

UCLA

UCLA Previously Published Works

Title

"You might lose him through the cracks": clinicians' views on discharge from Assertive Community Treatment.

Permalink

<https://escholarship.org/uc/item/19r2q02p>

Journal

Administration and policy in mental health, 42(1)

ISSN

0894-587X

Authors

Bromley, Elizabeth

Mikesell, Lisa

Armstrong, Nikki Panasci

et al.

Publication Date

2015

DOI

10.1007/s10488-014-0547-3

Peer reviewed

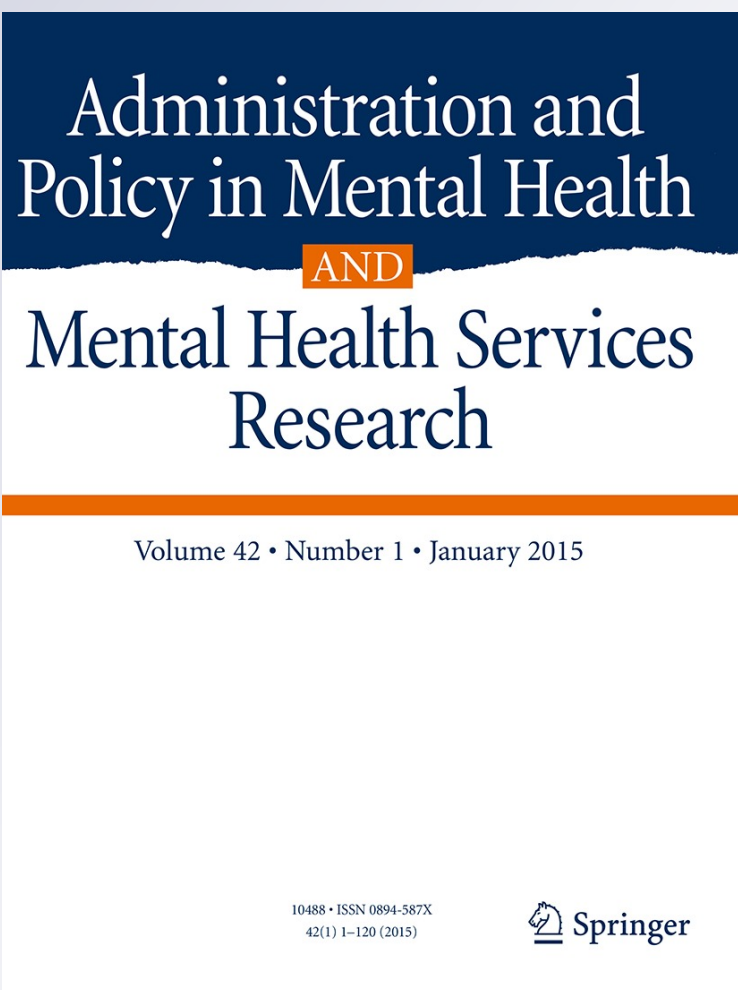
“You Might Lose Him Through the Cracks”: Clinicians’ Views on Discharge from Assertive Community Treatment

**Elizabeth Bromley, Lisa Mikesell,
Nikki Panasci Armstrong & Alexander
S. Young**

**Administration and Policy in Mental
Health and Mental Health Services
Research**

ISSN 0894-587X
Volume 42
Number 1

Adm Policy Ment Health (2015)
42:99-110
DOI 10.1007/s10488-014-0547-3



Your article is protected by copyright and all rights are held exclusively by Springer Science+Business Media New York (outside the USA). This e-offprint is for personal use only and shall not be self-archived in electronic repositories. If you wish to self-archive your article, please use the accepted manuscript version for posting on your own website. You may further deposit the accepted manuscript version in any repository, provided it is only made publicly available 12 months after official publication or later and provided acknowledgement is given to the original source of publication and a link is inserted to the published article on Springer's website. The link must be accompanied by the following text: "The final publication is available at link.springer.com".

“You Might Lose Him Through the Cracks”: Clinicians’ Views on Discharge from Assertive Community Treatment

Elizabeth Bromley · Lisa Mikesell ·
Nikki Panasci Armstrong · Alexander S. Young

Published online: 2 April 2014
© Springer Science+Business Media New York (outside the USA) 2014

Abstract Assertive Community Treatment (ACT) teams are increasingly interested in improving access to ACT through discharge of improved clients to less intensive mental health care services. We report results from a process evaluation of three teams in the VA’s ACT program, Mental Health Intensive Case Management (MHICM), that began to implement discharge. MHICM clinicians (n = 15) describe significant barriers to discharge. Clinicians support the concept of discharge but raise concerns

about clients’ future stability, clients’ feelings about discharge, and other aspects of the discharge process. We propose strategies that can be used to support clinicians and clients in discharge decision-making.

Keywords Assertive Community Treatment · Serious mental illness · Community mental health · Therapeutic alliance

Introduction

Assertive Community Treatment (ACT) is an interdisciplinary, field-based case management model of mental health care that provides responsive, assertive, and frequent contact with individuals living with serious mental illness in the community (Gilmer et al. 2010; Kreyenbuhl et al. 2010). Because early research showed that clients experience clinical decline after ACT discharge (Stein and Test 1980), the model has been understood to entail time-unlimited support (McGrew and Bond 1995; Monroe-DeVita et al. 2011; Teague et al. 1998). However, ACT clinicians and researchers have begun to reconsider this premise. Community mental health care services have evolved since ACT’s origination, with shorter hospital stays and a broader array of outpatient treatment and support options to address housing, socialization, and other areas of need traditionally managed by ACT teams (Rosenheck and Dennis 2001; Slade et al. 2012; Velligan et al. 2012). Public mental health funding challenges have highlighted the importance of maximizing the value of the ACT intervention through careful patient selection and treatment planning. Moreover, some advocates for recovery-oriented community mental health care have suggested that transitions to less intensive services are necessary to

E. Bromley · A. S. Young
Desert Pacific VA Mental Illness Research, Education and
Clinical Center (MIRECC), Greater Los Angeles Department of
Veterans Affairs Healthcare Center, Los Angeles, CA, USA

A. S. Young
e-mail: ayoung@mednet.ucla.edu

E. Bromley · A. S. Young
Center for Health Services and Society, Semel Institute for
Neuroscience and Human Behavior, Department of Psychiatry
and Biobehavioral Sciences, University of California,
Los Angeles, Los Angeles, CA, USA

E. Bromley (✉)
West Los Angeles VA Healthcare Center, UCLA Center for
Health Services and Society, 10920 Wilshire Blvd, Suite 300,
Los Angeles, CA 90024, USA
e-mail: ebromley@mednet.ucla.edu

L. Mikesell
School of Communication and Information, Rutgers University,
New Brunswick, NJ, USA
e-mail: mikesell.lisa@gmail.com

N. P. Armstrong
San Francisco Veterans Affairs Medical Center, San Francisco,
CA, USA
e-mail: nikki@hawaii.edu

encourage clients to pursue goals that transcend the patient role (Bromley et al. 2013; Cuddeback et al. 2013; Deegan 1988). Finally, recent studies indicate some ACT clients can be discharged without subsequent clinical decline.

For instance, Rosenheck and Dennis (2001) evaluated 1,617 clients with homelessness and serious mental illness at entry to an ACT program and over 18 months, comparing those discharged in that period with those retained. (Throughout this paper we use the term *discharge* to refer to transition from ACT to lower intensity mental health care). After controlling for sociodemographic and baseline clinical factors, discharged clients had no worse outcomes in mental health, substance abuse, and housing domains than clients who remained in ACT. Salyers et al. (1998), reported similar findings that outcomes among stepped-down clients were comparable to clients retained in ACT; as did Hackman and Stowell (2009) in a naturalistic follow up study. A randomized trial in previously homeless individuals with serious mental illness showed that an ACT-like intervention plus residential housing lowered risk of homelessness compared to residential housing alone over 9 months of post-discharge follow-up (Herman et al. 2011), though differences on other clinical measures have not been reported. McRae et al. (1990) found that 91 % of clients discharged to less intensive services after 5 years of ACT continued in treatment and hospital rates did not increase significantly. A study of the Veterans Affairs' (VA) ACT program, Mental Health Intensive Case Management (MHICM) (Rosenheck et al. 2010), found that only 5.7 % of those veterans discharged from MHICM needed a return to high intensity services. These studies demonstrate that some clients can be discharged from ACT to less intensive services and that clinicians can make sound clinical judgments about which clients are ready.

However, client-level factors that predict success following discharge are incompletely understood. The Rosenheck et al. MHICM-based study (Rosenheck et al. 2010) comparing MHICM clients transitioned to less intensive services to those retained in MHICM did not identify any differences between the groups at MHICM enrollment, but the clients who transitioned had fewer program contacts, higher quality of family relationships, and improved quality of life after 6 months of treatment. Two tools have been developed to assist in the assessment of clients' readiness to discharge from ACT. One, the ACT Transition Readiness Scale (TRS) (Donahue et al. 2012) uses an algorithm to analyze a systematic clinical dataset to assess readiness. The TRS algorithm generates a three-point readiness score (consider for transition, transition readiness unclear, and not ready for transition) through assessment of 7 domains of outcome included in the dataset (housing, psychiatric hospitalization or ER use, psychiatric medication adherence, engagement in routine services, substance abuse, forensic involvement, and any incident of

harmful behavior). Clinician judgments of readiness agreed with the TRS classification in 69 % of clients. In New York State, TRS readiness scores are routinely distributed to clinicians to encourage consideration of discharge. The second tool to assess readiness, the ACT Transition Readiness scale (ATR) developed by Cuddeback (2011), is an 18-item clinician survey that includes 4-point Likert scale items that assess symptoms, functioning, housing stability, treatment engagement, avoidance of risky situations, psychiatric hospital or ER use, abstinence from substances, medication adherence, social support, and insight. Since 2012, the VA has included the ATR scale in the program evaluation survey it collects routinely from MHICM clinicians.

Little is known about the clinical processes (e.g., team decision-making, preparation of clients, collaboration with step-down services) that lead to safe, high-quality discharges. The Salyers et al. study (M.P. 1998) examined transitions to less intensive care within the same ACT team, rather than discharge to other clinical services. Gold et al. (2012) have shown that ACT clinicians increase visit frequency but decrease visit length for clients with longer tenure in ACT, suggesting that even as clients improve, clinicians remain heavily involved in their lives. Chen and Herman (2012), using focus groups and interviews with ACT clinicians in New York State, identify significant clinician skepticism about ACT discharge, including the belief that ACT works best when time-unlimited because clients can be assured they will not experience rejection, and that a high level of service intensity should be continued—not curtailed—when the client appears to have benefited from it. Despite the adoption of readiness scales at a system level in New York State and the MHICM program, no reports have yet described whether, in what ways, and to what effect clinicians incorporate this information into their usual treatment planning.

Understanding ACT clinicians' views of discharge and their decision-making around discharge is critical to anticipate which types of implementation strategies might support ACT discharge while addressing clinicians' priorities. This study examines the perspectives of clinicians on three MHICM teams encouraged to discharge clients who no longer need intensive MHICM-level care. We describe these teams' discharge practices over 18 months, and we present semi-structured interview data from these teams' clinicians. Interviewed clinicians were implementing new discharge practices and engaging in decision-making with their teams and clients about who could be transitioned to less intensive services. Most had recently discharged a client to less intensive mental health services. The study explores the criteria these clinicians use to judge readiness, their perceptions of barriers to discharge, and the client- and team-level factors that influence their discharge decision-making.

Methods

Study Site

Data come from three MHICM teams in the Veterans Affairs healthcare system. MHICM and ACT teams differ slightly in team structure and process. Both teams treat clients with frequent emergency room and hospital use, problems with medication and treatment adherence, functional problems such as homelessness, and serious mental illness diagnoses (i.e., psychotic and severe mood disorders). Both teams use a team-based approach to care, with daily team meetings, team leaders that provide direct patient care, and multidisciplinary expertise (nursing, social work, psychology, psychiatry, vocational support). While ACT clients are cared for by the team as a whole, MHICM clients have a primary clinician (also called a case manager) on the MHICM team, but they nonetheless receive considerable management from the team (e.g., through sharing of care tasks; team-based outings and groups). While MHICM clinicians directly provide many services (e.g., supported employment, substance abuse treatment, cognitive behavioral therapy), MHICM teams may more often than ACT teams broker clients to services. Both teams offer 24-h and weekend coverage, visits during hospitalization, a majority of visits within the community, and a high frequency of visits. MHICM clinicians are encouraged to visit clients 2–3 times per week, and over 90 % of MHICM clients receive weekly or more frequent visits (Hunt et al. 2010, 2012). Visit frequency on ACT teams may be more frequent; for instance, ACT teams in NYC are required to have at least 6 visits per month (Chen and Herman 2012). Fully-staffed ACT teams include one clinician for every 10 clients, but MHICM case managers may carry caseloads of up to 15 clients.

MHICM teams at the three study sites served a total of approximately 240 veteran clients. Team 1 included 8 case managers (i.e., social workers, nurses, or psychologists) and one psychiatrist serving 112 clients; Team 2 included 4 case managers and one psychiatrist serving 50 clients; Team 3 included 6 case managers and one psychiatrist serving 79 clients. At the three sites, beginning in 2009, local leadership began to encourage teams to discharge improved clients to lower levels of care. Within mental health leadership meetings, policies to require higher rates of discharge were considered. As a result, psychiatrists and team leaders on all teams began to give routine encouragement for discharge and to debate about the discharge readiness of MHICM clients within team meetings. No quotas, readiness scales, or facilitative interventions were utilized. Nonetheless, routine encouragement of discharge differed from previous expectations that MHICM treatment would be time-unlimited. The present study was initiated to

track outcomes and clinician perspectives in response to this clinical change. Teams were followed over 18 months, from November 2010 to May 2012. Discharged clients' 9-month outcomes and client perspectives on discharge were also studied and will be reported elsewhere. The West Los Angeles VA Healthcare System Institutional Review Board approved the research protocol.

Clinicians were recruited in two phases. In phase 1, clinicians were recruited through discharged clients. When a MHICM team made a choice to discharge a client, the client was invited to participate in the study. Then, discharged clients provided permission for their clinician (i.e., their primary case managers and psychiatrist) to be approached for enrollment. Six of 7 eligible clinicians agreed to participate in phase 1; two of these clinicians participated in more than one interview, as each had discharged more than one client enrolled in the study. Because of low rates of clinician enrollment through their discharged clients, and in order to more fully explore barriers to discharge, in phase 2, all other clinicians on the three teams were directly invited to participate in an interview whether or not they had discharged a client. Nine additional clinicians agreed to be interviewed. Overall, of the 21 clinicians on the 3 teams, 15 participated in interviews, providing 18 total interviews. Ten of the 15 participating clinicians had discharged a client during the study period (though not all of their clients enrolled in the study), and 5 had not discharged a client. Participating clinicians included all disciplines (social work, nursing, psychiatry, psychology) and a proportionate sampling of all 3 teams (6 of 9 clinicians from Team 1; 3 of 5 clinicians from Team 2; 6 of 7 clinicians from Team 3). Clinicians had between 1 and 8 years of experience working in MHICM.

Semi-structured Interviews

A researcher who was not a member of the clinical team conducted interviews in order to encourage exploration of views that may run counter to the team opinion. Interviewers (EB, LM, NPA) asked clinicians who had discharged a client to describe why each client was being discharged, how the discharge decision was made, and what facilitated and hindered the discharge. Interviewers asked all clinicians to describe whether and why they agreed or disagreed with the concept of ACT discharge, the kinds of clients who are ready or not ready for discharge, whether and in what manner the clinician discussed discharge with clients, and their views on processes that could support discharge.

Data Analysis

To inductively explore clinician interview data on the discharge process, two analysts (EB, LM) used ATLAS.ti

to thematically code narrative data using iterative techniques of constant comparison and grounded thematic analysis (Maxwell 2005; Patton 2002). Analysts' codes distinguished descriptions of the discharge process, descriptors of clients, and general descriptions of the MHICM intervention. Analysts explored content-driven relationships between codes and thematic similarities in text across codes to identify the most frequently mentioned and the most highly elaborated concepts (Ryan and Bernard 2003). The resultant thematic categories, as described below, were then applied to the entire dataset in order to cross-check and develop themes and to identify disconfirming cases and text segments. Cross-case comparison was used extensively with clinicians who had and had not discharged clients to identify differences in perspective, which are noted below where they were identified.

Results

Based on review of the literature and discussions with local team leaders, we anticipated teams would discharge approximately 20 % of their caseload, or 49 clients, over the period of 18 months. Clinicians discharged substantially fewer clients than anticipated. Teams discharged a total of 21 clients to lower levels of care (9 %) over 18 months: 13 % of the caseload from Team 1, 4 % from Team 2, and 5 % from Team 3. Of the 21 clinicians on the 3 teams, 11 were directly involved in discharging a client. In comparison, Rosenheck et al. (2010) reported 9.2 % of MHICM clients receiving care between 2002 and 2006 were transitioned to lower levels of care; and 16.6 % of MHICM clients were discharge for any reason in 2011 (Hunt et al. 2012).

Attitudes Toward Discharge Policies

All clinicians agree that a well-implemented policy of discharge to lower levels of care would increase the value of the MHICM intervention. Thirteen clinicians spontaneously describe the advantages of improving a team's ability to discharge stable clients. Clinicians most often describe discharge as a strategy to ensure that the program serves the population of clients who could most benefit. As one clinician (ID12) says:

I think it's reasonable to discharge people from MHICM. I think otherwise the danger is it will become just some sort of mildly supportive program that extends off into the indefinite future, whereas if patients can be discharged, I think the ideal would be that they have obtained some sort of stepped up level of social functioning and also stepped up level of

Table 1 Clinician-identified barriers to discharge

Barrier	Representative quote
Concerns about future stability	"[Clients are] afraid that they may decompensate....and that's really hard to predict, if in fact they are going to do well or notMaybe [they're well] because of all our services...and if we remove that, they're going to decompensate So that's always a huge concern. ...[y]ou don't know how to address that [with clients] because you don't know for sure either."
Uncertainty about the management of disengaged clients	"[W]e have a lot of veterans who don't make any changes. At all. And that's not a requirement. They don't have to make a change because sometimes they're doing the best they can, just by even getting up in the morning. But we have some who don't necessarily utilize our services the way they could. And so those veterans [can be discharged]"
Disagreement about who decides	"[T]he people who pushed for the discharge don't know the particular clients as well as the person who works with them on a regular basis."
Perception of clients' reluctance	"We try to make it not sound like a negative that they're being discharged."

responsibility for their care and they don't need something as intense as MHICM...the ideal would be that the patient has incorporated some of the MHICM teachings and programs such that they can do things on their own.

However, many clinicians report that their clients do not meet this description. Those who did not discharge clients describe readiness for discharge as more hypothetical than actual. One clinician (ID14) says, "I mean, I could imagine that we have patients that are quite well, and taking their medications, and going to their appointments without reminders, and accomplishing what they want, personally, and then being able to transition them out of MHICM." Another (ID7) says, "If I ever had somebody at that point, I would have no problem letting them go on," and continues, "I've heard of [clients ready for discharge]; I just haven't really observed them a lot." A third (ID8) agrees that it is a good idea to discharge clients, "who are appropriate for the transition. Most of our guys are really not ready for a transition." Asked to explain further, the clinician says, "I mean, it hasn't really happened. If and when it does, I think that'll be a good thing when we're able."

Barriers to Discharge Implementation

As listed in Table 1, clinicians describe 4 concerns that impede discharge: (1) concerns about future stability, (2) uncertainty about the management of disengaged clients, (3) disagreement about who should make final decisions about discharge, and (4) a belief that clients will be reluctant to be discharged. Overall, the clinicians experience discharge as an ambivalent, risky, and challenging process that feels injurious to clients and that may have negative consequences.

Concerns About Future Stability

Stability is the most common reason given for discharge and the most commonly-mentioned indicator of discharge readiness. Clinicians define stability as an ability to take medications, to come to appointments, to maintain housing, to avoid violence or danger, to stay out of the hospital and jail, to be sober from drugs and alcohol, and to be working or engaging in a valued social role. Clinicians often equate stability with independence: “she had pretty much reached the level of care that she didn’t need us anymore” (ID3). Or, “Essentially he was independent on virtually everything.... He went to his various appointments independently. He lives at home with an extended family [who are] very supportive.... And he would go to visit his primary psychiatrist...once a month. And he was very motivated to work.” (ID11) As one clinician (ID3) says, stability implies that the client no longer needs MHICM-level care: “Generally we make [the determination of discharge readiness] based on their current level of functioning and how long they’ve had it. So if he’s able to function independently, [such as] he’s living independently on his own for quite a while with no problems, able to maintain his home, provide his basic necessities and is engaged with other activities and other clinicians, then we kind of look at if he actually needs our care, what we’re doing for him.” Clinicians’ definitions of stability correspond to the criteria assessed in readiness scales (Cuddeback 2011; Donahue et al. 2012).

While clinicians could readily recognize stability, they worried most about whether a client could remain stable without MHICM. One clinician (ID15) identified this as the “biggest concern” for both clients and clinicians in discharge decision-making. When this clinician discusses discharge with clients,

they’re afraid that they may decompensate. They’re afraid that they may not do well – and that’s really hard to predict, if in fact they are going to do well or not – and since they’re already doing so well, that old saying, ‘it ain’t broken, don’t fix it.’ Maybe [they’re well] because of all our services; that’s why they’re

doing so well. And if we remove that, they’re going to decompensate and they’ll go back to the hospital So that’s always a huge concern. It’s hard to tackle because you don’t know how to address that because you don’t know for sure either.

Clinicians struggle with the unpredictability of the future in discharge decision-making, and they are minimally reassured by the reality of present stability. They describe clients who appeared stable but then quickly decompensated; clients may appear ready for discharge but then “kind of unravel” (ID14) and need to be rehospitalized. As one clinician says (ID16), even earning a college degree while in MHICM is, “not a sign of stability”: “it shows initiative, it shows motivation, but yet, the next week the person might end up being hospitalized.” As another clinician (ID5) says, “We had someone who was discharged who was far more functional than [most other clients] we discharged her and a year later she was back in [MHICM] after being in the hospital a couple of times and we were shocked. She hadn’t been hospitalized in 9 years. So, what that taught me was anyone could be benefitting more than we’re realizing.”

In concept and practice, this perception of unpredictability undermined discharge decision-making because clinicians express a strong sense of responsibility to prevent clinical decline. One clinician (ID2) describes a client who appeared ready for discharge: “You know, what’s weird is the whole time I had him, he’s been pretty stable, and then about a month or two ago, he had a decompensation where he started being more delusional, and he had more rapid speech....And nothing had changed. He was taking his meds the same.” She learned that, “I guess that happens about once every year, year and a half or so. And so that’s why we don’t discharge him.” Many clinicians imagine worst-case scenarios: “I think the fear from the MHICM team is that if that happens and he’s not in MHICM, he could, like, lash out at someone, or have a run in with the law or something.” (ID2). A fourth clinician (ID3) describes a client who could decline substantially: “it’s possible that she could regress and go back into being homeless again, losing her apartment ... and [be] back to square one.” Only one clinician (ID13) accepts this risk of clinical decline as an opportunity for the client to learn. That is, “he will probably get into some trouble [after discharge]. He may lose his housing. I wouldn’t be surprised....And he may relapse.” After discharge, “he’s going to have to be more independent, basically, and maybe suffer the consequences of poor choices when he doesn’t do good.”

Uncertainty About the Management of Disengaged Clients

Disengagement was the second most common rationale for discharge. The disengaged client was described as

sufficiently stable yet not interested in pursuing the progress that the team recommended. For instance, this clinician (ID13) says a client is, “a little bit ambivalent about whether he really wants to check his life and get sober,” and “he was really kind of uncooperative, sometimes, with our efforts to try to steer him in that direction.” Similarly, this clinician describes a discharged client as in conflict about treatment goals, as he was “meeting resistance in getting what he wanted done, which wasn’t always seen by the team as productive.” Another clinician (ID5) says, “I never had the sense that we were somehow central to what was going on for him.” That is, “I think he had the idea that we were there, but he didn’t really make use of our relationship.” These clients were not in crisis but they were not as well as the team thought they could be. Clinicians interpreted disengaged clients’ lack of progress as a sign that they were not benefiting from MHICM.

Clinicians had trouble deciding whether the disengaged client was appropriate for discharge. Clinicians felt the clients could achieve much more yet felt powerless to affect this. One clinician (ID8) says without hesitation that the program needs to discharge clients who do not make progress. The client, “enjoys the weekly visits but he’s not really working on any goals. He has his goal, he’s not working on them and when I try to work with him, he resists it and focuses on something else.” Nonetheless, the clinician had not discharged the client. Another (ID3) is less certain when to set limits with clients who do not focus on progress, as the clinician believes that MHICM’s mission is to serve clients who do not or cannot advance. The clinician says,

we have a lot of veterans who don’t make any changes. At all. And that’s not a requirement. They don’t have to make a change because sometimes they’re doing the best they can, just by even getting up in the morning. But we have some who don’t necessarily utilize our services the way they could. And so those veterans – I mean, if they don’t want to take our suggestions – which is fine – and we see that they’re actually not trying to make an effort in any way at all... Then we’re more detrimental to them than we actually are helping them.

Other clinicians echo this equivocation, such as a clinician (ID13) who debated with her team but ultimately concluded that a disengaged client should be discharged. That is, “he wasn’t putting in the same amount of commitment” to improvement as he could, and the team, “saw that he wasn’t progressing, as we saw that we really weren’t doing anything for him to help him move along, and that we thought, okay, MHICM is not really [helping]. He doesn’t need it so much.” Another clinician (ID12) concurs that these cases raise difficult questions that have ambiguous answers: “I don’t think

[the client] and his case manager always agreed on things...which is not necessarily, you know, it’s not a bad thing, but I’m not sure the net day-to-day benefit was such that MHICM was absolutely required for him, so at that point it was an okay thing for him to leave MHICM.”

Disagreements About Who Should Decide

While stability and disengagement can be rationales for discharge, clinicians say discharge decision-making is ultimately handled case-by-case, which introduces new sources of ambivalence. Clinicians rely on subjective criteria. Discharge, “feels like a positive, good kind of ...I mean, I really have very little ambivalence about discharging him” (ID5); or, “I was pretty convinced once he was discharged that this was probably the right thing for him” (ID11); and, “I personally would have been happy to continue working with him, but I also feel ... the decision that he was ready for discharge is appropriate” (ID1). One clinician (ID2) summarizes evaluating discharge readiness as, “not a hard and fast rule. It’s just how I’m interacting with them, their diagnosis, [and] their social support.”

Clinicians disagree about who should ultimately decide about discharge. While most clinicians feel that “the clinician who knows the patient best” (ID5) should have the final decision, one clinician (ID14) strongly disagrees: “I think it, obviously, should be a team decision because sometimes I think that a case manager might be emotionally... you know, like, they just want that person off their caseload because they’re a pain in the neck.” Another (ID7) hopes to outsource the decision: “the doctors have to call the shots.” While all clinicians value team consultation, this did not always generate consensus. One clinician (ID1) says that, “the people who pushed for the discharge don’t know the particular clients as well as the person who works with them on a regular basis.” Another (ID3) agrees, that “sometimes the psychiatrists have thought that the patient should be discharged, and the case manager was like, ‘no.’ It’s usually because the psychiatrist will see him once a month ... and we see him weekly and we see those little things,” that the psychiatrist does not. This clinician continues that it is part of the case manager’s job to take charge of the discharge evaluation. She says, “some members are like, ‘we need to get rid of him, and we need to get rid of him now,’ and so you have to really advocate for your patient. You should be like, ‘I know the patient; it’s my patient; I’ve worked with him the longest. I know what the best transition for him is....That’s just part of what you have to do.’”

Clients’ Reluctance

Finally, all clinicians express worries that discharge would violate clients’ preferences. Clinicians describe clients

feeling rejected, abandoned, or frightened. As one clinician (ID2) says, “if we really bolster them, and get them to where they’re [looking for work], and then we, kind of, let them go, there might be feelings of abandonment.” Reflecting on various discharges, one clinician (ID14) says, “for each one of the patients, it’s been a really emotional, you know, disconnect for them. I mean, they really feel connected to MHICM. They really feel that this is valuable to them. They appreciate the visits every week. They appreciate having people check up on them. And they appreciate somebody who’s trying to motivate them, take a class, you know, just reminders.” As a second clinician (ID10) says, “Our clients that are actually really performing well in MHICM and have improved and have become more independent are really penalized because they’re thrown out of MHICM.” Clinicians struggle to articulate what clients might gain from discharge. As one (ID3) says, “We try to make it not sound like a negative that they’re being discharged.” This clinician (ID5) does not sound confident: “I would say the potential for positive impact would be perhaps his sense of being more independent.” This clinician thinks, “we need to figure out a way to describe it to the patients.”

Facilitation: ACT Clinicians’ Role

As the above narratives reveal, an important barrier to discharge decision-making is clinicians’ investment in the uniquely tailored role they play with clients, a critical component of which is to work closely with clients to support independence from *within* MHICM. In a rehabilitation model of ACT, the clinicians’ role is to supply the client with the skills and structure to move from a state of dependence to a state of less need, at which point discharge to less intensive services is appropriate (Deegan 1988). In contrast, these MHICM clinicians describe their clients as *both* dependent and independent, as needing intensive support at times and being able to do much on their own at others. Clinicians describe calibrating their intervention through attunement to the client’s clinical status in a manner that we call *facilitation*. This clinician (ID3) says her job is, “doing assessment and constantly looking at their strengths and weaknesses and talk[ing] to the team about them.” She says, “We assess all the time, like everyday. I mean, every time we see them—once a week, or twice a week—we’re constantly assessing how they’re doing, what’s going on.” Clinicians describe this role as central to their understanding of the MHICM intervention.

Many clinicians anticipate that the facilitation role cannot or will not be assumed by others after discharge. As one clinician (ID8) explains,

That’s the whole idea of MHICM: frequency of visits, close monitoring, looking at labs, educating.

You’re not going to get that from outpatient mental health [clinic] here. At best you’re going to get, like, once a month for your injection.... So I think for somebody like him, you might lose him through the cracks. And you might not, well, you might end up with him having a hospitalization where it was not really – an unnecessary hospitalization – if he’s not closely followed.

Clinicians perceive that they play a central role in clients’ lives. As clinician (ID2) says, “a lot of them have been in this program for so long, and they sort of know this is where they come every week to see their case manager, who a lot of them think of as their friends, or their go-to person. Whenever they have a problem with anything, whenever anything springs up, they know they can come to us.”

Rather than viewing withdrawal of the MHICM intervention as a means to support independence, clinicians describe encouraging independence from within MHICM. A clinician (ID16) describes pulling back support because she felt she was, “enabling [the client] a little bit.... and so my concern was that we didn’t want to make her more dependent and more need our services when she was actually doing very well.” Like the clinicians studied by Neale and Rosenheck (2000), clinicians describe setting limits with clients who request more help when they can do for themselves. But they also sometimes work to have clients accept their own limitations. One clinician (ID1) describes a client who often abruptly decides to move from his structured living facility to an independent living situation. “He’s comfortable at the Board and Care ... but he knows that he could ... live outside... but I personally wouldn’t push. I decided it’s not a good thing to push him to live independently because he tends to isolate,” when living alone. These descriptions mirror the conclusion of Appelbaum and Le Melle that, “supporting patients and building relationships ... were the preferred mechanisms for promoting treatment goals” in ACT (p. 463) (Appelbaum and LeMelle 2008).

Overall, clinicians describe the alternatives to MHICM in bleak terms, as akin to abandonment and exile (Drake and Deegan 2008). As one clinician (ID7) says, any client can benefit from MHICM because, “usually there’s something somewhere that’s really helping them a lot of times it’s just assistance with this med compliance issue and also just some accountability and that someone out there gives a damn. So then that kind of like keeps them—So they don’t slip off, end up nowhere.” This clinician contrasts this clinical role to a discharge model of “moving out the top” and finds that the latter does not describe her clinical experience:

[W]e get the ones that just keep falling in the hospital or can’t, like, get by without ending up in the

hospital. That's what we do. We try to keep them out of there. That's kind of just what we do. If we can get somebody and move them through and get them to take their meds and start to see that they can do things in life and you know, then they can move out the top. But it's like very rare. All the time with me, they always seem to go out the bottom eventually, like back to, backwards you know. They end up at the hospital, they end up in [a locked facility], you know but, but where they might have been in there two years ago, they've had two years in the community..... So yeah, having them move out the top is a weird thing around here.

Clinicians perceive that their usual work entails fortifying clients' tenuous grasp on independence and agency, and they fear the forces that might pull them into dependency or isolation.

Many clinicians accept discharge by imagining that it need not sever the client's ties to MHICM: the client can call on the clinician and can return to the program at any time. As one clinician (ID7) says, "I'd want [the clients] to understand that they—we're still here, whatever kind of—just because they're not in the program doesn't mean they can't stop by or whatever." Most clinicians imagine keeping an open door for clients after discharge. This clinician (ID3) emphasizes the continued availability of the program, "So [discharge] wasn't cold turkey." This clinician says that, "the good thing [about discharge] is that ... if something happens, we can come back in right away, right? We can re-enroll immediately. You're already in the program. There's no wait list for you. We can come and start back all over again." The clinician continues that, "we tell them if there's ever a need that you need us in the future we'll be there."

Discussion

Recent research demonstrates that some individuals with serious mental illness can safely transition out of Assertive Community Treatment (ACT) and other intensive outpatient mental health treatment programs like MHICM. Increasingly, many of these programs are exploring strategies to encourage discharges, sometimes with limited guiding evidence or through processes that may be arbitrary (Braslow 2013; Hansen 2013). This study of clinicians from three MHICM teams identifies considerable concern among clinicians regarding the implementation of discharge. MHICM clinicians consistently support the concept of discharge, concurring with the views of clinicians studied by McGrew and colleagues (McGrew et al. 2003), who rated "never discharging a client" as the least

important characteristic of an ACT team. As a result of routine encouragement alone, about half of these MHICM clinicians did facilitate the discharge of a client to less intensive mental health services over the 18-month study period. These clinicians nonetheless perceive considerable complexity and substantial risk in the practice of discharge. They identify those clients who are stable and those who are disengaged as the most ready for discharge, though they implement these discharges ambivalently. Moreover, they perceive ACT as a buffer from neglect and isolation. They see discharge as a negative event for clients, a conclusion supported by recent data from Cuddeback et al. (2013), and they work to obscure or disregard its finality.

Chen and Herman (2012), in a qualitative study of clinicians in non-VA ACT programs, similarly found that clinicians had multiple concerns about discharge. Like the ACT clinicians in their study, these MHICM clinicians worry that other providers will not be sufficiently responsive to clients' needs. Both sets of clinicians describe treatment and discharge planning in ACT as extremely individualized and express skepticism about "one size fits all" approaches. They also agree that they have difficulty determining the right time for discharge, that clients can decompensate unexpectedly, and that clinicians support independence from within intensive treatment. However, while the ACT clinicians preferred to consider ACT as a time-unlimited intervention, these MHICM clinicians describe discharge as a helpful practice. Perhaps because Chen and Herman primarily used focus groups while the present study used one-on-one interviewing, unlike the ACT clinicians they studied, these MHICM clinicians reflect at length on the team dynamics that can interfere with discharge, such as uncertainty about who should make discharge decisions.

Many of these MHICM clinicians express a conflict about the ethical principle of *distributive justice*: the need to allocate scarce resources in a fair manner in order to serve a group of patients, but without harming their own specific patients (Baumrucker et al. 2012; Holmvall et al. 2012). Clinicians describe MHICM as a cherished intervention for a highly vulnerable group. They see discharge as one way to further their mission by transitioning clients who no longer benefit and allocating clinical care to those who need it most. Yet, clinicians fear that discharge poses incalculable risks to their current clients, alluded to this with dramatic metaphors such as slipping through the cracks, ending up nowhere, going out the bottom, slipping off, and going back to square one. Clinicians weigh their worries about current clients against the needs of the community of clients like them. Interestingly, the clinicians studied by Chen and Herman (2012) appear not to have commented on this responsibility to a community of clients. VA clinicians may have a more tangible sense than

non-VA clinicians of the group of severely mentally ill veterans served by their own VA medical center.

In their usual clinical role, which we have called *facilitation*, these MHICM clinicians also weigh justice concerns. They question the equitable allocation of their clinical attention in an array of scenarios, not just discharge. For instance, they balance the desire to protect their clients from harm with the utility of letting clients face risks autonomously. Salyers and colleagues (Salyers et al. 2011) describe this ACT work through a contrast of coaching and parenting. In the coaching model, clients are viewed as capable. Clinicians have positive expectations of clients and do not intervene until clients have made their own choices. In the parenting model, clinicians work to protect clients by intervening early and making decisions for them. As Salyers and colleagues point out, coaching, because it discourages early intervention, may drift into a form of neglect: clinicians may fail to help clients avoid painful consequences. On the other hand, parenting can lead to paternalism and coercion: it authorizes assertive interventions that aim to eliminate the potential for failure. These tensions may be inherent to the ACT intervention, given that Stein and Test remark on this same dynamic in 1980, recommending that an, “ongoing treatment program must be organized so that it can provide a flexible system of delivery that gives the patient only what he needs when he needs it and where he needs it” (Stein and Test 1980) (p. 396). Some of these clinicians seem to embrace the parenting role, viewing themselves as responsible for minimizing risk and interpreting a clinical decline as an indication that discharge was a mistake.

While readiness scales focus on symptomatic and functional assessment, these clinicians’ concerns—Will stability be maintained? Is this disengaged client benefiting? Who is best able to decide? And, how will the client feel about it?—are debated with reference to personal knowledge gained through close relationships. As the clinician quoted above (ID3) says, “we see those little things,” that others may not see. The relationship is described as a value in itself, not a means to a clinical end. This clinician (ID5) describes a client who disengaged from the program and was discharged. Asked whether she believes the client benefited from the program, she says,

You know, he looks back fondly-when he first was here [in the MHICM program]. His case manager ... did a lot of, like, going on walks with him and really trying to engage his thoughts around his family. I think there was maybe some insight that [he] developed early on about [this]. It was maybe the first time he’d ever had someone really talking to him about his life and his family and things like that in that kind of way rather than just being the [one] who’s always a

problem.... he maybe developed more of a sense of himself ... through the efforts of our team.

Making no mention of improved clinical symptoms or functioning, this clinician suggests that the essential value of MHICM is relational: inviting, establishing, modeling, and protecting the beneficent relationship with a client. The clinical services literature indicates that the nature of therapeutic relationships in ACT can impact not only discharge decision-making (Mohamed et al. 2010) but also ethical and therapeutic decision-making, and ACT effectiveness (Angell et al. 2006; Brodwin 2011; Chinman et al. 1999; Fakhoury et al. 2007; Killaspy 2007; Williamson 2002).

Some scholars have described clinicians’ emphasis on the relational elements of ACT as efforts to counter the deprivation faced by many individuals diagnosed with serious mental illnesses. As Brodwin says, ACT clinicians “cannot solve the housing scarcity, the devastated economy, or the gang violence prevalent where their clients live....[and] their efforts run up against the fragmentation, scarcities, and organizational illogic that characterize post-asylum care as a whole” (p. 3) (Brodwin 2013). Other scholars express concerns that discharge policies reflect broader bureaucratic efforts to construct, “clinics without relationships” (np) (Hansen 2013) where clients move through clinical programs, “just as a shopper moves through a store” (p. 804) (Braslow 2013). The present findings, however, illustrate that the relational elements of ACT may be more robust and inherent than these formulations imply.

Behavioral health interventions that aim to improve the quality of mental health care are most effective and sustainable when they respond to the extant beliefs, practices, and priorities in specific healthcare settings (Damschroder et al. 2009; Donahue et al. 2012; Stetler et al. 2006). These findings indicate that clinicians and administrators working to implement discharge policies may want to take into account clinicians’ valuation of the relational elements of ACT, their concerns about distributive justice, and their skills in facilitating independence. In addition, the findings point to several specific strategies for supporting discharge practices. First, rating scales may be best seen as decision-support tools that can augment rather than replace clinical judgment. These clinicians spontaneously identified many of the criteria used in readiness scales. These scales may not address clinicians’ concerns about the future trajectory of stability, the management of disengagement, or clients’ preferences but they may facilitate case-by-case team discussions about readiness. At the same time, the routine use of standardized scales may ease some clinicians’ anxieties about discharge by introducing some benchmarks to be applied in all cases.

Second, some ACT clinicians may need to reconsider their tendencies toward paternalism (Moser and Bond 2009). In team-based settings that offer supervision and support, ACT clinicians can routinely reconsider their tolerance of the risk that clients may experience clinical difficulties. These conversations may allow clinicians to link their usual facilitative role encouraging independence to the possibility of discharge. In consultation with clients, other clinic teams, and systems of care, clinicians can make distributive justice-related concerns explicit. Recovery-oriented clinical trainings can help clinicians remain focused on eliciting and working toward client-identified treatment goals. Clinicians may be encouraged to collect follow-up data on discharged clients to test their assumptions about discharge readiness. Such data may also provide clinicians with narratives that assist them in discussing discharge with clients.

Third, ACT teams can consider strategies to address and alleviate the loss that discharge entails. In this paper we use the word discharge (rather than graduation, flow, or transition) to foreground the fact that leaving an ACT team means the loss of a therapeutic home. Clients often cannot choose their reenrollment, and the events that may trigger it are usually distressing if not tragic, such as a suicide attempt. Some of these MHICM clinicians do seem to want to camouflage these facts. Euphemistic terminology may complicate efforts to communicate to clients about discharge, as it can suggest the process is less disruptive than it is, and it may reinforce the ambivalence about closure that is a key complexity of the decision-making process. However, teams can take seriously these concerns about closure by approaching discharge as a process that can unfold over time. For instance, like the transition process in use on ACT teams in New York State (Donahue et al. 2012), assessing discharge readiness can be seen as the beginning of a process that may lead to discharge. Over months, clinicians and clients can rehearse potential risks of discharge, identify new sources of support, and process common feelings (e.g., fear, anger). Clients and clinicians can decide whether and how discharged clients will maintain a relationship with the ACT team (e.g., via alumni groups, occasional visits, attending some outings). If this process goes well, the team can then set a discharge date. This process may allow clients and clinicians to reflect on the work they have accomplished, and it may increase their confidence in the discharge decision.

Limitations

These conclusions are necessarily provisional as a result of limitations in the data set. Because of differences in process and structure between ACT and MHICM (e.g., use of primary case managers in the latter) not all of the findings may be relevant to non-VA teams with high fidelity to the

ACT model. In addition, these MHICM clinicians' views on discharge may be shaped by the relatively secure access to services within the VA system compared to some non-VA mental health treatment sites. Data are also limited because we sampled from three study sites only. These MHICM teams may differ from other MHICM teams with regard to the severity of clients' illnesses, the availability of step-down services, and team dynamics. Finally, these data come from a small, non-random sample of clinicians. Findings may underestimate the barriers to discharge, since clinicians were initially eligible to participate only after discharging a client. Those clinicians with the least experience and the most reluctance about discharge may have been least likely to participate.

Acknowledgments This material is based on work supported by the Department of Veterans Affairs, Veterans Health Administration, Office of Research and Development, Health Services Research & Development (HSR&D) Quality Enhancement Research Initiative (QUERI) grant #10-196. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government. The authors wish to acknowledge Dawn Glover, Amy N. Cohen, Stephen R. Marder, Jonathan Sherin, and Charles Nguyen for invaluable assistance with the conduct of the research. The authors would also like to thank Marcia G. Hunt, Daniel Bradford, and Gary S. Cuddeback for substantial support in conceptualizing strategies for responding to findings.

Conflicts of interest The authors declare that they have no conflict of interest.

References

- Angell, B., Mahoney, C. A., & Ishibashi Martinez, N. (2006). Promoting treatment adherence in assertive community treatment. *Social Service Review*, 80(3), 485–526.
- Appelbaum, P. S., & LeMelle, S. (2008). Techniques used by assertive community treatment (ACT) teams to encourage adherence: Patient and staff perceptions. *Community Mental Health Journal*, 44(6), 459–464.
- Baumrucker, S. J., Stolick, M., Mingle, P., Oertli, K. A., Morris, G. M., & VandeKieft, G. (2012). The principle of distributive justice. *American Journal of Hospital and Palliative Medicine*, 29, 151–156.
- Braslow, J. T. (2013). The manufacture of recovery. *Annual Review of Clinical Psychology*, 9, 781–809.
- Brodwin, P. (2011). Futility in the practice of community psychiatry. *Medical Anthropology Quarterly*, 25(2), 189–208.
- Brodwin, P. (2013). *Everyday ethics: Voices from the front lines of community psychiatry*. Berkeley and Los Angeles: University of California Press.
- Bromley, E., Gabrielian, S., Brekke, B., Pahwa, R., Daly, K. A., Brekke, J. S., et al. (2013). Experiencing community: Perspectives of individuals diagnosed as having serious mental illness. *Psychiatric Services*, 64(7), 672–679.
- Chen, F. P., & Herman, D. B. (2012). Discharge practices in a time-unlimited intervention: The perspectives of practitioners in assertive community treatment. *Administration and Policy in Mental Health*, 39(3), 170–179.

- Chinman, M., Allende, M., Bailey, P., Maust, J., & Davidson, L. (1999). Therapeutic agents of assertive community treatment. *Psychiatric Quarterly*, *70*(2), 137–162.
- Cuddeback, G. S. (2011). Transitions from assertive community treatment to less intensive services. A project report for the Ohio department of mental health and the health foundation of greater Cincinnati. Chapel Hill, North Carolina: Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill.
- Cuddeback, G. S., Shattell, M. M., Bartlett, R., Yoselle, J., & Brown, D. (2013). Consumers' perceptions of transitions from assertive community treatment to less intensive services. *Journal of Psychosocial Nursing and Mental Health Services*, *51*(8), 39–45.
- Damschroder, L. J., Aron, D. C., Keither, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*, *4*(50), 1–15.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, *11*(4), 11–19.
- Donahue, S. A., Manuel, J. I., Herman, D. B., Fraser, L. H., Chen, Henian, & Essock, S. M. (2012). Development and use of a transition readiness scale to help manage ACT team capacity. *Psychiatric Services*, *63*, 223–229.
- Drake, R. E., & Deegan, P. E. (2008). Are assertive community treatment and recovery compatible? Commentary on "ACT and recovery: Integrating evidence-based practice and recovery orientation on assertive community treatment teams". *Community Mental Health Journal*, *44*(1), 75–77. doi:10.1007/s10597-007-9120-9.
- Fakhoury, W. K., White, I., Priebe, S., & PLAO Study Group. (2007). Be good to your patient: How the therapeutic relationship in the treatment of patients admitted to assertive outreach affects rehospitalization. *The Journal of Nervous and Mental Disease*, *195*(9), 789–791.
- Gilmer, T. P., Stefancic, A., Ettner, S. L., Manning, W. G., & Tsemberis, S. (2010). Effect of full-services partnerships on homelessness, use and costs of mental health services, and quality of life among adults with serious mental illness. *Archives of General Psychiatry*, *67*(6), 645–652.
- Gold, P. B., Jones, D. R., Macias, C., Bickman, L., Hargreaves, W. A., & Frey, J. (2012). A four-year retrospective study of assertive community treatment: Change to more frequent, briefer client contact. *Bulletin of the Menninger Clinic*, *76*(4), 314–328.
- Hackman, A. L., & Stowell, K. R. (2009). Transitioning clients from assertive community treatment to traditional mental health services. *Community Mental Health Journal*, *45*(1), 1–5. doi:10.1007/s10597-008-9179-y.
- Hansen, H. (2013). Weighing the evidence: Risks and benefits of participatory documentary in corporatized clinics. *Social Science & Medicine*. doi:10.1016/j.socscimed.2013.05.030.
- Herman, D. B., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L., & Susser, E. S. (2011). Randomized trial of critical time intervention to prevent homelessness after hospital discharge. *Psychiatric Services*, *62*, 713–719.
- Holmvall, C., Twohig, P., Francis, L., & Kelloway, E. K. (2012). Applying justice and commitment constructs to patient-health care provider relationships. *Canadian Family Physician*, *58*(3), e159–e165.
- Hunt, M. G., Levinson, C., Ackles, A., Martin, Albina, Morrissey, J., Raymond, Denise, & Hoff, R. (2012). Mental Health Intensive Case Management (MHICM) in the Department of Veterans Affairs: The Fifteenth National Performance Monitoring Report, FY 2011. Report Veterans Health Administration. West Haven, CT: Northeast Program Evaluation Center (NEPEC).
- Hunt, M. G., Resnick, S. G., Castrodonatti, J., D'Amico, M., Levy, E., Martin, A., & Desai, R. (2010). Mental Health Intensive Case Management (MHICM) in the Department of Veterans Affairs: The Thirteenth National Performance Monitoring Report. Report Veterans Health Administration. West Haven, CT: Northeast Program Evaluation Center (NEPEC).
- Killaspay, H. (2007). Assertive community treatment in psychiatry. *British Medical Journal*, *335*(7615), 311.
- Kreyenbuhl, J., Buchanan, R. W., Dickerson, F. B., & Dixon, L. B. (2010). The schizophrenia patient outcomes research team (PORT): Updated Treatment recommendations 2009. *Schizophrenia Bulletin*, *36*(1), 94–103. doi:10.1093/schbul/sbp130.
- Maxwell, J. A. (2005). *Qualitative research design: An interactive approach* (2nd ed.). Thousand Oaks, CA: SAGE Publications.
- McGrew, J. H., & Bond, G. R. (1995). Critical ingredients of assertive community treatment: Judgments of the experts. *The Journal of Mental Health Administration*, *22*(2), 113–125.
- McGrew, J. H., Pescosolido, B., & Wright, E. (2003). Case managers' perspectives on critical ingredients of assertive community treatment and on its implementation. *Psychiatric Services*, *54*(3), 370.
- McRae, J., Higgins, M., Lycan, C., & Sherman, W. (1990). What happens to patients after 5 years of intensive case management stops? *Hospital & Community Psychiatry*, *41*(2), 175–179.
- Mohamed, S., Rosenheck, R. A., & Cuedon, T. (2010). Who terminates from ACT and why? Data from the national VA mental health intensive case management program. *Psychiatric Services*, *61*(7), 675–683.
- Monroe-DeVita, M., Teague, G. B., & Moser, L. L. (2011). The TMACT: A new tool for measuring fidelity to assertive community treatment. *The Journal of the American Psychiatric Nurses Association*, *17*(1), 17–29.
- Moser, L. L., & Bond, G. R. (2009). Scope of agency control: Assertive community treatment teams' supervision of consumers. *Psychiatric Services*, *60*(7), 922–928.
- Neale, M. S., & Rosenheck, R. A. (2000). Therapeutic limit setting in an assertive community treatment Program. *Psychiatric Services*, *51*, 499–505.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications Inc.
- Rosenheck, R. A., & Dennis, D. (2001). Time-limited assertive community treatment for homeless persons with severe mental illness. *Archives of General Psychiatry*, *58*(11), 1073.
- Rosenheck, R. A., Neale, M. S., & Mohamed, S. (2010). Transition to low intensity case management in a VA assertive community treatment model program. *Psychiatric Rehabilitation Journal*, *33*(4), 288–296.
- Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, *15*, 85–109.
- Salyers, M. P., Masterton, T. W., Fekete, D. M., Picone, J. J., & Bond, G. R. (1998). Transferring clients from intensive case management: Impact on client functioning. *American Journal of Orthopsychiatry*, *68*(2), 233–245.
- Salyers, M. P., Stull, L. G., Rollins, A. L., & Hopper, K. (2011). The work of recovery on two assertive community treatment teams. *Administration and Policy in Mental Health*, *38*, 169–180.
- Slade, E. P., McCarthy, J. F., Valenstein, M., Visnic, S., & Dixon, L. B. (2012). Cost savings from assertive community treatment services in an era of declining psychiatric inpatient use. *Health Services Research*, *48*(1), 195–217.
- Stein, L. I., & Test, M. A. (1980). Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, *37*, 392–397.
- Stetler, C. B., Legro, M. W., Wallace, C. M., Bowman, C., Guihan, M., Hagedorn, H., et al. (2006). The role of formative evaluation

- in implementation research and the QUERI experience. *Journal of General Internal Medicine*, 21, S1–S8.
- Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment. *American Journal of Orthopsychiatry*, 68, 216–232.
- Velligan, D., Mintz, J., Maples, N., Xueying, L., Gajewski, S., Carr, Heather, & Sierra, C. (2013). A randomized trial comparing in person and electronic interventions for improving adherence to oral medications in schizophrenia. *Schizophrenia Bulletin*, 39(5), 999–1007.
- Williamson, T. (2002). Ethics of assertive outreach (assertive community treatment teams). *Current Opinion in Psychiatry*, 15, 543–547.