THE ASSOCIATION BETWEEN PROGRAM CHARACTERISTICS AND SERVICE DELIVERY IN ASSERTIVE COMMUNITY TREATMENT

John H. McGrew and Gary R. Bond

ABSTRACT: The authors describe the relationship between service intensity and staffing, organizational, client, and site characteristics in 19 programs based on the Thresholds Bridge adaptation of the assertive community treatment (ACT) model. Pearson correlations were examined between 14 program characteristics and intensity of ACT services. Several staffing and organizational attributes were related to service intensity: larger team size, shared caseloads, greater supervisor involvement in direct client services, and assignment of primary responsibility for the client to the team. The potential facilitating relationship between several aspects of team operation and intensive services is discussed as are implications for local implementation of ACT.

A critical question facing program planners is how to organize services for differing treatments and client groups to both maximize client benefits and minimize costs. Largely in response to this issue, managed care and related service provision schemes, e.g., capitation and utilization review, attempt to maintain benefits while increasing service efficiency, thus, providing more care at less cost. This increased efficiency is often achieved through changes in practice parameters and the organization of care. Although used extensively for physical illness, the mental health arena is one of the last to begin to come under the umbrella of managed care (Feldman & Goldman, 1993). Mental illness, however, poses a special challenge...
for providers. Mental health care is often perceived as too expensive, too
open-ended, often ineffective, and with poorly specified outcomes. Of
those with mental illness, the most expensive and most difficult to treat are
persons with severe mental illness (SMI).

As with any medical population, program planners must face two issues
when choosing how to provide care for those with SMI: (1) how much
service do they need, and (2) how best to provide it. With respect to the
latter question, case management (CM), especially intensive CM, is often
advocated as one of the best methods for coordinating and providing care
to those with SMI. However, there are many different varieties of case man-
agement (Solomon, 1992). Moreover, case management models differ in
several important ways that affect the organization and planning of ser-
vices, for example, how services are delivered (team CM vs. individual CM,
out-of-office vs. in-office visits), client-to-staff ratios, caseload sizes, and
staffing (primary use of medical specialities such as nursing and psychiatry
as opposed to use of bachelor level or master’s level mental health work-
ers) (Brekke & Test, 1992; Reinke & Greenley, 1986). In addition, different
case management approaches likely are not equivalently effective.

Assertive community treatment (ACT) is the best known and most care-
fully researched intensive case management model available to program
planners. Based on the Training in Community Living (TCL) program
developed by Stein and Test (1980) in Madison, WI, ACT has been widely
disseminated as a model of mental health services for persons with SMI.
Recent reviews generally have concluded that ACT is effective in reducing
hospital use for persons with SMI (Bond, McGrew, Fekete, 1995; Levine,
Toro, & Perkins, 1993; Olsson, 1990; Solomon, 1992; Taube, Morlock,
Burns, & Santos, 1990; Test, 1992). ACT uses a low client-to-staff ratio, and
a team approach to provide intensive, continuous support for revolving
door clients for as long as they need treatment. Although ACT appears to
be cost-effective in reducing expensive hospital use (Bond 1984; Bond,
Miller, Krumweid, & Ward, 1988; Bond et al., 1990; Hoult, Rosen, & Reyn-
olds, 1984; Knapp et al., 1994; Weisbrod, Test, & Stein, 1980), a concern of
program planners is that features of the ACT model may be either
unnecessary or overly expensive to achieving adequate client outcomes
(Goldberg, 1991).

For example, some observers have argued that individual caseloads may
be more efficient than the team approach used in ACT, saving time re-
quired for intra-team communication. The additional time required for
meetings and other intra-team communication, by taking away from avail-
able clinical time, may reduce or reverse any potential increase in overall
services resulting from sharing caseloads (Rapp, 1993; Reinke & Greenley,
1986). The expectation in the ACT model of daily team meetings is a
concrete example of potential distraction from direct service. With this in