ANALYSIS
SELECTED CONFERENCE PROCEEDINGS

Assertive Community Treatment (ACT): 23 Cases

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The cases

These short cases are intended to stimulate thought or perhaps serve as a useful tool in a classroom or discussion group setting. The cases have been modified to protect confidentiality but do represent real life elements and situations that have been encountered by ACT team staff. Many or most case situations presented may be familiar to ACT Team staff members. Will all ACT team members view each of these as ethical problems? Were others aware that all of these things happen within the clinical milieu of assertive community treatment?

For those who are unfamiliar with Assertive Community Treatment Teams…

- small multidisciplinary teams (10 staff) doing community based interventions
- they provide rapid and intensive responses with flexible, all inclusive care
- they have long-term and full clinical responsibility for individuals with serious and persistent mental illness
- there are low staff: client ratios (often 1: 8 to10)
- ACT is often a program of last resort—the alternative is frequent or permanent hospitalization
- ACT may produce better outcomes than case management for those who are seriously ill
- ACT teams are cost effective because they keep clients out of hospital and because the in-house concentration of multidisciplinary services provides smooth and efficient continuity of care

Our Three Part Presentation Format:

The Case: (a real/composite case)

The Question: (e.g., "What should be done?")

A Comment: (e.g., "When in doubt don't do it")

Family/Caregiver Issues

Case 1: Beverley is a 25 year old capable woman with schizophrenia who lacks insight and lives at home with her parents. Every few months she starts to go without sleep and then decompensates. Her mother secretly puts lorazepam into her food when she sees a change in sleep pattern and this corrects the problem. The mother told the ACT team what she is doing and how this has kept her daughter out of hospital.

The Question: Should ACT staff try to stop this practice?

A Comment: The mother knows it is assault and deception but believes that it is her right as a parent to do so. The ACT team has remained silent on this matter with the client.

Case 2: The parents of a 33 year old male with schizophrenia do everything for him and he has no chores or responsibilities while living with them. The mother explains that in her culture this is the way it should be. The client is quite happy with this but the ACT team has trouble motivating the client to accomplish any rehab goals.

The Question: Should the ACT team try to educate the family about how they believe their efforts are being undermined by the family system?

A Comment: Cultural sensitivity should not be confused with family dynamics that are actually harmful to the client. Tact and modeling are critical.

Confidentiality Issues

Case 3: Lois is adamant that she does not want one ACT team member to know a particular bit of information about her; the information has clinical but not safety significance.

The Question: Should you risk splitting, fragmented care, or inconsistency of approach by allowing or fostering selective disclosure?

A Comment: No. Open sharing of information is the acceptable price of team care, and it is particularly necessary where safety is

a factor. This operational mode must be explained up front. Nonetheless selective disclosure occurs and we must trust the discretion and judgment of our fellow clinicians as they, and we, inevitably filter the information flow.

Case 4: The law in our jurisdiction requires mandatory disclosure of NCR ("not criminally responsible") status to a potential employer by the client or the ACT team. Susan really wants a particular job and begs the team to not disclose her NCR status because the law is unfair. She was charged with uttering threats to a family member (while manic) but she has no criminal record or history of violence otherwise. She is fine on meds and is happily compliant.

The Question: Should staff withhold the information in the client's best interest?

A Comment: No. The law should be respected but seeking the patient's permission for fuller disclosure (i.e., the context of the events and how well she is doing now) may serve to allay an employer's concerns in this instance.

Case 5: The landlord calls to say that Bill has been suggesting he would like to have a barbeque in the hallway of his large apartment building. The landlord demands to know if Bill has caused fires in the past. (The client hasn't; the barbeque comment is most likely an awkward attempt at conversation). He will be evicted unless there is a response. The paranoid client refuses to give permission for staff to talk with the landlord.

The Question: Do you tell the landlord the client is not a safety concern?

A Comment: Maybe. The 'letter of confidentiality law' should not violate the spirit, which aims at protecting best interests. Homelessness is a serious consequence.

Case 6: The streets are your office; team members regularly meet clients on sidewalks and in coffee shops for assessments.

The Question: If the client wants this, should the team go along with it?

A Comment: Yes. If best efforts at discretion are maintained and the client is not put at risk with public disclosure of status.

Case 7: ACT staff ask neighbours how a client is doing and if they have any concerns about him. The excuse is that everyone in town knows that he is followed by a mental health team.

The Question: Is there a breach in confidentiality?

A Comment: Yes. But if the information is volunteered unsolicited it can be accepted.

Care Issues

Case 8: Joanne enjoys wearing brightly coloured, oddly matched clothes that will make her stand out in any crowd. She is unconcerned about appearance. A particular ACT clinician always makes her dress more "appropriately" before allowing her to come out on her outing.

The Question: Is this demand to change acceptable?

A Comment: Some of what is justified under a therapeutic guise may be about clinician comfort or over-protectiveness.

Case 9: Alice is a 54 year old female who has a 25 year history of schizophrenia. She lives on a disability pension in an apartment with three cats and two dogs. Her apartment reeks of urine and her chairs are always wet and sticky. She has no concerns about hygiene, and never has visitors except for ACT staff?

The Question: Should ACT staff force her to clean as a condition of involvement?

A Comment: Health reasons prompt the need for cleaning but beyond that, staff comfort is not the issue, although the impact of cleanliness on personal relationships is a legitimate therapeutic and rehab concern.

Case 10: Mike always agrees to any suggested medication or dose change. He has persistent delusions that an electronic chip is in his brain preparing him to be transformed into Jesus. He takes the meds happily because they can have no effect on someone with his special powers. The psychiatrist has not declared him incapable and the team never raises this question at client reviews.

The Question: Should he be declared incapable and a substitute decision-maker sought?

A Comment: Yes. However, the reality (as on inpatient wards) is that it is easier to hide behind the presumption of capacity as long as treatment plans are followed.

Case 11: Fred has severe paranoia and has had extremely serious suicide attempts when ill. He does extremely well and is able to work and maintain relationships when on his depot medication. He completely lacks insight. Every two weeks he refuses his injection, is then told by the psychiatrist that his substitute decision-maker has authorized it, he in turn says he will leave the country to escape "evil psychiatrists", and finally the psychiatrist says he must accept the injection or the police will be called and he will be taken to the hospital where he will get it anyway. He complies.

The Question: Is this repeated exchange acceptable?

A Comment: He keeps coming back and hasn't left the country. Is each return motivated by fear or is it an expression of subconscious recognition of the benefits of the injection?

Case 12: Ed's bipolar disorder is fairly well controlled on meds. He

has burned down two houses when manic in the past. He is competent when taking his meds but refuses monitoring bloodwork. The psychiatrist refuses to keep prescribing meds without being able to monitor kidney and liver function every 3-6 months. He says he is aware of the (low) risks of possible lethal organ failure and will take his chances.

The Question: Should the ACT team discharge him?

A Comment: Not sure. After two years of trying to obtain bloodwork they did because the team psychiatrist refused to keep prescribing the meds.

Case 13: Judy, age 53, decompensates within several hours when she drinks. She has a history of grabbing young children off the street and taking them home because she believes they are her own. Staff see her twice a day. She wouldn't let them into her apartment building one afternoon but she answered the phone with slurred speech, all the while denying any alcohol consumption. The team member called the psychiatrist to her apartment. In order to certify her the law requires she be seen by the psychiatrist in person. When she refuses to let the psychiatrist in, he lies to her and says the intercom has so much static he can't understand her. She then buzzes him in and lets him up to the apartment, whereupon she is certified.

The Question: Was it acceptable for the psychiatrist to lie?

A Comment: No, but… if it were your child abducted would the question of lying even matter to you?

Case 14: Mark is required to follow a jointly prepared budget, but staff imposed a budget because he overspends on junk food and cigarettes. Although financially capable, staff controls his weekly spending money. He wants more spending money and he resents this tremendously.

The Question: Should the team interfere in a financially capable person's decisions in this way?

A Comment: Yes, if his rent and basic necessities are not being covered. However, how many people in the real world actually make a monthly budget in such a formalized way?

Case 15: Staff buy cheap cigarettes for clients from the native reserve store. Sometimes groups of clients are taken on "country drives" to the same store.

The Question: Should staff do this?

A Comment: No. It's a clear health issue. However, it is not really this simple. Savings may be spent on better food and thereby lead to an improvement in health.

Case 16: Margaret, an artist, wants to give her favourite team member a small, beautiful watercolour painting as an expression of gratitude. She says it is important to her that it be accepted.

The Question: Should it be accepted?

A Comment: Substantial gifts are always refused. Small, inexpensive gifts might be accepted only if they can be given to the whole team (e.g., this was explained to Margaret and the painting was displayed on the ACT office wall).The safer course may be absolute refusal of all gifts by all staff.

Case 17: Jimmy, a 22 year old with schizophrenia, has a calendar with pictures of naked women displayed on his living room wall. This has upset some female staff who asked him to move it to his bedroom where it will be out of site during visits. Jimmy grew up in a family where pornography was displayed openly in the house. He tells staff to mind their own business and "just get over it". These particular staff feel they should not have to see him now because of their discomfort. (He has no history of violence or inappropriate sexual behaviour.)

The Question: Have team members overstepped their bounds?

A Comment: Yes. Education about sexism should be done, but he is free to adorn his apartment with legal material.

Case 18: A 27 year old Caucasian with stable schizophrenia remarked to a staff member that "those brown people are different". He further relates with open approval how some "brown people" were harassed to the point they left his small village. At a family meeting his mother is openly and proudly racist. When challenged on their views they are disgusted by the ACT team members' "big city stupidity". Thereafter, staff never talk with the mother.

The Question: Should any staff of color have to see this client (he doesn't want to see them)?

A Comment: Staff comfort should be considered because countertransference may be blinding and diminish therapeutic efficacy. Some will argue the possibility of a corrective experience should not be avoided. Whatever the course, the decision for involvement is not the client's but the team's.

Case 19: Clinicians regularly do the laundry and clean the house of some clients "who will never do it themselves and won't do it even if you directly help them". The clinical issues are dependency and disempowerment and they are reviewed case by case.

The Question: Is this even an ethical issue (enabling vs disabling)?

A Comment: Sometimes it feels like an ethical issue and sometimes it doesn't which may reflect projections, intuitions, or suspicions about a fellow clinician's motivation. It is easier at times to clean for someone rather than with them, especially if they "never do a good enough job". This is an issue that is a source of resentment and splitting. "I do cleaning work for clients and so should you".

Case 20: Staff donate food, old TVs, their used computers, etc. for clients. Most on the team feel these items should be passed on with

the explanation that they have been received from anonymous donors. Some staff members say this is silly and that it is just common decency and kindness to give gifts, and they insist on identifying themselves as the source to the respective clients.

The Question: Is revealing yourself as the source simply self-serving?

A Comment: Yes. It meets your need and further sets up an "us and them" demarcation and barrier.

Case 21: A 33 year old client is on a government disability (which everyone on the team agrees is barely a subsistence allowance). If he works, an amount equivalent to his wages is deducted from his disability income. He is working under the table in construction.

The Question: Is the team duty bound to report this income, especially if doing so means the client will simply stop working?

A Comment: No. We are not required to report illegal activity if no one is harmed. (Some argue, cogently and correctly, that the underground economy is broadly harmful to society as a whole and unfairly burdens tax paying citizens.)

Case 22: Joe is 34 years old and has a history of significant substance abuse, with repeated visits to the ER with delirium and intoxication. He always ingests all pills in his possession. With this client it was agreed that he would only have access to his medications through twice daily visits to the pharmacy for a one time dose on each visit. This is a huge demand on his time.

The Question: Is this acceptable?

A Comment: In the alternative, he overdoses repeatedly.

Team Dynamics

Case 23: At a team meeting it was agreed that staff would stop lending clients money (up to $20 had been lent at various times). There was apparent agreement that it was a boundary crossing that should stop. Subsequently, some team members just kept doing it because they thought the team decision was wrong and punitive. Even after being confronted, the particular team members argued that their professional college or conscience did not prohibit the lending of money.

The Question: Must they go along with the majority view?

A Comment: Don't soil your own nest. Collective wisdom should be trusted; "buy-in" and follow through for decisions should not be passive-aggressive or lukewarm.

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