SPEAKER NOTES

The Assertive Community Treatment Model: A Higher Standard of Care for Mental Illness

Summarized by Thomas T. Thomas

A new model for treatment and care of persons with mental illness has aroused excitement in the National Alliance for the Mentally Ill (NAMI) and other organizations: assertive community treatment. Berkeley Mental Health, a unit of the Department of Health and Human Services, has a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to implement this treatment approach.

At our March 24 meeting, we heard **Patricia Hennigan, PhD,** a member of Berkeley Mental Health's Mobile Crisis Team, and **Robert Surber, MSSW,** a consultant in behavioral health who works with the San Francisco-AMI and California AMI on these issues, discuss what the program is and what it can do.

Assertive community treatment (ACT) was originally modeled in Madison, Wisconsin. It has since been mandated in every county in that state. The model, or variations of it, are now being tried all over the country, including three teams in San Francisco and individual teams in Modesto and Long Beach.

ACT involves a team of professionals, usually 10 in number, representing a mix of publicly funded and community-based organizations (CBOs). The team takes responsibility for a number of mental health clients, usually 100, who have been identified as high cost to serve and highly in need of services. The team does a comprehensive assessment of each individual and then seeks to provide whatever he or she requires: medication, housing, food and clothing, substance abuse treatment, and support. They also provide a relationship with the client so that he or she can express needs and goals.

The model is called "assertive" because the team will approach the client in the field—in the hospital, on the street, in jail—with the offer of help, instead of waiting for the client to come to an office or clinic. However, enrollment and participation are usually voluntary on the client's part. The model is "community" based because the team seeks representation and support from a variety of local resources.

In 1997, when Berkeley Mental Health (BMH) sought a SAMHSA grant to begin using the model, Hennigan said, they held over 60 meetings with various stakeholders. These people included mental health practitioners, municipal staff, community organizations, family members, and even the police department. ASA-AMI was also approached. The stakeholders put together what Hennigan called a Collaborative—in effect, a steering committee—that developed a program which blends BMH and CBO representatives on the team.

A partial team of five members will start operating later this year in Berkeley, serving approximately 50 clients. By July 2000, with funding from the Phase II program, they expect to be up to full strength with the following

complement: a program supervisor, administrative assistant, psychiatrist, nurse, and mental health clinician (all from BMH), and a housing specialist, substance abuse specialist, vocational specialist, and two peer counselors (from various CBOs). The full team is expected to serve 80 clients with the resources to provide whatever the client needs. The team will also work with families to provide support and education so that they can help the client.

Robert Surber, a professional who participated in the intensive case management program at San Francisco General Hospital, is enthusiastic about ACT. "As a social worker I saw patients being discharged from the hospital, only to come back in worse shape," he said. "And this happened over and over, with the patient getting worse each time. Clearly, the patient was not getting treatment, not going to the clinic on his own.

"We saw a better way with case management, where the one person accepts primary responsibility for the patient and helps coordinate treatment, housing, vocational education, and so on. The distinguishing feature between case management and ACT is that, here, the whole team has contact with the client. If one staff member leaves, moves away, or gets promoted, the client is not left stranded. And the services can be made available 24 hours a day, seven days a week."

The delicate part of the program is getting the client involved in the first place. Denial and suspicion are common to most forms of mental illness, and patients have a legal right to refuse medications and other forms of treatment.

"The trick," Surber said, "is to find something the patient wants. And it's better to establish the relationship while he or she is still in the hospital. Usually while the patient is there, he's looking for a place to stay when he gets out, and that's where the housing specialist is useful.

"This approach is not always successful—but it's more successful than not trying anything. We can enroll a patient in the hospital about 80 percent of the time, while success on the street is about 50 percent. Treatment of mental illness works better if you start early, with the first hospitalization. With the current mental health system, there is no financial incentive to do this, so you end up treating late—and more expensively."

Because of the high staffing ratio, one to ten, the ACT model is an expensive approach. Most communities that try it reserve the program for high-need patients. San Francisco's three teams require a client to have two hospitalizations in the year immediately preceding enrollment. In reality, the average client in that program has 11 lifetime hospitalizations.

"Participation in ACT," Surber said, "is inspiring communities like Berkeley to restructure all of their services for the severely mentally ill. They are trying to create a broader, more comprehensive system of care."

There is no set limit to the amount of time a patient may remain in the program. "Most patients do get better, and then they need less support. But when support stops, they slip back. So the program needs to be ongoing," Surber said. He urged BMH and the community to develop a system of advocacy so that clients can receive support for as long as necessary.

As to the cost, Surber said, "money is a funny thing. It's there if you look for it. Under our current system, we spend huge amounts of money on mental

illness, and it's totally wasted on jailings and repeated hospitalizations. This is money which could be better spent on ACT programs in the community."