Rare Encounters:
Medical Students Give Assertive Community Treatment Team Visits Rave Reviews

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ABSTRACT

Objective: For 8 years, Albert Einstein College of Medicine students have worked with the Bronx Psychiatric Center Assertive Community Treatment (ACT) team. We relate the medical student ACT team experience using the ratings and words of the students themselves. We describe the history, evolution, and structure of this novel program.

Methods: Third-year medical students (N = 120) spent 1 day of their 6-week psychiatry clerkship visiting patients with the multidisciplinary ACT team. At the end of the clerkship, they were asked to complete a voluntary, anonymous survey of the entire clerkship experience, one component of which was the ACT team experience. A Likert scale of 1–5 was used (5 = excellent and 1 = unsatisfactory). The ACT program was initiated in October 2007, had a 3-year hiatus, and was restarted in 2011.

Results: Fifty-five of the students completed the survey. Seven of the students gave no numerical rating to the ACT team experience and wrote only very favorable comments. In the remaining 48 evaluations, 61% gave the ACT team experience an excellent rating; an additional 30% gave it a very good rating. The students expressed their enthusiasm for this program, calling it a "great" experience. Other student comments included the following: "Good example of how patients can have continuity of care and stability." "A MUST. It was worth seeing how patients live and interact in home environments." "Incredible experience seeing the role psychiatrists play in the community." "One-of-a-kind experience that is different from anything else in medical school."

Conclusions: ACT teams are an underutilized medical student teaching tool. It is hoped that this review will encourage other schools and program directors to adopt an ACT team training model.

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Assertive community treatment (ACT) is a team treatment approach designed to provide comprehensive community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness, such as schizophrenia. ACT services are available 24 hours per day, 365 days a year. Beginning 12 years ago, the Bronx Psychiatric Center ACT team invited third-year medical students to join ACT team staff (psychiatrists, social workers, nurses, peer specialists, and vocational counselors) on their rounds. Over 8 years (due to a hiatus), clerkship students spent 1 day of their psychiatry rotation going into the Bronx with the ACT team to see patients and their families. Our program, to the best of our knowledge, is unique. We know of no other medical student program that offers an ACT experience. While medical students rotate through inpatient, outpatient, and consultation-liaison settings, the richness of the ACT experience is rarely encountered. We were surprised to hear and read how many students felt medical student training is deficient in teaching the biopsychosocial model. Other medical professionals have commented on the need to put more emphasis on this model.[1,2] The ACT team experience appears to partially correct for this deficiency. During a visit, the team reviews the patients' diagnoses and treatments, identifies environmental and psychological stressors and triggers, and observes their social circumstances. Also, by visiting their residences, students are exposed to the rich social fabric of the Bronx, New York, one of the most ethnically diverse counties in the United States.

The Evolution of the ACT Team as an Educational Component of the Clerkship

For clerkship directors considering the adoption of an ACT team training program, it is helpful to review the history of our program. In the spring of 2006, 2 Albert Einstein College of Medicine (AECOM) first-year medical students requested a summer research project on the treatment of the homeless mentally ill. When our negotiations with 2 homeless shelters fell through, and coincident with the hospital's concern about metabolic syndrome in outpatients, we organized a pilot project to study metabolic syndrome in 2 Bronx Psychiatric Center (BPC) outpatient populations: ACT team patients and patients attending the BPC outpatient clinic in the west Bronx. Expedited institutional review board approval was obtained, based on the survey being part of a hospital report, to evaluate the prevalence of metabolic syndrome at BPC. It was not considered an independent research study.

Clinical Points

- Assertive community treatment (ACT) teams are an underutilized medical student teaching tool.
- Many students indicated that medical school training is deficient in teaching the biopsychosocial model.
- Medical student exposure to ACT teams may partially correct the deficiency in biopsychosocial training.

The medical students spent 6 weeks, twice a week, administering a 17-item quick Weight, Activity, Variety and Excess (WAVE) Screener[3] that assesses diet and exercise habits and beliefs about weight and health. Measurements of weight, height, and waist circumference were taken and body mass index was calculated. When the students visited ACT team patients, an ACT team psychiatrist/faculty member accompanied and supervised them. Basic lifestyle counseling was provided with the use of WAVE-oriented counseling sheets. Half the outpatients surveyed were ACT team patients. When surveying ACT team patients, the students worked with the ACT multidisciplinary team members—the first time that AECOM students ever worked with the team. They received overall supervision from an ACT team psychiatrist and from the director of medical student training, the clerkship director, and other AECOM faculty in the Departments of Psychiatry and Epidemiology.

As the program progressed, the students and supervisors noticed how productive it was to conduct surveys and counseling in the patients' own homes. Many patients gave permission to open their refrigerators—which were often filled with junk food—and this facilitated dietary counseling. Visits to the patients' homes also highlighted their difficulties with exercise. For example, an extremely obese patient who lived in a fifth-floor walk-up apartment had limited options for exercise, as well as socialization. She was essentially confined to her apartment.

This summer project was a valuable learning experience for the students. The ACT team visits were well suited to conducting clinical and research surveys and giving informed lifestyle counseling. The students presented posters of their findings at the 2007 American Psychiatric Association Institute on Psychiatric Services meeting in New Orleans, Louisiana.[4–6] They were interviewed, and their work was reported in *American Psychiatry News*.[7]

In October 2007, due to the success of the summer project, an ACT team component was incorporated into the BPC clerkship. At the time, the BPC clerkship was 1 of approximately 7 psychiatry clerkship sites training 20–25 students per clerkship, with 8 clerkship rotations per year. The BPC clerkship took 4 to 5 students per rotation. It was based at the inpatient hospital but offered students a variety of clinical experiences: outpatient, consultation-liaison, and child psychiatry rotations and emergency department call. When the ACT team component was added, it was conducted 1 full day—usually the third or fourth week—each clerkship, and all students in the BPC clerkship attended. Unlike some of the other clinical rotations, the ACT team did not grade the students.

On the chosen day, the students would spend 30 minutes with an ACT team psychiatrist, reviewing the ACT team goals and functions, followed by hour-long rounds conducted at the ACT team offices in the BPC outpatient clinic. The students then went into the community with a psychiatrist and another ACT team member and were driven in a hospital car from patient visit to patient visit. They visited from 3 to 6 patients, whose apartments, homes, or supportive residences were in all sections of the Bronx, reflecting a broad range of socioeconomic conditions. The team chose stable patients who were due for follow-up visits, and all patients and families gave verbal consent before being seen. Most of the patients suffered from psychotic illnesses. The team met with families when available, took patients to medical and other appointments, and called 911 when hospitalization was required. At the end of each visit, the team expressed gratitude to the patients and family members for relating their stories and educating the students. We planned to have debriefing sessions with the students at the end of the day, but this was not always possible due to time constraints.

The program ran for 4 rotations through May of 2008. At that time, the program was suspended due to the concerns of 2 senior BPC psychiatrists about the safety of students in the community, although there were no incidents or complaints from students. Some ACT team members believed that students were at less risk on the ACT team than on an inpatient unit. The program was reinitiated in October 2011 because of several factors including (1) the strong support of a peer specialist on the ACT team, who supported the team when they successfully appealed to the executive director to reestablish the visits, and (2) the work of the clerkship director, who elicited a compromise solution: students would be apprised of the possible risks and informed that their participation was voluntary. Their final clerkship grade would in no way be contingent upon participation.

The program resumed and has run since 2011 with fewer students attending each clerkship; the size of the clerkship decreased from 4 students (in 2007) to 2 (in 2013) due to the downsizing of the hospital. In all, approximately 120 students have made ACT team visits. Only 2 have declined, due to religious reasons. There have been no safety incidents. On 1 visit, 2 students experienced "some anxiety" while meeting with a loud patient with bizarre delusions who painted the walls of his residence with "scary" images. This visit, like all student visits, was debriefed with the clerkship director and ACT team psychiatrist, and changes were made in the protocol for selecting patients. There was only 1 instance wherein a patient expressed dissatisfaction with seeing students.

METHODS

At the end of the clerkship, each student was asked to complete a voluntary, anonymous evaluation form distributed at the BPC clerkship site. The ACT component was included

within this much broader evaluation form. The students were also required by AECOM to complete a computer evaluation of the BPC clerkship and faculty. Feedback from these computer evaluations was not returned to the clerkships for at least 6 months, and this was one reason that a separate evaluation was distributed at the end of the clerkship—so the clerkship director could institute immediate changes in any program if necessary. It is also of note that the AECOM evaluations did not collect data on the ACT team.

All clerkship rotations and seminars were rated on a Likert scale of 1–5 in which 5 is excellent, 4 is good, 3 is adequate, 2 is marginal, and 1 is unsatisfactory.[8] We received 55 of these evaluations. Seven of the students did not give a numerical rating but only wrote very favorable comments. The remaining 48 evaluations had the following percentage distribution: 5 (61%), 4 (30%), 3 (6%), and 1 (2%). The students were specifically asked to write comments about the ACT team experience, and it was reiterated that the ACT team was a novel medical student training experience, which may have elicited the writing of long comments. We present many of these comments in the next section.

RESULTS

The ACT Team Experience in the Words of Third-Year Medical Students

The following items were taken from the local BPC clerkship evaluation (see Methods) that addressed all clerkship programs and seminars, which was distributed during the last week of the clerkship. The question used to elicit the information was the request for comments.

In most cases, students have given brief, positive feedback such as "great experience" or "excellent experience." A few have been critical: "I did not feel like the visit benefitted my education" or "Speaking to patients in the community was useful, and it was interesting to see them in the context of their own homes. However, waiting in the car for 2 hours straight at the end of the day was not enjoyable." In general, the student comments were overwhelmingly positive. We believe that the following comments best convey the student experience:

> "Physicians and students encounter patients on a daily basis in clinics and hospitals, where we see their medical and psychological conditions first hand. It is well accepted that no textbook or class could substitute for this opportunity. But, while patients bring their biology and psychology everywhere they go, they cannot bring their neighborhoods, their families, and their homes. We have to question them about this and, unfortunately, infer a great deal. How well do we do this when most physicians come from a completely different socioeconomic background than our patients? Probably rather poorly, leaving us with a textbook understanding of their social situations. On the ACT team, this is less of a problem. You see your patients in their own homes with their own families in their own environments, and, at least for a few minutes, you enter their environment yourself. You gain a sense of what patients' lives are like in a way you simply never would otherwise. It's a valuable opportunity and also somewhat disconcerting when considering that in times past, home visits and the insight that comes with them were the rule not the exception."

> "The experience really added a lot to the overall clerkship. It was very interesting to see how people lived and see them in a home environment that they controlled independently. I saw the homes of schizophrenics and one borderline [patient], and it helped put images to the lecture/textbook details. And, it is important to note that I felt safe and in control at all times. The patients handled having another person around well too."

> "A great experience that most students do not get."

> "Very cool experience."

> "It was great to be able to visit the patients in their home environment."

> "Every third-year medical student should have this experience."

> "It was an interesting side of psychiatry that I did not even know existed."

> "Good example of how patients can have continuity of care and stability."

> "A MUST. It was worth seeing how patients live and interact in home environments."

> "Incredible experience seeing the role psychiatrists play in the community."

> "One of a kind experience that is different from anything else in medical school."

> ". . . visit is very eye-opening to the lives of psychiatric patients who are not hospitalized."

> ". . . one of the most interesting aspects of this clerkship. We met multiple patients in their homes and really learned the impact of a biopsychosocial approach."

> "This was an awesome experience. The staff was excited to teach us and introduce us to their patients. It was a very unique experience to be able to go to patients' homes and see how they live. Definitely should be part of the clerkship, more visits would be welcome."

> "It was particularly helpful to see patients in their home environments, truly contributing to the biopsychosocial model by seeing their quality of life. It was also eye-opening to see the different apartments in the Bronx and the living situations of patients. I will never forget some of the patients we saw, in particular, seeing the side effects of antipsychotics, the refrigerator contents of another patient, and the chance to talk to these patients. I think the ACT team visit is an important aspect of psychiatry that all students should experience."

"Not only did we see a significantly more functional group of patients than at BPC, but we also saw directly how social and environmental factors play a role in outpatients' course of illness and recovery."

"Really appreciated the chance to see how patients with chronic mental illness live in the community. It was interesting to see how social circumstances affect mental illness. Also very interesting to be exposed to the ACT team model, since we are used to patients coming to see us. Great experience."

"Loved seeing patients in their own environments. I think you get a much fuller picture of their illness and the effect it has on their lives and those around them, their loved ones . . . love the interdisciplinary nature of the team."

"Not only did we see the patients at home, but we took some of them to run errands. This helped me to see how skilled these outpatients are at doing their ADLs [activities of daily living] and how they do things like make decisions at a grocery store . . . how they balance (or don't balance) their budgets. Most of the patients are on SSI [supplementary security income], and this element really makes you appreciate the nonpsychiatric barriers that they also have to deal with. Overall, a very valuable part of the experience . . . that should be included in the clerkship from now on, more than once if you could fit it into the schedule!"

". . . medical education often pays a great deal of lip service to the abstract ideas mentioned above (knowing one's patients as whole people, understanding their social environment, being a dedicated physician in the service of one's patients, etc). In practice, however, this frequently amounts to little more than rhetoric, with activities like lectures, discussion groups, and evaluations making up the bulk of time and effort devoted to developing these crucial values and ideas. This is probably not so much a shortcoming in medical education itself as a product of the way medicine is usually practiced today. Nevertheless, the ACT team visits were a refreshing exception to this rule. I would strongly recommend that future medical students be given the opportunity to observe them."

DISCUSSION

The BPC medical student ACT team program is unique. It offers medical students—who are trained on inpatient wards and in outpatient clinics—an opportunity to observe patients with severe mental illness living outside the hospital and interacting with family and residential staff. It enables them to work with a multidisciplinary team and teaches assessment and treatment skills in community psychiatry. The ACT team can provide a "rounded, 3-dimensional view of mental disorders,"[1(p496)] demonstrating the broader psychosocial factors influencing the onset and course of psychosis and seeking "a balanced biopsychosocial view of illness."[2(p4)] Most of the medical students who rotated through BPC did not enter the specialty of psychiatry. However, these skills are translatable to other fields and are used in primary care specialties, such as family medicine and geriatrics. Work with the multidisciplinary team can be seen as a form of interprofessional education, preparing students for collaborative care.[9]

As the ACT team grew and evolved over the course of 8 years, with a 3-year hiatus, many structural problems were identified and resolved, including the concern regarding student safety. The Bronx is a dense, urban area with unique safety issues. Other schools and programs will have different safety problems to address. It is notable that the inpatient and outpatient supervising psychiatrists held different views on safety concerns than the ACT team psychiatrists, who have extensive experience working in the community and who can identify and treat high-risk situations early. For other schools planning to initiate such a program, the training directors will need to work closely with the supervisors and administrators at the hospital or clinic where the ACT team is based.

The third-year medical student ACT team experience evolved from a highly productive first-year medical student summer project. There have been no electives or summer projects conducted with the ACT team since 2007. Montefiore/AECOM psychiatry residents, who rotate through BPC, have no mandatory ACT team experience at our facility or any other AECOM facility. There is discussion at AECOM about initiating a community psychiatry fellowship program. Perhaps this proposed new program can forge a more formal connection between the BPC ACT team and AECOM trainees—both medical students and residents.

There were reasons that less than half the students completed the evaluations, and one was time. The students were required to complete a comprehensive computer evaluation of the clerkship, which was disseminated by the medical school. As the BPC form was voluntary, there were students who put their time and effort into the evaluation that was required to receive a final grade. A second problem was that, while the evaluations were intended to be anonymous (and students were told no information would be shared prior to the submission of their final grade), when there were only 2 students evaluating, they were concerned we could identify them. Another problem reported by the students themselves was that they would "forget" the details of the seminars and rotations and thus we should rate each experience immediately after the event. Unfortunately, we did not have the resources to do so, but other programs may be able to do this type of rating process.

One major feature of the BPC program is the enthusiasm of the ACT team and program director for community psychiatry. All of the coauthors are unabashed ACT team advocates, and this enthusiasm may be a reason for the high ACT team ratings and the positive student comments. Other ACT teams need to confirm our findings. They could try variations on what we have done, as there are many unanswered questions concerning the structure of the program. For example, what is the optimal student ACT team exposure time? Is it important for a psychiatrist to

be present during the student ACT team visits? How will the nonpsychiatrist members of the ACT teams receive the students and which team members will participate? When and how should the students evaluate the experience?

Despite these unknowns, we are optimistic that there are other ACT teams that would welcome students and obtain similar encouraging results. ACT teams remain an underutilized medical student teaching tool, and it is hoped this article will encourage schools and program directors to adopt an ACT team training model.

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