

Assertive Community Treatment

Authored by
mohammad looti

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Assertive community treatment, or ACT, is an intensive and highly integrated approach for community mental health service delivery. ACT programs serve people whose symptoms of mental illness result in severe functional difficulties that interfere with their ability to achieve personally meaningful recovery goals in several major areas of life: working, having friends, living independently, and so forth.

Definition

The defining characteristics of ACT include:

- a clear focus on those participants (clients) who require the most help from the service delivery system;
- an explicit mission to promote the participants' independence, rehabilitation, and recovery, and in so doing to prevent homelessness and unnecessary hospitalization;
- an emphasis on home visits and other in vivo (out-of-the-office) interventions, eliminating the need to transfer learned behaviors from an artificial rehabilitation or treatment setting to the "real world";
- a participant-to-staff ratio that is low enough to allow the ACT "core services team" to perform virtually all of the necessary rehabilitation, treatment, and community support tasks themselves in a coordinated and efficient manner--unlike traditional case managers, who broker or "farm out" most of the work to other professionals;
- a "total team approach" in which all of the staff work with all of the participants, under the supervision of a qualified mental health professional who serves as the team's leader;
- an interdisciplinary assessment and service planning process that typically involves a psychiatrist and one or more nurses, occupational therapists, social workers, substance abuse specialists, vocational rehabilitation specialists, and certified peer specialists (individuals who have had personal, successful experience with the recovery process);
- a willingness on the part of the team to take ultimate professional responsibility for the participants' well-being in all areas of community functioning, including most especially the "nitty-gritty" aspects of everyday life;
- a conscious effort to help people avoid crisis situations in the first place or, if that proves impossible, to intervene at any time of the day or night to keep crises from turning into unnecessary hospitalizations; and
- a promise to work with people on a time-unlimited basis, as long as they demonstrate a continuing need for this highly intensive and integrated form of professional help.

In the array of standard mental health service types, ACT is considered a "medically monitored non-residential service" (Level 4), making it more intensive than "high intensity community based services" (Level 3) but less intensive than "medically monitored residential services" (Level 5) on the widely accepted LOCUS utilization management instrument.

Early developments

ACT was first developed during the early 1970s--the heyday of deinstitutionalization, when large numbers of patients were being discharged from state-operated psychiatric hospitals to an underdeveloped, poorly integrated "nonsystem" of community services characterized by serious "gaps" and "cracks." The founders of the approach were Leonard I. Stein, M.D., Mary Ann Test, Ph.D., Arnold J. Marx, M.D., Deborah J. Allness, M.S.W., William H. Knoedler, M.D., and their colleagues at the Mendota Mental Health Institute, a state hospital in Madison, Wisconsin. Also known in the literature as the Training in Community Living (TCL) project, the Program of Assertive Community Treatment (PACT), or simply the "Madison model," this innovation seemed radical at the time but has since evolved into one of the most influential service delivery approaches in the history of community mental health. The original Madison project received the American Psychiatric Association's prestigious Gold Award in 1974. After conceiving the model as a strategy to prevent hospitalization in a relatively heterogeneous group of prospective state hospital patients, the PACT team turned its attention in the early 1980s to a more narrowly defined group of young adults with early-stage schizophrenia.

Dissemination of ACT

Since the late 1970s, the ACT approach has been replicated or adapted widely. The Harbinger program in Grand Rapids, Michigan, is generally recognized as the first replication, and a family-initiated adaptation in Minnesota also traces its origins to the Madison model. In 1978, the Bridge program at the Thresholds psychosocial rehabilitation center in Chicago, Illinois, became the first big-city adaptation of ACT and the first program to focus on the most frequently hospitalized portion of the mental health consumer population. In the 1980s and '90s, Thresholds further adapted the approach to serve deaf people with mental illness, homeless people with mental illness, people experiencing psychiatric crises, and people with mental illness who had been inappropriately jailed. In British Columbia, an experimental assertive outreach program based on the Thresholds model was established in 1988 and later expanded to additional sites. Outside of North America, one of the first research-based adaptations was an assertive outreach program in Australia.

Other replications or adaptations of the ACT approach can be found throughout the English-speaking world. In Wisconsin, the original Madison model was adapted by its founders for the realities of a sparsely populated rural environment. The Veterans Health Administration has adapted the ACT model for use at multiple sites throughout the United States. There are also major program concentrations in Delaware, Florida, Georgia, Idaho, Illinois, Indiana (home of numerous research-based ACT programs and the Indiana ACT Center), Michigan (home of approximately 100 teams and a professional organization called the Assertive Community Treatment Association), Minnesota, Missouri (home of an exemplary program for homeless people

with co-occurring mental illness and chemical dependence), New Jersey, New Mexico, New York, North Carolina, Ohio, Rhode Island, South Carolina, South Dakota, Texas, Virginia, Australia, Canada, and the United Kingdom, among other places.

Although most of the early PACT replicates and adaptations were funded by grants from federal, state/provincial, or local mental health authorities, there has been a growing tendency to fund these services through Medicaid and other publicly supported health insurance plans. Medicaid funding has been used for ACT services throughout the United States, starting in the late 1980s, when Allness left PACT to head Wisconsin's state mental health agency and led the development of ACT operational standards. Since then, U.S. and Canadian standards have been developed, and many states and provinces have used them in the development of ACT services for individuals with psychiatric disabilities who would otherwise be dependent on more costly, less effective alternatives. Although Medicaid has turned out to be a mixed blessing--it can be difficult to demonstrate a person's eligibility for this insurance program or to find supplemental funding for necessary services that it will not cover--Medicaid reimbursement has led to a long-overdue expansion of ACT in previously unserved or underserved jurisdictions.

System planners have attempted to resolve the implementation problems associated with replicating the original Madison approach in sparsely populated rural areas or with low-incidence special populations in urban areas. A related issue for planners is to determine the number of ACT or "ACT-like" programs a particular geographical area needs and can support. Some promising areas for further development are identified in the section below on "Future of ACT."

Research on ACT

ACT and its variations are among the most widely and intensively studied intervention approaches in community mental health. The original Madison studies by Stein and Test and their colleagues are classics in the field. Another major contributor to the ACT literature has been Gary Bond, Ph.D., who completed several studies at Thresholds in Chicago and later developed a major psychiatric rehabilitation research program at Indiana University-Purdue University at Indianapolis. Bond has been particularly influential in the development of fidelity measurement scales for ACT and other evidence-based practices. He and his colleagues (especially Robert E. Drake, M.D., Ph.D., at Dartmouth Medical School) have attempted to consolidate and harmonize several major currents in this continuously developing area of practice, including:

the different "styles" of service delivery exemplified by PACT in Madison, Thresholds in Chicago, the Dartmouth/New Hampshire model of integrated dual disorders treatment, and other influential programs;

the various modifications of the original ACT approach over the years to maximize its effectiveness with particular service delivery challenges, such as helping consumers to recover from co-

occurring psychiatric and substance use disorders or to obtain and retain competitive jobs through a rehabilitation approach called supported employment; and the increasingly well-organized efforts to help consumers take charge of their own illness management and recovery processes.

ACT as an evidence-based practice

Because of its long track record of success with high-priority service recipients in a wide variety of geographical and organizational settings--as demonstrated by a large and growing body of rigorous outcome evaluation studies -- ACT has been recognized by the United States federal government's Substance Abuse and Mental Health Services Administration (SAMHSA), the Robert Wood Johnson Foundation, the National Alliance on Mental Illness (NAMI), and the Commission on Accreditation of Rehabilitation Facilities (CARF), among other recognized arbiters, as an evidence-based practice worthy of widespread dissemination.

Some critics, notably Tomi Gomory, Ph.D., at Florida State University have argued that ACT is inherently coercive and that the research claiming to support it is scientifically invalid; Test and Stein have replied to this critique, and Gomory, in turn, has answered their reply. Moser and Bond address coercion and the broader concept of "agency control" in a discussion of data from 23 ACT programs.

Future of ACT

The cost-effectiveness of ACT was relatively easy to demonstrate in the early days, when psychiatric hospital beds were more heavily used than they are now. In the years to come, ACT programs will have to continue justifying their comparatively high cost through the use of careful admission criteria and rigorous outcome evaluation. The defining characteristics of the ACT approach continue to be an attractive framework for services to meet the needs of special populations, such as individuals whose psychiatric symptoms get them into trouble with the criminal justice system, immigrants from foreign countries who also struggle with serious mental illnesses, and children and adolescents with serious emotional disturbances. One critical piece of unfinished business in the mental health field is the discovery that people with serious mental illnesses are dying, on the average, 25 years earlier than the general public--often from disorders that are inherently preventable or treatable--and this public health disaster is a critical issue for ACT providers and the people they serve. Another important area for future program design and evaluation work is the use of ACT in concert with other established interventions, such as integrated dual disorders treatment, supported employment, family psychoeducation approaches for concerned relatives, and dialectical behavior therapy for persons with borderline personality disorder. Ironically, the dissemination of separate evidence-based practices, not all of which are easily integrated with each other, has once again made service coordination a serious issue in

community mental health--as it was during the latter part of the 20th century, when ACT was born.

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