

Assertive Community Treatment: A “Living-Systems” Alternative to Hospital and Residential Care

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ABSTRACT

Assertive Community Treatment (ACT) is a widely researched method for serving individuals suffering from severe and persistent psychiatric issues. Endorsed by both governmental and public advocacy groups as an evidence-based best practice, it is generally accepted as a state-of-the-art approach to long-term care. This article describes ACT within a “living-systems” framework. Influenced by the work of Gregory Bateson, it argues that this framework offers a useful epistemological pivot for both understanding the effectiveness of ACT and also how ACT teams can stray from delivering effective treatment. [*Psychiatr Ann.* 2015;45(3):120-125.]



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Psychiatric treatments are starkly divided in intensity. At one end of this divide are psychiatric hospitals, and outpatient treatment is at the other. The lives of many psychiatric patients veer continually between these extremes; when symptoms emerge, they are often placed in hospitals as the only recourse, then discharged to such skeletal outpatient care that another hospitalization becomes inevitable. Programs for Assertive Community Treatment (PACT) and Assertive Community Treatment (ACT) programs aim to bridge this divide. The former term is used by the originators of the model,¹ whereas the latter term is more popularly used today. (This article uses Assertive Com-

munity Treatment, or ACT, to refer to the model.)

ACT programs are often described as a “hospital without walls.”² The model uniquely organizes care so that both the routine and ad hoc communication systems of a hospital are combined with treatment outside of institutions. As occurs with rounds in a hospital, ACT teams meet regularly, often every day, reviewing together each patient’s progress and changing the intensity and type of treatments through tightly coordinated group planning. Also similar to hospitals, these teams communicate with each other throughout the day when needed, responding to crises, to changes in their patients’ needs, and to updates on

interventions. The work of ACT teams is mostly performed in the homes and communities of their patients. These teams use a single-source treatment-delivery model in which most or all of a patient's psychiatric and psychosocial needs are met by its members. Accordingly, ACT programs are multidisciplinary and composed of psychiatrists, nurses, vocational experts, substance abuse specialists, therapists, peer specialists, and professionals with other expertise.

Although often seen as a “step-down” treatment after a hospitalization (similar to a physical rehabilitation program following surgery), ACT programs are, in reality, evidence-based alternatives to hospital and residential care. In fact, the criteria for admission to most ACT programs are designed to provide access for many patients deemed eligible for long-term hospitalization or residential programming. These individuals might be difficult to engage, homeless, at high risk for hospitalization, often in crisis and requiring frequent emergency interventions, and at risk for involvement in the criminal justice system.²

Significant research has been conducted on the effectiveness of ACT programs, the majority of which endorses ACT as increasing patients' ability to function,^{1,3-6} their capacity for alliance-building with clinicians,^{1,2} their chance of attaining a job,^{1,8} and quality of life;^{1,2,4,7} and as decreasing homelessness,^{9,10} hospital admissions and lengths of stay,^{1,3,6,11,12} and substance abuse.^{1,13} In 1999, the Surgeon General's Report on Mental Health¹⁴ endorsed the model as an effective means of helping individuals suffering severe and persistent mental illness, and both the National Alliance on Mental Illness (NAMI)¹⁵ and the Substance Abuse and Mental Health Services Administration (SAMHSA)¹⁶ validate ACT as an evidence-based best prac-

tice. SAMHSA names the use of ACT as one of three indicators of the quality of a state's mental health services.¹⁶

Clearly, a substantial quantity of research supports ACT as effective, and

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it has gained the “seal of approval” as an evidence-base practice. But what is it about this model that works? Proponents of ACT argue that the model is a way of organizing staff and structuring the way services are delivered, not a clinical philosophy aimed toward specific interventions.^{1,2,16} In fact, the best-practice fidelity measures for ACT are formed completely by organizational principles. When teams comply with hiring certain types of experts, conduct team meetings a certain number of times a week, and engage with patients in certain places, they meet fidelity measures.^{2,16} In this light, ACT is an efficient treatment-delivery device, but it is not the treatment itself; metaphorically, it is like a syringe or a capsule, and not the medicine they deliver. I argue below that, whether intentionally or not, the way in which ACT delivers treatment is, itself, a kind of therapy. It is not, in other words, the organizational parts that make up ACT nor any combination of them that gives this model its ameliorative power. Instead, it is the Aristotelian “whole greater than the sum of its parts” that makes ACT effective.

Anthropologist and systems thinker Gregory Bateson¹⁷ provides an epistemological framework for this investigation. Bateson argued that humans approach the world around them from two different stances: either as part of “pleroma” (the nonliving world, such as rocks or other inanimate objects) or as part of “creatura” (the living world, filled with complex and communicative entities that are forever changing within larger systems). From Harry Stack Sullivan,¹⁸ Otto Allen Will, Jr.,¹⁹ and Frieda Fromm Reichmann,²⁰ to R.D. Laing,²¹ the psychiatric profession is not devoid of voices endorsing a more ecological outlook on human experience. However, it is Bateson's precise delineation between pleroma and creatura that gives us the clearest path to understanding the sum-effect of ACT.

A LIVING-SYSTEM MODEL

Anyone who has taken an introductory biology class knows the basic characteristics of living beings. Living beings (1) are complex and multidetermined; (2) are open systems that metabolize energy from the outer world; (3) are responsive to what is occurring around them; (4) grow; (5) produce; (6) adapt; and (7) exist in larger ecologies.²² In Bateson's view, when we have the hubris to apply nonliving-systems criteria to a living system—defining it and labeling it as inert and solitary—we do it a kind of violence and often wreak havoc on that system; it is like treating a rabbit as if it were a brick. But when we participate in the living world with an appreciation for its ever-changing, relational, and communicative nature, we have a greater chance to support its natural tendency toward growth and survival. When built well, ACT programs lean toward a creatura profile, both organizationally and in how they treat their patients as living systems.

TABLE 1.

Service Principles of Assertive Community Treatment Programs

- Specific admission criteria
- Primary service responsibility
- Transdisciplinary team
- Shared caseload
- Comprehensive care
- Intensive services
- *In vivo* services
- Assertive and flexible
- Individualized services
- Open-ended

Adapted from Morse and McKasson.²

This article investigates ACT service principles—the basic means by which programs are measured for fidelity to the model—to illustrate how the sum of these principles can lead to a “living-system” type of care. Here, I put ACT programs to a “living-system test,” showing how their organizational and communication structure is formed by living-system values, and, more importantly, how they are built to provide a kind of care sensitive to their patients as complex living beings. In this sense, ACT is a co-adapting, or co-evolutionary model, one in which the living-systems values of the team result in a living-systems approach to their patients.

The “Whole” of ACT Team Principles

Morse and McKasson² list 13 service principles for ACT programs, the first 10 of which are a summation of the basic core fidelity measures developed by the originators of the model¹ (Table 1), and the latter three described as “emerging” principles. I describe nine of the original principles below (excluding “admission criteria”) depicting them as linked and interrelated.

ACT teams assume primary service responsibility for their patients, provid-

ing all, if not most, of a given patient’s services. This includes 24-hour crisis response conducted by members of the team. Assuming this level of responsibility is what makes ACT teams different from typical case management models, in which an agency or person organizes treatment with outside providers and patients in crisis typically meet with police or external psychiatric crisis teams. Assuming responsibility for all or most of their patients’ needs, ACT teams are transdisciplinary, ideally composed of as many as 10 members, all from different disciplines. Unlike most outpatient case management models, in which one person determines and leads the treatment, these multidisciplinary teams share responsibility for their patients, communicating regularly to remain up-to-date, and are continually modifying treatment based on the changing needs of their patients. A team meets 2 to 5 times per week to review the previous days’ therapeutic engagement with each patient.

Taking on the full responsibility for the clinical care of their patients, and being transdisciplinary and democratic in expertise, ACT teams are comprehensive in their approach to treatment, viewing patients as multidetermined in their behavior and symptoms, and they attempt to simultaneously address a range of issues through the synergy of their expertise. This distinguishes ACT programs from other community providers, who typically approach the gamut of issues in any person’s life (be they family, work, psychiatric symptoms, or substance abuse) as distinct and isolated from one another, and who communicate minimally with one another during treatment.

To achieve comprehensive care, ACT teams meet with their patients regularly during the week to address specific treatment goals, with meetings typically held daily, and sometimes more than once a day. This level of in-

tensity is determined by the patients’ needs, with intensity increasing not only due to acute issues (such as psychiatric crises), but also in response to progressive change (eg, when a patient needs more support as she returns to college).

The majority of the services delivered by ACT teams are conducted *in vivo*, with up to 80% of contacts performed in the community by specialists in different areas of recovery and aimed toward specific goals. Mandated with the goal of working with “difficult to engage” patients, ACT teams are assertive in the sense that ACT teams continue to attempt to make contact and creatively find ways to relationship-build with patients who are difficult to engage; the teams adapt to patients who might not feel comfortable coming to an office or lack the organizational ability to regularly attend scheduled meetings. The outreaches are typically conducted by clinicians with trained expertise. Thus, the purpose of these assertive and flexible outreaches is not to woo patients into office-based contacts, but to engage in therapeutic contacts where the patients are most comfortable. This makes ACT quite different from office-based work, in which therapeutic exchanges only occur within the physical domains of clinics and outpatient offices, and patients who do not come to such settings are seen as “noncompliant” and “treatment resistant.”

Although they are transdisciplinary, well-functioning ACT teams lean toward the psychosocial goal of a patient’s return to their social role. Thus, not only are their interventions conducted *in vivo*, but their goals, too, aim toward reintegration into noninstitutional life. Whereas office-based work aims to achieve similar goals exclusively through symptom relief, ACT teams work toward these goals (sometimes despite ongoing symp-

toms, and always as a target for direct assistance) through job and educational coaching, job searches, and support onsite at school or work.

A transdisciplinary approach in which all or most of a patient's care is delivered by one team that comprehensively addresses multiple issues in a patient's life, assertively engages with patients, is flexible in how treatment is provided, and adapts the intensity of services to a patient's needs leads to services that are individualized. Unlike most outpatient care, in which office-based treatment and groups are geared to categories rather than to individuals (typically, specific treatments and particular diagnoses), ACT contours treatment around the unique needs of each patient.

ACT treatment planning is open ended and long term. Unlike other community-based treatment programs, reaching treatment goals is not an indication that a discharge is imminent. ACT programs remain with their patients, adapting to changes in their lives, until they have recovered to the point of needing only minimal services. In fact, an ACT team might increase its services to a patient who is exhibiting growth, providing extra treatment as a person faces such psychosocial challenges as a return to work, school, or independent living.

When put to a "living-systems" test, ACT programs are organized more like living systems than are typical community-based mental health programs. ACT programs are made up of complex parts that are integrated, rather than disparate entities; readily take in and metabolize information, rather than simply dispensing formulations; are immediately responsive, not routinized; are open-ended (not oriented toward a defined termination) and thus able to adapt and grow in relation to their patients' changing needs, rather than providing care as if on an assem-

bly-line; and live and function in the social ecologies that surround them, rather than being sequestered from the surroundings in clinics, private outpatient settings, and hospitals. This living-systems way of organizing care offers a model in which clinicians can deliver services that are sensitive to their patients as living systems themselves. Below I review in detail how each of the seven criteria for living systems is addressed by ACT teams (Table 2).

Living-System Criteria and ACT

Complex, Multidetermined, and Responsive. Providing transdisciplinary care from one source, in which no single outlook dominates treatment planning and in which treatment aims toward comprehensive, flexible, and assertive care, an ACT team is better able to approach and help a patient as a complex and multidetermined being in a manner that is rare in a typical outpatient setting. Through a regular meeting structure, the team is also able to treat patients as responsive individuals, understanding them as not only reactive to events in their environment, but also comprehending its own effect on patients in real-time through daily reevaluation. When operating well, an ACT team is thus capable of quick and regular modifications in the intensity and kind of treatment it offers, depending on the responses of their patients.

Openness, Growth, and Adaptation. Meeting regularly and reviewing information on their patients in real time, ACT teams are organized in a manner that allows them to engage in open feedback loops, in which they adapt to changes in their patients. By adapting, they promote growth in their patients, flexibly modifying treatment based on how the patient is changing. As mentioned above, this focus on adapting to growth can lead teams to increase services when a client is fac-

TABLE 2.

The Seven Criteria for a Living System

- Complex and multidetermined
- Responsive to what is occurring around them
- Adaptive
- Open systems that metabolize input from outer world
- Growing
- Productive
- Ecological—always behaving in relationship to others and the environment

Adapted from Trifonov.²²

ing productive challenges. As a patient enters the workforce, for example, the vocational expert might counsel him or her on interviewing skills, and drive him or her to job interviews; the cognitive-behavior therapy therapist might help the patient manage his or her anxiety regarding the interview; and the psychiatrist, concerned about how medication side effects might jeopardize the patient's job performance, might alter their medications. All these new interventions will likely translate into an increase in services for the patient even though they are the result of the person's improved status. In this light, ACT teams are engaged with their patients in a mutual adaptation, in which the changes in their patients become signals for adaptations of the team.

Productivity and Ecology. The term "whole-person approach" in mental health care is frequently used to describe and market programs that offer multidisciplinary treatment. However, the term "whole person" is clearly a misnomer if these programs are not addressing psychiatric recovery as connected to a person's productivity and place in their environment. All living creatures are productive through

reproduction; many, through fabrication. Always existing in relationship to others, living creatures are ecological beings. As inventors of culture, humans are arguably the most productive of living creatures, and are also highly dependent on relationships with others for their survival. ACT programs appreciate productivity and ecology as primary issues in their patients' lives. Whether focused on the arenas of work, school, or family, treatment planning conducted by ACT teams targets productivity as a prime goal. Conducting the majority of their clinical contacts in their patients' own environments, they are keenly oriented toward an ecological standpoint, seeing recovery as occurring within a person's normal milieu, rather than behind the walls of another's domain.

Balancing a Creatura Approach

ACT is a model of care sensitive to a living-systems perspective. From a "Batesonian" point of view, this "creatura" approach, with its focus on adaptation, responsiveness, and ecology, leads to a greater chance for recovery than a "pleroma" one, which is routinized, closed, nonadapting, and—according to Bateson—harmful to living systems. Yet ACT, although an excellent delivery device for creatura-oriented care, can also be misused.

For many patients with mental illness, a "hospital without walls" does not promise flexible care attuned to their needs, but something more draconian: monitoring, coercion, and forced treatment. In fact, assertively filling the divide between hospital and outpatient resources forebodes an invasion of people's privacy, and the mandate of ACT programs to reach those patients most difficult to engage threatens their autonomy and self-determination.^{23,24} "ACT teams utilize engagement and retention strategies that include repeated attempts to contact consumers

despite their refusals, close monitoring of medication compliance, behavioral contracting, use of outpatient commitment, and representative payeeship," write Salyers and Tsemberis.²⁵ And thus, as Diamond²⁶ describes it, these teams make it "possible to coerce a wide range of behaviors in the commu-

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nity." In the state of New York, for example, the services of ACT programs are often required as part of Assisted Outpatient Treatment, the state's outpatient commitment law.²⁷ Here, these teams partly perform a function similar to probation officers—making sure their wards attend appointments and follow through with plans set down by the court.

Leaders in the current development of ACT are aware of these tendencies, both immediate and potential. To ensure that the model remains oriented toward psychosocial rehabilitation and recovery, they have added three new criteria to the ACT principles: "family-focused," "consumer-centered," and "recovery orientation,"²² the latter two criteria referring to the philosophies emerging from the consumer survivor and recovery movements, which emphasize self-direction, autonomy, and choice, and a focus on recovery from the effects of institutionalization and stigma as central to helping individuals. This orientation, reflected in the President's New Freedom Commission on Mental Health,²⁸ which defines recovery as "the process in which people are able to live, work, learn, and participate fully in their communities," can pro-

tect ACT programs from engaging in a "plenum"-orientation.

At their core, ACT programs balance psychosocial goals with traditional clinical care. Adding the social justice concerns of the recovery movement helps hold this balance in place, keeping all eyes on assisting people in their recovery as social beings, rather than solely intervening in their symptoms. Yet, a perfect balance between recovery principles (developed in large part as a revolt against the medical model) and robust psychiatric care will likely never be fully achieved. A better way of understanding ACT, and its increasing inclusion of consumer voice and choice in its processes, is to see this inclusion as another adaptation toward a creatura model. Bateson would tell us that world of creatura is unknown and unknowable; it is multifaceted, multidetermined, and polyphonic. Including consumer voices, although partly the result of a larger social movement not always welcomed by mental health professionals, is the obvious and integral next step for this ever-adapting living-systems model.

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