

Getting our ACT together

By Richard Lakeman © 2001

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ABSTRACT

Assertive Community Treatment (ACT) refers to a loosely related set of principles and practices focused on improving the lot of those identified as 'heavy service users', or those people who have historically been difficult to engage in treatment. A burgeoning body of research testifies to the effectiveness of ACT and a bewildering number of acronyms such as PACT, MIT, MCT, TCL and MST have been coined to describe services more or less faithful to ACT principles. This paper describes the key principles of ACT, research on outcomes and ACT programmes, presents a sketch of the Mobile Intensive Treatment Team in Townsville and critiques ACT from an ethical perspective. It proposes that ACT ought to commence from a philosophy of community mental health firmly grounded in respect for people, and ought to be the primary business of community mental health services.

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INTRODUCTION

ACT may best be conceptualised as a 'middle way' of psychiatric service provision, neither passively neglecting the individual with mental illness nor aggressively riding rough shod over his or her human rights to enforce treatment. ACT is a return to the traditional values of sound nursing or human service, founded on respect, human engagement, and which is orientated towards facilitating the right conditions for growth and development. The success or otherwise of ACT is largely dependent on the capacity for individual clinicians to engage in a meaningful helping relationship, to build on the strengths of the individual and community, and to assist in the negotiation of problems of everyday living.

DEFINING AN ACT PROGRAMME

Public mental health services and mental health professionals may have many faults but a questionable strength is the capacity to create pithy acronyms to name and describe what they do. Assertive community treatment or ACT is a trendy acronym, which can lead to confusion in part because it is synonymous with many other terms and embodied in many mental health programmes. It is a term that encompasses a range of principles and practices, which are more or less synonymous with:

- Assertive Case Management
- Intensive Case Management
- Intensive Community Care
- Assertive Outreach

Mental health programmes more or less faithful to ACT principles include:

- Training in Community Living Program
- Program for Assertive Community Treatment (PACT)
- Mobile intensive Treatment Teams (MITT)
- Mobile Intensive Support Teams (MIST)
- Mobile Community Management Teams (MCMT)

Some have even suggested that clinical case management is synonymous with ACT (Burns, 1997), which is particularly problematic given that ACT is frequently compared and contrasted with variations of clinical case management.

There is considerable variation between ACT programmes and some disagreement on the components that are critical to success. However, most services share the following features:

- Services are targeted to clients who have traditionally been poorly served by inflexible systems of care e.g. heavy service users, the 'seriously mentally ill'.
- Treatment, support and rehabilitation services are provided directly by the ACT team rather than brokered to external agencies.
- 'Outreach' or mobile services are provided and tend to be carried out where problems occur, in the person's home or other community setting rather than in hospital or clinic settings.
- The staff to client ratio is small (1 to 10) and team members share responsibility for the individuals served by the team.
- Treatment and support services are individualized and flexible with the case manager participating in the everyday life of the client e.g. through assisting with transport, accompanying shopping etc.

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- Services are available 24 hours a day.
- Clients are contacted frequently (usually more than weekly) and engagement is assertive, that is the client is contacted even if ambivalent or negative.
- Services are provided for as long as support or treatment is required.

THE HISTORY OF ACT

The “training in community living program” developed during the 1970s as an alternative to mental hospital treatment, is widely accepted as the first model of assertive community treatment (Dixon, 2000). The programme evolved out of work credited to Arnold Marx, Leonard Stein and Mary Ann Test at the Mendota Mental Health Institute in Madison, Wisconsin. Its aims were similar to the aims of most community mental health teams today, that is, to

...enhance patient's community adjustment, decrease time spent in institutions, and ultimately to prevent the development of the chronic patient role. Additionally the program focuses on decreasing patients' symptomatology and increasing their self-esteem and satisfaction with life. (Gold Award, 2000, p.6).

In order to meet these goals substantial human resources were committed to provide whatever assistance people needed in order to live in the community, e.g. assisting with securing accommodation, finding employment, budgeting, shopping, and personal care. Services were provided in two shifts, with one staff member being on call at night, seven days a week. The training in community living programme eventually evolved into the Program of Assertive Community Treatment (PACT), a reasonably standardised service that is popular in the United States today.

Hoult, Reynolds, Charbonneau-Powis, Coles, and Briggs (1981) are credited with being responsible for introducing a variation of ACT to Australia and demonstrating the feasibility of providing assertive treatment by mobile community teams with the back up of crisis services as a viable alternative to in-patient care without significantly increasing care-giver burden. Since then Mobile Intensive Treatment or Support Teams has become part of the mental health service landscape in Australia.

Today ACT as a system of care, whilst not available universally to those who might benefit from it is being promoted as standard practice (Phillips et al., 2001). Burns (2001) suggests that the UK is awash with outreach programmes. In the United States ACT programmes have been implemented in 35 states (Phillips et al., 2001) and the National Alliance for the Mentally Ill (NAMI) aims to have PACT programmes operating in every state by 2002 (Carolla, 1998). Adaptations of ACT have been implemented in Europe and Canada (Phillips et al., 2001), Australia and New Zealand. ACT principles are being employed in the establishment and development of general community mental health teams and services targeting groups such as those with recent onset of illness, concurrent drug related problems and mental illness, the homeless, forensic or hard to engage patients (Burns, 2001).

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BENEFITS OF ACT

Assertive Community Treatment is one of the most well evaluated and documented non-pharmaceutical mental health interventions. Many substantial reviews of ACT have been undertaken. The most recent Cochrane Review (Marshall & Lockwood, 2000) concluded that compared to standard community care people allocated to ACT were:

- More likely to remain in contact with services
- Less likely to be admitted to hospital and when admitted spend less time in hospital
- More likely to be living independently
- More likely to have found employment
- More satisfied with the service they receive.

There were no differences between ACT and control treatments on mental state or social functioning (Marshall & Lockwood, 2000).

In contrast the Cochrane Review examining general case management for people with severe mental illness presented some scathing criticisms (Marshall, Gray, Lockwood, & Green, 2000). The review found that case management approximately doubled the rate of hospital admissions with little evidence of improvement in mental state, social functioning or quality of life. It conclude that

... case management is an intervention of questionable value, to the extent that it is doubtful whether it should be offered by community psychiatric services. It is hard to see how policy makers who subscribe to an evidence-based approach can justify retaining case management as 'the cornerstone' of community mental health care. (Marshall et al., 2000)

Ziguras and Stuart (2000) undertook a meta-analysis of controlled trials examining the effectiveness of case management over 20 years and had a more liberal approach to study inclusion than the Cochrane Review. They examined 44 studies, 9 of which directly compared ACT with clinical case management and 35 compared ACT or clinical case management with usual treatment. Both types of case management were found to:

- reduce family burden
- increase family and client satisfaction with services
- reduce the overall cost of care
- reduce symptoms
- increase client contact with services and reduce dropout rates
- improve social functioning.

ACT was found to reduce hospitalisation frequency and length of stay. However, they found that whilst clinical case management increased the frequency of hospitalisation, it decreased the total number of hospital days.

There is little doubt that ACT is helpful in reducing hospitalisation, improving housing stability, and possibly contributes to modest improvements in quality of life and psychiatric symptomatology. However, the research evidence does not elucidate what elements of ACT contribute to improvements or whether or not improvements are sustained over time once ACT services are withdrawn (Mueser, Bond, Drake, & Resnick, 1998). Furthermore, ACT has largely only been examined in the context of discrete, well-resourced teams, often comparing outcomes with poorly resourced services.

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Successful ACT programmes described in the literature have also often been implemented as part of well-resourced and planned integrated services. For example Hambridge and Rosen (1994) described a reduction of 62% in bed occupancy by clients referred to a newly developed mobile community management team in suburban Sydney. However, this service was also part of an integrated programme that included supervised residences and residential rehabilitation, a transitional work programme, two community mental health centres with 24 hour mobile crisis services and living skills centres. Such a range of services would be the envy of many regions and beyond the reach of less populace centres. ACT must invariably be adapted to the specific needs of communities, geographic settings and adapted to the presence and availability of additional services. Little research has been undertaken examining how ACT fits in to a wider integrated service.

The United Kingdom has been slower to adopt ACT. Results of a recent random controlled trial of ACT in the UK have been less impressive than elsewhere. Burns et al. (1999) randomly assigned 708 psychotic patients to standard case management (case load 30 to 35) and to intensive case management (case load 10 to 15) at four sites. They reported no significant gains in clinical or social functioning in either group at one or two years, and no significant difference in hospital use between groups (Burns et al., 1999). It appears that simply reducing caseload does not lead to an improvement in outcomes. It might also be that without careful targeting of interventions to those that might benefit the most, clients risk being over-serviced without improvement in outcomes. However, in a later study examining effects of case load size Burns et al. (2000) concluded that "UK standard care contains many of the characteristics of assertive outreach services and differences in outcome may require that greater attention be paid to delivering evidence-based interventions." It matters more what individual case-managers do with their time with clients than how often they see them.

PROGRAMME FIDELITY & THE ESSENTIAL INGREDIENTS OF ACT

Programme fidelity is the term used to describe conformity to prescribed elements and the absence of non-prescribed elements in a programme. Programme fidelity is particularly important in research in order to ensure that one is comparing similar services i.e. apples with apples. There also comes a point when an intervention or programme deviates so much from recognised elements that it can no longer be said to be that entity. There is some evidence that those programmes that are more faithful to the ACT model have superior outcomes (McGrew, Bond, Dietzen, & Salyers, 1994; McHugo, Drake, Teague, & Xie, 1999; Teague, Bond, & Drake, 1998). The Dartmouth Assertive Community Treatment Scale (Teague et al., 1998) includes the following factors which are indicative of high fidelity in an ACT team:-

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Structure and Human Resources:

- Small caseload (10 or fewer consumers per case manager)
- Shared caseload (90% or more of consumers have contact with more than one staff member in a given week)
- Programme meetings (at least 4 per week)
- Practicing team leader (TL provides direct services at least 50% of the time)
- Continuity of staff (less than 20% turnover in 2 years)
- Staff capacity (Programme operated at 95% or more of full staffing in past 12 months)
- Psychiatrist on staff (At least one full time psychiatrist per 100 consumers)
- Nurse on staff (2 or more per 100 consumers)
- Substance abuse and vocational specialist on staff
- Programme size (Is of sufficient absolute size to provide the necessary staffing diversity and coverage ... at least 10 FTEs)

Organisational boundaries:

- Explicit admission criteria
- Intake rate – low
- Full responsibility for treatment services
- Responsibility for crisis services (24 hr coverage)
- Responsibility for hospital admissions (95% of admissions are initiated through the programme)
- Responsibility for discharge planning (95% of discharges are planned jointly by the programme)
- No time limit on services

Nature of services:

- In vivo (80% of service time in the community)
- No dropout policy (95% retention over 12 months)
- Assertive engagement (outreach services)
- Intensity of services (as much as is needed; 2 hours or more per week)
- Frequency of contact (on average 4 or more times per week)
- Work with support system
- Individualised substance abuse treatment
- Dual disorder treatment groups
- Consumers are employed on the treatment team

Most programmes that would claim to be ACT services deviate from these specifications in some way. Burns, Fioritti, Holloway, Malm, and Rossler (2001) suggest that a significant influence of national culture is evident both in the acceptability of case management and in approaches to researching and undertaking it. This is also likely to be the case across Australasia. Experts disagree on the relative importance of different components (see: McGrew & Bond, 1995; Schaedle & Epstein, 2000). For example, twenty-four hour care by a dedicated team may be an expensive luxury and duplication of service when alternative crisis services are available. In early implementations of ACT avoidance of office or clinic visits was pursued pedantically, however avoidance of office visits may be better thought of as an outcome of assertive outreach, rather than an end in itself. The need to have one team member as a co-ordinator and a team approach are often considered important structural elements of ACT programmes (McGrew & Bond, 1995).

TARGETTING AND TRIAGE

One general principle of ACT is that the service is targeted to those who might most benefit from it. From its conception ACT has targeted those perceived as being 'heavy service users' or those with the most intractable symptoms of severe illness and the

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greatest level of functional impairment. Kent, Fogarty, and Yellowlees (1995) describe the heavy service user as the 10 to 30 percent of patients who use 50 to 80 percent of resources. Abbott et al. (1997) undertook a literature review and engaged a panel of 'experts' to arrive at 13 factors, which characterised the heavy service user and qualified them for involvement in a Mobile Intensive Treatment Team (MITT) service. The Townsville MIT team utilises the instrument and a comprehensive referral for screening potential participants in the programme.

THE MOBILE INTENSIVE TEAM SCREENING INSTRUMENT

MITT ENTRY CRITERIA

Mandatory

- | | RATINGS |
|---|----------------|
| • To be within the age range of 18-64 and resident within the health district for most of a 6 month period | Yes / No |
| • To have a major psychiatric condition where the primary diagnosis is not intellectual impairment or drug dependence | Yes / No |
| • To require constant input of more than weekly contact i.e. actual / potential heavy service users. | Yes / No |
| • If not regulated, accepting of MITT involvement | Yes / No |

Other

Prolonged, frequent or multiple hospitalisations	9 (83%)*
Unstable accommodation	8 (67%)*
No or few support systems	7 (67%)*
Poor living skills	6 (100%)*
Unable to benefit from existing services because of:-	
Inability to access independently	1 (67%)*
Lack of insight	1 (92%)*
Lack of motivation	1 (92%)*
Inability to organise him / herself	1 (75%)*
Physical limitations	1 (8%)*
	<hr/>
	/ 35

* Percentage of Townsville MITT client referrals at time of writing.

To be considered eligible for MITT services all mandatory criteria must be met and a score of at least 16 out of 35 points needs to be attained. Abbott et al. (1997) suggested that the tool might be used as an exit-screening instrument e.g. when scores fall below 16 consideration is given to discharging the person from the service, although the instrument has not been used in this way.

DISCHARGE FROM ACT

Discharge from ACT is not an issue that has been examined in sufficient detail to specify rigid criteria. In practice, a fair amount of clinical judgement based on amongst other things, the nature and type of supports available to the person, a knowledge of the natural history of the person's illness, stability of insight and symptoms, compliance with aftercare, and the person's wishes, determine the need for discharge.

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A number of people grow beyond the need for ACT, and for others the need is ongoing. Most are likely to require some type of follow-up from mental health services and a lengthy period of shared follow-up with a new case-manager is useful. Abrupt withdrawal of ACT often amounts to an abrupt withdrawal of a key form of stabilising support which can act as a buffer to life's stresses.

Case Example

Eric was a 46 year old man with a diagnosis of paranoid schizophrenia. For many years the focus of his life had been the care of his elderly mother who also prompted him to take his medication. Eric did not have a good relationship with his father during his childhood, and tenaciously maintained that he was the son of a very important person, probably a member of a royal family and certainly extremely rich and powerful. He believed that his birth father kept a close eye on him. However, evil forces sought to prevent his father from making contact with him and enabling him to claim his rightful inheritance. Some time after the death of his mother he had an acute relapse in which he became acutely psychotic. He was convinced that one of his foe had spiked his drink with LSD in a local coffee shop. Following a siege like situation involving the armed defenders squad he was admitted to the acute psychiatric unit and referred to the MIT team after a lengthy admission.

Eric's symptoms stabilised quickly. His case manager visited him often and assisted him with activities of living such as shopping, and spent time with him walking and riding a bike (Eric wanted to lose weight). He lived reasonably close to a sympathetic GP practice and his case manager would accompany him to appointments. He was fully compliant with treatment. After about 18 months some pressure was placed on the MIT to discharge clients and accept new referrals. Eric's HoNos scores had improved and he had achieved a clinically significant improvement in LSP scores. He was introduced to a new case manager in the general case management team and discharged in one month. Within two weeks of discharge he had an acute relapse and was admitted to the acute psychiatric unit.

In the absence of further details this vignette might raise many questions about client dependence on MITT services, the failure to facilitate natural supports, the quality of rehabilitation provided and of planned after care. However, in my view it best illustrates the provision of ACT as a human undertaking and the importance of supportive relationships in maintaining well-being. Klinkenberg and Calsyn (1996) describe **community support, receipt of aftercare** and **system responsiveness** as the key mediating factors leading to nonrecidivism in vulnerable mentally ill populations. Certainly ACT increases the certainty of aftercare and ought to act to bolster community support for the person and where needed act as a surrogate to natural supports. ACT ought to be responsive not only to gross changes in mental health status, but to the changing and emerging needs of the person on a day to day basis. Indeed, these factors ought to be central concerns of a mental health system, not just a dedicated team.

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THE MOBILE INTENSIVE TREATMENT TEAM IN TOWNSVILLE

The Mobile Intensive Treatment Team in Townsville was set up in 1998 with federal funding to provide assertive community treatment to those within the Townsville and Thuringowa Metropolitan areas (population approximately 135,000). It also had a mandate to case manage people under Project 300, a scheme that targeted resources to assist people who had been hospitalised for long periods to be integrated and treated in the community. Originally the MIT team was a stand-alone service but in 2001 the team was relocated with other community health services and made operationally responsible to a team leader for all adult community mental health services.

At the time of writing the MIT team in Townsville consisted of a Clinical Nurse Consultant, Clinical Psychologist, Social Worker, Occupational Therapist, a part time administrative officer with shared duties and a consultant psychiatrist working approximately 0.2 FTE for MITT. The hours of operation are 8-5 Monday to Friday. Referrals are received from within adult mental health services, and have included zonal inpatient rehabilitation units in Kirwan and Charters Towers, the acute inpatient unit and the general case management teams. The team is currently responsible for providing care and treatment to approximately 30 people.

Most clients have a diagnosis of a psychotic disorder although several have a diagnosis of bipolar affective disorder or a primary personality disorder. Most have some other confounding co-morbidity such as an acquired brain injury, intellectual handicap, substance use disorder, or borderline personality traits. A forensic history is common. The majority also had few supportive relationships, had frequent or lengthy hospital admissions, and had unstable accommodation on referral (See page 7).

UNIQUE CONTEXTUAL FACTORS

- Townsville is a multicultural town with a relatively young population. It has the largest urban concentration of Aboriginal and Torres Straight Islanders outside of Darwin.
- It is located in the tropics and as such certain health practices such as maintaining personal hygiene and rubbish disposal are important to maintain personal and public health.
- A relatively generous welfare net is provided. Those on pensions are entitled to subsidised or public housing, cheaper public transport, educational subsidies, childcare subsidies, medication subsidies and free dental treatment. However, a complicated bureaucracy administers the welfare system and many people find it hard to access entitlements.
- Intravenous amphetamine use is common.
- Homelessness is a problem in Townsville. It can take up to 5 years to access public housing and accessing private rental accommodation is expensive and difficult. People may be permanently 'blacklisted' because of non-compliance with tenancy agreements. Consequently many people live in caravan parks, boarding houses, or on the streets.
- There is no professionally supported or supervised accommodation for people with mental illness outside of the rehabilitation units.

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- A large number of non-government organizations are publicly funded to provide various support services.

FIDELITY TO ACT MODEL IN TOWNSVILLE

In many ways the Townsville MIT is faithful to the ACT model:

- Most services are provided as outreach.
- The team meets at least 3 times a week to discuss the entire case list and formal reviews occur at least weekly involving all clinical staff.
- Client reviews occur at least every three months but usually more frequently and involve the collation of outcome data.
- Case managers know all clients supported by MIT and have frequent contact with clients not on their case list. All staff leave is covered from within the team.
- Case managers are concerned about community development and all are involved with different causes.
- Case managers are readily able to facilitate admission to the acute inpatient unit should the need arise and are active in discharge planning.
- Clients are able to see a consultant psychiatrist frequently.

DEVIATION FROM ACT MODEL IN TOWNSVILLE

The MIT team deviates from the ACT model in a number of significant ways:

- No extended hours support by the MIT team - On request the Intake and Assessment Team has provided telephone contact to people out of office hours and on weekends. Some aftercare is brokered to nursing agencies. Whilst adequate for most people, the lack of after hours routine face to face clinical support has contributed to the rehospitalisation of a number of MIT clients
- There is presently no designated co-ordinator of MIT who carries a clinical workload.
- Support services are brokered out – Lifestyle, recreational and vocational support for people with disabilities are funded by departments other than health and brokered to a number of support agencies. An elaborate and lengthy referral process for lifestyle support is required and often initiated by MIT. Acceptance can take many months and only one in five applications assessed as high priority are presently funded. Emergency funding for 100 hours support can be obtained but many clients receive inadequate or no lifestyle support. MIT liases closely with agencies that provide support to MIT clients and attempts to provide whatever support is needed to those without packages.
- Staff Turnover – Two of the case managers within MIT are in acting rather than permanent positions.
- No consumers or support staff are employed by the MIT team although close and mutually respectful relationships are maintained with non-government support organizations such as the Schizophrenia Fellowship and Adult Relatives and Friends of People with Mental Illness (ARAFMI).
- Rapid response – Previously MIT enjoyed dedicated administrative assistance and the use of answer phone facilities. Since relocating the MIT team has lost these facilities, which mean that case managers cannot be contacted as quickly.

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OUTCOMES AND EVALUATION

Specific desirable outcomes are negotiated with each client throughout involvement with the MIT team. Measures such as the Health of the Nation Outcome Scale (HoNOS), Life Skills Profile (LSP) and Global Assessment of Functioning (GAF) are collated regularly for all clients at least 3 monthly. Other measures such as the Positive and Negative Syndrome Scale (PANSS) are used as required. The majority of clients have shown clinically significant improvements in functioning (LSP improvement of >16) and the frequency or length of hospitalisation for acute reasons has diminished. One client has 'dropped out' of the service over the last twelve months (left town), 3 were readmitted to residential rehabilitation largely due to the lack of extended hours face-to-face support, and another is presently incarcerated after committing arson. Five have been discharged to other services for follow-up.

A survey of clients, family members and non-government organizations was undertaken using semi-structured interviews and thematic analysis early in 2001. This indicated a high degree of satisfaction with the services provided, particularly relative to other services. Clients commented on their satisfaction with the availability of their case manager and how the case manager would offer assistance with activities of daily living such as shopping. Families and non-government organizations commented positively about the quick response to their concerns from MIT and how they were confident that the person would be followed up.

THE WORK OF THE CASE MANAGER IN AN ACT TEAM

The success of an ACT programme is dependent on the right mix of people and skills.

He Aha Te Mea Nui o te Ao?
He Tangata! He Tangata! He Tangata!

What is the most important thing in this world? It is people, it is people, it is people.

What case managers actually do with clients has not been investigated in great detail (see: Bjorkman & Hansson, 2000). There is considerable support for psychiatrists, nurses and social workers being on ACT teams, but also increasing support for vocational and substance abuse experts being available for consultation, if not as full team members. Often people have complex medical needs and nurses are well suited to bridging roles that are required. In the United States it appears that providing most clinical services from within the team is a priority. In part this is due to substance abusing clients having poorer outcomes regardless of intervention (Havassy, Shopshire, & Quigley, 2000), and evidence that brokerage of services is related to decreased satisfaction with service (Huxley & Warner, 1992). Of paramount importance is that ACT workers are suitably experienced and skilled to provide a full range of mental health services.

What ACT case managers actually do with clients is dependent on what needs to be done, thus people are likely to assume numerous roles in relation to the person. Unlike other form of clinical case management the boundaries of involvement tend to be loose rather than tight. The following case example illustrates some of the interventions that might be provided:

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Case Example

N.B. The client in this case example gave permission for discussion of his case in order "to teach others how to be better case managers". Some details have been changed or omitted.

Captain Good Vibes is a 35 year old man who earned the nick name because he believes that he can project his thoughts to other people and send out 'vibes' which can influence other people's emotions. The title Captain is apt, as soon after meeting him I came to appreciate as his MITT case manager that I might need to help navigate from time to time, or occasionally take the rudder but he was definitely the Captain of his own ship.

The Captain was diagnosed with Schizophrenia in his early twenties. He has used illicit drugs such as LSD, magic mushrooms and cannabis, over the counter drugs and alcohol on almost a daily basis since his teens. He has, had lengthy and frequent admissions to hospital over his adult life often following excessive consumption of a cocktail of drugs. He has engaged in petty crime including drug dealing and burglary over the years. He was placed under a forensic order of the Mental Health Act following stabbing his stepfather some years earlier, whilst under the influence of LSD and believing that his stepfather was the devil. On the weekend prior to my meeting him for the first time the Captain and a friend had washed down approximately 30 procyclidine tablets with a bottle of whisky. He became psychotic and had literally trashed his unit, smashing the door and was apprehended by the police after walking naked to the corner store to get something to drink.

The captain spends much of his waking time attempting to communicate with celebrities and key public figures via the television and radio. He believes he is able to project his thoughts or vibes around the neighbourhood and will construe noises, changes in posture, eye contact or tone of voice as evidence of his powers. He has a strong sense of his power and also feels responsible for world events. He can provide a lengthy list of clang associations and anecdotal evidence, which supports a belief that he is especially chosen by God and is the most powerful man in the world. He believes it is inevitable that he will be killed or be required to suicide to bring salvation to the world at a time when nuclear war is imminent or he receives a sign from God such as witnessing lightening on a clear day. He finds it difficult to leave his unit without being under the influence of drugs, as he believes he "puts people down" with his thoughts and draws attention to himself. Drugs assist in dulling his thought processes and removing anxiety.

I met him at home with his former case manager and quickly gained rapport. A fairly comprehensive assessment was made over a two-week period and certain goals for MITT involvement were agreed upon. He had many strengths and assets that were identified which could be drawn upon to assist his recovery. The following are a sample of some of the roles that I assumed over a twelve-month period:

Budget advisor and advocate:

The Captain wanted help with budgeting as he was in considerable debt to drug dealers, pawnbrokers and the corner store who were generous with the credit they gave him. I established some credibility as being potentially helpful early on, by negotiating with a

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pawnbroker to waive further interest repayments on a treasured item the Captain had pawned. The Captain drew up a budget and shopping list each week and I assisted him with grocery shopping and prioritising debt repayment. The need for assistance diminished with time as the Captain learned to plan meals and anticipate his tobacco consumption ahead of time rather than use the corner store for impulse purchases.

Vocational counsellor:

In part the need for budgeting assistance became less acute as the Captain gained a number of part time cleaning jobs. Assistance was given in putting him in touch and liaising with an employment agency. The Captain appreciated getting help filling in the forms required and notifying different government agencies of his changing circumstances. As the Captain had a brittle pre-existing back injury education was provided on safe lifting and posture. He has since traded up a motorbike he owned and has accrued a considerable number of new household appliances.

Medication resource person and educator:

Finding a suitable and acceptable medication regime is an issue of ongoing negotiation with the Captain. He is reluctant to look at non-pharmaceutical interventions to deal with anxiety, which arises from his entrenched beliefs. He visits with a consultant psychiatrist approximately every two months or more often if there is a need. Initially I visited him weekly to administer a depot injection, assessed for the presence of extrapyramidal side effects and dispensed small quantities of benzotropine mesylate as required. He wasn't happy with receiving an injection and did not wish to take clozapine. He was eventually placed on Olanzapine and a small dose of haloperidol. Mood stabilisers and antidepressants have been added to his regime. However, he first required on-going coaching to dissuade him from holding his breath and stretching in order to achieve an anoxic 'high'. He used to engage in this behaviour several times a day and had lost consciousness and injured himself on several occasions. Eventually this behaviour ceased. Education regarding the expected effects and limitations of medication is on going.

Mental Health Expert & Counsellor

The Captain's beliefs about his powers and his responsibilities are held tenaciously and have been constructed over his entire adult life. At times the knowledge that he is special brings him joy but often he becomes distressed or overwhelmed by his beliefs and has a tendency to ruminate and try intensely to project his thoughts often furthering his distress unless he engages in distracting behaviour. The Captain recognises that others do not understand his thoughts and he identifies with the consultant psychiatrist and I as people he can trust to talk frankly and with understanding. A basic cognitive therapy approach is utilised focusing on alleviating distress and his sense of alienation from others. Reality testing experiments are negotiated. It has been possible to capitalise on "the big 1% of doubt" the Captain says he has about his powers and to refute some of the evidence which supports his beliefs. His experiences with hallucinogenic drugs can be used to address some of his emotional reasoning e.g. having experienced LSD the Captain can appreciate that 'Perceptions can sometimes be misleading' and having experienced paranoia as a direct consequence of taking cannabis he can appreciate that 'A strong feeling (e.g. paranoia) is not necessarily related to outside forces'. When feeling alienated from others the Captain has found it helpful to explore what he has in common with other people.

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Life Skills Educator:

The Captain was on an emotional roller coaster for the first few months. He had got into a pattern of forcing himself to remain awake (with the help of approximately 30 cups of coffee a day plus several litres of caffeinated soft drinks) for 24 to 48 hour stretches. He would take large amounts of clonazepam and enjoy a paradoxical high. He would rationalise his staying up saying he needed to stay awake so he wouldn't sleep through the alarm. However, several days later his mood would plummet and he would become acutely anxious and suicidal. A plan to gradually reduce caffeine intake and establish a regular sleep pattern was implemented. He now drinks mostly decaffeinated coffee and he has not stayed up all night for some months.

The Captain had a very limited repertoire of cooking skills and requested assistance developing some skills. An Occupational Therapy Student volunteered her time to meet with the Captain weekly and plan a menu for the week and cook a new dish once a week for two months.

Alcohol & Drug Counsellor:

The Captain is quick to admit that he enjoys drugs and is honest about his illicit drug use. I do not take a moralising or judgemental stance on his usage but have assisted him to see the effect of his drug use on his mood and behaviour. On several occasions early in our relationship he used cannabis and became acutely paranoid. On one occasion he attempted to hang himself from his ceiling fan. He acknowledges that he cannot safely use the drug and has abstained for close to twelve months. He has also avoided hallucinogens and has moderated his alcohol intake to the occasional 'few beers' but the excesses of the past have diminished. The consultant informed him that his clonazepam use would have to cease, as it wasn't medically indicated in his situation. This caused considerable anxiety and the Captain was initially convinced that he would have to be hospitalised if ever it was stopped. I negotiated a reduction regime by quarter tablets (around 4-6 mg per day to 0) over a three-month period. At the same time the occupational therapist undertook some basic relaxation training and I provided literature and counselling in relation to social anxiety. The Captain was surprised that he was able to cope without clonazepam.

Coach and Personal Trainer:

The Captain wished to improve his personal fitness and physique. It was with pride that he would describe his athletic prowess in the past. I had also been encouraging him to undertake some moderate exercise in order to lift his mood, better cope with anxiety and to distract him from the television. No amount of talking or encouraging seemed to help so I accompanied him for a swim at the beach on several occasions. Later he wished to purchase gym equipment and I accompanied him on a shopping trip to look for weights. He now does 60 bench presses a day and feels better for it.

Service Broker

I have assisted the Captain to access external services such as the public dental clinic, and his GP as required.

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Relationship Counsellor

The Captain is a likeable gregarious man by nature but is often inhibited from socialising outside the house because of social anxiety and his thought projection. He has had a number of short-term relationships with women since I have known him. He often invites people he meets who are homeless and have their own problems to come and live with him but inevitably finds living with them for any length of time difficult. As the need arises the Captain initiates discussion about his relationships, including those with other health professionals he encounters and seeks advice on how to assist others or put them in touch with helping services..

Over a twelve-month period the Captain has shown a linear improvement in LSP, HoNOS and GAF scores. He attends a drop in centre regularly and has made great strides in terms of independence. The Captain now is typically the one to initiate contact with MITT, which has diminished in frequency to a couple of times a week. He has been discharged from his forensic section under the Mental Health Act and has not had an admission to hospital since commencing MITT involvement. His relationship with his mother has improved and other health professionals have hinted that he is too well to now be involved in MIT. However, recent world events such as the world trade centre bombing have caused the Captain grave concern and he is currently considered at risk of self-harm.

The above provides just a small sample of roles that may be assumed by an ACT case manager, none of which are particularly unique. Case managers require a depth of knowledge about medical treatments, and well-developed problem solving and counselling skills. It also often requires skills in appraising risk so a degree of experience in mental health services is needed. Unlike programme specifications, the particular mix of roles that may be assumed by case managers will be unique for each individual.

ETHICAL PROBLEMS ASSOCIATED WITH ACT

A cursory review of the literature relating to ACT might suggest that the holy grail of mental health services has been found. That is, a way of configuring mental health service provision, which achieves good outcomes, is mostly acceptable to families and consumers, and reduces hospitalization. However, it is possible that an ACT services can be ethically bankrupt, whilst being faithful to prescribed standards. At the very least the nature of ACT work is a profoundly ethical undertaking and clear conflicts often arise between beneficence and autonomy, between beneficence and nonmaleficence, and between nonmaleficence to the individual and to the community (Stovall, 2001).

Many of the ethical problems arising in ACT are common to mental health care generally but are particularly problematic in ACT due to the persistent and intrusive nature of outreach. ACT has its routes in institutional hospital care in which staff were a permanent and visible part of every aspect of people's lives. ACT was conceived of originally as "a hospital without walls" and has many elements of institutional care despite such care having lost favour in recent years. At the very least it is considerably more intrusive than office or clinic based approaches in which people may exercise the choice not to attend appointments, to disengage from services and can at least enjoy the relative sanctuary of places free from the surveillance of mental health professionals. Control over medication

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and money are often of central concern to people with chronic mental illness and when problems arise in these areas the result can be incarceration, hospitalization or homelessness (Stovall, 2001).

ACT can and sometimes does impinge on the personal autonomy of clients. The Program of Assertive Community Treatment (PACT) in the United States has met with some considerable opposition from anti-psychiatry groups. Concerns center around PACT as a coercive vehicle to enforce medication compliance, particularly when combined with involuntary outpatient commitment. Support Coalition International (2001) likens PACT to a Trojan horse: "This 'wraparound' service, as it's sometimes called, looks pretty on the outside, but inside you can find a lot of 'medication militia' hiding out". ACT teams usually have a biomedical bias in which medication compliance and symptom monitoring are frequently seen to be a cornerstone of treatment and can give rise to a paternalistic approach to care (Spindel & Nugent, 2001). When a biomedical conceptualisation of problems becomes the sole focus or when carried to extreme the benevolent paternalism of psychiatry can become malevolent. Even when treatment appears to be negotiated rather than enforced, the voluntariness of treatment must be acknowledged as shaky when the power to enforce treatment involuntarily rests with mental health services. Coercive strategies to enforce compliance are always ethically problematic.

It is undeniable that psychiatry has a social control function (Lakeman & Curzon, 1997) which in relation to people receiving ACT services creates tensions between the team's allegiance to the person, their family and to wider society. One often unacknowledged goal of psychiatric treatment is to minimise the risks posed to society by the person's behaviour. Those referred to ACT are more likely to have a forensic history, be homeless, impoverished, unemployed and on the margins of society. Extreme caution must be exercised to ensure that ACT doesn't further subjugate already marginalised groups. Solomon, Draine, and Meyerson (1994) suggest that case management may easily deteriorate into providing monitoring rather than rehabilitative services and thus may facilitate reincarceration. It has been suggested that limit setting is a feature of ACT which sets it apart from other programmes (Neale & Rosenheck, 2000) yet clearly this must be balanced with the provision of care. Health professionals must balance these conflicting demands and interests in their day-to-day work. They also have a duty to address the wider social justice issues which lead to marginalisation of people in the first place; to attempt to create a mental health "care" system (Lakeman, 1998) rather than merely providing a service which is palliative to a sick society.

A further significant ethical problem arises from the exclusive nature of ACT and its relationship with other services. A considerable number of people who might benefit from ACT are denied the service because of stringent entry criteria. To some extent ACT as it is located within many services is the ambulance at the bottom of the cliff and can reflect 'too much to late'. If an ACT approach is implemented earlier many problems might be avoided or become less entrenched. ACT embodies many of the principles, which ought to be a feature of wider community mental health services, for example, a commitment to stick with people for as long as is needed and to do what is needed.

The ethical problems inherent in ACT are not insurmountable. Szmukler (1999) suggests that "...approaches to resolving ethical problems include increasing patient involvement

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in their care, clarifying the grounds for 'paternalistic' interventions, and re-examining grounds for acting to reduce the risk of harm to others". In practice the resolution of ethical problems must commence from a sensitivity to situations as problematic (Lakeman, 1999). Christensen (1995, p.1217) identifies further virtues that ought to influence our ethical reasoning:

- Compassion which "... impels us to stand with our clients and take seriously the reality of their pain and confusion."
- Humility which "... reminds us of our humanness as persons and our fallibility as health care providers."
- Fidelity which "... inclines us to not easily abandon those whom we have forged commitments to help. Fidelity serves to remind us that clients have a claim on us that endures even when they refuse the treatment we offer."

The experiences of implementing ACT over 30 years, and the ethical problems inherent in it can provide some lessons to assist in the development of a unifying philosophy of community mental health.

TOWARDS ASSERTIVE COMMUNITY CARE

Whilst not a new phenomenon, many mental health services have a 'Spin them out when they stop spinning out' response to people with long term and relatively enduring problems of mental health, that is only dealing with the person in an acute phase of illness rather than having a longer term rehabilitation focus. The goal has become to get the person 'off the books' as soon as possible. The word 'care' has been lost from the lexicon of many services, and notion of "continuing care" has become highly unfashionable. 'General case management teams' often become disgruntled with being unable to provide what they know might be helpful and a negative consequence is an increased emphasis on gate keeping and boundary enforcement rather than provision of care or therapy. ACT provides a broad philosophy of practice that ought to be adopted by all community mental health services, which can counter these disturbing and negative trends.

ACT, like community mental health services is in a state of evolution. Historically, it has its roots in ensuring treatment but over time the best examples of ACT have evolved into systems of care which go well beyond merely providing medical treatment. To use a Buddhist metaphor it reflects a middle way of psychiatric services and is a 'skillful' activity in both the technical and ethical sense. Programme specifications are not ends in themselves, but assist in mandating the conditions for ACT to take place.

Assertiveness precludes a passive neglect of people with mental illness. It means not allowing a person to fall through the cracks and knowing when to act and when to stand by. This is not something, which is easily prescribed and requires skills in engagement, negotiation, knowledge of good mental health practices and ethical sensitivity. Neither should ACT be aggressive and ride rough shod over people's human rights in the enforcement of treatment. Stovall (2001) points out that establishing long term relationships based on respect fosters collaboration and minimises the utilisation of coercive approaches.

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Community in ACT is both the location of care and is also acknowledged as the source of natural support and sustenance for the person. ACT should aim to develop the capacity of families and communities to provide care and if necessary to provide that care from within the ACT service for as long as is needed.

Treatment in ACT not only entails medical treatment for mental illness but involves care in the broader sense. It involves building on the strengths of the individual and the community to assist in the negotiation of problems of everyday living. As with all good mental health care the focus should be on growth and attempting to facilitate the right conditions for growth to occur so that the person and his or her family are best able to negotiate everyday living themselves. Having clear treatment goals which are negotiated with the person provide a context for interactions with the team.

ACT in the manner described above is by no means a new concept and harks back to principles of good nursing and human service. It is or ought to be founded on respect for people. **ACT represents a set of ideals and an orientation to working which should form the heart of all mental health service delivery.**

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HAVE YOU GOT YOUR ACT TOGETHER?

What are the critical ingredients of assertive community care?

Which critical ingredients of assertive community care are available to all consumers of your service?

What are the factors, which enable and inhibit responsiveness to people's needs in your service?

Describe the characteristics of those who currently use the most inpatient and outpatient mental health services in your region?

What resources do the heaviest service users need to reduce reliance on inpatient services?

Who currently receives assertive outreach in your region and what is the threshold for admission to your assertive community treatment team?

Which groups may benefit from assertive community care but currently do not receive such services?