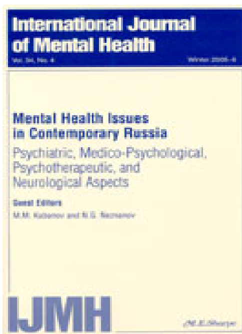

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Resource Group ACT (RACT) – A Review of an Integrative Approach to Psychoeducation of Individual Families Involving the Patient

Ulf Malm,[1] Lennart Lundin,[2] Pia Rydell,[2] Tommy Nordén,[3] and Torsten Norlander[3,4]

[1]*Sahlgrenska Academy, Institute of Neuroscience and Physiology, University of Gothenburg, Gothenburg, Sweden*

[2]*Psychosis Division, Sahlgrenska University Hospital, Gothenburg, Sweden*

[3]*Center for Research and Development, Evidens University College, Gothenburg, Sweden*

[4]*Department of Clinical Neuroscience, Karolinska Institutet, Solna, Sweden*

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Abstract: The implementation of evidence-based treatment methods for patients with severe mental illness must be deeply rooted in clinical case management and an ACT service delivery model, where the patient user can be involved in shared-decision making in the cycle of "assess-plan-act-follow up-feedback". In order to prepare and empower the client for the new role as a participating decision maker in the management of his/her own illness, various psychoeducational strategies are employed. The original 'family unit in the community' of the Integrated Mental Health Care program (IC) was developed step-by-step through practice-based evidence and clinical expertise to include significant others as resource persons in a so called Resource Group, and therefore the program was subsequently named as "Resource group ACT" (RACT). The service delivery by community mental health teams involving the patient by way of resource groups as well as the psychoeducational treatment conditions involving both individual patients and family groups may contribute to the understanding of how RACT added clinical effectiveness in functioning and satisfaction.

Keywords psychoeducation; family; severe mental illness; user involvement; clinical case management; ACT; clinical microsystems

INTRODUCTION

The original 'family unit in the community' of the Integrated Mental Health Care program (IC) [1] was developed step-by-step through practice-based evidence and clinical expertise to include significant others as resource persons, and a new concept, the 'resource group', was introduced in the beginning of the 2000's [2]. The IC program has been given a number of different names but since the content continues to be developed with ever greater emphasis

Address correspondence to Ulf Malm, Sahlgrenska Academy, Institute of Neuroscience and Physiology, University of Gothenburg, Gothenburg, Sweden; E-mail: ulf.malm@neuro.gu.se; ulf.malm1@gmail.com

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on the central position of the patient through the participation in the resource group it has recently been decided to call the generic methodological program the "Resource group ACT" or "RACT". Furthermore, the findings of a new qualitative study identified the resource group as a major key component of RACT [3].

The RACT program is a person-centered flexible assertive community treatment approach delivered through a novel mechanism: a resource group clinical microsystem for each patient [4].

METHODS

Service Delivery

In the RACT program shared decision making was carried out by a clinical microsystems approach [5] within a resource group for the individual client. A clinical microsystem is defined as a small group of people (including health professionals, patients, and families who work together in a defined setting on a regular basis (or as needed) to create care for discrete subpopulations of patients. As a functioning unit it has clinical and business aims, linked processes, and a shared information and technology environment and produces care and services that can be measured as performance outcomes. The clinical microsystem evolves over time and is often embedded in larger systems or organizations. The resource groups of the program provide care for patients with severe mental illness. The group meets quarterly for about two years. The shared decision making procedures are supported by psychoeducation about illness management and workbook sheets for analysis, systematic problem solving, communication, and planning. RACT was managed by a workbook manual shared by service users and professionals.

The core of the service delivery practice of community mental health, the community mental health team [6], may be enriched and augmented by resource groups implementing the ACT model built upon the orthodox US ACT model [e.g., 7, 8], or its revised versions like the UK Assertive Outreach model [9] or the Dutch Flexible ACT [10]. Some original key ingredients of ACT have been further developed in the RACT practice: 'assertive engagement mechanisms' by shared decision making procedures involving the patient, 'the support system' included in the clinical management by the resource group teamwork.

As a rule, most patients receive service by their resource groups acting on an intensive clinical case management level. If the state of the patient service user requires a more intensive intervention her/his resource group acts at an ACT-level and the ACT primordial ingredients such as shared caseload, daily planning and review, 24-hour availability and more frequent visits are applied. This notion corresponds to the ideology of the Dutch flexible ACT model.

The Outcome Research Design

The efficacy of the RACT program for functioning and user satisfaction in patients with schizophrenic disorders are supported by two randomized controlled trials with a two year follow-up [11] and a five-year controlled follow-up study [4], respectively. The program as a whole has been scientifically researched and field-tested in a number of countries each of which

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has adapted the approach to its own particular system for providing health care and welfare support [e.g., 11–16].

RESULTS

The outcomes are summarized as a GRADE [17] summary of findings comparing RACT, the Resource group ACT approach, with good clinical practice programs in the treatment of schizophrenic disorders (Table 1).

There were significant improvements in the primary outcome measure, the GAF-Disability scale, for the changes from baseline over two and five years favoring the RACT group. The effect sizes for the differences in change between RACT and Rational Rehabilitation programs at two and five years were 0.52 respectively 0.79. Durability of the two-year outcomes was also demonstrated.

The five-year findings for primary outcomes were improved social functioning and satisfaction with care for the Resource group ACT (RACT) group. These results are in accord with findings of a recent meta-analysis [18]. There is now up-to-date research evidence in favour of the RACT integrative approach as being an effective program to implement community mental health services for patients with schizophrenic disorders. The studies included in the meta-analysis all show outcomes in terms of large effect sizes. There were six RCT studies and 11 observational studies and the follow-up periods ranged from one to five years. Participation in the RACT program resulted in improved social skills functioning, increased well-being, as well as a reduction of symptoms.

DISCUSSION

Psychoeducation of Individual Families Involving the Patient

In the RACT program psycho-education involving the patient in optimal combinations of cost-effective biomedical and psychosocial interventions is employed throughout and implemented

TABLE 1
GRADE Summary of Findings Comparing RACT with Best Clinical Practice [16]

Research design	*Studies*	*Outcomes*	*Effect size Cohen's* d	*No of participants*	*Quality of evidence*
Primary	Two-year RCT [11]	The DSM-IV split-GAF Function rating scale	.52	84	High
		UKU-Consumer satisfaction scale	.55		
		The DSM-IV split-GAF Symptoms rating scale	.15		
	Five-year RCT [4]	The DSM-IV split-GAF Function rating scale	.79	66	Moderate
		UKU-Consumer satisfaction scale	.82		
		The DSM-IV split-GAF Symptoms rating scale	.07		
Secondary	Meta-analysis Six two-year RCTs [18]	Function	.93	400	High
		Wellbeing	1.16		
		Symptoms	.57		

Effect sizes are in-between comparisons between RACT and Best Practice in the RCT trials.

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by resource group task forces. Treatments employed include effective drug strategies targeted to changing symptom profiles and specific pharmacological strategies, such as patient control of flexible doses or a clozapine program (Mike Firn personal communication 2011-02-28), illness-specific psycho-education, family interventions, person-centered psychological strategies for residual or emerging symptoms such as CBT for depression and psychotic symptoms, and living skills training for daily life. In contrast to the Illness Management and Recovery (IMR) [19], an over-arching strategy of the RACT approach is to involve the whole social network in the clinical management.

A major difference between this RACT/IC integrative flexible approach and the currently best community-based practices is the extensive psychoeducation, training and consultative support for patient users and significant others (families and other informal caregivers, family practitioners, primary care nurses, social workers and people from other agencies in the community). Thus, one objective is empowerment of the patient user to be become a 'heroic client' [20]. Informal caregivers are then to become active participants in all aspects of the personal recoveries.

In the RACT practice there is an emphasis on training mental health professionals in the competent application of a range of assessment and intervention strategies that have been demonstrated to be those most effective and currently available for most of the common disorders found in the community. By various psychoeducational procedures the professionals transfer their know-how to their patients in accordance with individual needs and personal goals (person-centered care).

In the RACT program there is also psychoeducation through group methodological supervision for the case managers on their practice patients, including training to use applications by forms of tracking and recordings of ongoing processes [21]. Assessments of the competence of therapist skills and program fidelity are conducted at yearly audits to ensure that core skills are maintained, and that a high degree of consistency is achieved throughout the service [22].

Efficacy and Effectiveness

The recent meta-analysis [18] and a critique paper [23] concluded that the Resource Group ACT 'demonstrated through the scientific research literature to be efficient and effective treatment strategies for people experiencing severe mental illness'.

In a recent Cochrane analysis on psycho-education for schizophrenia involving individuals and groups in 44 hospital-based trials [24], it was concluded that 'psycho-education does seem to reduce relapse, readmission, encourage medication compliance, as well as reduce the length of the hospital stay'.

The two programs compared in our two primary outcome studies (Table 1) were both provided by community mental health teams employing psychoeducation by multiple family groups without user participation similar to those of multiple family group therapy [25] and the S.A.F.E. program [26]. Only the RACT program comprised psychoeducation involving the participation of the patient user and through individualized resource groups as well. By this design we think that we have met the challenge of carrying out 'more applicable research in this area aimed at fully investigating' the promising psychoeducational approach [24]. The novelty

of the RACT approach of combining psychoeducation with patient participation may be one treatment condition explaining the added clinical effectiveness of RACT.

Service Delivery and Implementation

At an organizational system level, the Swedish welfare adapted RACT approach version seeks to involve all agencies in an integrated balance of highly specialized community psychiatry, addictions services, emergency hospital bed services, primary care, and municipal social services (Fig. 1).

Any team which integrates functions will meet challenges where the wider care system is less integrated. Brokering of services from social care and primary care should not involve unnecessary delay and dispute. Preferably there should be written agreements of services and protocols guided by local needs sustained by financial agreements. The community mental health team provides a stable platform for the professional practitioners but cannot function as an island within a dysfunctional system.

Ideology

The RACT approach is anchored in the disability model of mental health care ideology, integrating key elements of the medical model and considering the risk-management model by zero tolerance for losing a client engaged in the program [27] (Table 2).

And 'the role of the consumer' has become well defined as being a knowledge-empowered collaborative partner of professional carers in the management of clinical decision making.

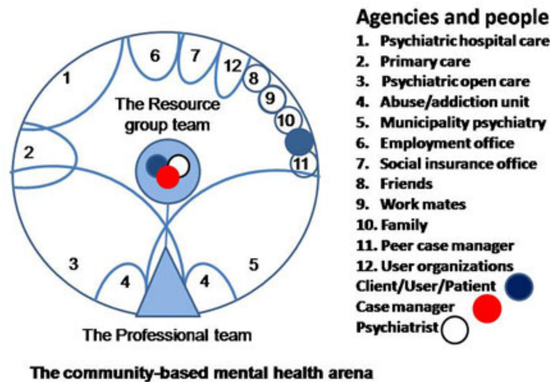

FIGURE 1 The organizations concerned (bows) and patient, family and significant other persons (circles) and the community arena where service delivery is by a multidisciplinary professional team and resource groups for each patient. The basic building block in community psychiatry in the Swedish context is a multidisciplinary community mental health team of professionals from both the municipality and the county: a social-psychiatric team. The RACT program is a person-centered flexible assertive community treatment approach delivered through a novel mechanism: a resource group clinical microsystem for each patient. The program is an integrated health technology approach to the systematic coordination of general and behavioral health care.

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TABLE 2
Three Mental Health Care Ideologies

	The medical model	*The disability model (RACT)*	*Risk-management model*
Focus	Emphasizes mental health as an illness requiring treatment	Based on normalization concepts where users are perceived as citizens making their own decisions	Perception of users as a danger and threat to public safety
Policy and service	Based on hospitals, evidence-based drug treatments and psychological therapies with doctors as key decision makers	Argues for user empowerment, autonomy and enforces citizen's rights with a long-term objective of the user in charge of her/his illness	Perception of social problems in terms of risk and reduced solidarity
Frames of users	In terms of their diagnosed mental illness. Accords users a passive role as 'patients'	Individualized and tailored with a coordinated support network of public, voluntary and private actors to meet users' individual priorities and preferences. User-generated support and services	Emphasizes steering strategies and increased control strategies. Perception that risks can be managed and a focus on ideas that risks have a cause, and failure to control means someone is to blame.

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Within the constraints of their abilities, each person is trained to participate as a full member of the resource group team, through psycho-educational strategies e.g., motivational interviewing, stress management, systematic communication training, problem analyses, and systematic problem solving as well as crisis management.

People with severe mental illnesses are all unique. The more well timed and co-ordinated person-centered treatment and illness management intervention options that are available, the more successful the outcomes and personal recoveries will be.

CONCLUSION

The original 'family unit in the community' of the Integrated Mental Health Care program (IC) was developed step-by-step through practice-based evidence and clinical expertise to include significant others as resource persons, and a new concept, the flexible "Resource group ACT" (RACT).

Our review indicates that the psychoeducation of individual patients involving the patient by clinical microsystem resource groups (RACT) can add effectiveness to any program for patients with severe mental illness.

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