〔特別寄稿〕

Developing and implementing Assertive Community Treatment : Towards the Evidence-Based Best Practice

Tomie Kratz，L.C.S.W.

Mental Health Division,
Department of Health and Human Services,
City of Berkeley,
Berkeley, California, U.S.A

本稿は、2003年10月15日に新潟青陵大学で行われたトミエ・クラッツ氏による全学特別講義（本学国際交流委員会主催）の内容を氏自身によって論文として寄稿していただいたものである

Since the 1960's there has been a movement in the public mental health community seeking a way to improve the system of care for adults with severe and persistent mental illnesses. It was started in Madison, Wisconsin, where an innovative community-based care program, later named The Program of Assertive Community Treatment (PACT), was developed and implemented. By the end of the 1980s, at least a few states such as Michigan, Illinois, and Indiana had joined Wisconsin in implementing the new model in some mental health system jurisdictions. By 2001 at least 35 states and four other countries (Australia, Canada, England, and Sweden) had adopted PACT. California has also joined the movement and some counties have started implementing the new model. The positive outcome of the extensive research, which proved the PACT model as evidence-based best practice, is certainty the major force behind the acceleration of the movement for adaptation of the model. Another force was the consumer movement which has become very active during this era. As a result, consumers of mental health services and their families were able to participate in policies and praogram planning and development. Their input was not only actively sought in the policy development or program planning, but they were sought to provide education for professionals. For instance, some of them have made keynote speeches in major conferences for mental health professionals. These activities by consumers and families gave significant influence on the community based care concept of client care and helped enhance the new model. Also, they helped open the doors for consumers and family members to work in the public mental health system.

A model of community-based mental health care was developed by practitioners and researchers such as Leonard Stein and Mary Ann Test and other leaders. In the late 1960's, there was a movement to improve inpatient care at Mendote State Hospital in Medison, Wisconsin. Observing repeated hospitalizations of the same patients and resulting in institutional syndromes such as dependency, passivity, breakdown of social skills and network, this group started implementing new psychosocial programs in the hospital to help patients adjust to community living. The new programs helped patients to improve their functioning during their stay in the hospital, but not after discharge. At the same time, political and social movements, namely reducing hospital beds (cost-effectiveness), and the patient civil rights movement gained strength nationally. State govemments provided more funds for outpatient treatment centers while reducing hospital beds significantly. These new mental health policies made major impact in community mental health practices. During this era, halfway houses, psychosocial rehabilitation centers, family home-based care, and day-hospitals became more available for the post discharge patients. However, they were not for everyone, and dropout rates from these probrams were high. Most importantly, public mental health agencies were not well prepared to serve the most needful in the community who had been historically institutionalized. Professionals in general were continuously utilizing traditional approaches which were more appropriate for a higher functioning population. They were not trained to help those with most severe impairment and most high risk, who were often unable to seek help by themselves or not interested in mental health services. As a result, those clients were left on their own. There was clearly lack of clinical and theoretical focus on this population, therefore no knowledge base for the professinonals to apply in daily clinical operations to help them.

The Mendota group continued their efforts to explore a new approach to help post discharge patients make better adjustment in the community. Finally, they set up aftercare services for post dischage patients which had three major components : first, clinicians provided community outreach services ; second, staff were available 24 hours 7days a week, and third, clinicians worked closely with patient's families and other significant social network. This experiment proved to be effective. As they improved and strengthened this community-based care model, the researchers of the group pursued further outcome studies. The repeated research confirmed the positive outcomes such as patients had fewer hospitalizations or stayed a shorter period in the hospital, thus resulting in more stable community living.

In 1978, this approach was named a Program of Assertive Community Treatment (PACT). Also, recognizing that some clients needed less intensive care, some of the leaders in the movement started moving toward a complex system of care which included various levels of care. Clients were assessed as to their service need and assigned to an appropriate team. Numerous studies about PACTs and their positive research results were published, which accelerated national recognition. Noticing the positive outcomes, some counties and states started adopting this approach. However, they had to modify it in various ways to implement it due to significant differences and needs in target populations due to difference in social and community environments, in addition to fiscal limitations. For instance, large urban areas have had more poverty stricken areas, lack of inexpensive housing, and thus a significant homeless population. Furthermore, a problem of substance use has been prevalent among the people with serious and persistent mental illnesses. Another problem has been the increased number of clients with a criminal justice history. Thus, the model was modiffied and enhanced to fit to the local needs.

The overall objective of the model is to help clients improve the quality of their lives by helping them learn to live independently, to learn skills to manage their own symptoms, to maintain housing, to integrate into the community, etc. The basic philosyophy for ACT work is based on the theory that the client will progress along the path to wellness/recovery through the therapeutic partnership of the climician and client. Care is individualized according to each client's needs. Another important factor is that it is a strength-based model instead of the traditional, pathology-focused model.

The major principles of the Assertive Community Treatment (ACT) follow:

１. This is a team approach in the true sense of the phrase. Every client is assigned to a team, not to an individual clinician, so all clinicians have to be familiar with each client whom the team serves. The team meets daily in the early morning to inform all team members of the status of each client and discuss and plan what is needed to be done for the day. Further discussion will determine the team work of the day such as which clinicians will participate in a treatment meeting at a hospital, who will be in the family meeting that day, who will help a client to move into a new residential hotel, etc. In this approach, during the absence of a clinician, any clinician or clinicians in the team can take over and provide appropriate services for the client whithout difficulty. Also, every team member is able to give input in developing a care plan.

２. This is a multidisciplinary team, consisting of social workres, psychiatrist, nurse and peer counselor, among whom some may be a substance abuse specialist, vocational specialist, and/or housing specialist. Besides those specialities, each clinician has different clinical strengths which argument the team work, resulting in a higher quality of clinical work. For example, one staff may have strong ability to do family therapy and to teach family members skills to set limit with clients. Another may be good at doing assertive engagement work with longtime homeless client who had been on the street for 10 to 20 years without any mental health and physical care due to their paranoid delusions, mistrust of public agencies and/or their strong denial of having any mental illnesses etc.

３. The target population is the seriously and persistently mentally ill with sever impairment in daily functioning, including people with personality disorders. Some have a history of substance abuse/dependence. Others hava a climinal history. Many have a history of numerous hospitalizations and/or incarcerations. Another category includes client with a long history of homelesssness who avoided contact with the health care system. Especially among this group it was found that quite a few clients have had serious medical conditions as well. Among them, many have been treatment-noncompliant and diffidult to engage. Some may require several months to few years to engage.

4. A team has client to clinican ratio of ten to one and is a single point of responsibility, meaning that the team provides all needed care except in those cases when a client needs to be referred to an appropriate agency/facility for such as inpatient care, medical or dental care, substance use recovery program residential facility, etc. Even in these cases the team maintains the primary responsibility for the client care.

5. The services are comprehensive and primarily provided in the community where the client needs to learn skills to deal with daily problems and needs support. The team uses assertive approach to engage client. Also, after hours services are available 24hours seven days a week when needed.

The content of comprehensive services is the following:

Treatment:

Assessment (including psychiatric history, level of risk, medical history, family history and relationship with family and significant others, use of drugs and alcohol, criminal justice history, housing history, level of self-care, work history, case fromulation) and individualized care plan
Crisis interventions
Medication support services (including psychoeducation)
Psychotherapy (individual and group)
Substance abuse treatment

Rehabilitation:

Personal-hygiene/grooming, money-management, shopping/coocking (healthy nutrition) housing support (obtaining and maintaining housing) and safety
Socialization/leisure, interpersonal relationship (sex education)
Vocational rehabilitation/education
Support acquiring medical and dental care

Support/Advocacy:

Support client to obtain benefits
Psychoeducation for families
Family therapy, family reunification
Support landlord and group home/hotel managers
Support employer and coordinate with school counselors/staff
Support client to obtain legal help

As to issues of implementation of the ACT model, administrators have to have a clear sense of the mission and vision of organaization and a good understansing of the model. They have to be willing to restructure their system of mental health care for the agency mission if warranted in order to integrate the ACT model. ACT is a part of the adult system of care since not every client needs this level of care. A careful planning phase is crucial because it will determine success of the team. For example, having ample time to include front-line staff, consumers and their families, and leaders of community agencies for planning discussion is important.

Having a consultant help this process is also useful. A designed training program should start early, and should be provided to all staff who work at the agency because ACT is a part of the system. Later, the training for ACT staff should focus on the detail of the ACT work process. Finding appropriate staff is a major project for administrators since this is a very challenging job to continue day after day. The clients are often treatment resistant, having poor hygiene, often with serious medical conditions and/or substance abuse/dependence, a history of numerous hospitalizations and/or incarcerations, or a history of serious assaultive/suicidal risk. Thus, the job demands high tolerance and persistence to help this clientele. Staff need to be flexble, creative and street smart in addition to having a good clinical background. Also, they have to be able to maintain strict confidentiality and clear boundaries with clients and family members. Further, they have to be able to work interdependently as a part of a team and yet independently, since most work is performed in the field. Providing consistent support for staff is crucial through supervision, consultation, training (including safety issues) and team activity such as process meeting, fun activity, retreats, etc. Finally, funding for ACT could be difficult, especially during hard fiscal periods.

An outcome study for the model is also necessary to measure its cost-effectiveness. According to the research results, the following structural and service modalities are found to be most vital for better outcome:

All cases are assigned to a team, not an individual ; services are primarily provided in the client's own environment instead of in a clinic, client to staff ratio is 10 to1 (low caseload), staff uses the assertive approach, meets clients where they are and is consistent, and the target population is well defined and clear to staff.

Currently the Dartmouth Assertive Community Treatment Fidelity Scale (DACTS) is frequently used measure a program's level of fidelity to the program standards. DACTS defines the critical elements of a PACT model, focusing on and defining four areas in the model : structure and human resources, organizational boundaries, and nature of services. (It should be noted here that the impact of the consumer movement is demonstrated in the DACTS' definition for ACT fidelity which not only requires ACT to include a consumer staff, but also defines the role of consumers on the ACT team as clinicians with full professional status.) Especially for administrators it is important to assess the program effectiveness and that of the overall system of care. There has been some criticism of the approach such as that it is an coerced intervention, paternalistic approch etc. However, the positive research result of ACT model is repeatedly demonstrated and, according to anecdotes, some of the clients' recoveries are quite remarkable, which reminds providers how important it is to hold hope and not to give up on any client's path to wellness/recovery. Thus, until further innovation, the ACT model is the evidence-based best practice for individuals with most severe and persistent mental illnesses.

References

1. 19th Annual Assertive Community Treatment Conference, San Antonio, Texas, June 2003.
2. Allness, D. J.; Knoedler, W. H. :The PACT Model or Community-Based Treatment for Persons With Severe and Persistent Mental illnesses:A Manual for PACT Start-Up. Arlington, Va, National Alliance for the Mentally III, 1998.
3. Consumer and Family Member Employment in the Public Mental Health System:California Mental Health Planning Council, October 2003.
4. Mueser, K.; Bond, G. R. ;Drake, R, E, et al:Models of community care for severe mental illness:a review of research on case management. Schizophrenia Bulletin 24:37-74, 1988.
5. Phillips, S. D.; Bums B. J, Edgar, E. R, et al:Moving Assertive Community Treatment into Standard Practice. Psychiatric Services 52:771-779, 2001.
6. Thompson, K. S.; Griffith, E, H. ;Leaf, P. J. :A Historical Review of the Madison Model of Community Care. Hospital and Community Psychiaty 41:625-634, 1990.