

ASSERTIVE COMMUNITY TREATMENT (A.C.T.) MODEL

Key Concepts

Outreach and engagement of homeless individuals can take many forms, including, for example: **case management, information and referral services, Assertive Community Treatment outreach on-the-streets teams, and basic housing assistance centers**, just to name a few. (Each is discussed separately.) At its core, outreach is designed to engage homeless persons so as to build trust and ultimately, help these people move off of the streets and into housing, connected with the supportive services they need.

Assertive Community Treatment entails the provision of services delivered by an **integrated service team**, *i.e.*, a community-based, mobile, multidisciplinary outreach team. Services are designed for individuals with long-standing psychiatric illnesses, substance use disorders or dual diagnoses. ACT services are designed to be flexible in supporting individuals who have a demonstrated inability to independently access and sustain involvement with needed services due to history of treatment non-engagement and/or functional limitations. ACT services assist these individuals in developing the competencies needed to achieve recovery, function as independently as possible and sustain a support network.

Teams actively work to make contact with clients and engage them at the level and in the manner in which they are willing and able to connect. Interventions are carried out in the field, at locations where clients congregate and are comfortable rather than in traditional treatment settings. Direct service provision includes assistance in meeting basic survival needs (food, showers, a place to come in from the streets) as well as clinical services. Referrals, advocacy and intensive case management are provided without time limits in order to address the client's full range of needs, including linkages with medical, psychiatric, and alcohol and drug treatment services; benefits programs; and emergency, transitional, and/or permanent supportive housing. Homeless people with mental illness and substance use disorders are able to move into stable housing and receive mental health, substance use and other needed services.

EXAMPLES AND COMMON SOLUTIONS

Program	Pathways to Housing, New York
Web Information	www.endhomelessness.org
Practice Used	<ul style="list-style-type: none"> • HHISN is a multi-disciplinary effort involving both mainstream and homeless agencies who collaboratively provide a range of treatment and services to PCH clients living in supportive housing. • The IST's offer clients a web of individually-configured services and support that are delivered in the home of the client. • Teams are on-call 24 hours a day, 7 days a week. However, the tenant determines the type, frequency, and sequence of services. Service requirements are that the tenant meet with a service coordinator twice a month and participate in a money management program. • The primary goals of the ACT teams are to meet basic needs, enhance quality of life, increase social skills, and increase employment opportunities. • When a team cannot provide the services directly, tenants are referred and accompanied to the relevant programs.
Program	Assertive Community Treatment Association (A.C.T.A.)
Web Information	www.actassociation.org
Practice Used	<p>Assertive Community Treatment services adhere to certain essential standards and the following basic principles:</p> <ul style="list-style-type: none"> • Primary provider of services: The multidisciplinary make-up of each team and the small client to staff ratio, helps the team provide most services with minimal referrals to other mental health programs or providers. • Services are provided out-of-office: Services are provided within community settings, such as a person's own home and neighborhood, local restaurants, parks and nearby stores. • Highly Individualized Services: Treatment plans, developed with the client, are based on individual strengths and needs, hopes and desires. • Assertive approach: ACT team members are pro-active with clients, assisting them to participate in and continue treatment, live independently, and recover from disability.

	<ul style="list-style-type: none"> • Long-term services: ACT services are intended to be long-term due to the severe impairments often associated with serious and persistent mental illness. • Emphasis on vocational expectations: The team encourages all clients to participate in community employment and provides many vocational rehabilitation services directly. • Substance abuse services: The team coordinates and provides substance abuse services. • Psycho-educational services: Staff work with clients and their family members to become collaborative partners in the treatment process. Clients are taught about mental illness and the skills needed to better manage their illnesses and their lives. • Family support and education: With the active involvement of the client, ACT staff work to include the client's natural support systems (family, significant others) in treatment, educating them and including them as part of the ACT services. It is often necessary to help improve family relationships in order to reduce conflicts and increase client autonomy. • Community Integration: ACT staff help clients become less socially isolated and more integrated into the community by encouraging participation in community activities and membership in organizations of their choice. • Attention to health care needs: The ACT team provides health education, access, and coordination of health care services.
--	--

SELECTED RESOURCES

Online Resources

Evidence Based Practices

www.mentalhealthpractices.org/act.html

National Alliance for the Mentally Ill

www.nami.org/Template.cfm?Section=ACT-TA_Center

Harm Reduction Coalition

www.harmreduction.org

Substance Abuse and Mental
Health Services Administration

www.nrchmi.samhsa.gov

National Library of Medicine

www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.61302

HomeBase

www.homebaseccc.org

Publications

Corporation for Supportive Housing and Conrad N. Hilton Foundation, (2004) *Closer to Home Initiative*.

Davis G., Johnson, G., & Mayberg, S.W., (2002) *Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness*.

Houghton, Ted, (2001) *A Description and History of The New York/New York Agreement to House Homeless Mentally Ill Individuals*.

Zerger, Suzanne, (2002) *Chronic Medical Illness and Homeless Individuals. A Preliminary Review of the Literature*.

HomeBase/ The Center for Common Concerns, Inc., (2003) *Peer Training Manual: Outreach Procedures and Protocols Manual for Working with Homeless Adults*.