

ACT model specifications regarding assertive outreach, engagement, retention, drop-out, and hospital coordination

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The Importance of Assertive Outreach and Engagement. Unlike traditional mental health services, ACT participants are not discharged from an ACT program due to failure to keep appointments or participate in treatment. Retention and assertive outreach is a high priority for ACT teams. It is not uncommon for engagement to take a long time, sometimes a year or more of persistent outreach. When anosognosia is a predominant symptom of an individual's mental illness, this may create additional challenges to the engagement process and require more clinically creative engagement strategies. Assertive outreach and active recruitment are core key ingredients to the ACT model. In-reach into hospital settings is common practice. The ACT team (or its organizational representative) typically actively recruits new members who could benefit from ACT through frequent visits to referral sites (hospitals, jails, shelters) for regular screenings and planning for new admissions to the team. Regular contacts with external referral sites and good relationships with social workers at those agencies are indicators of Assertive Outreach. ACT clients more effectively engage in services when there are strong personal relationships developed with the ACT staff to establish trust and a strong therapeutic alliance. This is why in-reach into hospitals and other restrictive service settings is critical.

Because the specific target population served by ACT programs are individuals who have not effectively used less intensive mental health services, reliance on passive approaches to recruit participants, such as using typical mental health organizational intake systems or internal referrals does not typically ensure that ACT services are reaching those most in need.

ACT Retention and Drop-Out. The effectiveness of ACT is due, in part, to ACT teams' ability to have a high retention rate. Teams that admit the intended population for ACT and are serving them well (effective engagement, strong rapport and therapeutic alliance, and meeting service needs) should be able to retain the vast majority of their caseload. ACT teams that discharge members who are admitted to higher levels of care would normally be considered an adverse outcome. Discharges to institutional settings (e.g. hospitals, nursing homes, group homes, residential treatment centers) may be warranted in some cases, but may also reflect poor client selection, lack of engagement and inadequate service provision. A low retention rate can also reflect broader system issues beyond the control of the team, such as an external authority insisting the team serve individuals not appropriate for ACT or a managed care company denying authorization for ACT services for individuals who clearly need ACT. This is why it is critically important that the national program standards for admission to ACT are applied universally and all individuals who are clinically determined in need of ACT services receive these services. ACT programs that discharge individuals from ACT as a result of going to more restrictive service settings are not demonstrating good fidelity to the ACT model. The only exceptions to this are if there is clear evidence that an ACT participant had significant medical needs or safety concerns that were beyond the team's reasonable ability to address. We will have to establish as an ACT community some operating guidelines and common understanding among all stakeholders in the service delivery system that clarify what these are.

An example of safety concerns that might justify an ACT discharge: A client was discharged from ACT to a nursing home after the team attempted to address his poorly managed diabetes. The team saw him twice a day to monitor glucose levels, provided constant education around diet and administration of insulin, and brought in additional home nurses. Despite these efforts, the individual continued episodes of hyper- and hypoglycemia and the team and primary physician agreed the individual needed 24/7 monitoring by medical staff.

ACT Teams Involvement in Psychiatric Hospitalizations: To ensure appropriate use of psychiatric hospitalization and continuity of care, the ACT team is involved in the hospitalization process and decisions. It is expected that ACT teams make every effort to provide effective services and help ACT participants avoid hospitalizations. However, when psychiatric hospitalization is required for stabilization, maintaining good continuity of care and maintaining community supports is the ultimate goal to assist the person's return to the community. The ACT model expectations for hospital coordination include:

- 1) The ACT team is closely involved in psychiatric hospitalization admissions and discharges.
- 2) The ACT team actively provides preventative and crisis interventions that would hopefully divert the need for hospitalization, however, if the need for hospitalization is necessary for stabilization, the ACT team assists with both voluntary and involuntary admissions.
- 3) The ACT team has regular contact with the ACT participant during his/her hospital stay, and collaborates with hospital staff throughout the course of hospital stay and assists with coordination of discharge medications, community disposition, and housing upon discharge.

From recent ACT fidelity reviews and the conversations that have transpired in recent weeks regarding ACT referrals and discharges from the state hospital, it appears that it might be useful to discuss these specific ACT model expectations and create some general operation guidelines for how to increase the service coordination between levels of care and ensure the ACT team is involved in hospital stays as well as discharges back into the community without disruption or discharge from ACT services in the process.