

Table 1. Summary of responses on the structure and human resources of ACT for people with intellectual disabilities

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Component	ACT statement	Summary of responses	Conclusion
A. Small caseload	<i>Service user to staff ratio of 10:1</i>	Responses were very mixed, equally positive and negative. A ratio of 10:1 was seen as realistic by some but unrealistic by others. Many participants felt that caseload should be lower whilst others thought it should be higher. Suggestions ranged between 5 and 25:1.	No agreement
B. Shared caseload	<i>Provider group functions as a team rather than individual practitioners. Clinicians know and work with all service users</i>	Most participants said that working as a team with a shared caseload would be beneficial. The few negative responses suggested that this way of working was unsuitable for people with intellectual disabilities who may prefer to deal with one individual, that it was unrealistic and would not work in practice. There was concern that specialists would be providing a generic function.	Should be a feature of ACT
C. Team meeting	<i>Team meets regularly to plan, review services for each client.</i>	All participants expressed positive views on holding regular team meetings. This was seen as an important and realistic way of working although some participants explained that it could be difficult to maintain in practice.	Should be a feature of ACT
D. Practicing team leader	<i>Supervisor of front-line clinicians provides direct service</i>	This was seen as a useful and important way of working. Some participants had reservations about team leaders having sufficient time to fulfill both roles but all felt they should be involved to some extent.	Should be a feature of ACT
E. Continuity of staff	<i>The service maintains same staffing over time</i>	Responses were mainly positive. Participants thought that continuity was important and helpful. However, this was seen as an ideal that would be difficult in practice. Issues around recruitment, high staff turnover and training rotations were mentioned. Some participants felt that an element of change could be beneficial.	Should be a feature of ACT
F. Staff capacity	<i>The service operates at full staffing</i>	Participants had mixed views about whether this was possible, though many felt it was a good ideal. Operating at full staff capacity by using temporary staff to cover short term absences or gaps in appointments was mentioned as being at odds with maintaining continuity.	No agreement
G. Psychiatrist on staff	<i>At least one full-time psychiatrist per 100 service users assigned to the team</i>	There was an assumption that there would be a psychiatrist on staff. Participants focused on whether one per 100 service users was enough. This was seen by most as too high a caseload. Some participants felt that this might be feasible if the psychiatrist had a more consultative role but not if they were a full team member.	The team should include more psychiatrists than 1 per 100 service users

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H. Nurse on staff	<i>Two or more full-time nurses per 100 service users</i>	All participants said there should be more than two nurses per 100 service users. This was seen as necessary to achieving a small caseload. Suggestions ranged from 3 or 4 nurses per 100 service users up to 10 per 100.	The team should include more nurses than 2 per 100 service users
I. Vocational specialist on staff	<i>Two or more with one year's training or experience in vocational rehabilitation/support</i>	This received a mainly positive response. Participants felt it that having a vocational specialist of staff would be important and that helping service users into work was beneficial. Some thought this should be provided by the team's occupational therapist. Many participants acknowledged the difficulties faced by people with intellectual disabilities in accessing vocational support from other services and finding employment in general.	Should be a feature
J. Service size	<i>Sufficient absolute size to provide consistently the necessary staff diversity and coverage</i>	Participants felt that staff diversity and adequate coverage was important. Many expressed doubts on whether it was possible to have sufficient absolute size to achieve this. Difficulties within the UK NHS and with resources were cited as the main problems. The need for flexibility and a balanced skill mix were also mentioned.	No agreement

Table 2. Summary of responses on the organizational boundaries of ACT for people with intellectual disabilities

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Component	ACT statement	Summary of responses	Conclusion
A. Explicit admission criteria	<i>Clearly identified mission to serve a particular population; measurable, operationally defined criteria to screen out inappropriate referrals</i>	Most participants thought it would be important to have explicit admission criteria but acknowledged that this would be difficult to apply. Some felt that this should be assessed case by case, that it was important to be flexible and that it would be good to operate an inclusive service. Participants suggested there would be pressure from other services for an ACT team to take service users who didn't fit the criteria. They also mentioned problems regarding diagnosis and complex needs in this population.	Should be a feature of ACT
B. Intake rate	<i>Takes service users in at a low rate to maintain a stable service environment</i>	This received a large number of negative responses. Participants felt it was unrealistic and difficult in practice. One participant said that it could lead to staff becoming bored and a culture of dependency. Those who felt that intake should be low acknowledged that there might be a high number of people who need or want access to the service and that refusing to accept them would be difficult.	Should not be a feature of ACT
C. Full responsibility for treatment services	<i>As well as case management/ psychiatric services programme directly provides counselling/ psychotherapy, housing support, employment and rehabilitative services</i>	Many participants had both positive and negative views on accepting full responsibility for all these services. Some thought that mental health services should be provided but were unsure about housing, employment and rehabilitation. They felt this was either outside the role of an ACT team, that it went against the principles of Valuing People UK (White Paper on intellectual disabilities services), or that other services were better placed to provide specialist support. But, some participants did feel that this would be effective and could be done. They felt it would be smoother for service users even if it was hard to implement.	No agreement
D. Responsibility for crisis services	<i>Twenty-four hour coverage of psychiatric services</i>	Many participants felt this was neither necessary nor realistic. Those who gave a positive response also said that boundaries would be needed, that it might not be feasible and that there may be resistance from staff. Participants felt that 24-hour coverage could be subject to inappropriate use and that services in place for the general population were appropriate for people with intellectual disabilities.	Should not be a feature of ACT
E. Responsibility for hospital admissions	<i>Programme is involved in hospital admissions</i>	Involvement in hospital admissions was viewed positively. It was seen as necessary to providing continuity and important when service users were admitted to mainstream wards. However, some participants were less sure that the team should remain responsible for service users. Roles as an education or support service were suggested. A few thought this was outside the team's remit and that it would be	Team should be <i>involved</i> in hospital admission.

difficult in practice.

F. Responsibility for hospital discharge planning	<i>Programme is involved in planning hospital discharges</i>	All participants felt the team should be involved in discharge planning, provided the service user still fulfilled the admission criteria. A distinction was made between involvement or providing support and whether the team should be responsible for this.	Team should be <i>involved</i> in hospital discharge planning
G. No time limit on services.	<i>Programme closes no cases, remains point of contact for all service users as needed</i>	Participants saw a distinction between having no set time limit and closing no cases. Not closing cases provoked a large number of negative responses. Participants felt this went against the principles of valuing people and that the team should be working to get people into mainstream services and that service users had to take some responsibility. Some said it was sometimes necessary to close cases if service users weren't engaging or were ready to move to another service. In some cases closure could be beneficial to service users. However, there was a view that there should be no set time limit on service users' involvement with the team and that even after a case had been closed the service could still be available for re-referral, advice or a point of contact.	Cases should be closed if appropriate. There should no set time limit on service users' involvement with team

Table 3. Summary of responses on the nature of ACT for people with intellectual disabilities

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A. In vivo services	<i>Service monitors status, develops community living skills in community rather than the Service system</i>	Most participants responded positively, they said that in vivo services would be more user friendly and that it was better to see service users in a naturalistic environment. Some participants felt there was still a place for inpatient setting for more complex cases and some outpatient services. There were reservations over the amount of time that community visits take up and the resources implications of this.	Should be a feature of ACT
B. No-dropout policy	<i>Service engages and retains clients at a mutually satisfactory level</i>	There were mixed views on having a no-dropout policy. Some participants agreed that it was necessary; they felt that services should be proactive in their engagement with services users but acknowledged that there were some limits as to how much service users could be pursued. Others felt that service users had to take responsibility for their engagement and that their motivation was necessary.	No agreement.
C. Assertive engagement measures	<i>Uses outreach involvement, plus legal mechanisms (e.g., representative payees, probation/parole, OP commitment) as indicated</i>	Participants felt it was important that these measures were available but that they should only used when necessary. There was concern that the rights of service users should be considered and that more restrictive, coercive measures should only be used as a last resort.	Should be a feature if necessary
D. Intensity of services	<i>High total amount of service time, as needed</i>	High intensity of services was seen as positive in theory but many participants felt there would be resources limitations and that some limits would have to be in place. A need for flexibility was mentioned with intensity varying according to the need of each service users at particular times. Participants felt there would be difficulties balancing the amount of input needed with the resource needs of the team and that prioritizing needs might be required.	No agreement
E. Frequency of contact	<i>High number of service contacts, as needed</i>	Some felt that high frequency of contact was important if required so long as the type of contact varied and included brief visits or telephone calls. Others felt this was unrealistic and not necessary.	No agreement
F. Work with support system	<i>With or without the service user present, programme provides support /skills for client's support network families,</i>	Involving service users' support system was viewed very positively. Participants said it was essential. Many felt this needed to be done in a formal and systematic way. There was some concern about service user confidentiality.	Should be a feature of ACT

employers, etc.

G. Dual disorder treatment groups	<i>Group modalities used as treatment strategy for clients with substance abuse disorders</i>	Views on whether the team should provide substance abuse services were mixed. Though most people felt it was important that these were available, many felt that mainstream mental health or substance abuse services might be better placed to provide them. Those who felt this was part of the team's role said they would need more training and would want to seek specialist help from mainstream services. Those who discussed group modalities had differing views on whether it was suitable for people with intellectual disabilities.	No agreement
H. Dual disorders model	<i>Uses stage-wise treatment model that is non-confrontational, follows behavioural principles, considers interactions of mental illness/substance abuse and has gradual expectations of abstinence</i>	Participants thought this model sounded reasonable and that if it had an evidence base within generic mental health then it should be used by intellectual disabilities services. There was concern that there wouldn't be any evidence on this approach for people with intellectual disabilities and that it should be adapted to suite their abilities and needs. Many participants expressed concern at the lack of knowledge among existing services and others felt that substance abuse issues weren't common enough to require inclusion.	Should be a feature of ACT
I. Role of consumers on team	<i>Service users and carers are involved as team members providing direct services</i>	Many participants thought that services users had a role in providing advocacy, support, role modeling or points of contact for other service users. But involving service users as team members was viewed less positively, particularly with respect to providing direct services. Whilst some felt this would be a good idea and would be useful, many participants felt it would be inappropriate and would result in ethical and confidentiality problems. Obtaining feedback from service users and involving them in the development of services was seen as important.	ACT should encourage service user involvement
