ACT for Life: Why Psychiatrists Pound the Pavement to Provide Care

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To better understand the experience of psychiatrists working on assertive community treatment (ACT) teams and the factors that may draw them to this work, the authors created a survey and distributed it through e-mail groups of the American Association of Community Psychiatrists, the Columbia University Public Psychiatry Fellowship Alumni, and the New York State Center for Practice Innovations ACT Institute. A second survey, with questions primarily regarding safety concerns for ACT providers, was distributed to respondents of the first survey. Responses suggested that ACT leaders should foster teamwork, fieldwork, creativity, flexibility, safety, and leadership opportunities on ACT teams if they wish to engage psychiatrists in this work.

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For almost 50 years, assertive community treatment (ACT) has helped individuals with serious mental illness to live and thrive in the community. This work is accomplished by bringing care to individuals, whether in the home, shelter, or street, transcending numerous barriers to traditional outpatient care. These barriers include patients' cognitive impairments and negative symptoms, the lack of insight characteristic of those with schizophrenia, and the fragmentation of the health care system. ACT is recognized as an evidence-based service model, delivered by a multidisciplinary team, including a psychiatrist, nurse, social workers, counselors, and peers, which provides care that may include medication, psychotherapy, family therapy, substance use treatment, vocational services, and just about anything else directed toward the recovery goals of the individual (1).

Over the years, the original ACT model has been replicated and adapted around the world, and almost 1,800 teams are located in the United States. A number of academic institutions have developed centers to study outcomes and implement best practices for clinicians (2–4). Evidence suggests that treatment is most effective when ACT teams show close adherence to the model on fidelity measures (5). Such measures define psychiatrists' responsibilities, including monthly visits with clients, participation in team meetings, shared decision making with patients, whole health care, brief therapy, and interprovider communication. For the team, the psychiatrist provides psychoeducation, collaboration, and after-hours support. The psychiatrist shares clinical leadership with the team leader.

ACT team psychiatrists comprise a specialized group; the home visitation component of ACT alone makes the job unique. It is no surprise, then, that recruiting psychiatrists for these jobs can be challenging. A literature search revealed articles on job satisfaction and team turnover for ACT staff in general but no articles specifically on ACT psychiatrists (6–9). For psychiatrists in general, adequate time with patients has been associated with job satisfaction; for community psychiatrists, ambiguity over roles and leadership, divergent understanding of accountability, and interprofessional misperceptions have been found to be obstacles to service provision (10, 11). Results of a survey of American Association of Community Psychiatrists members suggested that career satisfaction persists longer for those with medical director responsibilities (12).

A recent expansion of ACT in New York City led ACT team leaders and medical directors to ask for technical support in recruitment and retention. We surveyed ACT

HIGHLIGHTS

- Psychiatrists on assertive community treatment (ACT) teams were surveyed about their experience in order to better understand the factors that may influence recruitment and retention.
- Responses suggest that ACT leaders should foster teamwork, fieldwork, creativity, flexibility, safety, and leadership opportunities to engage psychiatrists in this work.

psychiatrists about their experiences in order to better understand the factors that might draw providers to the job.

Methods

We created a 25-question survey in SurveyMonkey and distributed it on March 18, 2019, to e-mail groups associated with the American Association of Community Psychiatrists, the alumni network of the Columbia University Public Psychiatry Fellowship, and the New York State Center for Practice Innovations. Responses were accepted until May 17, 2019. The survey questions are detailed in the online supplement to this column and included the following domains: ACT team and provider characteristics, ACT psychiatrist duties, factors affecting quality of care, quality of the team relationships, and ways to improve ACT. On July 25, 2019, a second, five-question survey (see online supplement) with questions regarding provider safety concerns and more specific questions on job satisfaction was distributed to respondents of the first survey who had provided their contact information. Responses were accepted until August 18, 2019.

Results

ACT team and provider characteristics. Fifty-five people responded to the first, 25-question survey, and 21 of those people responded to the second, five-question survey. Responses are tabulated in the online supplement to this column and are presented as proportions of people who answered each question. Eighty percent (N=43) of respondents to the first survey had worked in ACT settings for more than 2 years, with 35% (N=19) working in ACT for more than 10 years. Only 19% (N=10) worked in ACT full time. Sixty percent (N=31) were the sole psychiatric provider on their teams. Caseloads ranged from 40 to 125 individuals, with most teams serving between 50 and 75 individuals.

Respondents worked in 18 states, representing all regions of the United States as well as one Canadian province. More than a quarter of respondents (N=15) worked in New York State. Other states with three or more respondents included California, Illinois, Maryland, Massachusetts, Pennsylvania, and Washington. Eighty percent of the respondents (N=45) worked in urban settings, and 15% (N=8) worked in rural settings. Three-quarters (75%, N=41) had an assisted outpatient treatment (court-mandated) program in their state. About two-thirds (N=37) of the ACT teams represented were affiliated with not-for-profit agencies.

ACT psychiatrist duties. A majority of respondents saw patients primarily in the field (64%, N=35) versus in the office (31%, N=17) and used a variety of modes of transportation, with about a third making visits on foot (N=18). None of the respondents provided care primarily through telepsychiatry. Most (70%, N=39) scheduled their own visits. Seventy percent (N=39) of respondents who made home visits traveled primarily alone, with the remainder traveling with one other person or with students. Some noted that they would travel with another team member if there was a risk of danger on the visit. Three-quarters (N=41) completed documentation primarily on an office computer, whereas others used mobile devices or paper charting. All respondents endorsed performing tasks when off duty, particularly returning calls, completing documentation, and managing prescriptions. More than half of the respondents (56%, N=31) had medical leadership roles outside of the ACT team. Nine (16%) respondents were the primary or sole leader of the ACT team.

Respondents reported a range of duties other than psychiatric evaluations and medication management, including administering injectable medications; providing physical examinations, entitlements support, and prior authorizations; teaching; supervising; providing psychotherapy, psychoeducation, family work, and group work; and providing vocational support, treatment planning, and meetings and advocacy with other providers or community support services. Multiple respondents expressed an openness to tasks outside the traditional medical model. One respondent stated, "I try to help my patients and/or their families however I can. If this means taking someone grocery shopping or helping a family member understand their medical [paperwork] or prescriptions, I'll do that. . . . Being able to be present with people in such gentle ways makes this job everything."

Factors affecting quality of care. Respondents endorsed a number of factors affecting quality of the care provided, including lack of funding or resources, staff shortages, leadership deficits, dysfunctional team dynamics, poor fidelity to the ACT model, travel time between visits, and documentation requirements. About two-thirds (N=37) reported experiencing staff shortages more than 50% of the time. Although 22% (N=12) of respondents endorsed poor fidelity to the ACT model as an issue, 40% (N=22) reported feeling limited in being creative and flexible in their treatment approach because of pressure to adhere to fidelity measures. Specific concerns referenced a mandated number or location of monthly visits required by some states. For example, a respondent commented that sometimes "patients need regular therapy with one provider, but this is difficult to provide [in] ACT."

Team relationships. About two-thirds (N=37) of the respondents felt their team respected their opinions "a great deal." One respondent felt the team respected their opinion on medication and diagnosis but not on other topics, and another felt the system was too bureaucratic and rigid to implement any of their recommendations.

Team leader relationships were given at least four of a possible five stars by 86% (N=47) of the respondents. Two people commented on high leadership turnover or the lack of a team leader. One person who had worked on several

ACT teams over the years said, "It seems like a lot of the challenges on teams arise from dysfunctional team dynamics or ineffective leadership."

A majority of respondents (71%, N=39) rated their relationship with their agency as deserving at least four stars, although 20% (N=11) rated it with one or two stars. A few people noted a lack of communication with agency leadership or administrative services or a lack of respect for physicians or physician leadership.

How to improve ACT. There were a variety of responses to the question, "What changes might you suggest making to the ACT model or to how ACT teams are run?" Thirteen (24%) respondents suggested increased flexibility around the requirement of six visits per month (which may be specific to certain states), for example, allowing fewer visits for a patient preparing to transition from ACT to outpatient clinic services. Comments included the following: "The visits become repetitive, and the patients get tired of it. It is actually pushing them away." "It is counterproductive that they are not allowed to participate in other mental health or substance abuse services while they are enrolled with ACT." "Allow doctors more discretion in how often, how long, and in what setting to see patients." "Services should be driven by the patient."

A number of people suggested measures to improve ACT staff retention, including higher pay for case managers and decreased documentation requirements. Technological support, such as telemedicine and facilitation of documentation in the field, and transportation support, such as provision of agency vehicles and parking passes, were suggested by several others. Three people suggested support for integrating general medical services, because of patients' poor access to this care, and another three suggested increased integration of substance use disorder services. Integrating phlebotomy services into ACT would also facilitate cardiometabolic monitoring and clozapine treatment and could reduce some of the frustrations associated with coordinating lab visits. Systems improvements, including housing and work options for patients, were sought. Physician leadership and support, caseload and/or workload adjustments, greater focus on evidence-based psychotherapeutic treatments, involvement of team members (including peers and patients) in administrative decision making, and increased team control of admissions and discharges were suggested. Recognition of the increased travel burden for ACT providers in rural communities was also requested.

Safety concerns. One respondent noted a number of violent incidents experienced by the team and suggested that this was a reason many people do not do this work. This comment prompted the development of a follow-up survey to explore this issue further. First-round respondents were asked how often they felt unsafe working in the community and whether they had ever been hurt on the job. More than half of the 21 respondents reported they had rarely (47%, N=10) or never (10%, N=2) felt unsafe, but one person reported that he or she usually felt unsafe, and the remainder reported sometimes feeling unsafe. Four respondents reported being hurt while working in ACT; specifically, they reported a patient throwing an object, needlestick injury, inappropriate touching, and a community hazard (slippery stairs). An additional respondent reported having had to "run for it" twice in 10 years, and another reported traffic hazards as a safety issue.

Job satisfaction. Almost half of respondents (43%, N=24) rated their overall satisfaction with ACT work as five of five stars, 26% (N=14) rated it as four stars, and 30% (N=17) rated it as three stars. Several people commented that they "love the work," with two people putting "LOVE" in capital letters. "I feel very fortunate to have a physician job that fosters so much teamwork, creativity, and time outdoors," said one respondent. Another said, "I love my patients and find the work meaningful, but the caseload is so high that it is difficult to follow patients closely, complete paperwork, [and] provide clinical supervision to other staff. Ultimately it leads to less satisfaction from the work because its so harried and emergency driven." A third stated, "I eventually burned out from ACT work. It required phone calls and catching up on work outside of work hours. I was often thinking about my patients, which eventually became too emotionally draining." She added, "I was also pregnant and then pumping while [working in] ACT, which was particularly difficult given the nature of field work."

A follow-up question regarding what people liked most about ACT work revealed a slight preference for "being part of a team" (33%, N=7), with the remainder of respondents about evenly split between "being out in the field," "being creative," and "the patients." When asked what they might tell a colleague considering ACT work, responses included the following: "Teamwork provides the patients with all the supports that they need." "ACT provides an important system of care to our patients. Meeting with them in the community or in their homes changes the power dynamics." "The amount of information that you acquire seeing people in their world. . . . There is no way to replicate this in our offices." "Once you work ACT, you can handle any psychiatric complexity or 'refractory condition.'" "It is super fun." "Try it!"

Discussion

ACT work recalls an earlier era of medicine when many doctors served patients in their homes; at the same time, it brings psychiatry to the cutting edge of recovery-oriented care. The work is not for everyone, but the results of this survey suggest that those who choose to work in ACT may become enthusiastic proponents. The survey sample represents a very small proportion of the total ACT provider group, and it is uncertain whether the respondents were

representative of ACT providers in general. To learn more about reasons for departure from ACT, a future survey might specifically target psychiatrists who have left ACT positions.

The survey results suggested that ACT leadership should foster teamwork, fieldwork, creativity, and flexibility on ACT teams if they wish to engage psychiatrists in this work. Ensuring that policies, procedures, and agency support are in place to reduce risk of violence or injury is also crucial, which is consistent with previous reports (7) of the importance of a "safety and quality climate" to ACT team job satisfaction. The quality of the team leadership, dynamics, and structure appear to be key factors in the ACT psychiatrist's job satisfaction. Assuming the leadership role of a medical director adds an additional focus beyond purely clinical demands, which may help keep some ACT psychiatrists engaged, as evidenced by a majority of respondents having leadership roles. Team leaders should explicitly define the coleadership of the team with candidates for the team psychiatrist position and should look for someone who has leadership skills and, ideally, who can fill a larger agency-level leadership role.

As health care becomes more outcomes driven and value based, expansion of ACT and ACT-like models of care aimed at reducing high-cost hospitalizations is likely to continue. Increasing trainee exposure to ACT work by requiring rotations, in addition to electives, may allow new providers to discover the fulfillment in this work that the survey respondents have reported. It appears that providers who find that they "LOVE" working in ACT may continue this work for years, which is ideal for continuity of care.

ACT remains one of the best options to promote community living for individuals with serious mental illnesses. Now and in the future, leaders in this field will have to ensure that the role of the psychiatrist on these teams remains appealing.

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