have just learned about ACT in their own clinical work with consumers, and, at the same time, ensure through clinical supervision that they follow the model.

It is very easy to stray and do something similar to, but not quite the same as, ACT. Sometimes this happens because teams believe they are diligently following the ACT model, but they miss some of the more subtle aspects of it. In other cases, teams start well, but, as more consumers are admitted to the program and pressure mounts on the team, they revert to older, more familiar ways of working.

To ensure that your team follows the ACT model, work with a consultant throughout the first year of operation. A consultant can provide ongoing telephone and in-person support to help you with your challenging leadership role.

If you need help finding a trainer or consultant, contact the Assertive Community Treatment Association and the National Alliance on Mental Illness (mentioned above).



Cross-train

It is important that staff throughout your agency develop a basic understanding of ACT. Cross-training will ensure that other staff support the work that the ACT team undertakes. To help you meet this need, we include these multimedia materials in the ACT KIT:

- the introductory PowerPoint presentation,
- sample brochure, and
- the **Introductory Video**.

Once trained, ACT team members will be able to use these materials to conduct routine in-service seminars to ensure that all staff within the agency are familiar with the ACT program.

We also recommend that you use these materials to train members of your ACT advisory group. The more information that advisory group members have about ACT, 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 one another. Make sure that the advisory group members and team members introduce themselves and that team members are familiar with one another's roles.

For more information

We adapted much of the material in this workbook from *A Manual for ACT Start-Up* (Allness & Knoedler, 2003), published by the National Alliance on Mental Illness.

This manual, written by Deborah Allness and Bill Knoedler, is a valuable tool. *Training Frontline Staff* and other ACT KIT booklets complement but do not replace the manual.

We consistently found that agencies used *A Manual for ACT Start-Up* in conjunction with this KIT to develop and manage their ACT programs. For this reason, we recommend that you obtain a copy of the manual.

Contact:

National Alliance on Mental Illness

(800) 950-NAMI
www.nami.org

Notes to the facilitator and ACT leader:

Prepare for Module 1:

- Make copies of module 1, *Basic Elements of Assertive Community Treatment*. Your copy is in this workbook; print copies for your team from the CD-ROM.



- Distribute the material to the team members who will participate in your group session. Ask them to read this module before meeting as a group to discuss it.

- Make copies of these exercises:

- ☐ Explore the Benefits of ACT
- ☐ Build an ACT Team
- ☐ Write a Mission Statement



but do not distribute them until your team meets as a group. Again, your copies are on the next pages; print copies for the team from the CD-ROM.

Conduct your first session:

- When you convene your group, view the *Introduction and Basic Elements of ACT* on the *Practice Demonstration Video*. Discuss the video and the content of module 1.



- **Facilitating the dialogue:** Some people have difficulty speaking in a group, perhaps because they are timid or soft-spoken. Others may feel professionally intimidated by those with more experience or higher degrees. Conversely, some team members will be self-confident and outspoken and will need to learn to listen openly to what others have to say.

- Distribute your agency's ACT admission and discharge criteria to review and discuss.

- One at a time, distribute the exercises to the group and complete them. One of the roles of a facilitator and ACT leader is to encourage people who are more withdrawn to express their views and make sure that more vocal team members give others a chance to speak. There will be an opportunity to assess the anxiety that team members may feel about working on an ACT team.



Consider this additional training activity:

Identify communication styles:

Many exercises identify differences in how people communicate and work. Often they 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 still cannot find an exercise of this nature, the Myer-Briggs Type Indicator is used for this purpose but requires someone who is trained in interpreting it. Many adaptations are available.

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

Training Frontline Staff

Module 1: Basic Elements of Assertive Community Treatment

Module 1 explains the basic elements of the ACT model, including the principles of ACT, how ACT compares to case management as a service delivery system, how the ACT team approach compares to other team approaches, and characteristics of the population that receives ACT services. This module introduces cross-training by having team members begin to think about the professional knowledge and expertise they have and how they could be valuable to other team members.

Practice principles of ACT

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

How ACT began

ACT began when several mental health professionals at the Mendota Mental Health Institute in Madison, Wisconsin, realized that many consumers were discharged from inpatient care in stable condition, only to return shortly after. At best, revolving door hospitalizations were accepted as inevitable. At worst, consumers who did not fare 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 consumers who were not benefiting from existing mental health services, the originators of ACT, 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 serious mental illness could become integral members of the community.

What the originators found

- After discharge, the variety and intensity of services to support consumers in their lives outside the hospital decreased dramatically.
- Services, often clinic-based, differed by admission criteria, the types of services offered, and discharge criteria.
- Regardless of consumers' needs, many programs were available only for a limited period and did not follow up with discharged consumers.
- Services were structured in a way that assumed consumers progressed steadily from more- to less-structured services without considering individual differences in the course of recovery.
- If a service was not available, no one was responsible for ensuring that consumers got the help they needed.
- Even when a considerable amount of time was spent in the hospital teaching consumers 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 consumers diagnosed with a serious 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 that each consumer needed at the appropriate frequency, intensity, and length of time, and in which team members were available 24 hours a day, 7 days a week.

Services were provided *in vivo*—in the community in places and situations where problems arise, rather than in an office or clinic setting. Interventions were integrated through collaboration among team members. The consumer'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.

How we know that ACT is effective

Since the original ACT program began in Madison, Wisconsin, nearly 30 years ago, programs have been implemented in 35 States and in Canada, England, Sweden, Australia, and the Netherlands. As ACT spread, researchers carefully studied its effectiveness. Reviews of ACT research consistently conclude that, compared with other treatments (e.g., brokered or clinical case management programs), ACT greatly reduces psychiatric hospitalization and leads to a higher level of housing stability (Phillips et al., 2001).

Research also shows that, compared to other treatments, ACT has the same or better effect on consumers' quality of life, symptoms, and social functioning. In addition, consumers and family members report greater satisfaction (Bond et al., 2001; Phillips et al., 2001).

While studies consistently show that ACT 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 ACT often do not receive this intervention (Lehman et. al., 1998). Those findings ultimately led to creating this KIT. For more information about the effectiveness of the ACT model, see *The Evidence* in this KIT.

Active ingredients of ACT

One of the unique features of ACT is that the important characteristics of this intervention have been delineated. The characteristics of ACT have been translated into program standards to help make certain that programs that want to replicate ACT can.

An instrument called the **ACT Fidelity Scale** is available to help teams assess how closely their program follows the ACT model (See *Evaluating Your Program*). Your ACT leader will distribute this to you to review and discuss during this training.

Some of the basic characteristics of ACT include:

- **Team approach:** ACT team members with various professional training and general life skills work closely together to blend their knowledge and skills.
- **In vivo services:** Services are delivered in the places and contexts where they are needed.
- **Small caseload:** A team of 10 to 12 staff serves approximately 100 consumers, resulting in a staff-to-consumer ratio of approximately 1 to 10.
- **Time unlimited services:** A service is provided as long as needed, not according to pre-set timelines.
- **Shared caseload:** ACT team members do not have individual caseloads, rather the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals.

- **Flexible service delivery:** The team meets daily to discuss how consumers are doing. The team can quickly adjust the services they are providing to respond to changes in consumers' needs.
- **Fixed point of responsibility:** Rather than sending consumers to various providers for services, the team provides the services consumers need. If using another provider cannot be avoided (e.g., medical care), the team makes certain that consumers receive the services they need.
- **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 avoid crises.

The ACT model vs. case management

ACT is a model of care that provides treatment and rehabilitation, as well as case management services. While *case management has been defined as the coordination, integration, and allocation of care within limited resources* (Bond et al., 2001), ACT is a more comprehensive service model.

The typical goals of case management—preventing hospitalization, improving quality of life, improving client functioning—as well as some typical case management activities—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, linking consumers to other service providers, rather than intervening directly. Case managers usually have individual caseloads, unlike ACT teams with shared caseloads and a team approach. Unlike case managers, ACT team members meet daily as a team and offer comprehensive services to consumers.

Table 1: Comparing 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 consumers
Change in intensity of services means change in providers	Type and intensity of services can be varied easily
Consumers receive services they need IF the service exists, the consumer meets eligibility criteria, and space exists in the program	Team members provide ANY service consumers need
Consumers may be dropped from caseload if they are noncompliant, in jail, or receiving services elsewhere	Team is responsible for ensuring consumers 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 quits or goes on vacation, other team members who know the consumer continue service plans
Treatment plans are updated monthly or less often	Team discusses changes in consumers’ status daily and adjusts treatment, as needed

(Bond et al.,2001)

ACT teams vs. other team approaches

ACT uses transdisciplinary teams

Although on ACT teams, people from multiple disciplines work together, technically they are not multidisciplinary teams. Rather, ACT teams are **transdisciplinary teams**.

Transdisciplinary teams blend the knowledge and skills of professionals from multiple disciplines. They transcend the typical provider-consumer relationship by giving consumers a decisive voice in *which* services they receive and *how* they receive them.

This model allows providers to deliver a comprehensive and integrated array of services to consumers who have complex needs.

ACT teams are set up around a goal—keeping consumers 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.

In contrast, the configuration of ACT services is not predetermined. Rather than trying to fit consumers into a rigid service system, services fit consumers’ goals and needs.

See Table 2 on the next page for a comparison of team models.

Table 2: Comparing 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 one another	Team members and consumers develop plans together
Service plan implementation	Team members implement part of the plan related to their discipline	Team members implement their section of the plan and incorporate other sections where possible	The team is jointly responsible for implementing and monitoring the 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 are 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 service plans
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

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 consumers receiving ACT services. In traditional service models, services may be delivered sequentially. For instance, one provider at one agency treats the consumer's mental illness and, after that problem is treated, the consumer 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 consumer might never see the next provider.

Another problem under the typical care system is providing parallel services. For instance, a mental health professional and a substance abuse treatment provider work with consumers at the same time. Although these professionals may communicate with one another, they may also duplicate effort, miss information that might be relevant to the other provider, or work at cross-purposes.

In transdisciplinary teams, team members work together intimately so that each team member can draw on other team members' knowledge, skills, and observations, and on a precise combination of carefully crafted, well-integrated services.

Communication and cross-training are key

Open communication is essential to providing integrated services. ACT teams work in shared space to facilitate sharing information informally. They meet daily to talk about each consumer.

Since it is difficult to have transdisciplinary teams if some consumers are “yours” and some are “mine,” members of ACT teams do not have individual caseloads. Specific consumers may be assigned to mini teams for administrative purposes, where a subgroup of team members works closely with particular consumers, but the team as a whole is responsible for the success of every consumer.

For transdisciplinary teams to function optimally, cross-training must occur. This does not mean that every member of the team must prescribe medicine or perform physical examinations; some tasks are governed by licensure and laws. However, many things that team members know that are specific to their discipline can be taught to people from other disciplines. Team members then become extra eyes and ears, can recognize when a problem is brewing, can help deliver or reinforce interventions, and can communicate from a broader perspective about what is happening with each consumer.

Cross-training occurs during comprehensive assessments, treatment planning, and daily meetings. On new teams, cross-training can be facilitated by having members of different disciplines work together with consumers. By observing the types of questions that team members from other specialties ask and by finding out why that information is important, colleagues can begin to understand one another’s professional perspectives and skills. Teams can also make opportunities for members from various disciplines to “teach” their team members about their discipline.

Working on a transdisciplinary team can be taxing, requiring flexibility and a willingness to set aside professional turf. But it can also be very rewarding. Many professionals who have worked in this model find that it reduces stress because other team members are available for expertise and support. They enjoy opportunities to learn from other disciplines. They also see that the work environment is enriched and problem-solving is easier. 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.

How ACT teams relate to other services

Many capable people in mental health and related systems deliver quality care. However, 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.

Your ACT team may find that other professionals within the mental health system envy your team’s resources, training, and skills. You will need to build relationships with other providers to ensure seamless and coordinated care, for instance, if hospitalization is unavoidable or if a consumer who has been stable for an extended period must be “stepped down.” Team members must partner with professionals in other services to ensure that consumers receive proper and continuous care.

Who uses ACT services

ACT is designed for consumers who are characterized as those in the greatest need—estimated to be 20% to 40% of people with serious mental illness. Criteria for selection include psychiatric disorders (e.g., schizophrenia and bipolar illness), which severely impair functioning in the community. Impairment is likely in multiple areas:

- inability to perform practical tasks required for basic functioning in the community,
- inability to be consistently employed or to carry out homemaker roles, or
- inability to maintain a safe living situation.

These consumers are also likely to have a history of high-service needs, for instance, repeated hospitalizations, a history of being involved with substance abuse or the criminal justice system, substandard housing, or homelessness. Some programs focus exclusively on a single facet, for example, on a criminal justice or homeless population, influencing the amount of specialized expertise required by the full team.

Consumers 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, consumers 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 consumers with severe psychiatric conditions have persistent impairments that cause 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 impairment requires a long-term, ongoing, and consistent approach to intervention.

Even more than symptoms, impairments produce enduring challenges in employment, personal care, and socialization making living in the community often difficult and, in some circumstances, impossible without extensive and regular assistance from others. Many consumers struggle with day-to-day living tasks, such as personal hygiene, cooking, shopping, and managing money. As a result of the impairments associated with serious mental illnesses, consumers are often single and isolated with 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 consumers experience from the rest of the community.

As a consequence of problems in daily living, consumers are typically poor and financially dependent on family and on entitlements and other benefits, such as Supplemental Security Income, Social Security Disability Insurance, Medicaid, or veterans' benefits. Many consumers cannot afford decent housing, making them a significant portion of the homeless population in the United States. Further, poverty along with mental illness makes consumers more vulnerable to victimization and to arrest and incarceration, mostly for misdemeanor offenses. Consumers also frequently become involved in using and abusing alcohol or other substances and they more often die prematurely from suicide or physical illness.

About the consumers in greatest need

ACT programs serve consumers with the greatest need—people 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 being involved with traditional mental health services.

Consumers in greatest need...

- have major symptoms (such as experiencing hallucinations and delusions most hours of the day and, consequently, being fearful and isolated) that improve only partially or not at all with medication and other treatments
- are seriously disabled from mental and behavioral impairments (such as being evicted because they cared poorly for their residence and disrupted neighbors, or losing jobs because of poor concentration and anxiety about co-workers)
- have co-existing substance use disorders, physical illnesses, or disabilities (such as diabetes or visual impairments)
- avoid being involved in services, do not acknowledge that they have a mental illness, and view mental health services as a threat or as unnecessary
- have limited ability to meet the participation expectations of standard psychiatric services due to:
 - symptoms (i.e., they are disorganized and confused),
 - impairments (i.e., they are anxious, withdraw socially, and have limited attention span), and
 - associated problems (i.e., substance use or sexual inappropriateness)
- are diagnosed with serious mental illness and sometimes view such traditional programs as stigmatizing and limiting rather than as 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 consumers go without services and persistently experience symptoms and impairment. They 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 result in the greatest costs to society of people with serious mental illnesses. In particular, these consumers are more likely to:

- frequently use emergency and inpatient medical and psychiatric services,
- be homeless or live in substandard housing,
- be arrested and incarcerated, or
- die prematurely from suicide or physical illness.

Many of these consumers 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 them requires providers to reach out and:

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

Exercise: **Explore the Benefits of ACT**

Studies that have explored what makes a difference in whether ACT team members adopt a new approach to treatment have found that ACT team members are more likely to adopt a practice if it addresses an area in which they feel they must improve. With ACT, it may not be so much a matter of whether an individual ACT team member needs to improve, but of radically addressing how services are organized and delivered. Share your experiences where the traditional service delivery system has been inadequate and identify aspects of ACT that address those inadequacies.

Some experiences where the traditional service delivery system has been inadequate:

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How ACT may address those inadequacies:

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Exercise: **Build an ACT Team**

Answer the following questions to help reinforce your understanding of ACT and how it might help the consumers you work with.

1. Before ACT, which characteristics of mental health services made it difficult for “consumers with the greatest need” to get the services they needed? What were these problems?

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- Have you ever encountered any of these problems when working with people diagnosed with a serious mental illness? If so, what happened to these people?

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- Which aspects of ACT might have made a difference? Explain.

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

3. What characteristics of ACT programs help to facilitate communication among team members?

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4. What are your agency's ACT admission and discharge criteria?

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5. As you anticipate working on an ACT team, what do you expect to be the most difficult or challenging aspect of it?

6. What do you expect to be the most satisfying aspect of working on an ACT team?

Exercise: **Write a Mission Statement**

Part of being familiar with the ACT model and working as a team is being clear about goals. Develop a brief mission statement, a one-line motto, and a team logo.

■ **Mission statement**

■ **One-line motto**

■ **Team logo**



Notes to the facilitator and ACT leader:

Prepare for Module 2:

- Make copies of module 2, *Recovery and the Stress-vulnerability Model*. Your copy is in this workbook; print copies for your team from the CD-ROM.
- Distribute the material to the team members who will participate in your group session. Ask them to read this module before meeting as a group to discuss it.



- Make copies of these exercises:

- ☐ *Practice What You've Learned About Stressors*
- ☐ *Practice What You've Learned About Treatment Planning and the Stress-vulnerability Model*



but do not distribute them until your team meets as a group. Again, your copies are on the next pages; print copies for the team from the CD-ROM.

Conduct your first session:

- When you convene your group, view the *Recovery and the Stress-vulnerability Model* on the *Practice Demonstration Video*. Discuss the video and the content of module 2.
- One at a time, hand out the exercises to the group. Complete them.



Consider these additional training activities:

Panel discussion: To learn about consumers' and family members' perspectives, set up a panel discussion. Invite 3-5 people who have received mental health services and those who have family members who have been diagnosed with a serious mental illness. Include members of the team's Advisory Group, consumers, or people identified through local consumer or family groups.

Ask panelists who have experienced mental illness to be ready to discuss the effect of their illness and to share any experiences with the mental health system that were helpful and not helpful. Ask family members to discuss how they found out their family member had a mental illness, how the illness has affected the family, and what experiences they have had with the mental health system that were helpful and not helpful.

Have panelists each speak and then ask them if they would answer questions from the team.

Learn from the National Empowerment Center (NEC):

NEC's website has stories and articles written by people who have experienced psychiatric disorders. The articles give you a glimpse of what it is like to receive mental health services and include 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. www.power2u.org

Read more about recovery: Much of the information on recovery in this module comes from a SAMHSA report called *A Review of Recovery Literature* by Dr. Ruth O. Ralph (2000). You can download this report in its entirety (approximately 30 pages) from the National Technical Assistance Center for State Mental Health Planning (NTAC) through the National Association for State Mental Health Program Directors (NASMHPD) website at www.nasmhpd.org/ntac/reports/ralphrecovweb.pdf

Training Frontline Staff

Module 2: Recovery and the Stress-vulnerability Model

Two concepts are essential to understanding the goals and objectives of ACT:

- Recovery, especially in the context of serious mental illness, embraces a hopeful vision for people who experience psychiatric disorders. Since the ultimate goal of ACT services is to support the consumer's recovery process, it is important to focus on this concept.
- The Stress-vulnerability Model provides a useful framework for understanding mental illness and factors that influence its onset and course. The stress-vulnerability model also offers a framework for thinking about the objectives of the services that ACT teams provide and skills that consumers need for recovery.

Recovery means more than just coping

The idea of recovery from serious mental illness may be new to you if you came of age professionally in an earlier era when the mental health field generally held low expectations for people with serious 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 serious mental illness can live a life in which mental illness is not the driving factor for their lives.

Recovery means more than expecting people to simply “cope” with mental illness or “maintaining” people with mental illness in the community. In a recovery framework, as a mental health practitioner, you are called on to be a source of hope, support, and education, and to partner with

consumers on their journey through mental illness and the accompanying social consequences. 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.

A SAMHSA publication by Dr. Ruth Ralph, prepared for the National Technical Assistance Center for State Mental Health Planning (NTAC) and the National Association for State Mental Health Program Directors (NASMHPD), describes recovery as:

“...a process in which consumers learn to approach daily challenges, overcome disability, learn skills, live independently, and contribute to society” (Ralph, 2000).

Helping consumers in the process of recovery is the ultimate goal of ACT teams.

The dictionary talks about *recovery* in terms of regaining something or getting something back. In consumers’ comments about recovery, they repeat themes of regaining:

- hope,
- motivation,
- self-confidence,
- meaning, and
- independence.

Consequently, it is important for ACT team members 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 developing the ACT KIT materials discussed the importance of goals in providing meaning and instilling hope. As one consumer said:

“I have to have goals. That’s what gives my life meaning. I’m looking to the future.”

According to another consumer:

“It’s about motivation.”

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.”

ACT 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 by relating to them as partners in the treatment process rather than as the subjects of treatment.

For more information about the idea of motivation and how to use it in helping consumers with recovery, see the Illness Management and Recovery KIT.

Learn from other perspectives

We are not suggesting that recovery means that consumers simply go back to where they were before the onset of illness. For one thing, we are all continuously changing, growing, and learning. Further, being diagnosed with a serious 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.

For a broader view of consumers' thoughts about the experience of mental illness, consider these quotes:

"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" (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" (Cohan & Caras, 1998).

Think about recovery as a process

Recovery does not mean the same thing as cure.

When we use the term recovery in this book, we do not imply that consumers will never experience psychiatric symptoms again; we are talking about an ongoing process.

Based on a review of the literature about recovery and serious mental illness in the publication by Dr. Ralph, consider this ongoing process as a journey through mental illness to a place where consumers have the courage, skills, knowledge, and aspiration to struggle persistently with psychiatric symptoms and the impairments that can limit them 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, at the mental health system, and at society's treatment of people with mental illness.

As you work with consumers, 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 that a person who is diagnosed with a major illness might experience. Be careful not to ignore these feelings as being merely symptoms of mental illness, mood swings, or labile affect.

Listen and validate consumers' feelings, without discounting or minimizing their experience. Help them refocus on what they are able to do and how they can decrease the symptoms they experience, prevent them from recurring, and become involved in meaningful adult activities that interest them.

Convey hope

It is easy for a person who is diagnosed with a serious mental illness to lose hope. The symptoms of psychiatric illness can be very difficult to live with. Historically, we have sent a clear message that people who experience psychiatric illnesses are less valued members of our society. Until recently, even the mental health profession has sent the message that the best a consumer might hope for is to “cope.”

While progress is slowly being made to change attitudes and eliminate the stigma associated with mental illness, people who are diagnosed with a serious mental illness still receive many negative messages, which are easy to internalize. 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 those of patient or consumer.

For more than a decade, Barbara Julius directed the Outreach Program in Charleston, South Carolina. She remembers her struggle coming to believe in the possibilities for people diagnosed with serious 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 risk. What about our program’s liability?”

During a consultation with Debbie Allness, a member of the original program for ACT, 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 an ACT leader, hold the dream of possibility for another person, then you should not be leading an ACT team. If your thinking is so restricted that you cannot envision consumers getting better and you think they will require constant supervision, then why do ACT?

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 ACT team members in changing attitudes:

ACT 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, and 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.

Understand the Stress-vulnerability Model

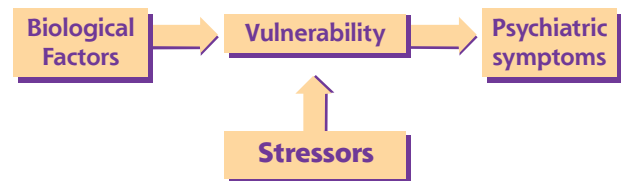
The ultimate goal of ACT is to help consumers reach a point where having a mental illness is not central in their lives. To help them reach that point, you must understand something about the onset and course of mental illness. The Stress-vulnerability Model gives you a framework for thinking about mental illness; it is 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. For people to develop a mental illness, they must have the biological vulnerability for that particular illness. The illness may then develop spontaneously or when they are exposed to stress. Triggered by stress, the illness may reoccur periodically.

In some consumers with severe disorder, vulnerability appears to increase with repeated episodes of illness. The criteria for admission to ACT 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.

Stress-vulnerability Model



Researchers are not certain of the exact precursors of biological vulnerability, but some research implicates 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 3. Some stressors are major unpleasant life events, such as losing a loved one, being fired, losing your home, being arrested, and being hospitalized.

Table 3: 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
Loss of your home	A new relationship	Cranky children	Crowded living environment	Social support
Divorce or separation	Getting married	Paying bills	Social isolation	Opportunities to relax
Having a child taken away	Starting a new job	Not receiving a check on time	Negative or pessimistic attitude	Exercise
Arrest or incarceration	A promotion		Lack of meaningful stimulation	Positive or optimistic attitude
Loss of a job	A pay raise			
Family crises	Giving up addictive drugs			

Stressors can also be events and experiences that are generally considered positive or desirable. For example, being discharged from the hospital, being released from prison, giving birth to a child, receiving a job promotion, getting 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. Even when it is for the better, change 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. At times, people may be particularly susceptible to stress. Sometimes even little things that normally would not bother people can be stressful, such as feeling hungry, tired, lonely, or ill (as shown in Table 3).

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

Implications for intervention

Considering the basic premise of the Stress-vulnerability Model, you could conclude that when people who are biologically vulnerable to mental illness encounter stressors, they risk relapse. Logically then, interventions that change someone's biochemistry, exposure risk, and factors that influence susceptibility to stressors can favorably alter a person's odds of experiencing psychiatric symptoms (and chances of reaching a point where life does not center around mental illness).

Change consumers' 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 consumers and their doctors.

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

Change consumers' 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 ACT programs. When consumers initially enter the program, the team will focus on helping them through the aftermath of these experiences.

To change consumers' exposure to stressors, you must think ahead about what skills, support, and resources people need to prevent such events from recurring. For instance, perhaps you can avoid future evictions by helping consumers devise and carry out a plan to pay their rent on time or by coaching them to keep their apartment reasonably clean.

Perhaps you can help avoid future arrests through coordinated interventions that include helping consumers occupy their time with activities that provide alternatives to using illegal substances.

The *Comprehensive Assessment and Psychiatric/Social Functioning History Timeline* (We discuss this in detail in module 3) can help your team anticipate antecedents of these negative life events. You can use this information to inform approaches to prevent these stressful events from recurring.

Confront some stressors

There are some stressors that people may not want to avoid, for example, moving to a new apartment, being discharged from the hospital, or finding a new job. In these instances, your team will want to think about how to make the changes less stressful for consumers.

One approach to managing positive events is to break them into manageable pieces. For instance, the move to a new apartment might begin with the consumer spending part of a day there with familiar people. On the next visit, the consumer's supporters might stay for only part of the time. The next step might be for the consumer to spend time in the apartment alone, eventually spending a night alone.

Starting a new job might be done similarly. The consumer might spend increasing amounts of time on the job, gradually reducing the amount of immediate support until the consumer is comfortable in the situation. These types of interventions—and the need for them—will vary from consumer to consumer.

Help consumers deal with hassles

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 you can anticipate them; then you can plan to either avoid the hassles or you can rehearse strategies for coping with them.

For instance, if traveling to a job during rush hour is intolerably stressful for a consumer, your team might want to help that person plan to leave work at a different time to miss the rush. Another alternative might be to rehearse a conversation that the person might have with a job supervisor about starting work at a different time.

Team members might also help consumers recognize signs of stress and practice ways to relax. For instance, the consumer might decide to try listening to quiet music on a headset when a sign of stress appears.

Change factors that influence susceptibility to stress

Table 3 also listed factors that affect people's susceptibility to stress, such as health, nutrition, social support, and attitude. One approach to reducing the likelihood of psychiatric symptoms is to focus on ensuring that consumers have 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 consumers to organize and carry out basic activities to care for themselves and their homes. For instance, proper nutrition involves planning which foods to purchase, managing a budget, traveling to the store, selecting food, paying for it, bringing it home, and preparing it. Fatigue and disorganized thinking may make it difficult for a consumer to plan and follow through on the steps involved in purchasing and preparing food.

Similarly, in part, good physical health requires 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 (Allness & Knoedler, 2003). Side-by-side help and support mean that team members actively participate with consumers to plan and carry out any activities to live independently, work, and socialize.

Exercise: Practice What You've Learned About Stressors

Read about Mr. Jones in the *Comprehensive Assessment* on the next page. In the list of stressors below, identify which factors Mr. Jones experienced in the year before the assessment. Which were present when the comprehensive assessment was done?

Stressors and hassles that influence Mr. Jones' susceptibility to stress	During the past year	When the comprehensive assessment was done
Illness or injury to self	<input type="checkbox"/>	<input type="checkbox"/>
Illness or injury of loved one	<input type="checkbox"/>	<input type="checkbox"/>
Moving	<input type="checkbox"/>	<input type="checkbox"/>
Poverty	<input type="checkbox"/>	<input type="checkbox"/>
Discrimination	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization/Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Family crises	<input type="checkbox"/>	<input type="checkbox"/>
Changes in employment	<input type="checkbox"/>	<input type="checkbox"/>
New baby	<input type="checkbox"/>	<input type="checkbox"/>
Arrest or incarceration	<input type="checkbox"/>	<input type="checkbox"/>
Death of a loved one	<input type="checkbox"/>	<input type="checkbox"/>
Victimization	<input type="checkbox"/>	<input type="checkbox"/>
Loss of an important relationship	<input type="checkbox"/>	<input type="checkbox"/>
Social isolation	<input type="checkbox"/>	<input type="checkbox"/>
Lack of meaningful stimulation	<input type="checkbox"/>	<input type="checkbox"/>
Pessimistic environment	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate rest	<input type="checkbox"/>	<input type="checkbox"/>
Poor nutrition	<input type="checkbox"/>	<input type="checkbox"/>
Conflicts	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
Giving up or reducing substance use	<input type="checkbox"/>	<input type="checkbox"/>
Feeling rushed	<input type="checkbox"/>	<input type="checkbox"/>
Crowded living conditions	<input type="checkbox"/>	<input type="checkbox"/>
Noisy living conditions	<input type="checkbox"/>	<input type="checkbox"/>
Lack of privacy at home	<input type="checkbox"/>	<input type="checkbox"/>
Marriage	<input type="checkbox"/>	<input type="checkbox"/>

Sample Comprehensive Assessment

Part 1: Psychiatric History, Mental Status and Diagnosis

Client name: Mr. Jones

Date of evaluation: 9/30/99

Reason for admission (chief complaint) as stated by consumer, 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 48-year-old, black male who was referred to the ACT team for after-care following his release from a 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 co-existing substance use disorder, and
- a recent history of involvement with the criminal justice system.

Previous 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 the State hospital for treatment and released on 9/29/99.

Mr. Jones was admitted to the State hospital forensic unit in 7/88 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 5 or 6 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 Department of Corrections 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 State syndicate has a contract out on him for \$10,000.

The 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 8/98 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. H. (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 the State hospital.

A report from the 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 5 admissions to the State hospital and 14 to XX medical center. He has been offered outpatient treatment since 1992. Other past diagnosis includes psychotic D/O, NOS; organic hallucinosis; 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 4 of them longer than 2 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 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 2 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 consumer

Jones states that his goals are:

- “Find a doctor that can get rid of these germs that the 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:

- “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 and psychiatric illness:

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 alcohol 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 2 months in the 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 (1984-88)	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 State 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.

**State Hospital
(4/14/88-7/11/88)**

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
(1988-92)**

During this period, Jones was incarcerated at the 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 decreased 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.

**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.

**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, who required several days of hospitalization (i.e., a broken wrist and bruising to the face). Charges were dropped and he was released.

Hospitalizations

Medical Center (11/4/93 – 11/19/93)
Medical Center (11/26/93 – 12/5/93)
Medical Center (2/4/94 – 2/15/94)
Medical Center (8/20/94 – 8/29/94)
Medical Center (11/1/94 – 11/5/94)
Medical Center (1/12/95 – 5/4/95)
Medical Center (6/28/95 – 7/6/95)
Medical Center (8/21/95 – 8/28/95)
State Hospital (8/28/95 – 9/8/95)
Medical Center (3/1/96 – 3/5/96)
Medical Center (7/19/96 – 7/30/96)
State Hospital (10/4/96 – 12/1/96)
State Hospital (12/13/96 – 2/8/97)
Medical Center (5/17/98 – 5/24/98)

In the review of the hospitalizations at the Medical Center and the 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 the 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 ongoing 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 3 days at a time there per their policy/procedure. The County Sheriff’s Department reports many “criminal trespass” arrests during this time as well.

It appears that Jones’ 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, it appears that 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 threatening.

**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.”

**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.

**State Hospital
(8/27/99-9/29/99)**

Transferred from the State Hospital after the felony charges were dropped to allow for further treatment. Reports indicate that Jones was aggressive and easily agitated toward staff. He was verbally loud and escalated easily. He was also engaging in self-talk and laughter at levels suggestive of 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. His primary advocate on a weekly basis will provide psychoeducation during medication 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

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:	U.S. only
Prosthetic devices:	None
Review of systems:	<ul style="list-style-type: none">■ 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 esophageal 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. <p>At physical examination, this patient is alert, active, somewhat cooperative, delusional.</p>

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:	Normal cephalic; face is symmetrical; scalp is normal except for some sores that are also self-inflicted
Eyes:	Conjunctivae are pink; sclera are white; pupils are equal, round, they react to light and accommodation; there is no ptosis; there is no nystagmus; the extraocular 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 there were no obstructions.
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 lymph edema 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 “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 14 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

Ongoing 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

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, 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 the 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 he was able to sell these drugs 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 drug “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 other people 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' 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 XX High School in (city). 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 (city, State). He has 9 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 when he was a child. He graduated from XX High School. He states that he liked being alone except when he needed to “satisfy his manly urges.” When he was older, 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 2 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 he would barricade them in the apartment for days at a time. He has 3 children with whom he has no contact.

Culture and religious beliefs:	Both of Jones’ 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 the “white” people discriminate against him, that the KKK is out to get him, and that the State 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 (city). 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 of 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 3 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 barbeque. 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 baths. 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’ 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 1 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’ 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 6 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 ongoing monitoring of his diet to ensure that he is eating properly.

Exercise: Practice What You've Learned About Treatment Planning and the Stress-vulnerability Model

Read the treatment plan on the next page that was developed for Mr. Jones. Then review each action step identified in the plan and decide which step addresses each of the changes shown. Check all that apply.

Action step	Check all that apply			
	A	B	C	D
	Change the person's biochemistry	Change the person's risk of exposure to stressors	Change the person's susceptibility to stressors	Other
See MD every 4-6 weeks for prescriptions, symptom assessment, supportive therapies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have daily contact with Integration Specialist (IS) to assess symptoms and develop coping strategies (e.g., anger management, environmental issues)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Be available 24/7 for crisis response and support services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meet monthly with IS to educate Mr. Jones about relationship between mental health and behaviors, involvement in criminal justice system, and developing coping strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schedule a one-to-one motivational interview 3 times a week with substance abuse specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attend weekly dual diagnosis group at ACT program office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Find safe, affordable housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have weekly contact to monitor apartment maintenance. Adjust, as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meet monthly to review budget and liaison with payee, as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor food supply, trips to grocery, and education about nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sample Treatment Plan

Use this treatment plan to complete this exercise. These exercises are intended to reinforce ACT practice principles and skills. The Sample Treatment Plan is not intended to serve as a model; separate SAMHSA-supported initiatives are currently underway to create model individual treatment plans of care.

ACT Treatment Plan		Name:	Mr. Jones	SSN:	123-45-6789	
		Tx Plan Date:	10/21/99			
		Review Date:	4/21/99			
Primary treatment team: Sally S., Integration Specialist (IS) Fred F., Substance Abuse Specialist (SAS) Jane J., Employment Specialist (ES) Nancy N., Nurse (RN) Mike M., Psychiatrist (MD)		Discharge criterion: 1. No significant major psychotic or affective symptoms for 2 years, and 2. No major role dysfunction in areas of work, socialization, and self-care for 1 year under conditions of minimal treatment.				
DSM IV Diagnoses						
Axis I 295.30 Schizophrenia, Paranoid Type 304.80 Polysubstance Dependence		Axis IV Psychosocial Stressors: Rejection by family Inadequate social support Unemployed Inadequate housing/unsafe neighborhood Multiple arrests/convictions Hostile relationships w/others Severity: 3 – Moderate				
Axis II 301.7 Antisocial Personality Disorder w/Borderline Features		Axis V Current GAF: 30 Highest GAF past year: 30				
Axis III History of exposure to Hepatitis A, B, & C as validated by laboratory studies; Esophageal reflux Non-tuberculosis mycobacterium		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				
Focus Area 1						
Jones' experiences: 1. persistent delusional thoughts of a religious, satanic, and paranoid theme (i.e., "The County 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.		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. Goal Through 4/00, Mr. Jones will have no incidents of unplanned hospitalization as measured by staff, community, and crisis report.				

Plan

1. MD to see every 4-6 weeks for medication prescriptions, symptom assessment, and supportive therapies;
2. Daily 1:1 with 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); and
4. ACT team to be available 24/7 for crisis response, support services.

Focus Area 2

History of involvement with the criminal justice system including 3 felony convictions, multiple arrests, and hospitalizations

Plan

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 SAS to interact with law enforcement officials to provide education about mental illness and function as liaison, as needed.

Goal Through 10/00, Mr. Jones will have no arrests or physical altercations as measured by self, staff, community, and police reports.

Goal Through 10/00, Mr. Jones will revisit his timeline on a monthly basis during 1:1 to identify pattern and develop pre-crisis coping strategies as monitored by staff report.

Focus Area 3

Extensive history of substance abuse which contributes to an increase in psychotic symptoms and possible suicidal/homicidal risk (see Focus Area 1). History of burglaries to obtain money to purchase substances (see Focus 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."

Plan

1. 1:1 motivational interview 3 x week – SAS
2. Weekly dual-diagnosis group at ACT program office – SAS

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 3 or more different occasions prior to 4/00.

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 3 or more different occasions prior to 4/00.

Goal By 1/00, Mr. Jones will identify 1 or more factors he personally views as benefits from reducing or eliminating the use of alcohol or other substances.

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.

Plan

1. IS and SAS 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 as needed basis.
4. Weekly monitoring of food supply/trips to grocery store and education about nutrition

Goal Mr. Jones will maintain his residence in a safe environment for 3 consecutive months by 10/00 as monitored by self, staff, and apartment manager.

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.

Focus Area 5

Care and management of medical and dental needs is complicated by Mr. Jones' difficulties in recognizing the need for intervention and in following through with medical recommendations due to Focus Area 1.

Plan

1. RN to schedule dental appointment and accompany Mr. Jones.
2. RN to schedule appointment with family practitioner to address medical needs.



Goal F/U re: esophageal reflux, non-TB mycobacterium, and sores on head/face.

Goal dental appointment

Goal ongoing monitoring


Notes to the facilitator and ACT leader:

Prepare for Module 3:

- Make copies of module 3, *Core Processes of Assertive Community Treatment*. Your copy is in this workbook; print copies for your team from the CD-ROM. 
- Distribute the material to the team members who will participate in your group session. Ask them to read this module before meeting as a group to discuss it. 
- Make copies of these exercises:
 - ☐ Case Studies Discussion — 1
 - ☐ Case Studies Discussion — 2
 - ☐ Compare Assessment Procedures
 - ☐ Construct a Psychiatric/Social Functioning History Timeline
 - ☐ Prepare for Your Weekly Consumer Schedule
 - ☐ Complete a Weekly Consumer Schedule

but do not distribute them until your team meets as a group. Again, your copies are on the next pages; print copies for the team from the CD-ROM.

Conduct your third session:

- When you convene your group, view the *Core Processes of ACT* on the *Practice Demonstration Video*. Discuss the video and the content of module 3. 
- One at a time, distribute the exercises to the group and complete them.

Consider this additional training activity:

Food for discussion. After you complete the exercise, *Compare Assessment Procedures*, review your agency's new ACT assessment form with the group. Discuss what specific assessments each discipline would be responsible for completing and the timeline for completing the assessment.

Training Frontline Staff

Module 3: Core Processes of Assertive Community Treatment

Module 3 introduces you to the core processes of ACT, including the principles of engaging consumers in treatment, how to conduct a comprehensive assessment, and the tools that are specific to providing ACT services, such as the *Psychiatric/Social Functioning History Timeline*, the *Weekly Consumer Schedule*, and the *Daily Team Schedule*. We discuss each process conceptually and administratively to help you see how ACT teams function most effectively.

Core processes of ACT

- Compiling a thorough and comprehensive assessment of the consumer's current and past psychiatric and social functioning
- Constructing an historical timeline depicting the consumer's psychiatric and social functioning and prior treatment experiences
- Developing a treatment plan based on needs and goals that the consumer articulates
- Translating a consumer's treatment plan into a schedule of day-to-day activities
- Developing a daily schedule so team members can carry out the activities that must occur that day.
- Sharing the outcome of the previous day's contacts with team members
- Conducting an ongoing assessment of the effectiveness of interventions

At first, you might think that the core processes are too time consuming and burdensome and that you will never be able to spare the time for them. That is simply not true. Effective teams that serve consumers with very complex and demanding needs follow these processes. In fact, it is part of what makes them effective.

Following the core processes will determine whether your team is proactive or reactive. You are beginning a long-term relationship with consumers—which gives you the luxury of time. Take the time up front to really get to know them. To engage consumers in treatment, your team must work on goals that are important to the consumers.

You also have the luxury of having team members who are equally responsible for consumers. If one team member needs to spend time with a consumer to gather assessment information, someone else on the team can set time aside to obtain clinical records. Most information for the comprehensive assessment is collected while working with consumers to meet their initial needs.

In the long run, it is much more productive to invest time up front getting to know consumers, forming sound detailed plans, and tracking those plans closely than it is to grope along ill-informed and unprepared. If your team does not invest resources to thoroughly sort out the experiences consumers have had, does not learn what consumers hope to accomplish, and does not diligently monitor if goals are being met, your team will be managing crises rather than helping consumers progress.

Psychosocial timelines, which monitor consumer progress, help team members learn what has and has not helped in the past. With the psychosocial timeline, you translate the treatment plan into a schedule of specific activities that become the schedule of contacts the team will have with the consumer. Your 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.

Here's an overview of ACT processes

- A consumer is referred to your ACT program.
- The ACT leader and other staff who may potentially work closely with the consumer meet with the consumer to explain the program and assess the person's initial needs.
- Multiple team members meet with the consumer as the work of meeting the consumer's initial needs begins. During these contacts, team members gather information for the comprehensive assessment and timeline.
- After 30 days, team members meet to pool information (to complete the comprehensive assessment and timeline).
- Based on the comprehensive assessment and timeline, team members plan what they will do. This plan specifically includes what will be done by whom, at what times, on what days.
- A team member meets with the consumer to review and achieve consensus about the plan.
- The activities in the treatment plan are translated into a weekly schedule of contacts between the consumer and the team.
- Just before the team's daily meeting, a designated team member checks the *Weekly Consumer Schedule* for each consumer that the team serves. The team member 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.
- Next, the person who drafts 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, follow up on a job lead, or look at an apartment that has become available—activities that the team provides

support for, but which do not recur. These are also written on the *Daily Team Schedule* in the appropriate time slot. If a particular team member should attend the appointment, that person's name is written next to the activity.

- The person who drafts 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.
- The team begins going through its *Communication Log*. A team member calls out each consumer's name. When a 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.
- During the daily team meeting, if team members report that a consumer is having a difficulty, the team will strategize about how to address the problem if it 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.
- 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 ensure that all the things that must 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. Someone else will have to cover the original appointment.

Engagement is a continuous process

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 the consumer's needs and goals and, at the same time, also knows that what is being done focuses on reaching those goals.

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

Ideally, engaging consumers in the process of ACT starts before they are formally admitted to the program. Team members meet with consumers and their family members or other supporters, describe the program, find out the consumer's immediate needs and goals, and perhaps arrange for the consumer to visit the program. Whenever you meet with consumers, you learn more about the consumers' immediate needs and what their goals are.

As members of your team begin to work with consumers to meet their immediate needs, consumers are introduced to other members of the team. For instance, if one consumer needs a place to live, a team member might take that person to find an apartment, but also might stop by the office to introduce the person to the program receptionist and other team members. The next time the team member meets with that consumer, someone from a different discipline might come along to be introduced. That way, a new team member will begin to get to know the consumer.

At times, consumers may be admitted to your program while they are experiencing serious psychiatric symptoms. The consumers' thinking may be very disorganized or they may be experiencing delusions. In these instances, you may have to move more slowly in introducing the consumers to multiple members of the team so that they are not overwhelmed. You will want to decide which team member will best help each consumer feel most comfortable and let that team member initially be the primary contact. Until you have established a degree of trust, you may want to involve other team members gradually.

Assessments are comprehensive, not isolated interrogations

In a more traditional assessment process, people from different specialties often sequentially “interrogate” consumers to elicit the information they need to complete assessment forms that are relevant to their specialty. For example, nurses ask about medical problems; social workers ask about benefits. Assessments seldom include any observations of consumers 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 ACT team members from other disciplines, ACT team members have to take the initiative to read all the assessments in the consumer's chart. Even when they do read all the assessments, 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 consumer's life or which factors in the environment may be exacerbating a problem.

Sometimes assessment information is shared at staffing or treatment planning meetings. Unfortunately, a practitioner from one discipline may have some information that seems irrelevant, not realizing that it fits with information that another team member has. These bits of information must be shared so the whole picture fits together.

In an ACT program, services are “made to order.” Before you know which services you will provide to a particular consumer and who will be involved in delivering them, you have to do a comprehensive assessment. Unlike the traditional process, all the team members who work with that consumer must know what was learned in each assessment.

Learn about the comprehensive assessment process

The comprehensive assessment is completed after the team has had 30 days to get to know the consumer. Individual team members are given primary responsibility for completing particular elements of the assessment.

Table 4 gives you an overview of these elements, while Table 5 provides a more detailed profile. These are based on assessment forms included in *A Manual for ACT Start-Up* (Allness & Knoedler, 2003).

Table 4. Principles of ACT Assessment

Start at the first meeting	The assessment process begins during visits with consumers, family members, or other supporters while consumers are being admitted to the program.
Address 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 works with the consumer 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. Then, as trust develops, more personal information is elicited (e.g., drug use, sexual activity).
Focus on the consumer's needs	A critical part of the assessment is finding out what consumers' preferences are and what they want to accomplish.
Share what you know	Assessments are not proprietary. (For example, medical assessment may be important to mental health professionals; family assessment may be important to employment specialists.)
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 consumers' lives.

Table 5: Elements of a Comprehensive Assessment

Purpose	Who is responsible	Sources of information	Timeframe
Assessment: Psychiatric history, mental status, and diagnosis			
<ul style="list-style-type: none"> ■ Ensure accuracy of diagnosis ■ Inform plans that will be made with consumer for treatment 	Psychiatrist	<ul style="list-style-type: none"> ■ Consumer ■ Family ■ Supporters ■ Past treatment records about onset, precipitating events, course and effect of illness ■ Past treatment and treatment response ■ Risk behaviors ■ Current mental status 	<p>Within 30 days</p> <p>Findings presented at daily meetings or to ACT leader and individual treatment team at the first treatment planning meeting</p>
Assessment: Psychiatric history narrative			
Establish timeline of course of illness and treatment response	Psychiatrist	<ul style="list-style-type: none"> ■ Psychiatrist's interview with consumer ■ Psychiatric/Social Functioning History Timeline 	<p>Started at admission or first interview the consumer has with psychiatrist.</p> <p>Completed within first 30 days</p>

Table 5: Elements of a Comprehensive Assessment

Purpose	Who is responsible	Sources of information	Timeframe
Assessment: Physical health			
<ul style="list-style-type: none"> Identify current medical conditions. Ensure proper treatment, follow-up, support Determine health risk factors Determine medical history Determine if there are problems communicating health concerns 	Registered nurse	<ul style="list-style-type: none"> Consumer Medical records 	<p>First interview within 72 hours of admission</p> <p>If consumer is experiencing problems concentrating or needs time to get to know staff to discuss sensitive areas, such as sexual issues, assessment may need to be completed over 2 to 3 interviews</p> <p>Presented at first treatment planning meeting unless immediate concerns exist, in which case nurse should consult team psychiatrist and ACT leader and present those concerns at daily meeting</p>
Assessment: Use of drugs and alcohol			
<ul style="list-style-type: none"> Determine if consumer currently has a substance use disorder Determine if consumer has history of substance abuse treatment Develop appropriate treatment interventions to be integrated into the comprehensive treatment plan Establish chronology 	Substance use specialist	<ul style="list-style-type: none"> Composite International Diagnostic Interview - Substance Abuse Module (CIDI-SAM) or similar standardized instrument Consumer interviews or discussions conducted in home or community settings Psychiatric History, Mental Status, and Diagnosis Assessment and the Health Assessment Past treatment providers 	<p>Assessment begins at admission</p> <p>It may take several interviews to collect information since it is sensitive and requires a sufficient level of rapport and trust between consumer and mental health professional</p> <p>Presented at first treatment planning unless immediate concerns exist, in which case substance abuse specialist should consult ACT leader, psychiatrist, and individual treatment team and present information at daily organization staff meeting</p>
Assessment: Social development and functioning			
<ul style="list-style-type: none"> Assess how illness interrupted or affected consumer's social development Information gathered about: <ul style="list-style-type: none"> 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 legal system social and interpersonal issues appropriate for supportive therapy 	Mental health professional	<ul style="list-style-type: none"> Consumer interview Discussions conducted in home or other community settings 	<p>Begins at admission</p> <p>Information may be gathered over several meetings</p> <p>Completed within 30 days</p> <p>Presented at daily meeting, to ACT leader, or at the first treatment planning meeting</p>

Table 5: Elements of a Comprehensive Assessment

Purpose	Who is responsible	Sources of information	Timeframe
Assessment: Activities of Daily Living (ADL)			
<ul style="list-style-type: none"> Consumer's current ability to meet basic needs Adequacy and safety of consumer's current living situation Current financial resources Effect of symptoms on consumer's ability to maintain independent living situation Consumer's individual preferences Level of assistance, support, and resources consumer needs to re-establish and maintain activities of daily living 	Mental health professional	<ul style="list-style-type: none"> Consumer interviews Discussions in home or other community settings Interviewer must pay special attention to consumer's preferences and serve as consumer's advocate to ensure activities of daily living and other services meet consumer's preferences 	<p>Initial ADL plan completed at admission to identify all immediate services consumer may need (e.g., assists with nourishment, circumventing eviction)</p> <p>Information may be gathered over several interviews</p> <p>Comprehensive ADL assessment completed within 30 days</p> <p>Presented at daily meeting, to ACT leader, to individual treatment team, or at first treatment planning meeting</p>
Assessment: Education and employment			
<ul style="list-style-type: none"> How consumer is currently structuring time Consumer's current school or employment status Consumer's past school and work history (including military service) Effect of symptoms on school and employment Consumer's vocational/educational interests and preferences Available supports for employment (e.g., transportation) Source of income Education, military, and employment chronology 	Employment specialist	<ul style="list-style-type: none"> Consumer interviews School records Past employers 	<p>Assessment may be completed over several meetings, leading to ongoing employment counseling relationship between consumer and vocational specialist</p> <p>Presented at daily meetings, to ACT leader, team members working with consumer, or at the first treatment planning meeting</p>
Assessment: Family and relationships			
<ul style="list-style-type: none"> Allows team to define with consumer the contact or relationship ACT will have with family or other supporters Obtain information from consumer's family or other supporters about consumer's mental illness Determine family's or other supporters' level of understanding about mental illness Learn family's or other supporters' expectations of ACT services 	Mental health professional	<ul style="list-style-type: none"> Consumer Family members or other supporters 	<p>Begun during the initial meeting with consumer and family or other supporters participating in admissions process</p> <p>Completed within 30 days of admission</p> <p>Presented at the first treatment planning meeting unless immediate concerns exist, in which case mental health professional should consult team psychiatrist and ACT leader and present information at daily meetings</p>

For the most part, assessments are carried out while team members are working with consumers around their initial needs. Team members with various specialties may schedule a time to meet with consumers to talk about issues related to that specialty. However, whenever anyone on the team is with consumers, they are assessing:

- symptoms,
- the effect of those symptoms on everyday activities,
- the consumers' 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 look at things not only from the perspective of their own specialty, but they also serve as the “eyes and ears” of other specialties. For instance, if the vocational specialist provides transportation for the consumer to go grocery shopping, the specialist could ask about employment goals and past work experiences while they are together. During that trip, if the consumer mentioned an interest in art, the vocational specialist could mention that interest during the next daily meeting so that the team members who are responsible for assessing the consumer's leisure interests could follow up. In addition, the team has learned about an interest that the consumer might use for stress management.

The goal of the comprehensive assessment is for team members to understand consumers' strengths, hopes, and experiences with mental illness and mental health services. As you learn about consumers, you share that information in “real time” with your team. If you uncover potentially urgent needs—for instance, if you learn about a critical medical condition or an extremely unsafe housing situation—you would communicate those needs immediately to the ACT leader.

When all the assessments have been completed, the ACT leader or a designee takes the information and compiles the comprehensive assessment. The people who contributed to the assessment review it and discuss it as part of the initial treatment planning meeting. If team members later learn something about the consumer that is relevant to the assessment, you would add that information to the assessment.

We suggest comparing your assessment forms to the forms in *A Manual for ACT Start-Up* (Allness & Knoedler, 2003). to determine if any elements are missing. If you find that elements of this comprehensive assessment are missing from your assessment, you may want to consider creating a supplemental form or revising your forms. For a sample *Comprehensive Assessment*, see module 2.

Use a Psychiatric/Social Functioning History Timeline

The *Psychiatric/Social Functioning History Timeline* is used to develop a detailed overview of the significant events in consumers' lives, consumers' experience with mental illness, and their treatment history.

Information for completing the timeline is obtained only with the consumer's permission. You may need written releases to obtain some of the records that are used to create the timeline. You should also get the consumer's consent before you speak with 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 consumer;
- interviews with family members or other supporters;
- interviews with employers; and
- interviews with past treatment providers.

The timeline begins at the point a consumer first started experiencing problems relating to mental illness and it continues to the present time. After you initially complete the timeline, you may add more information as it becomes available. You will receive a copy of the timeline form with one of the exercises for this module.

Steps for constructing timelines

Step 1 Carefully review the information gathered about the consumer to determine the earliest date that the consumer experienced problems with mental illness. This is the beginning date for the timeline. Write the date in the first blank space under the column, Timeline Date.

Step 2 Decide what increment of time will be represented by each row in the timeline. This could be 1 or multiple months or years. For instance, each row might represent 1 month, 6 months, 1 year, 2 years, etc.

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 consumer first experienced problems in September 1975, and you decide to use a 1-year time interval, you would label the first row under *Timeline Dates* as *September 1975 to August 1976*.

You would label the next row *September 1976 to August 1977*, etc., until the present. For the example in module 2, the final row would be labeled *September 1999* – the date the consumer was admitted to the ACT program.

Step 3 After you identify the earliest date and marked the time intervals covered by each row in the *Timeline Date* column, **go back through your source information**. By date, compile events, facts, and other information that may be important on the timeline.

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

- Is any information missing about a particular period?
- Does any of the information conflict? For example, do records show the consumer was incarcerated and working during the same period?
- Have any treatments worked well in the past?
- Do any situations or events appear to have contributed to the deterioration in this consumer's condition in the past?

When the timeline is complete, it gives you a picture of how various events relate. It can help you check for gaps in the information you have about a consumer's life, and, if inaccuracies or conflicting information in clinical records exist, they will become apparent.

The timeline can be particularly useful in helping you see how various events in the consumer's life are related. For instance, you will be able to see the relationship between:

- various treatments and the consumer's symptoms and functioning,
- events that precede 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.

Create a treatment plan

ACT team members will find that the treatment plans that ACT teams develop tend to be dynamic and more intimately linked to services than those developed in more traditional settings. The day-to-day contacts between team members and consumers are taken directly from the treatment plan. Every day the team reviews the contacts from the previous day. If the team's activities aren't helping consumers meet their goals or if new needs arise, the team can quickly modify the plans.

Treatment plans define the specific issues and problems that the team will address in both the short-term (2-3 months) and long-term (6 months). The plans also detail 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*.

Consumers' perception of their needs and goals are an important part of treatment plans. If treatment plans are not meaningful to the consumers you serve, consumers may let you know in direct or indirect ways. For example, you might notice that a consumer is never home when you go to visit or that the consumer has more unscheduled after-hour contacts.

Changes in consumers' responsiveness to the team or changes in consumers' level of symptoms or functioning should signal your 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?

The team should formally review the treatment plans every 6 months. However, you should revise them immediately when consumers' service needs increase (e.g., symptoms return, heavy and dangerous use of substances occurs, an eviction is pending). On the other hand, when needs decrease (e.g., significant symptom remission, successful integration into a new job), the team should review the plans with the consumers before you decrease support and services.

Make a Weekly Consumer Schedule

After you write the treatment plan, translate the goals into a weekly schedule of contacts and activities that will occur between team members and consumers.

Each consumer has a weekly schedule that is filled out in pencil so it can be easily changed. Keep these schedules in a central location and use them to complete the *Daily Team Schedule*. Some teams use a 5" x 8" card to represent a 1-week period. Others use a sheet of paper that has all the days in the month on it.

How a weekly schedule might work

Paula was recently admitted to your program. She has two children ages 5 and 7 and was reported to Child Protective Services (CPS) for neglecting her children. She is at risk for having her children removed from her care.

No evidence exists 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 ensure that the children are adequately cared for and to prevent them from being placed in CPS custody.

After the meeting, the goals decided on were that Paula had 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 also required that Paula attend parenting skill classes 1 hour a week for 6 weeks; however, she said that it is difficult for her to listen to what the instructor is saying.

Paula and the team agreed that a team member will call in the evening to help her plan what clothes to lay out for the morning and what 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,
- remind her to follow the routine she developed for getting the children up,
- check to see if any last-minute problems have occurred, and
- offer positive reinforcement for her efforts to get her children to school on time.

Team members will also provide transportation once a week so Paula can buy groceries and they will assist with meal planning. Transportation to parenting classes is being provided by CPS, but the team 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 Table 6.

Table 6: Example of a <i>Weekly Consumer Schedule</i>						Paula J.	
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	7:30 phone call to prompt morning routine SALLY	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	7:30 phone call to prompt morning routine SALLY		
	8:30 laundry SALLY			8:30 laundry SALLY			
	11:00 meal planning for the week: grocery store MARY						
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 MARY	4:00 visit to reinforce & model parenting skills SALLY		7:00 phone call to prompt preparations for the morning MARY
			7:00 phone call to prompt preparations for the morning GEORGE				

Make a *Daily Team Schedule*

Each day during the daily team meeting, have a team member complete the *Daily Team Schedule* (Table 7). Many teams hold their meetings at 10:00 a.m., thus allowing team members time to take care of early morning contacts as they arrive at the office. If team meetings are at 10:00 a.m., the *Daily Team Schedule* covers the contacts that occur from 11:00 a.m. on the day of the meeting through 10:00 a.m. the next day.

The ACT leader goes through the *Weekly Consumer Schedule* for each consumer and notes all the activities that are indicated for that day. Write these activities in the appropriate time slot, along with the name of the person who is responsible for the contact. Next, check for other appointments that have been scheduled, such as doctor visits, job interviews, appointments with Social Security, or other meetings that are not part of the recurring schedule of contacts.

If you use a monthly calendar for consumers' schedule, note these types of appointments directly on the consumer's calendar. If you use a 5"x 8" card system, have separate calendars to note these appointments

The ACT leader also checks a calendar on which team members note when they will be unavailable to see consumers, for instance, when a vacation is planned, training is scheduled, or other discipline-specific activities are occurring. Also block off time for charting and documentation.

After noting the routinely scheduled contacts from the *Weekly Consumer Schedules*, special appointments, and staff availability, draft a tentative *Daily Team Schedule*. During the team meeting, a team member might report a crisis that developed the previous evening that requires an unscheduled visit to a consumer. In that case, adjust the Team Schedule to accommodate this visit.

It is also likely that during the meeting team members may decide they need to contact a consumer to follow up on something that another team member mentioned. Also work these contacts into the schedule.

At the same time, the person developing the schedule should also listen for team members to mention appointments that were made for consumers. When these appointments are mentioned, the scheduler should check to see that they are on the calendar.

As soon as the meeting ends, the person who filled out the *Daily Team Schedule* should immediately make copies for everyone on the team. Keep your copy with you throughout the day. To protect consumers' confidentiality, use only consumers' initials on the *Daily Team Schedule* (See Table 7).

Table 7: Example of a *Daily Team Schedule*

Date:	
On Call and Vehicle Status	Acute or hospitalized clients
<i>List staff carrying beepers with beeper numbers</i> <i>List description of available vehicles</i>	<i>List client's name, status or location</i>
AM Calls	Planning
<i>List client's name and reason for call</i>	<i>List clients scheduled for initial or revised treatment planning.</i>
8-10 <i>In each time slot, list clients' names, reason for contact and name of responsible team member.</i>	2-3
10-11	3-5
11-12	5-7
12-1	7-9
1-2	PM Calls <i>List client's name and reason for call</i>

If your team covers an extensive geographic area, when you develop the *Daily Team Schedule*, also consider where team members will be throughout the day. Consider having someone who 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.

However, if you use this approach, be careful to vary who covers different areas so that the program does not become a case management program where staff are assigned to a limited geographic area and consumers are deprived of the benefit of working with multiple team members.

Conduct a daily team meeting

At times, everyone on your team will be busy and you may be tempted to forego the daily team meeting. Do not give in to this temptation. **The daily team meeting is a vital activity for ACT programs.**

The daily team meeting is critical for ensuring open communication between team members. The daily meeting is the place where all team members are kept current on what is happening with consumers.

If a crisis is brewing, the team can talk about how best to respond. Perhaps the team will decide to talk to the consumer about having someone visit more often. If a consumer is having trouble getting access to a resource, the team can quickly decide another course of action. If a consumer is doing well, team members can provide reinforcement.

The team meeting is structured around the *Daily Communication Log*, a 3-ring binder that has an index tab for each consumer, followed by several sheets of notebook paper.

During the meeting, the ACT leader who is responsible for the *Communication Log* states the first consumer'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 a more complicated problem has arisen or if a more thorough discussion of the team's response to a situation is needed, the team members who are the primary contacts for the consumer 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.

Hold other team meetings

In addition to the daily team meeting to review consumer progress, the team also meets once a month to handle administrative issues and issues related to team development. During this meeting, the ACT leader deals with administrative housekeeping issues.

Also during this time, the ACT leader shares information about consumer outcomes and ACT fidelity. (See *Evaluating Your Program* for more information.) This is also the time for team members to work on issues of team dynamics.

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.

Think about and describe how you might engage Harold in ACT.

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 regularly. She kept up her contact with Harold and introduced him to the doctor who visited with Harold at his apartment. Harold agreed to letting the doctor continue to administer the psychotropic injections he had received 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 Harold loved to play tennis as a child. By luck, a public court was 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 has 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 backyard 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.

Think about and describe how you might engage Lucy in treatment.

How one team responded

It took us weeks to find Lucy. Once we found her, we just kept visiting and talking with 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.

Exercise: Compare Assessment Procedures

Since it is important to become familiar with assessments related to other disciplines, first think about your own discipline, then we will share information from the disciplines of our team members so that we gain a full picture of what we offer.

List up to 5 things that are included in the assessments that members of your discipline typically complete.

What is included in your discipline's assessments?
1.
2.
3.
4.
5.

Now, let's share our lists. Taking each specialty represented on our team, list what is included in that discipline's assessment.

Discipline _____	Discipline _____
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
Discipline _____	Discipline _____
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Discipline _____		Discipline _____
1.		1.
2.		2.
3.		3.
4.		4.
5.		5.
Discipline _____		Discipline _____
1.		1.
2.		2.
3.		3.
4.		4.
5.		5.

Are any items listed in another specialty area relevant to your specialty? What is it? How might it be relevant?

How would you typically find out about this?

If an item is listed under more than one specialty, what would you do with this information?
Is it the same thing or something different?

Exercise: **Construct a Psychiatric/Social Functioning History Timeline**

If you were constructing a timeline about someone being admitted to your ACT program, a wide range of sources would go into making up the timeline. However, for the purposes of this exercise, use the comprehensive assessment in module 2 (for Mr. Jones) to complete the timeline on the next page.

This exercise will help you understand how to construct a timeline and how you can use it to check the thoroughness and accuracy of the information your team has about a consumer. You will also learn how you can use a timeline to detect treatments and other circumstances that have and have not been helpful to the consumer.



Psychiatric/Social Functioning History Timeline

Client name _____

Page _____

Timeline date	Admission or discharge date	Institution or provider	Presenting problem or legal status	Diagnosis, symptoms, significant events (suicide attempts, threats, violent acts, self-neglect)	Medication	Services rendered	Reasons for discharge	Living situation, dates, address or type, reason for leaving, Activities of Daily Living (ADL) (Personal hygiene, household activities, housecleaning, cooking, grocery shopping, laundry, and financial source and money management)	Employment or education (Dates held, employer position, type reason for leaving, other educational activities)	Other (Alcohol or drug use treatment, family relationships medical other: specify)

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Exercise: Prepare for Your *Weekly Consumer Schedule*

Using the completed treatment plan on the next pages (This is a copy of the one we used in module 2), list the activities that need to happen to carry out the plan. Then check how often the activities are scheduled to occur and note if any activities are scheduled on specific days (e.g., every Wednesday).

[illegible]

<h2>ACT Treatment Plan</h2>		Name:	Mr. Jones	SSN:	123-45-6789	
		Tx Plan Date:	10/21/99			
		Review Date:	4/21/99			
Primary treatment team: Sally S., Integration Specialist (IS) Fred F., Substance Abuse Specialist (SAS) Jane J., Employment Specialist (ES) Nancy N., Nurse (RN) Mike M., Psychiatrist (MD)		Discharge criterion: <ol style="list-style-type: none"> 1. No significant major psychotic or affective symptoms for 2 years, and 2. No major role dysfunction in areas of work, socialization, and self-care for 1 year under conditions of minimal treatment. 				
DSM IV Diagnoses						
Axis I 295.30 Schizophrenia, Paranoid Type 304.80 Polysubstance Dependence		Axis IV Psychosocial Stressors: Rejection by family Inadequate social support Unemployed Inadequate housing/unsafe neighborhood Multiple arrests/convictions Hostile relationships w/others Severity: 3 – Moderate				
Axis II 301.7 Antisocial Personality Disorder w/Borderline Features		Axis V Current GAF: 30 Highest GAF past year: 30				
Axis III History of exposure to Hepatitis A, B, & C as validated by laboratory studies; Esophageal reflux Non-tuberculosis mycobacterium		Strengths <ol style="list-style-type: none"> 1. Survival skills developed while living on the streets 2. High school diploma 3. Desire for more stability in his life 4. Engaging personality 				
Focus Area 1						
Jones' experiences: <ol style="list-style-type: none"> 1. persistent delusional thoughts of a religious, satanic, and paranoid theme (i.e., "The County 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. 		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. Goal Through 4/00, Mr. Jones will have no incidents of unplanned hospitalization as measured by staff, community, and crisis report.				

Plan

1. MD to see every 4-6 weeks for medication prescriptions, symptom assessment, and supportive therapies;
2. Daily 1:1 with 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); and
4. ACT team to be available 24/7 for crisis response, support services.

Focus Area 2

History of involvement with the criminal justice system including 3 felony convictions, multiple arrests, and hospitalizations

Plan

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 SAS to interact with law enforcement officials to provide education about mental illness and function as liaison, as needed.

Goal Through 10/00, Mr. Jones will have no arrests or physical altercations as measured by self, staff, community, and police reports.

Goal Through 10/00, Mr. Jones will revisit his timeline on a monthly basis during 1:1 to identify pattern and develop pre-crisis coping strategies as monitored by staff report.

Focus Area 3

Extensive history of substance abuse which contributes to an increase in psychotic symptoms and possible suicidal/homicidal risk (see Focus Area 1). History of burglaries to obtain money to purchase substances (see Focus 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."

Plan

1. 1:1 motivational interview 3 x week – SAS
2. Weekly dual-diagnosis group at ACT program office – SAS

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 3 or more different occasions prior to 4/00.

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 3 or more different occasions prior to 4/00.

Goal By 1/00, Mr. Jones will identify 1 or more factors he personally views as benefits from reducing or eliminating the use of alcohol or other substances.

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.

Plan

1. IS and SAS 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 as needed basis.
4. Weekly monitoring of food supply/trips to grocery store and education about nutrition

Goal Mr. Jones will maintain his residence in a safe environment for 3 consecutive months by 10/00 as monitored by self, staff, and apartment manager.

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.

Focus Area 5

Care and management of medical and dental needs is complicated by Mr. Jones' difficulties in recognizing the need for intervention and in following through with medical recommendations due to Focus Area 1.

Plan

1. RN to schedule dental appointment and accompany Mr. Jones.
2. RN to schedule appointment with family practitioner to address medical needs.

Goal F/U re: esophageal reflux, non-TB mycobacterium, and sores on head/face.

Goal dental appointment

Goal ongoing monitoring

Exercise: Complete a *Weekly Consumer Schedule*

Translate your list of activities from the previous exercise onto the sample *Weekly Consumer Schedule*. Use this opportunity to point out strengths and weaknesses of the treatment plan. For instance, does the treatment plan communicate the plan clearly enough so that other ACT team members can follow it?

Sample <i>Weekly Consumer Schedule</i>							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							

Notes to the facilitator and ACT leader:

Prepare for Module 4:

- Make copies of module 4, *Service Areas of Assertive Community Treatment*. Your copy is in this workbook; print copies for your team from the CD-ROM.



- Distribute the material to the team members who will participate in your group session. Ask them to read this module before meeting as a group to discuss it.

Conduct your fourth session:

- When you convene your group, view the *Service Areas of ACT* on the *Practice Demonstration Video*. Discuss the video and the content of module 4.
- Distribute the criteria upon which the ACT program will be evaluated (fidelity and outcome measures) to review and discuss.



Consider this additional training activity:

Integrate EBPs into comprehensive

services: As a team, view the *Introductory Video* from other EBP KITS. Discuss how your team will integrate the principles of those evidence-based practices into the comprehensive services you offer.



Training Frontline Staff

Module 4: Service Areas of Assertive Community Treatment

ACT services include treatment, habilitation, and support. Module 4 discusses the range of services areas that team members provide to comprehensively meet the needs of ACT consumers, including:

- medication support,
- psychosocial treatment,
- community living skills,
- health promotion,
- family involvement,
- housing assistance, and
- employment.

Services that you provide in these areas are not discrete, disconnected services, but rather are part of the larger, coordinated intervention of the team.

Treatment, habilitation, and support: An overview

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 to reduce the negative effects of their mental illness and associated impairments in cognitive and social functioning.

This process includes overcoming problems that result from past experiences, as well as minimizing the risk of further acute episodes of illness.

The services that ACT teams deliver are not discrete, disconnected services, but rather parts of an integrated intervention. Services provided by ACT teams target problems and address objectives in multiple areas of consumers' lives (see Table 8).

Table 8: ACT Service Components

Medication support	Psychosocial treatment	Community living skills
<ul style="list-style-type: none"> Educate about medications Order medications from pharmacy Deliver medications to consumers Organize medications Monitor adherence and side effects Monitor use of medications 	<ul style="list-style-type: none"> Take a problem-oriented approach to counseling/psychotherapy Manage illness Maintain crisis intervention — Be available 24/7 Treat co-occurring disorders Coordinate care (e.g., hospital with community) 	<ul style="list-style-type: none"> Practice good hygiene Follow proper nutrition Buy and care for clothing Use transportation Keep house Manage money Enjoy social relationships and leisure activities
Health promotion	Family involvement	Housing assistance
<ul style="list-style-type: none"> Conduct preventive health education Ensure medical screening Schedule health maintenance visits Act as liaison for acute medical care Assess need for reproductive counseling 	<ul style="list-style-type: none"> Manage crises Provide family psychoeducation Actively engage family members in consumers' recovery 	<ul style="list-style-type: none"> Find suitable shelter Support housing once established Develop relationship with landlord
Employment		
<ul style="list-style-type: none"> Provide support in finding work Act as liaison with employers and educate employers Serve as job coach Support employment 		

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 who are diagnosed with a psychiatric disorder benefit to the same extent from medications. Some will decide they do not want to take them.

If consumers decide not to take medications, your team should continue to work with them in other areas. If consumers are considering discontinuing medications, it may be helpful to talk to them about what happened before when they stopped taking medications. Help them plan ahead of time what they would like to have happen if their symptoms worsen.

If consumers' symptoms are exacerbated when not taking medications, team members can work with them to assess the relationship between not taking medications and experiencing acute psychiatric symptoms. You should also weigh the relative costs of taking medications instead of experiencing symptoms.

Educate consumers and families about medications

Educate consumers and families about how medications work and their roles in treating symptoms. Remember that education occurs over time in both verbal and written forms and in language geared to consumers and families.

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 consumers to get 2 months' worth of a prescription at once to stagger the task of ordering medications.

You can also work with pharmacies about packaging pills so that they are easier to take.

Deliver medications to consumers

When consumers have difficulty taking medications as prescribed, having a team member visit their apartment to give medications to them can be extremely helpful. This contact may be very brief or can also offer a chance to check about other needs. For some consumers, telephone calls are sufficient to monitor medication.

Organize medications

When multiple medications are prescribed, it can be difficult for consumers to take the proper doses at the right time. The team psychiatrist can help by simplifying medication regimens, by prescribing the fewest medications taken the least number of times to effectively control symptoms with minimal side effects.

Until a simplified regimen has been worked out, team members can help consumers organize their medications in special containers that hold individual doses.

Monitor medical compliance and side effects

Some consumers may not wish to take medications because of their side effects. Team members should carefully monitor medication adherence and side effects and facilitate communication between consumers and the team psychiatrist so that medications can be adjusted quickly when needed.

You will also need to work closely with consumers and the team psychiatrist to develop strategies to help consumers relieve minor side effects.

Psychosocial treatment: A problem-oriented approach to counseling/psychotherapy

Counseling/psychotherapy in ACT follows a problem-oriented and supportive approach, integrated into the continuous work of all team members who contact consumers. Consumers' goals as laid out in the treatment plan are the focus and, thus, are an integral part of the treatment, habilitation, and support that the team provides.

Manage Illness

Teaching illness management and recovery skills is a method of systematically helping consumers recognize the symptoms of mental illness that they experience and using 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 integral parts of illness management.

We recommend formal training with the Illness Management and Recovery KIT for one or more team members.

Crisis intervention: Be available 24/7

ACT teams can respond in various ways to acute situations and may be able to prevent the need for consumers to be hospitalized. When consumers have acute needs, your team must quickly assess the situation and devise a short-term treatment plan.

This plan usually addresses:

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

In responding to these needs, your 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, and
- limit substance use that exacerbates or causes the situation, such as providing more frequent supports and prompts or arranging a temporary change of residence.

If your ACT team is available around the clock, you will be able to quickly respond to a crisis. Knowing that the team will see or talk with consumers whenever it is necessary reassures 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 forthcoming, the number of crises usually diminishes and can often be handled by telephone.

Integrated treatment for co-occurring disorders

Rather than sending consumers with co-occurring substance abuse problems to a separate program for substance abuse treatment, the ACT team delivers both individual and group interventions targeting substance abuse. When a consumer is suspected or known to have a substance abuse or dependency disorder, assign one of your team's substance abuse specialists to work with that person. Although the substance abuse specialist has primary responsibility for assessing the consumer's substance use disorder and planning treatment, the substance abuse specialist will collaborate extensively with other team members in carrying out these interventions.

Using 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 you do use outside services, your team will refer consumers to those programs that are adapted specifically to consumers with co-occurring disorders.

We recommend formal training with the Integrated Treatment for Co-Occurring Disorders KIT for one or more team members.

Acute psychiatric hospitalization

Since ACT teams can quickly respond to changes in a consumer's status and increase the number of contacts to address problems, ACT services often reduce hospitalizations. However, sometimes inpatient care is appropriate.

A Manual for ACT Start-Up (Allness & Knoedler, 2003) suggests that short-term psychiatric inpatient treatment may be appropriate for consumers 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 ACT 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 ACT 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;
- need 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 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 consumer with high needs.

According to *A Manual for ACT Start-Up* (Allness & Knoedler, 2003), 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 intense daily team efforts and repeated short-term psychiatric hospitalizations over an extended period of time.

When consumers are in the hospital, your ACT team is still responsible for care. This means that you must make certain that the inpatient staff have critical information for treatment needs. When consumers are admitted to an inpatient setting, your 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.

Collaborating with inpatient staff facilitates the rapid development of a treatment plan and provides continuity in treatment to the greatest extent possible.

Admitting consumers to the unit

At times, consumers will seek emergency admissions on their own or they may be taken to the hospital by family, emergency personnel, or the police. But in most cases, your ACT team will usually initiate inpatient admissions.

When your team is involved in the admission process, you can provide emotional support to consumers. You can share information with the inpatient staff to help them understand consumers' history and current status and to create a smoother transition between outpatient and inpatient care.

It is difficult to admit consumers unless funding for the hospitalization is ensured ahead of time, though in true emergencies, hospitalization will proceed even if funding is not guaranteed. When consumers

have insurance (e.g., Medicare or Medicaid), funding may not be a problem, though increasingly, payors require preadmission and concurrent review.

When preadmission assessment is required, staff must usually 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 that demands patience and skill.

After the funding for the admission has been approved, a team member should call the attending psychiatrist of the inpatient unit to request admission and explain the details of the case. You should then inform a nurse on the unit.

When the inpatient unit has approved the admission, the team member should:

- accompany the consumer to the unit,
- help him or her through the admission process,
- assist the inpatient staff in establishing communication with the consumer, and
- settle the consumer into the unit.

You should bring a copy of the current treatment plan and a list of current medications with dosages and side effects.

Key tasks during hospitalization

Your team should stay actively involved with consumers who are hospitalized. Someone on the team who has worked closely with the consumer should visit the consumer at least once a day (assuming geography permits) 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 consumer.

When your team works with hospitalized consumers and inpatient staff, follow these practical rules of conduct:

- Tell the staff of your presence on the unit, ask them about the consumer's status, 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 to the inpatient staff (e.g., whether the consumer seems to be in distress, is losing control, or needs monitoring and support).
- Respectfully suggest changes that the inpatient staff can make in their approach with the consumer (e.g., avoid giving detailed information and direction to a consumer who processes information poorly).
- Monitor medication side effects with the consumer. You may also present your observations to the team's psychiatrist so that person can use these observations while conferring with the inpatient psychiatrist.
- Model interpersonal approaches to the consumer that your team has found helpful in the past (e.g., being supportive to a consumer who is feeling irritable or hostile, eliciting information about psychotic symptoms from a nondisclosive consumer, or 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, they hold an initial staff meeting within the first few days of admission, with others scheduled as needed or at regular intervals. Consumers often attend part of the meeting. Your 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 1 to 2 days after they are admitted to allow staff to assess and treat presenting symptoms. After that, it is useful for most consumers (unless they are suicidal or very easily distressed) to continue to be involved with their life and treatment in the community, even on a daily basis.

When they are not clinically counter-indicated, passes for consumers to visit the community might be part of the overall treatment plan that you develop with the inpatient staff. While they are still in the hospital, passes allow consumers to stay involved in:

- normal activities (e.g., handling tasks like paying bills or returning to work);
- social and supportive relationships (e.g., visiting family and friends, staying in contact with the team); and
- personally satisfying activities (e.g., going for a walk, shopping).

Overnight or weekend passes provide a method for consumers and your team to assess improvement and readiness for discharge.

Planning for discharge and return to the community

Some consumers will be hospitalized for only a short time and will need very little change in the treatment plan that guides your ACT team's interventions in anticipation of discharge.

In other cases, however, markedly different interventions may be needed at discharge. You can use passes to test new interventions before consumers are discharged.

Long-term hospitalization

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

Typically, your team would initiate 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 the team, team members should approach consumers who were hospitalized long-term with the same commitment, energy, and community orientation as they do any other consumer.

At the same time, they must support and assist the inpatient staff to provide optimal treatment. This means visiting consumers at least weekly to assess progress and status, developing treatment plans in collaboration with the inpatient staff, attending regular staff meetings, and involving consumers in regular treatment and rehabilitation 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 consumers move closer to discharge. In fact, readiness is determined by consumers' ability to handle increased expectations in the community.

You may have to secure necessary resources (particularly housing) and introduce the consumer to them (e.g., overnights, extended visits). The outpatient plan is usually an intense and structured one. It anticipates the need for daily contact, including:

- supervision,
- medication management,
- self-care,
- housing support,
- financial management or support,
- socialization, and
- other activities.

Community living skills

Practicing good hygiene, maintaining proper nutrition, buying and caring for clothing, and using transportation are community skills that you must approach with the same sensitivity as other foci on skills development or redevelopment.

When consumers request a change in any of these areas, take a direct approach to work on them. When such goals are clearly incorporated in the treatment plan and agreed to by the consumer, you have a basis to address them.

Other consumers may be unaware of problems in any of these areas and may not want to change. Limited performance may be related to stigma about mental illness or personal issues.

You may have to tie work on community living skills into related goals expressed by the consumer. For example, a consumer who is interested in working may understand that good hygiene and reasonable attire are necessary to obtain and keep a job. A consumer who is interested in a specific social activity may accept that good nutrition is necessary to have the energy to engage in activities. A consumer who is interested in living independently may realize that housekeeping is necessary to keep an apartment. Team members can help with related activities (such as shopping for groceries or clothes, and apartment cleaning), encouragement, and reminders.

The goals of community living skills are to:

- guarantee that consumers' basic needs are being met;
- continually assess consumers' Activities of Daily Living (ADL) functioning to ensure they get the help needed to live with quality in community settings;
- help consumers upgrade their quality of life (e.g., move to nicer living arrangements, increase possessions); and
- provide ongoing ADL services which meet consumers' needs and preferences so that they can manage ADL functions as autonomously as possible.

Housekeeping

You must respect consumers' housekeeping style and preferences—just imagine your team members coming into your home and imposing their standards and methods on you.

However, some minimal level of housekeeping is necessary to ensure basic hygiene, such as putting food away, washing dishes, taking the trash out, etc. There is also the practical aspect of organizing things to make them easier to find. Finally, housekeeping rituals can help bring a sense of structure to a consumer's day and a degree of order to the environment.

If consumers need help organizing and planning housekeeping tasks, team members might work with them to define a list of tasks. It is worth the effort to discuss how often the task will be done. For example, should the consumer make the bed every morning, some time during the day, more often than not, or when the mood strikes? Should consumers wash dishes when no more clean ones are available, before going to bed, or immediately after meals? Does washing dishes include drying and putting them away? This level of detail is particularly important because multiple people work with consumers and the plans must be consistent to avoid confusion.

Whatever decisions are made, the team must make certain that consumers have basic information (i.e., which day the trash is picked up, which dumpster the trash is put into) and the equipment or tools (trash bags, dish soap, broom) needed.

Money management

Some consumers will manage their own money but may need assistance from the team in other ways. For example, they may need help setting up a checking account, developing a system for paying bills on time, or obtaining entitlements (usually involving going with the consumer to apply for benefits and assisting with documentation and completing forms).

For other consumers, the team may help prevent them from being taken advantage of financially (e.g., mail or TV scams) or advocate for them to obtain a release from such commitments.

ACT 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 consumer's budget. The purpose of this system is to help consumers manage money and to give them 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, the consumer suffers high stress, which is counterproductive to treatment. The team should work with the consumer to devise a plan to allocate the spending money. The team would hold the spending money and take 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) and Social Security Disability Insurance (SSDI), under the supervision of a payee or financial guardian.

Consumer services money

Consumer services money are funds allocated in the ACT 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 consumers on inpatient units longer than their psychiatric treatment requires and contributes to homelessness.

Consumer services money can also be used for emergencies, rent, security deposits, food, clothing, recreation, and transportation costs. Your ACT leader will inform you if a consumer service fund is available for your ACT program.

Individual consumer funds

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

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

- dispense money to consumers from individual consumer accounts according to the consumers' monthly budget,
- maintain an account with a local bank for deposits and withdrawals of consumer money,
- document all cash transactions with receipts that consumers sign when they receive cash and return these receipts to the payee or guardian to document that consumers' received 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, and
- receive money from guardians or payees and maintain records of receipt and current balances for each consumer.

Interpersonal relationships and social activities

The onset of mental illness can interfere with social development. It may impede consumers' ability to form relationships, get and give emotional support, and relate as adults with families, employers, and landlords.

The ACT team provides a broad array of services to help consumers:

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

According to *A Manual for ACT Start-Up* (Allness & Knoedler, 2003), the nature and quality of a consumer's social and sexual relationships before the 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 consumers' ability to relate interpersonally. Consumers often lack social skills because of the symptoms of mental illness, the effects of institutionalization, or the lack of learning opportunities during childhood and adolescence.

The following two case examples model how ACT teams may support consumers in developing or maintaining relationships:

Jerome

Jerome 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 re-establish 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 re-establish 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 experiences fluctuations in his symptoms.

Marcia

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 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 was also 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” and assertiveness) to increase her social competence and comfort.

Services to restore interpersonal relationships

Services to help consumers restore interpersonal relationships include:

- assessing consumers’ social and interpersonal functioning, social development, culture, social skills, and interests;
- developing individualized plans 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 consumers normally interact with people;

- identifying and overcoming stressors, behaviors, and environmental issues which affect and diminish the quality of interpersonal relationships;
- reducing the stress of unstructured time – evening, weekends, and holidays – and fostering normal social routines; and
- planning, participating in, and handling holidays, family, and other social obligations with less stress and greater competence.

Service features

Identifying consumer goals

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, before a holiday, the team reviews plans with consumers and helps them work out how they will spend that day. If they usually spend the holiday with family, the plan may include helping them call the family to make arrangements.

In addition, the team will problem-solve and provide side-by-side coaching and assistance to help consumers determine how long to visit, the best means of transportation, what to wear, and how to manage interpersonal interactions with family. Team members may meet with consumers and their family before the holiday to problem-solve and plan ways to make it an enjoyable time for all.

The team works out how to establish an understanding and trusting relationship with each consumer and then provides it. Each team member plays 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.

Interpersonal support is offered to consumers over time in a gradual, step-by-step fashion. Continuous services allow consumers the time to restore social functioning. Consumers may delay having to function in some social situations until they feel better. Continuous interpersonal support allows consumers to practice social skills in real-life social situations during their recovery.

Restoring social relationships

The team and the consumer evaluate the relationships in consumers' lives that have been affected or disrupted by mental illness. Together they develop and implement strategies to reconcile or renegotiate these relationships. The stigma of mental illness and 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, consumers make goals and plan approaches to reconcile or renegotiate relationships. Intervention may also include team members working with consumers and friends or family members in an intermediary role, or supporting consumers in meeting with the individual to either get closure or re-establish the relationship on mutual terms.

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 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 helps consumers move from the 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, such as:

- redirecting a question to the consumer that the landlord directed to the team member,
- drawing the consumer into a social conversation,
- practicing before an interaction with an employer how the consumer prefers to respond to anticipated feedback, and
- helping a consumer to shop for a present to have something to take to a parent's birthday party.

Promote health

All consumers need access to high-quality preventive and health maintenance care. Some consumers who receive ACT 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 experience acute psychiatric symptoms, is to keep a pulse on consumers' medical conditions, and their response to treatment for those conditions.

Provide preventive health education

Good basic health practices – daily hygiene, adequate food, proper rest – can make it 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 consumers have limited incomes. Supplies for daily hygiene like soap, shampoo, and toothpaste can be a luxury when income is extremely limited.

If available, you can buy hygiene items with consumer services funds; however, you should be able to find community agencies that will donate these items. The team should monitor daily hygiene since marked changes may signal a change in consumers' clinical status.

The team also needs to monitor whether consumers are 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 to adjust the consumer's medication regimen.

Along with encouraging good basic health practices, the team also provides education on preventing certain communicable diseases, including HIV and sexually transmitted diseases. This education is particularly important for consumers who are 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 can lead to serious health problems. Consumers must be educated about the medications they are taking and possible interactions. The team psychiatrist might also communicate directly with medical providers (with consumers' permission) to work out medication regimens that safely address both consumers' mental health and physical health needs.

Arrange 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, such as:

- eye exams and opticians, if needed;
- periodic testing for HIV, which is essential for people with risk factors; and
- mammograms for women according to age guidelines.

This task might involve helping consumers schedule appointments with their medical provider, providing transportation, and even helping consumers practice explaining their health concern to medical providers.

Schedule health maintenance visits

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

Serve as a liaison for acute medical care

Acute medical care refers to emergency or inpatient medical treatment. Consumers may be anxious about a medical crisis or about being in a medical environment. ACT team members may offer additional support. Similar to the support offered during a psychiatric hospital admission, the team should:

- provide interpersonal support,
- ensure financial coverage,
- facilitate admissions,
- communicate with medical providers,
- ensure that consumers understand and communicate their choices, and
- facilitate discharge after care.

Provide reproductive counseling

Consumers vary in how much they know about safe sex practices and birth control. It is important to assess whether or not consumers say they are sexually active. Team nurses, or other well informed staff, should counsel consumers on the approaches to birth control.

When a pregnancy occurs, team involvement is usually very important. The team must adapt consumers' psychiatric treatment so that it meets the needs of the pregnancy and delivery. The team must ensure that consumers receive prenatal care and maintain communication with hospital staff both during and after delivery.

Involve families

Historically, consumers 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 decreased hospitalization and increased emphasis on outpatient treatment.

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

On the other hand, some consumers have little or no contact with their family and may say they have none. It is a tragedy when consumers have been separated from parents, brothers, sisters, or other family because of their mental illness. It is also a serious shortcoming when practitioners assume that families want nothing to do with consumers without making an effort to find out if this is really the case.

At the point of admission, ACT team members should ask consumers for permission to involve family or other supporters in their treatment. Relationships between families and consumers may have been damaged during the course of the illness. The family may hesitate to become involved. In such cases, the team, with the consumer's consent, tries to contact 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 relatives become aware of the consumer's improvements and the team's comprehensive service delivery, they often reconsider and wish to have more contact.

Initiating the collaboration process involves:

- meeting with consumers and family members to learn about consumers' developmental and illness history, current symptoms, functional status, and the consumer-family relationship (e.g., typical ways of coping with and helping consumers, relationship stresses, conflicts, and family strengths);
- presenting basic information about the ACT model and developing an initial plan that specifies what the team, consumer, and family member will do; and
- scheduling subsequent meetings and phone calls to exchange information and ideas.

Family meetings can occur at consumers' homes, the family home, or the ACT office. Family meetings usually involve consumers, but they 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.

Provide ongoing family support and psychoeducation

ACT team members should maintain routine contact with families and other supporters. Open communication with families often prevents crises and minimizes the likelihood that families and ACT team members work at cross purposes.

Routine contact may include ongoing education about mental illness (i.e., etiology, symptoms, functional problems, course, and treatment). When necessary, the team may help families learn new attitudes toward themselves and the consumer, such as not blaming themselves or being overly critical of the consumer.

We recommend formal training using the Family Psychoeducation KIT for one or more team members.

Lessen consumers' over-reliance on family

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

- First, team members take over many practical functions (e.g., shopping, laundry, money management) that family members perform. They then help consumers to carry out these tasks on their own.
- Second, since teams can easily increase the intensity of the contacts they have with consumers, they can even provide intensive support to help consumers gradually move out of the family home into their own residences if this is a consumer goal.

Manage crises

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. Talk with the family about their experience with types of crises that arise and how they have previously been handled. Such information can be used to develop a plan if similar crises should arise.

Assist consumers with children

As many as one-third of women consumers give birth to children both before and after developing mental illness. Unfortunately, mental illness can compromise their ability to parent. The needs of consumer parents are complex and demand that the team alter services to address both the needs of the parent and children.

The team helps 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; and
- educating the consumer about birth control.

All activities involve partners and other people participating in the consumers' 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 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 helps consumers and their families 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 and by reviewing agency recommendations with consumers and establishing plans to carry them out. Over time, staff often function as extended family and friends to consumers and their children.

Another role of the ACT team is supporting the mother-child relationship for single parents. A single woman consumer often has difficulty effectively and safely raising her child. Even with intensive assistance by the team, other family members, and social services agencies, consumer 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, despite 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. Where this is not harmful to the child and is potentially to the child's benefit, the team advocates with the court and social services for the consumer's continued contact and a visitation plan. The plan 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 that they have more limited contact with their children until they feel better.

Assist with housing

The type of housing consumers live in may be influenced by their 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 ACT program budget are often needed to cover many 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 ACT 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 or credit histories if they know that the ACT program is providing support around payment of rent and monitoring upkeep of the residence.

Find suitable shelter

Allness & Knoedler suggest that working with consumers to find housing begins by meeting with consumers to learn about their housing needs and housing history (Allness & Knoedler, 2003):

- Where has the consumer been living?
- How often has the person moved?
- What did the person like and 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 every step of the process including:

- discussing important considerations in choosing housing:
 - security deposit;
 - rent;
 - utilities;
 - accessibility to transportation, laundry, stores;
 - safety; and
 - personal preferences.
- looking for leads in the paper or by contacting property owners that the team or consumer knows;
- 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;
- accompanying the consumer to meet the landlord, if appropriate and necessary; and
- securing leases and ensuring that the consumer pays the rent.

Help with shared housing

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

- how they will split the rent and utilities,
- how they will handle cooking and cleaning, and
- what their preferences are for social activities.

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

Monitor 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 they will live in areas of relatively high levels of crime. When it comes to the safety of the property, your team must be prepared to help consumers hold property owners to meeting at least minimum legal standards for safe housing. For instance, gas should not leak from appliances, electric wiring should not be exposed, toilets should flush, floors should not have holes in them, and faucets should turn on and off. If needed, municipal authorities may be able to help you pressure property owners to bring housing up to code.

In some instances, consumers will live in areas in which drug activity and other types of crime are abundant. Consumers can be easy prey for people who are looking for a place to sell drugs or for someone to carry drugs for them. Consumers 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 help consumers in not permitting entry to those who might take advantage of them. Your local law enforcement agency may also provide tips for crime prevention. You will want to take advantage of training opportunities 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 consumers are using drugs and have contact with people who are selling drugs. In such instances, part of the substance use treatment plan might include changing residence or involving the consumer in alternative activities.

Help with consumers' landlord and neighbors

Sometimes landlords and neighbors may be anxious about renting to or living near someone with a serious mental illness. This may have nothing to do with anything that the consumer does. It may simply come from stereotyped misperceptions about people with mental illness.

It may help if consumers make an effort to get to know their landlord and neighbors and even mention that they have an illness as a way of educating people about what mental illness is really like. Consumers might also choose to have landlords or neighbors meet members of the team and give them information about how to contact the team.

Help purchase and repair household items

Consumers may need help buying household items at reasonable prices. They may also need some instruction for performing simple repairs (unclogging a sink) or how to get help if the power goes out or telephone is disconnected.

Employment

ACT supports consumers' goals for obtaining 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."
(Allness & Knoedler, 2003)

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.

Provide support in finding work

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

Promote consumer interest and motivation to work by:

- talking about work, stimulating thinking about work, and raising expectations to work;
- offering formal and informal interactions with working consumers to help them realize that they can work;
- determining consumers' work interests and competencies; and
- finding work opportunities for consumers to boost their confidence.

Direct placement in competitive jobs

Experience with ACT has demonstrated that consumers can work competitively if they receive sufficient help to get a job and continued support to retain it. ACT employment services are based on the Evidence-Based Practice Supported Employment model in which the employment specialist works directly with individual consumers to find competitive work in the community as quickly as possible.

Job opportunities are matched with consumer preferences and skills. Consumers rarely lose jobs because they do not have the skills for the job. More often, they lose jobs because mental illness and related symptoms and behavior affect job performance.

For this reason, the assessment process includes a careful review not only of consumers' education and past work experience, but also of the specific behaviors or other issues that have been problematic on the job. Consumers are matched with jobs that play into their strengths.

Serve as a liaison with employers and educate them

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 to understand their employment needs and ensuring availability of the ACT team for consultation and support.

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 find jobs. For some consumers, employment specialists may encourage employers to create jobs that fit both a particular consumer's needs and goals with those of the work setting.

Provide ongoing support

Employment specialists provide ongoing support to help consumers and employers solve any problems that arise on the job. Employment specialists also assist consumers in transitioning to a new job, as needed.

After gaining work experience (e.g., working at several jobs) consumers often begin to:

- gain confidence that they can maintain a job,
- successfully meet expectations that go with work, and
- feel a sense of accomplishment and belonging.

We recommend formal training with the Supported Employment KIT for one or more team members.

