Assertive community treatment and psychiatric pharmacy

Kelly N. Gable, PharmD, BCPP[1]
Kelly E. Williams, PharmD, BCPP[2]

[1]Assistant Professor
Southern Illinois University Edwardsville, School of Pharmacy
Clinical Pharmacy Specialist
Places for People (ACT Teams)
[2]Clinical Pharmacy Specialist (ACT Teams)
Wishard Health Services/ Midtown Community Mental Health Center

KEYWORDS

Assertive Community Treatment, pharmacy, innovative practice

Assertive Community Treatment (ACT) is an intensive, community-based psychiatric service developed by a team of researchers at the Mendota State Hospital in Wisconsin.[1] It was initiated during the movement of deinstitutionalization in the 1960s, allowing for an increase in hospital discharges from state operated institutions into community-based programs. The research team derived ACT from the inpatient psychiatric treatment team model and proposed ACT to be a "hospital without walls."[2] In addition, the research team hypothesized that providing 24-hour mental health services to newly discharged clients would reduce the amount of rehospitalizations and psychiatric symptom relapses. Since its implementation in the 1970s, it has proven to be an extremely effective evidence-based practice that has grown and flourished in the United States, Canada, Australia, and the United Kingdom.[3] ACT teams are multidisciplinary and consist of a psychiatrist, nurses, social workers, peer specialists, vocational specialists, and substance abuse specialists. ACT services are considered more intensive than case management and the majority of services are provided to clients in the community and at their place of residence. One of the core features of this service model is to promote client recovery and independence in all aspects of their life. As seen in the sample daily ACT schedule below (Table 1), treatment is intended to be comprehensive and may include housing assistance, vocational or educational support, assistance with activities of daily living, substance abuse treatment, medication support, and mental and physical health treatment. Crisis intervention is always available and clients have access to an ACT staff member via telephone 24 hours a day.

The target population for ACT services includes individuals with severe and persistent mental illnesses, such as schizophrenia, bipolar disorder, depression, and anxiety disorders. Clients must also have significant functional impairments that may include poor self care, chronic unemployment, and unstable living or homelessness. Other criteria for services include high usage of emergency department services or frequent hospitalization, refractory psychiatric symptoms, co-occurring substance dependence, and involvement in the legal system. ACT teams may vary from 50 to 120 clients, depending on the area served (i.e. urban vs. rural). The staff to client ratio should be approximately 1 to 10, allowing for 10 to 12 staff members on a team.[4]

The ACT team is responsible for the prescribing and administration of all psychiatric medications for enrolled clients. Psychopharmacologic goals include the management of active psychiatric symptoms through medication monitoring, prevention of psychiatric symptom relapse, and identification and treatment of adverse effects. Medical conditions are also monitored and assessed routinely by the team; however, primary care physicians (PCP's) are not routinely a part of an ACT team. All clients have a medication schedule, which may include daily, weekly, or monthly medication management. The client's schedule is often dependent upon their mental health stability and environmental support. Goals for treatment and recovery often include gaining independence in managing medications. ACT teams frequently utilize daily and weekly pill organizers and daily packets for medication administration in an effort to improve adherence. Psychosocial techniques such as motivational interviewing are employed with those individuals who continue to struggle with treatment adherence.

Table 1. Sample ACT Daily Staff Assignment Schedule (Date: 10/31/12)

7:30 – 9:30 AM
Client 1: medication management- CH
Client 2: ADLs, laundry- JJ
Client 3: laboratory draw, "eyes on meds"- MT
Client 4: Risperdal Consta injection- DM
Client 5: anger management, mental health- AB
Client 6: grocery shopping-TR
9:30 – 11:00 AM
Client 7: trauma group- AB
Client 8: trauma group- AB
Client 9: housing support- MT
Client 10: smoking cessation- CH
11 – 12 PM
All staff team meeting
12 – 1 PM
Client 11: vocational support- JJ
Client 12: hepatitis C education- CH
Client 13: urine drug test- YM
Client 14: PCP appointment – MT
2 – 4 PM
Client 15: laundry assistance- TR
Client 16: vocational support- JJ
Client 17: substance abuse 1:1- AB

THE ROLE OF AN ACT TEAM CLINICAL PSYCHIATRIC PHARMACIST

Medication adherence is critical to the success or failure of treatment on an ACT team.[1] When the ACT model of care originated in the late 1960s, clinical pharmacists were not included in the structure of the treatment team. Though the ACT model has evolved and changed throughout the years, the services a clinical psychiatric pharmacist can provide for the team and clients have still gone unrecognized. The exact number of pharmacists practicing in the ACT setting currently is unknown and likely small.

The provision of clinical pharmacy services is a well-established practice in most health care environments. The literature is replete with examples of the benefits of such services in the hospital setting,[2] in contrast to the outpatient/clinic settings. Pharmacists providing medication education, symptom and adherence assessments, and monitoring at a client's home is not common or well researched in the United States. However, a study conducted in Tasmania, Australia evaluated the impact of pharmacist-conducted home visits on the outcomes of dyslipidemia lowering therapy. The authors concluded that pharmacists demonstrated a useful role in reducing morbidity and mortality associated with coronary heart disease.[3]

National policies over the last several years have been to encourage the implementation of evidence-based practices that focus on recovery from mental illness.[4] In order for clients to be successful in recovery, it is crucial that they understand and realize the impact their medications have in treatment. The pharmacist is the ideal professional to provide clients with medication information, listen to their concerns, explain side effects, discuss medication non-adherence, and address their expectations of the medication. Additionally, the clinical psychiatric pharmacist is often responsible for optimizing drug treatment and client care by monitoring client response, conducting assessments, recognizing drug-induced problems, and recommending appropriate treatment options.[5]

In addition to the client's mental illness, clients frequently have co-occurring medical conditions such as asthma, diabetes, hypertension, hyperlipidemia, HIV/AIDS, liver dysfunction, COPD, and cardiac dysfunctions. The pharmacist can be an asset to the team by providing recommendations for the management of these co-occurring illnesses. Recommendations are often made to primary care physicians in the community via phone or consult letter because primary care physicians are not a part of the ACT team. In fact, the pharmacist and/or nurse on the treatment team are often the best equipped to explain co-occurring physical health conditions and answer questions or concerns about non-psychiatric medications. We have successfully incorporated clinical pharmacy services into ACT teams in both St. Louis, Missouri and Indianapolis, Indiana. Below are sample job functions, schedules and case scenarios from our ACT practice sites. Daily client/staff schedules are developed based on the client's weekly schedules, treatment plan goals, and staff availability.

ACT Team Clinical Psychiatric Pharmacist Essential Job Functions:

- Actively participate in treatment team staffing and meetings
- Discuss medication changes, issues, or concerns with the psychiatrist, nurse, team leader, and/or case managers
- Assist with medication management (side effects, laboratory monitoring, dosing, and frequency) and make appropriate and realistic recommendations

- Assess clients for symptom improvement or decompensation in the community (on home visits) and in the clinic
- Assess treatment / medication adherence
- Provide high-quality medication education and training, if applicable, for psychiatric and non-psychiatric illnesses to clients and their family in the community and in the clinic
- Medication reconciliation during transitions of care
- Assist with continuity of care (inpatient and primary care providers)
- Problem solve pharmacy related issues (e.g. identifying and formulating solutions to drug therapy process)
- Respond to drug information requests from providers, treatment team members, or clients
- Assist with formulary management, insurance prior authorization, and prescription assistance programs
- Provide continuing education to the treatment team regarding medication changes and new treatment options

ACT MEDICATION MANAGEMENT CASE EXAMPLES: CLINICAL PSYCHIATRIC PHARMACIST INTERVENTIONS

"How often do you have to check my blood?"

Kathy is a long-time ACT client with schizophrenia. She receives daily home visits for medication management. She has a history of taking multiple psychotropic medications including: olanzapine, haloperidol, aripiprazole, risperidone, and ziprasidone. She is currently taking fluphenazine and asenapine. Team members have noticed that Kathy frequently presents with abnormal mouth and tongue movements. The ACT clinical pharmacist reports in the team meeting that Kathy would be an excellent candidate for clozapine therapy due to her refractory symptoms and development of tardive dyskinesia. The pharmacist is assigned a home visit to discuss this new treatment option with Kathy and the required monitoring associated with its use.

"I guess I'll take an injection."

Jason is a 45 year-old male client recently discharged to the ACT team from the local state hospital, where he has stayed for 10 years. Since his discharge, he has not taken his aripiprazole for around two weeks. The team is beginning to notice a relapse of symptoms, such as mild paranoia and auditory hallucinations. He has been court-ordered to take medication, and agrees to receive an injection instead of oral medication. His state insurance has not been activated since his hospital discharge. The ACT clinical pharmacist is assigned the task of acquiring an affordable antipsychotic injection for Jason.

"My head has been pounding for a long time since I started that green pill."

Sheila is a 38 year-old female on an ACT team with a diagnosis of schizoaffective disorder. Sheila is seen three times a week for medication and symptom management by ACT staff. Today in the team meeting a staff member reports that Sheila was complaining of severe headaches for which she takes 4-5 aspirin a day to help with the pain. Sheila attributes her headache to the risperidone, which she refused to take yesterday. The ACT clinical pharmacist is assigned to see Sheila today. Prior to the visit the pharmacist reviews Sheila's medical record and discovers a history of hypertension, which is currently untreated. During the home visit, the pharmacist educates Sheila on hypertension and its relation to her pounding headaches. Sheila allows the pharmacist to do a blood pressure check, which is 160/90 mmHG. The pharmacist utilizes the principles of motivational interviewing while explaining in great detail the short-term and long-term complications of untreated hypertension. Sheila then agrees to continue the risperidone and to see a PCP.

REFERENCES

1. Stein LI, Santos AB. Assertive Community Treatment for People with Severe Mental Illness, New York, W.W.Norton & Company. 1998.
2. Dixon L. Assertive Community Treatment: Twenty-five years of gold. Psychiatric Services. 2000;51(6):759- 765. DOI: 10.1176/appi.ps.51.6.759.
3. Assertive Community Treatment Association. Available at: http://www.actassociation.org/. Accessed October 2012.
4. Stull LG, McGrew JH, Salyers MP. Staff and consumer perspectives on defining treatment success and failure in assertive community treatment. Psychiatr Serv. 2010;61(9):929-32. DOI: 10.1176/appi.ps.61.9.929. PubMed PMID: 20810593.
5. Leape LL, Cullen DJ, Clapp MD, Burdick E, Demonaco HJ, Erickson JI, et al. Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. JAMA. 1999;282(3):267-70. PubMed PMID: 10422996.
6. Peterson GM, Fitzmaurice KD, Naunton M, Vial JH, Stewart K, Krum H. Impact of pharmacist-conducted home visits on the outcomes of lipid-lowering drug therapy. J Clin Pharm Ther. 2004;29(1):23- 30. DOI: 10.1046/j.1365-2710.2003.00532.x.
7. President's New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Final Report. DHHS Pub.. No. SMA -03-3832. Rockville, MD: Substance Abuse and Mental Health Services Administration.
8. Gable KN, Stunson MJ. Clinical pharmacist intervention on an assertive community treatment team. Community Ment Health J. 2010;46(4): 351-5.

How to cite this editor-reviewed article
Gable KN, Williams KE. Assertive community treatment and psychiatric pharmacy. Ment Health Clin [Internet]. 2013;2(8):243-5. Available from: http://dx.doi.org/10.9740/mhc.n133902