

ACT and Recovery: Integrating Evidence-Based Practice and Recovery Orientation on Assertive Community Treatment Teams

Michelle P. Salyers, Ph.D.

Sam Tsemberis, Ph.D.

ABSTRACT: We examine whether Assertive Community Treatment (ACT), a widely implemented and rigorously studied practice, can successfully incorporate a recovery-oriented approach while continuing to retain program fidelity. We briefly review the effectiveness of ACT as an evidence-based practice, with a focus on adaptations to changing populations and contexts. We explore philosophical similarities and differences between ACT and recovery and examine how fidelity standards, a widely used indicator of how ACT teams operate, support or interfere with the adoption of a recovery-oriented practice. Finally, we provide recommendations on how best to incorporate a recovery orientation into existing ACT teams.

KEY WORDS: severe mental illness; recovery; assertive community treatment

INTRODUCTION

There is currently an unparalleled focus on improving the quality of services for individuals with severe mental illness, with at least two

Dr. Salyers is Co-Director of the ACT Center of Indiana, Associate Research Professor, Department of Psychology, IUPUI, and Research Scientist, VA HSR&D Center on Implementing Evidence-based Practice, Roudebush VAMC and Regenstrief Institute, Inc.

Dr. Tsemberis is Founder and Executive Director of Pathways to Housing, Executive Director of the New York State Institute for ACT and Recovery Based Training, and Assistant Professor, Department of Psychiatry, NYU Medical Center.

Address correspondence to Michelle P. Salyers, Ph.D., Roudebush VA Medical Center, 1481 W. 10th St. (11H), Indianapolis, IN 46202, USA; e-mail: mpsalyer@iupui.edu.

major factors contributing to this phenomenon. The first is an effort to implement evidence-based practices (EBPs) in mental health systems across the country; EBPs are well-defined clinical interventions that can be replicated and have demonstrated effectiveness across a wide variety of settings (Drake & Goldman, 2003; Lehman et al., 2004). The aim of this effort is to improve the services currently in place (Lehman, Steinwachs, & Co-Investigators, 1998), reduce the disparities between research and clinical practice highlighted in the Bridging Science and Service Report (NIMH, 1999) and the Surgeon General's Report (General, 2000), and meet the mandate of the President's New Freedom Commission Report on Mental Health that calls for services that are based on the best available evidence (President's New Freedom Commission on Mental Health, 2003).

The second major factor influencing mental health policy and programming is the emphasis on providing services that support recovery (Anthony, 2000, 2004; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Provencher, Gregg, Mead, & Mueser, 2002). The New Freedom Commission report defines recovery as "the *process* in which people are able to live, work, learn, and participate fully in their communities" (President's New Freedom Commission on Mental Health, 2003), and longitudinal studies of people with severe mental illness report recovery rates of better than 50% (depending on the definition of recovery) which support the feasibility of achieving this goal (DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Strauss, Hafez, Lieberman, & Harding, 1985). The policy mandates, combined with the research findings, fuel new hope for consumers and challenge some clinicians to change long held assumptions concerning the limited capabilities and poor prognosis for those diagnosed with severe mental illnesses.

ACT Effectiveness: The Evidence Base for the Practice

Since the initial demonstration study (Stein & Test, 1980), ACT has proven to be a robust model of community based treatment for people with severe psychiatric disabilities. Numerous controlled studies document the effectiveness of ACT in the treatment of consumers with extensive histories of psychiatric hospitalizations (Baronet & Gerber, 1998; Bedell, Cohen, & Sullivan, 2000; Bond, Drake, Mueser, & Latimer, 2001; Gorey et al., 1998; Herdelin & Scott, 1999; Latimer, 1999; Marshall & Creed, 2000; Ziguras & Stuart, 2000), although some recent studies with strong comparison conditions (e.g., Essock et al.,

2006) and studies in the United Kingdom (Fiander et al., 2003; King, 2006) have found that intensive case management programs can be as effective as ACT. ACT is remarkable for the articulation of its structural and functional features (McGrew & Bond, 1995), as well as for having a widely-used fidelity scale to assess a team's adherence to an ideal ACT model for staffing and services (Teague, Bond, & Drake, 1998).

From its initial inception more than 30 years ago, ACT has evolved and adapted to new developments in mental health systems and to changing policies and directives. Initially, ACT was designed to reduce the recidivism rates of consumers who were frequent users of inpatient services, focusing on how to help consumers discharged from psychiatric hospitals stay in the community. The first ACT teams were deliberately modeled after the hospital inpatient staffing structure and, consistent with the value orientation in the mental health system at that time, operated with a clinician-driven approach (Stein & Test, 1980). Today, ACT teams generally remain effective in their initial mission of reducing inpatient stay and increasing community tenure even as failed economic, social, housing, and mental health policies have resulted in people with psychiatric disabilities being found in disproportionately high numbers utilizing shelters, emergency rooms, and jails, or living on the streets (Haugland, Siegel, Hopper, & Alexander, 1997; Hopper, Jost, Hay, Welber, & Haugland, 1997; Kuhn & Culhane, 1998). Furthermore, ACT teams have been adapted to incorporate supported housing in ways that have been very effective in ending and preventing homelessness for consumers with co-occurring psychiatric and substance use disorders, long histories of homelessness, and disengagement from traditional supportive housing services (Tsemberis, Gulcur, & Nakae, 2004).

Recovery-Oriented Practice and ACT: Opportunities and Challenges

Consumer choice and recovery are currently at the forefront of mental health policy, perhaps for the first time accurately representing consumer concerns (Deegan, 1988; Mead & Copeland, 2000; Ridgway, 2000). According to the President's New Freedom Commission (2003) and mental health advocates (Anthony, 2000, 2004), consumer choice and recovery should be the guiding voice of services. The emphasis, and to some extent the definition, of recovery has grown out of several sources of mental health advocacy. One branch is the first-person narrative accounts (Chamberlin, 1997; Deegan, 1988; Fisher, 1999) that developed into the present alignment with basic human rights and

social justice, emphasizing collaborative treatments, equal access to effective services, and opportunities for employment, education, and self-advancement (Jacobson & Greenley, 2001). Another branch emerged from the psychiatric rehabilitation philosophy and practice (Anthony, Forbess, & Cohen, 1993) which drew on theories from physical rehabilitation to emphasize the fact that people with severe mental illness are complex beings far beyond their symptoms or diagnosis (Jacobson & Curtis, 2000). Anthony (2004) maintains that recovery practices are manifestations of one transcendent principle, which he calls “personhood,” or the recognition that people with mental illness have the same wants and needs as everyone else (e.g., work, housing, relationship, recreation). Consistent with this view, the Substance Abuse and Mental Health Services Administration (SAMHSA) recently issued a consensus statement on recovery, identifying the 10 fundamental components as self direction, individualized and person-centered approaches, empowerment, holistic views, non-linearity, strengths-based, peer support, respect, responsibility, and hope (SAMHSA, 2005).

Practicing with a recovery orientation requires training, policies, procedures, and interventions that support the fundamental components of recovery. Recovery oriented practice also requires providers to shift from the ‘clinician-as-expert’ model to a practice where clinicians—“in full partnership with consumers and families”—develop individualized treatment plans where *consumers* choose ‘who, what, and how’ treatment will be provided (President’s New Freedom Commission on Mental Health, 2003). In the new recovery-oriented mental health system, consumers are included as full partners in every aspect of services including setting service priorities, sharing decision making authority, and most importantly, having the option to agree or disagree with the treatment plan (Deegan & Drake, 2006). Finally, services embracing recovery-oriented practice must recognize that individuals can and do recover from severe mental illness and consistently convey the message of hope that plays an integral part in the individual’s recovery.

In addition to clinical and organizational practices, recovery-oriented practice must be incorporated into the norms, attitudes, and values that emanate from the shared culture of an ACT team. The spirit, or attitude, with which services are offered can be as important as the service itself. For example, a recent assessment of consumer perceptions of mental health providers’ “recovery promoting competence”

identified perceived attitudes as critical in communicating trust, hope, and respect (Russinova, Rogers, & Ellison, 2006). In a related study of NY State ACT teams, Mancini, Finnerty, and Tsemberis (2006) examined the effects of ACT practitioner attitudes on intervention strategies. While all of the teams in this study were structurally comparable (i.e., they scored well on fidelity), teams in which staff members scored lower on a scale of recovery orientation had more negative beliefs about persons with mental illness, lower expectations regarding their capabilities, and endorsed more coercive treatment interventions. Both attitude variables (negative beliefs and lower expectations) and coercive intervention strategies showed marked team effects highlighting the highly interdependent nature of ACT teams, in which practitioners must work very closely with one another to deliver services and have a powerful influence on each other's beliefs and values (Mancini et al., 2006).

Moving towards a recovery-oriented approach presents several challenges for ACT teams that have been traditionally clinician driven. Starting with the target population, most ACT teams are designed to serve consumers who are not effectively engaged with treatment and are frequent users of acute care systems including psychiatric hospitals, substance abuse detoxification centers, jails, shelters and other facilities. To complicate matters further, some consumers are assigned to ACT services as part of a mandatory outpatient commitment order, and many others are assigned to ACT because they have had numerous negative experiences with traditional mental health services and may be suspicious and rejecting of professional help. In efforts to address these challenges, 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. Consequently, some observers conclude that ACT teams must employ some forms of coercion in order to be effective (Dennis & Monahan, 1996). However, such methods directly contradict recovery-oriented practice values of consumer choice, empowerment, and responsibility. If applied indiscriminately or with force or threat, these approaches are in clear violation of recovery-oriented practice. For these and other reasons, critics have suggested that ACT teams are paternalistic or coercive and therefore anti-recovery (Anthony, Rogers, & Farkas, 2003; Gomory, 2001; Williamson, 2002).

Although there are valid concerns about the ACT model, the extent to which ACT teams are recovery oriented has not been definitively answered in the empirical literature (Bond, Salyers, Rollins, Rapp, & Zippel, 2004). ACT practitioners report using only sparingly, and as a last resort, more coercive techniques and instead report employing “friendly persuasion” as their primary means of therapeutic limit-setting (Neale & Rosenheck, 2000). To obtain a more reliable report of the extent to which these practices are used, it would be more useful to obtain consumer perceptions of coercion rather than perceptions of practitioners, since the former are less subject to a social desirability bias. However, consumers generally report high levels of satisfaction with ACT services (Rapp & Goscha, 2004), which belies the criticism that ACT is coercive. Moreover, when asked what they like least about ACT, few consumers indicated that ACT staff are coercive, and levels of perceived coercion were lowest in programs judged to have high fidelity to the ACT model (McGrew, Wilson, & Bond, 2002). The NY Housing study of ACT teams combined with supported housing and operating with a consumer driven approach to end homelessness (Tsemberis et al., 2004), reported consumer choice had a positive impact on reducing psychiatric symptoms. In addition, perceived choice was positively related to self-efficacy, and increased self-efficacy was also significantly related to a reduction in psychiatric symptoms (Greenwood, Schaefer-McDonald, Winkel, & Tsemberis, 2005).

Does Fidelity to the ACT Model Help or Hinder a Recovery Orientation?

Although the literature is in the early stages, there are several theoretical concerns regarding the ability of ACT teams to practice in a recovery-oriented way. First is the tension between balancing the implementation of ACT as an evidence-based practice and maintaining the recovery-oriented principle of individualized services. The ACT model has clear criteria for implementation, i.e., fidelity standards, that necessitate specific uniform structures or services be in place in order for a team to be identified (or certified) as an ACT program. Explicit quantitative monitoring of program fidelity is increasingly recognized as an important quality assurance technique (Torrey, Finnerty, Evans, & Wyzik, 2003), and greater fidelity to ACT has been related to positive outcomes such as reduced hospitalization (Bond & Salyers, 2004; McHugo, Drake, Teague, & Xie, 1999). In some states, mental health departments have adopted these standards as a certification tool to license teams and to pay for ACT services. However, at

the individual consumer level, it may be difficult to balance the need for providing individualized services based on consumer choice which is at the heart of recovery with establishing and maintaining specific programmatic standards that promote uniformity of implementation and practice. Moreover, there are specific fidelity standards that are at odds with recovery-oriented care and these are discussed below.

The most widely used fidelity scale for ACT is the Dartmouth Assertive Community Treatment Scale (DACTS; Teague et al., 1998) that is included in SAMHSA's implementation resource kit for ACT (Phillips & Burns, 2002). The DACTS outlines 28 items related to the structural and organizational integrity of ACT and has been shown to discriminate between ACT and other approaches to care (Teague et al., 1998). These items are organized into three subscales: human resources, organizational boundaries, and nature of services. For the most part, the items define structural properties for team composition and practice. However, embedded in these dimensions, especially the 'nature of services' factor, is a practice philosophy that can be interpreted as clinician directed. Thus, we explore the question of whether it is possible to achieve the goals prescribed by the DACTS while using a recovery-oriented approach. As shown in Table 1, we examine each item and consider the extent to which the item may support or interfere with recovery-oriented practice. Below we highlight potential problem areas and provide recommendations for items that appear to be in conflict with recovery-oriented practice.

Factor I: Human Resources. Items in this factor support small caseload ratios, continuity of staffing, and prescribe a staffing pattern that is well suited to providing consumers intensive mental health and substance abuse treatment. One potentially problematic item requires a 'team approach,' specifically that the 'provider group functions as a team rather than individual practitioners.' The team approach specified in the DACTS requires that multiple staff visit with each of the consumers to help ensure cross-coverage and continuity of care (Test, 1979). However, for some consumers, multiple providers may be untenable, perceived as confusing, or interfere with building a strong working alliance with one team member; one-on-one therapeutic alliances have been related to better outcomes in a number of areas (Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Frank & Gunderson, 1990; Neale & Rosenheck, 1995). Anecdotally, some consumers express strong preferences for individual relationships or particular team members that are often inconsistent with a shared caseload approach.

TABLE 1
DACTS Fidelity Items and Implications for Recovery-Oriented Practice

| <i>Fidelity Item</i> | <i>Implication for Recovery-Oriented Practice</i> |
|---|---|
| <i>Human Resources: Structure & Composition</i> | |
| H1 SMALL CASELOAD: client/provider ratio of 10:1. | Supportive: allows for intensity of services, really getting to know consumers and their goals. |
| H2 TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients. | Possibly interferes: working alliance is more difficult with a team than individual supporters, but allows for continuity in services when team members are absent. |
| H3 PROGRAM MEETING: Program meets frequently to plan and review services for each client. | Supportive: can pay close attention to consumer needs. |
| H4 PRACTICING TEAM LEADER: Supervisor of front line clinicians provides direct services. | Supportive: leader also knows consumers well. |
| H5 CONTINUITY OF STAFFING: program maintains same staffing over time. | Supportive: allows for consistency over time in working with consumers towards their goals. |
| H6 STAFF CAPACITY: Program operates at full staffing. | Supportive: team has the capacity to address consumer needs. |

| | | |
|-----|--|--|
| H7 | PSYCHIATRIST ON STAFF: there is at least one full-time psychiatrist per 100 clients assigned to work with the program. | Supportive: can address psychiatric needs of consumers and provides increased time and availability over traditional services. |
| H8 | NURSE ON STAFF: there are at least two full-time nurses assigned to work with a 100-client program. | Supportive: can address psychiatric and health education needs resulting in more holistic care. |
| H9 | SUBSTANCE ABUSE SPECIALIST ON STAFF: a 100-client program includes at least two staff members with 1 year of training or clinical experience in substance abuse treatment. | Supportive: substance abuse is common in 50% or more of ACT consumers and integrated services are most effective. |
| H10 | VOCATIONAL SPECIALIST ON STAFF: the program includes at least two staff members with 1 year training/experience in vocational rehabilitation and support. | Supportive: most consumers report that working is important to their recovery goals. |
| H11 | PROGRAM SIZE: program is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage. | Supportive: allows for high intensity of services and access to services after regular hours and during vacations. |

TABLE 1 (Continued)

| <i>Fidelity Item</i> | <i>Implication for Recovery-Oriented Practice</i> |
|--|--|
| <i>Organizational Boundaries</i> | |
| <p>O1 EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.</p> | <p>Supportive: Allows team to focus on consumers in greatest need of ACT services.</p> |
| <p>O2 INTAKE RATE: Program takes clients in at a low rate to maintain a stable service environment.</p> | <p>Supportive: Allows time to adequately assess consumer strengths, goals, and service needs.</p> |
| <p>O3 FULL RESPONSIBILITY FOR TREATMENT SERVICES: in addition to case management, program directly provides psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.</p> | <p>Supportive: Allows for integrated treatment to focus on a variety of consumer needs and provide holistic care.</p> |
| <p>O4 RESPONSIBILITY FOR CRISIS SERVICES: program has 24-hour responsibility for covering psychiatric crises.</p> | <p>Possibly interferes: Allows for preventative measures by a team that knows the consumer well, but may be perceived as intrusive. In instances where the team believes the consumer poses a danger to self or others, emergency intervention (even involuntary hospitalization) takes precedence over consumer choice.</p> |

| | |
|---|---|
| <p>O5 RESPONSIBILITY FOR HOSPITAL ADMISSIONS: program is involved in hospital admissions.</p> | <p>Possibly interferes: Close coordination by the team that knows consumer well can prevent unnecessary hospitalizations, but the team may also have to take the lead role in initiating hospitalization.</p> |
| <p>O6 RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: program is involved in planning for hospital discharges.</p> | <p>Supportive: Can shorten length of stay in the hospital and facilitate a smooth transition back into the community.</p> |
| <p>O7 TIME-UNLIMITED SERVICES (GRADUATION RATE): Program rarely closes cases but remains the point of contact for all clients as needed.</p> | <p>Possibly interferes: Allows for ongoing work with consumers, but may retain consumers longer than needed if discharge criteria are not adequately specified or followed.</p> |
| <p><i>Nature of Services</i></p> | |
| <p>S1 COMMUNITY-BASED SERVICES: program works to monitor status, develop community living skills in the community rather than the office.</p> | <p>Supportive: Allows for skills training in the environments where consumers use the skills and where consumers may prefer to meet.</p> |
| <p>S2 NO DROPOUT POLICY: program retains a high percentage of its clients</p> | <p>Possibly interferes: Allows for ongoing work with consumers, but may retain consumers longer than needed if discharge criteria are not adequately specified or followed.</p> |

TABLE 1 (Continued)

| <i>Fidelity Item</i> | <i>Implication for Recovery-Oriented Practice</i> |
|--|--|
| <p>S3 ASSERTIVE ENGAGEMENT MECHANISMS: as part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g., probation/parole, OP commitment) as indicated and as available.</p> | <p>Possibly interferes: Allows for engagement of consumers, but can be misused if mechanisms are applied coercively or indiscriminately.</p> |
| <p>S4 INTENSITY OF SERVICE: high total amount of service time as needed (average two or more hours of face-to-face contacts per week).</p> | <p>Possibly interferes with consumer choice.</p> |
| <p>S5 FREQUENCY OF CONTACT: high number of service contacts as needed (average four or more face-to-face contacts per week).</p> | <p>Possibly interferes with consumer choice.</p> |
| <p>S6 WORK WITH INFORMAL SUPPORT SYSTEM: with or without client present, program provides support and skills for client's support network: family, landlords, employers.</p> | <p>Possibly interferes: Allows for inclusion of natural supports, but may interfere with consumer choice.</p> |

| | | |
|-----|--|--|
| S7 | INDIVIDUALIZED SUBSTANCE ABUSE TREATMENT: one or more members of the program provide direct treatment and substance abuse treatment for clients with substance use disorders. | Supportive: For consumers with substance abuse problems allows for integrated treatment. |
| S8 | DUAL DISORDER TREATMENT GROUPS: program uses group modalities as a treatment strategy for people with substance use disorders. | Supportive: For consumers with substance abuse problems allows for integrated treatment. |
| S9 | DUAL DISORDERS (DD) MODEL: program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence. | Supportive: Does not require abstinence. |
| S10 | ROLE OF CONSUMERS ON TREATMENT TEAM: Consumers are involved as members of the team providing direct services. | Supportive: Provides role models, peer support, and unique engagement strategies. |

In order to incorporate recovery principles of consumer choice, this standard needs to be adapted or modified. For example, teams can be flexible and respect consumer choice for particular staff or use an individualized treatment team (ITT) as a smaller team-within-a-team that can provide the majority of individualized services. In this way, the consumer maintains close contact with a smaller number of people, but the idea of continuity and shared knowledge of the consumer is also maintained. Further, the philosophy behind this item may be applied in different ways for team members and consumers. For example, because team members generally alternate on-call responsibility, it is important that *all* team members know about each consumer, but it is not essential that every consumer must know and work with each team member unless he or she chooses to do so.

Another issue concerning human resources is that the current staffing patterns are primarily focused on mental health and addiction services. Although the DACTS also includes employment specialists, teams embracing a recovery-oriented approach will need to provide for a much broader spectrum of services and incorporate specialists in other areas such as housing and family systems.

Factor II: Organizational Boundaries. The items in this factor define the responsibilities of the team with regard to access and assisting consumers to navigate the broader service system such as hospitalizations and managing crises. The round-the-clock availability of ACT teams, to be accessible in day-to-day activities, crises, and times when the consumer 'just needs to talk' may be one of the most important features of ACT. If performed well, 24-hour services can be experienced as very supportive, attending to consumer priorities as needed; but these same services can be regarded as intrusive when the constant presence is out of sync with consumers' needs. In addition, teams must sometimes hospitalize a consumer who meets local laws related to presenting 'a danger to self or others.' Hospitalizations are one of the more controversial and yet essential services of good community mental health practice. In these cases, the team continues to follow the consumer into the hospital, visits throughout the hospitalization, plans for the discharge, and is there at the time of discharge to continue supporting the consumer on return to the community. The items relating to crisis intervention and hospital admission touch on a critical issue for recovery: that there *are* times when involuntary treatment may be needed in order to save the person's life, and failing to do so may mean

no chance of recovery. The key, then, becomes how the procedures are done—humanely, respectfully, and to the extent possible, following the directions of the consumer (e.g., through advanced directives).

Time unlimited services relate to the long-term nature of ACT. Initially, ACT was thought to be a life-long treatment with assertive outreach to engage and maintain consumers on the caseload over time. This item guarantees that the team will not be quick to discharge consumers until they are ready; however, work has shown that consumers can and do successfully graduate from ACT programs (Salyers, Masterton, Fekete, Picone, & Bond, 1998). The possibility of recovery, and consumer choice about service provision, will require this item to include language concerning discharge policies that shift expectations from life long service to planning for future graduation and emphasize the role played by the consumers' choice in this key decision.

Factor III: Nature of Services. This subscale of the DACTS refers to the services provided, and in our view, has the most potential for discrepancies with recovery-oriented practice; not because of the services themselves, but because the items may be read as directives for teams without including a mandate to obtain input from consumers. Items in this factor are prescriptive and have clear standards for the type of services and frequency of services that the team must provide as well as items such as a 'no dropout policy' that implies the decision to stop receiving services is solely a team decision. Such items are clearly problematic for a recovery-oriented practice.

One concern is that the services currently prescribed as optimal do not take into account the stage of the consumers' recovery (Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Solomon & Stanhope, 2004). Some clinicians and researchers contend that consumers who are severely disabled by their symptoms (for example, extreme lack of awareness or inability to make decisions) would benefit from a highly structured and prescriptive approach, and as symptoms remit and the person improves, the consumer should have more control over the decisions concerning their treatment and services plan (Frese et al., 2001). However, on the DACTS, fully implemented ACT programs see consumers an average of four times per week, and some states or payers have translated this frequency into a set number of contacts for each consumer. Thus, ACT teams may be required to visit consumers a fixed number of times per month, regardless of consumer need, desire, or choice. For example, while daily visits for medications may be

appropriate for some consumers at the early stages in their recovery, the need for visits changes over time as consumers develop greater self-management skills and assume more personal responsibility. This example illustrates challenges currently faced by ACT teams seeking to practice with a recovery orientation: this particular standard would have to be applied flexibly so that the team can adjust the service dosage (i.e., level of services) in a way that is consistent with each consumer's needs and choices at different time periods while still maintaining fidelity to the model and the ability to bill fully for ACT services.

In addition to balancing specific fidelity standards with consumer choice and empowerment, ACT teams may also be grappling with providing "court mandated" or "forced treatment." In these cases the team typically provides services and the consumer must participate in order to comply with the court order. This introduces enormous complexity into the relationship if the team is striving to maintain a recovery orientation. Although there is no singular solution, it is important that the team remain very clear and instructive in explaining the role of each of the clinical and criminal justice staff and explain to the consumer their rights and responsibilities with regard to each system, i.e., what is the role and expectation of the judge, the court monitor, probation office, and the ACT team. One useful perspective is Monahan's (Monahan et al., 1995) concept of 'procedural justice': if those in authority are careful to advise consumers about every aspect of their role and responsibility, make the complex system as transparent as possible, and assist consumers to obtain fair treatment and representation in these multiple systems, then consumers will feel that they have been treated fairly even in instances when they disagree with the decision or outcome. Taking Monahan's advice to heart we would caution ACT teams to avoid the temptation to leverage the court order in order to coerce the consumer into treatment, to leverage the housing with treatment (Allen, 2003), to refrain from colluding with the various agencies, and to remain the advocate of the consumer.

Despite these potential clashes between DACTS fidelity standards and recovery-oriented practice, differences in approaches can be resolved to inform and improve practice. For example, the DACTS would be more directly supportive of recovery-oriented practice if the language (and items) emphasized services that include negotiation and choice. Implementing a recovery orientation would also require ACT teams to be trained in various consumer-driven techniques such as

motivational interviewing (Miller & Rollnick, 1991) and shared decision making (Deegan & Drake, 2006) to engage consumers in services in a manner consistent with consumer choice. Other modifications of the DACTS should include items about consumer choice in the type and frequency of services; the choice of not participating in treatment for a while but remaining engaged with the team; that teams must actively convey hope; and that consumers must be present as decision makers on every aspect of their treatment plan. Further, modifications could allow for changes in computation so that as consumers move through the various stages of their recovery they will need fewer services or different types of services.

Integrating ACT and Recovery-Orientation

Even with some of these liabilities, ACT can still be particularly well suited to a recovery orientation. Fundamentally, the goal of ACT, like the goal of recovery, is to assist people to participate fully in their communities, and there are many DACTS fidelity standards that are compatible with and support a recovery orientation. Because of the *in vivo* focus of service provision, ACT is an optimal approach for assisting consumers to integrate into their communities. The intensive, long-term nature of ACT (modified to allow for reduced services) is also consistent with the generally long-term process of recovery. It can take years to develop the kind of relationships in which the consumer is known, understood, accepted, so that the team and the consumer can notice and celebrate even small steps along the long road to recovery. Similarly, by knowing consumers well and over a long period of time, relapses and crises can be better anticipated and addressed before they develop into full blown crises. Another strength of this model is the no-drop-out policy; while it has the potential for keeping people longer than needed, it also gives consumers the flexibility to set their own pace for treatment and graduation. The multidisciplinary team is well suited to facilitating recovery in an integrated, holistic fashion. Work, relationships, leisure activities, managing home and budget, keeping substance use from interfering with life, and managing the illness are all part of the recovery process and can best be addressed by a team, including the consumer and his or her natural supports, working together. Many teams now include consumer providers as staff. The peer on the team can be not only a messenger of hope but the embodiment of hope and possibility of recovery, a role model to other

consumers, and a key member of the team facilitating greater understanding between consumers and staff.

Below we provide four recommendations to help ensure recovery-oriented ACT practices.

1. *Integrate other evidence-based practices on ACT teams.* ACT is best understood as a way of organizing services through integration, teamwork, and continuity of care. Thus, the ACT model specifies structure and procedures for providing services, whereas many other evidence-based practices delineate the content of specific clinical interventions aimed at specific outcomes. For example, motivational strategies and cognitive-behavioral interventions are specified in Illness Management and Recovery (IMR; Mueser et al., 2002) and Integrated Dual Disorders Treatment (IDDT; Mueser, Noordsy, Drake, & Fox, 2003). We have seen the synergistic effects of ACT with IDDT (Drake et al., 1998, 2001), and we are beginning a program of research to integrate IMR with ACT (Hicks, Salyers, Baumgardner, & Kim, 2004). Other interventions, such as supported employment and the Wellness Recovery Action Plan (WRAP; Copeland, 1997), can also be easily integrated onto ACT teams and facilitate recovery-oriented care.
2. *Monitor recovery orientation.* Recovery-oriented treatment is contrasted to traditional clinician-driven treatment; both are descriptive terms that define a philosophical and intentional attitude or value set that underlies a complex set of clinical practices. Further, recovery orientation is a continuum, not a dichotomy; teams are more or less recovery-oriented or clinician driven. In programs we can see and feel this quality, and we can also measure it. There are now a variety of measures available to quantify the degree of recovery orientation (O'Connell, Tondora, Evans, Croog, & Davidson, 2005; Onken, Dumont, Ridgway, Dornan, & Ralph, 2004; Ridgway & Press, 2004). ACT programs can use such tools to monitor their current level of practice and use the feedback to guide improvements in recovery orientation similarly to the use of fidelity scales as developmental tools.
3. *Provide training and supervision in recovery-oriented work.* Along with monitoring and feedback, we also recommend on-going training and supervision. In our own experience in training ACT teams at the ACT Center of Indiana and the NY State Training Institute for ACT and Recovery Based Practice we have found the

need to develop clinical practice skills as well as the need to develop, foster, and reinforce the attitudinal and value shifts required for a recovery-oriented practice. In NY, all ACT staff receive training on recovery and exposure to the IMR toolkit (Mueser & Gingerich, 2002). In a recent observational study of ACT team members' responses to this training, Felton, Barr, Clark, and Tsemberis (2006) observed that the majority of the trainees responded positively to the training, including accounts of working with consumers using the IMR strategies. There were several challenges observed. One of the most frequently stated concerns by trainees is how to work with consumers who 'will not admit that they are mentally ill.' One practical solution offered by a trainee was to consider that perhaps the first step in recovery was to assist the consumer to recognize the way that their symptoms interfere with their life's goals. During the course of training, trainees began to shift their perspective from a symptom-dominant view to describing their service recipients in holistic terms: "in terms of their talents, strengths, and social and emotional concerns" (p. 117). Both ACT Centers include consumers as co-trainers. They help develop and present training materials. They also provide personal stories of recovery and what helped them in the process so that trainees can see strong examples of recovery in action. This training practice also models the inclusion of consumers as colleagues.

4. *Hire consumers as ACT team staff members.* The work of Solomon and others has established that case management teams comprised of consumers can be as effective as teams comprised of non-consumer professionals (Solomon & Draine, 1995), and there is evidence that consumer peer specialists on an ACT team can have a positive impact on the outcomes for service recipients (Felton et al., 1995). Consumers can have a powerful effect on non-consumer providers by changing the nature of the team meetings and serving to humanize the team by introducing their perspective (Solomon & Draine, 1998). It is also apparent that consumers approach the role of case management differently than do non-consumer professionals, drawing more on their self-management techniques and role modeling in their interventions with service recipients (Lyons, Cook, Rath, Karver, & Slagg, 1996; Paulson et al., 1999). Thus, the inclusion of consumer providers on ACT teams is a natural way to enhance recovery-orientation.

Recovery-oriented practice and ACT have sometimes been viewed as incompatible. While we may debate the percentage of

people who can recover fully or discuss the best methodology for measuring recovery, there is no doubt that the principles identified by the recovery movement—consumer choice, hope, respect, patience, and compassion can and must be incorporated into today's ACT teams.

REFERENCES

- Allen, M. (2003). Waking Rip van Winkle: Why developments in the last 20 years should teach the mental health system not to use housing as a tool of coercion. *Behavioral Sciences & The Law*, 21(4), 503–521.
- Anthony, W. A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal*, 24(2), 159–169.
- Anthony, W. A. (2004). The principle of personhood: The field's transcendent principle. *Psychiatric Rehabilitation Journal*, 27(3), 205.
- Anthony, W. A., Forbess, R., & Cohen, M. R. (1993). Rehabilitation-oriented case management. In M. Harris, & H. C. Bergman (Eds.), *Case management for mentally ill patients: Theory and practice* (pp. 99–118). Harwood Academic Publishers, Switzerland.
- Anthony, W. A., Rogers, E. S., & Farkas, M. D. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, 39, 101–114.
- Baronet, A., & Gerber, G. J. (1998). Psychiatric rehabilitation: Efficacy of four models. *Clinical Psychology Review*, 18, 189–228.
- Bedell, J. R., Cohen, N. L., & Sullivan, A. (2000). Case management: The current best practices and the next generation of innovation. *Community Mental Health Journal*, 36, 179–194.
- Blatt, S. J., Zuroff, D. C., Quinlan, D. M., & Pilkonis, P. A. (1996). Interpersonal factors in brief treatment of depression: Further analyses of the national institute of mental health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology*, 64, 162–171.
- Bond, G. R., Drake, R. E., Mueser, K. T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. *Disease Management & Health Outcomes*, 9, 141–159.
- Bond, G. R., & Salyers, M. P. (2004). Prediction of outcome from the Dartmouth Assertive Community Treatment fidelity scale. *CNS Spectrums*, 9(12), 937–942.
- Bond, G. R., Salyers, M. P., Rollins, A. L., Rapp, C. A., & Zippel, A. M. (2004). How evidence-based practices contribute to community integration.[see comment]. *Community Mental Health Journal*, 40(6), 569–588.
- Chamberlin, J. (1997). Confessions of a non-compliant patient. *National Empowerment Center Newsletter* (Summer/Fall), 8–9.
- Copeland, M. E. (1997). *Wellness recovery action plan*, Brattleboro, VT: Peach Press.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 12–19.
- Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services*, 57, 1636–1639.
- Dennis, D. L., & Monahan, J. (1996). *Coercion and aggressive community treatment: A new frontier in mental health law*. Plenum Series in Social/Clinical Psychology.
- DeSisto, M., Harding, C. M., McCormick, R. V., Ashikaga, T., & Brooks, G. W. (1995). The Maine and Vermont three-decade studies of serious mental illness. II. Longitudinal course comparisons. *The British Journal of Psychiatry*, 167(3), 338–342.
- Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L. et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, 52, 469–476.
- Drake, R. E., & Goldman, H. H. (Eds.). (2003). *Evidence-based practices in mental health care*. Arlington, VA: American Psychiatric Association.
- Drake, R. E., McHugo, G. J., Clark, R. E., Teague, G. B., Xie, H., Miles, K. et al. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry*, 68, 201–215.

Michelle P. Salyers, Ph.D. and Sam Tsemberis, Ph.D.

- Essock, S. M., Mueser, K. T., Drake, R. E., Covell, N. H., McHugo, G. J., Frisman, L. K., et al. (2006). Comparison of ACT and standard case management for delivering integrated treatment for co-occurring disorders. [see comment]. *Psychiatric Services*, *57*(2), 185–196.
- Felton, B., Barr, A., Clark, G., & Tsemberis, S. (2006). ACT team members responses to training in recovery-oriented practices. *Psychiatric Rehabilitation Journal*, *30*, 112–119.
- Felton, C. J., Stastny, P., Shern, D. L., Blanch, A., Donahue, S. A., Knight, E. et al. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. *Psychiatric Services*, *46*, 1037–1044.
- Fiander, M., Burns, T., McHugo, G. J., & Drake, R. E. (2003). Assertive community treatment across the Atlantic: Comparison of model fidelity in the UK and USA. *British Journal of Psychiatry*, *182*, 248–254.
- Fisher, D. J. (1999). *A New Vision of Recovery: People can fully recover from mental illness; it is not a life-long process*. Lawrence, MA: National Empowerment Center.
- Frank, A. F., & Gunderson, J. G. (1990). The role of the therapeutic alliance in the treatment of schizophrenia: Relationship to course and outcome. *Archives of General Psychiatry*, *45*, 228–236.
- Frese, F. J., Stanley, J., Kress, K., & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services*, *52*, 1462–1468.
- General, S. (2000). *Surgeon General's report on mental health*, Washington, DC: US Government Printing Office.
- Gomory, T. (2001). A critique of the effectiveness of assertive community treatment. *Psychiatric Services*, *52*, 1394.
- Gorey, K. M., Leslie, D. R., Morris, T., Carruthers, W. V., John, L., & Chacko, J. (1998). Effectiveness of case management with severely and persistently mentally ill people. *Community Mental Health Journal*, *34*, 241–250.
- Greenwood, R. M., Schaefer-McDonald, N. J., Winkel, G., & Tsemberis, S. (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. *American Journal of Community Psychology*, *36*, 223–238.
- Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry*, *144*(6), 727–735.
- Haugland, G., Siegel, C., Hopper, K., & Alexander, M. J. (1997). Mental illness among homeless individuals in a suburban county. *Psychiatric Services*, *48*, 504–509.
- Herdelin, A. C., & Scott, D. L. (1999). Experimental studies of the Program of Assertive Community Treatment (PACT): A meta-analysis. *Journal of Disability Policy Studies*, *10*, 53–89.
- Hicks, L., Salyers, M. P., Baumgardner, H., & Kim, H. (2004). *Real systems change mini grant final report*. Adult & Child Mental Health Center, Inc.
- Hopper, K., Jost, J., Hay, T., Welber, S., & Haugland, G. (1997). Homelessness, severe mental illness and the institutional circuit. *Psychiatric Services*, *48*, 659–665.
- Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, *333*–341.
- Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, *52*, 482–485.
- King, R. (2006). Intensive case management: A critical re-appraisal of the scientific evidence for effectiveness. *Administration & Policy in Mental Health*, *33*(5), 529–535.
- Kuhn, R., & Culhane, D. P. (1998). Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: Results from the analysis of administrative data. *American Journal of Community Psychology*, *26*, 207–232.
- Latimer, E. (1999). Economic impacts of assertive community treatment: A review of the literature. *Canadian Journal of Psychiatry*, *44*, 443–454.
- Lehman, A. F., Kreyenbuhl, J., Buchanan, R. W., Dickerson, F. B., Dixon, L. B., Goldberg, R. et al. (2004). The Schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2003. *Schizophrenia Bulletin*, *30*, 193–217.
- Lehman, A. F., Steinwachs, D. M., & Co-Investigators, P. (1998). At issue: Translating research into practice: The Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. *Schizophrenia Bulletin*, *24*, 1–10.

Community Mental Health Journal

- Lyons, J. S., Cook, J. A., Rath, A. R., Karver, M., & Slagg, N. B. (1996). Service delivery using consumer staff in a mobile crisis assessment team. *Community Mental Health Journal, 32*, 33–40.
- Mancini, A. D., Finnerty, M. T., & Tsemberis, S. (2006). *Defining intervention strategies on ACT teams and exploring correlates of their use*. Paper presented at the annual meeting of the MacArthur research network on the law and mental health, Cambridge, MA.
- Marshall, M., & Creed, F. (2000). Assertive community treatment: Is it the future of community care in the UK? *International Review of Psychiatry, 12*, 191–196.
- McGrew, J. H., & Bond, G. R. (1995). Critical ingredients of assertive community treatment: Judgments of the experts. *Journal of Mental Health Administration, 22*, 113–125.
- McGrew, J. H., Wilson, R., & Bond, G. R. (2002). An exploratory study of what clients like least about assertive community treatment. *Psychiatric Services, 53*, 761–763.
- McHugo, G. J., Drake, R. E., Teague, G. B., & Xie, H. (1999). The relationship between model fidelity and client outcomes in the New Hampshire Dual Disorders Study. *Psychiatric Services, 50*, 818–824.
- Mead, S., & Copeland, M. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal, 36*, 315–328.
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*, New York: Guilford Press.
- Monahan, J., Hoge, S. K., Lidz, C., Roth, L. H. et al. (1995). Coercion and commitment: Understanding involuntary mental hospital admission. *International Journal of Law and Psychiatry, 18*(3), 249–263.
- Mueser, K. T., Corrigan, P. W., Hilton, D. W., Tanzman, B., Schaub, A., Gingerich, S. et al. (2002). Illness management and recovery: A review of the research. *Psychiatric Services, 53*, 1272–1284.
- Mueser, K. T., & Gingerich, S. (Eds.). (2002). *Illness management and recovery implementation resource kit*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*, New York: Guilford Publications.
- Neale, M. S., & Rosenheck, R. A. (1995). Therapeutic alliance and outcome in a VA intensive case-management program. *Psychiatric Services, 46*, 719–721.
- Neale, M. S., & Rosenheck, R. A. (2000). Therapeutic limit setting in an assertive community treatment program. *Psychiatric Services, 51*, 499–505.
- NIMH (1999). *Bridging science and service: A report by the National Advisory Mental Health Council's Clinical Treatment and Services Research Workgroup*, Rockville, MD: National Institute of Mental Health.
- O'Connell, M. J., Tondora, J., Evans, A., Croog, G., & Davidson, L. (2005). From rhetoric to routine: Assessing recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal, 28*, 378–386.
- Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2002). *Mental health recovery: What helps and what hinders?*, Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.
- Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2004). *Update on the Recovery Oriented System Indicators (ROSI) measure: Consumer survey and administrative-data profile*. Paper presented at the 2004 joint conference on mental health block grant and mental health statistics, Washington, DC.
- Paulson, R., Herinckx, H., Demmler, J., Clarke, G., Cutler, D., & Birecree, E. (1999). Comparing practice patterns of consumer and non-consumer mental health service providers. *Community Mental Health Journal, 35*, 251–269.
- Phillips, S. D., & Burns, B. J. (Eds.). (2002). *Assertive community treatment implementation resource kit*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America. Final Report*. DHHS Pub. No. SMA-03-3832, Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Provencher, H. L., Gregg, R., Mead, S., & Mueser, K. T. (2002). The role of work in the recovery of persons with psychiatric disabilities. *Journal of Psychiatric Rehabilitation, 26*, 132–144.

Michelle P. Salyers, Ph.D. and Sam Tsemberis, Ph.D.

- Rapp, C. A., & Goscha, R. J. (2004). The principles of effective case management of mental health services. *Psychiatric Rehabilitation Journal, 27*.
- Ridgway, P. A. (Ed.). (2000). *The recovery papers volume 1*. University of Kansas School of Social Welfare.
- Ridgway, P., & Press, A. N. (2004). *An instrument to assess the recovery and resiliency orientation of community mental health programs: The Recovery Enhancing Environment Measure (REE)*.
- Russinova, Z., Rogers, E. S., & Ellison, M. (2006). *Conceptualization and assessment of mental health practitioners' recovery promoting competence*. Paper presented at the national association of mental health program directors 16th annual conference, Baltimore, MD.
- 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*, 233–245.
- SAMHSA (Artist). (2005). *National Consensus Statement on Mental Health Recovery* [Brochure].
- Solomon, P., & Draine, J. (1995). The efficacy of a consumer case management team: 2-year outcomes of a randomized trial. *Journal of Mental Health Administration, 22*, 135–146.
- Solomon, P., & Draine, J. (1998). Consumers as providers in psychiatric rehabilitation. In P. W. Corrigan, & D. F. Giffort (Eds.), *Building teams and programs for effective psychiatric rehabilitation. New directions for mental health services* (pp. 65–77). Jossey-Bass/Pfeiffer, San Francisco, CA.
- Solomon, P., & Stanhope, V. (2004). Recovery: Expanding the vision of evidence-based practice. *Brief Treatment and Crisis Intervention, 4*(4), 311–321.
- Stein, L. I., & Test, M. A. (1980). An alternative to mental health treatment. I: Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry, 37*, 392–397.
- Strauss, J. S., Hafez, H., Lieberman, P., & Harding, C. M. (1985). The course of psychiatric disorder, III: Longitudinal principles. *American Journal of Psychiatry, 142*, 289–296.
- Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry, 68*, 216–232.
- Test, M. A. (1979). Continuity of care in community treatment. *New Directions for Mental Health Services, 2*, 15–23.
- Torrey, W. C., Finnerty, M., Evans, A., & Wyzik, P. F. (2003). Strategies for leading the implementation of evidence-based practices. *Psychiatric Clinics of North America, 26*, 883–897.
- Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis. *American Journal of Public Health, 94*(4), 651–656.
- Williamson, T. (2002). Ethics of assertive outreach (assertive community treatment teams). *Current Opinion in Psychiatry, 15*, 543–547.
- Ziguras, S., & Stuart, G. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. *Psychiatric Services, 51*, 1410–1421.