

A Clinical Translation of the Research Article Titled

“Measuring the Recovery Orientation of ACT”

Michelle P. Salyers, PhD

Associate Professor, Department of Psychology, Indiana University Purdue University
Indianapolis (IUPUI); Co-Director, ACT Center of Indiana; Research Scientist, Regenstrief
Institute, Inc.

Running Head: CT of Recovery Oriented ACT

Address correspondence to:

Michelle P. Salyers, Ph.D.

Department of Psychology, IUPUI

402 N. Blackford Street

Indianapolis, IN 46202

(317) 274-2904 (tel.); (317) 988-3222 (FAX); Email: MPSALYER@IUPUI.EDU

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STUDY PURPOSE

The purpose of this study was to compare different ways to measure how well treatment programs support recovery from severe mental illness. The treatment programs were assertive community treatment (ACT) teams, which have been shown to be effective in reducing hospital use and homelessness, but have been criticized for not attending to other aspects of recovery such as offering choices, and instilling hope, empowerment, and personal responsibility in consumers they serve. Two ACT teams were compared -- one that had been selected by program consultants for providing a strong level of recovery support (“high recovery orientation”) and the other selected for providing a low level of recovery support. Researchers observed the treatment teams, reviewed charts, provided diaries for staff and consumers to record what happened on treatment visits, distributed surveys to all staff and consumers of both teams, and interviewed a subset of staff and consumers.

BACKGROUND

The mental health treatment system has increasingly embraced the idea that people with even the most severe mental illnesses can recover to have a life of meaning and purpose. Policies and programs have been established to help ensure that treatment providers deliver services that support this vision of recovery. That is, recovery oriented services should provide hope for recovery (as defined by the individual) and include what are thought to be essential ingredients such as honoring choices, and encouraging empowerment and personal responsibility (SAMHSA, 2011). Yet, there is also a tension between providing care that has been shown to be effective in research, while also supporting the autonomy and recovery goals

of individual consumers. One treatment model that has been the center of debate in this regard is ACT. Structurally, ACT has many characteristics that could make it an ideal model to provide a high level of recovery support. ACT involves an interdisciplinary team of treatment providers, including nurses, psychiatrists, social workers, employment specialists, substance abuse specialists, and peer specialists (e.g. consumers doing well in their own recovery who provide treatment). This structure allows for a holistic approach that can address a number of different domains in consumer's life. At the same time, the model is also known for assertive outreach to consumers who have been the most difficult to engage in treatment services. ACT teams often use strategies that place power and control in the hands of the treatment provider rather than in the hands of the consumer (such as close medication monitoring, using contracts for controlling behaviors, outpatient commitments, and representative payeeships where the agency controls the consumer's social security entitlements). Because these approaches to engagement and treatment are commonly used, ACT programs have been criticized for being paternalistic or even coercive (Anthony, Rogers, & Farkas, 2003; Dennis & Monahan, 1996; Gomory, 2001; Williamson, 2002). Prior research is mixed on the extent to which ACT teams provide services in a recovery oriented way (Kidd et al., 2010; Moser & Bond, 2009; Neale & Rosenheck, 2000; Rapp & Goscha, 2004; Tschopp, Berven, & Chan, 2011).

The authors of this study were interested in developing methods that could best assess recovery orientation and understand differences in treatment practices in ACT programs. In terms of methods, survey research is often used to assess recovery beliefs and practices. However, surveys can also result in a bias where respondents may want to appear "good," endorsing concepts they believe are valued (e.g., belief in recovery, consumer choice, absence of coercion). At the same time, other methods of assessment may be too labor intensive

requiring high levels of research staff and high cost or intrusive to the treatment process itself.

The authors used multiple methods to identify assessment tools that would be feasible to comprehensively assess the recovery orientation of ACT teams. They hypothesized that the high recovery oriented team would have consumers who reported being more satisfied, hopeful, and able to manage their illnesses more independently. They also hypothesized that staff of the high recovery oriented team would have more positive expectations that consumers could recover. In addition to survey reports, the authors also expected that diaries and ratings of treatment plans and treatment control would show that services are provided differently on the two teams.

METHODS

The teams were located in a state with defined standards for providing ACT, combined with training, consultation, and technical assistance to support ACT teams. State consultants monitored programs through annual visits to determine the degree to which teams followed the ACT model (i.e., fidelity). On the basis of state consultant ratings, the research team identified two teams were for study: one to represent the high end of recovery oriented care and the other to represent the low end. Study participants included both staff and consumers of these two ACT teams. The high recovery team had 9 staff and 43 consumers, and the other team had 12 staff and 74 consumers. Teams were visited six times by the researchers over a period of two to three months. Researchers reviewed assessments and treatment plans for ten randomly selected consumers, conducted interviews, and distributed diaries. They observed morning meetings and shadowed staff on visits to consumers when feasible. Staff completed a survey assessing expectations that consumers could recover. Consumers completed surveys about how active they are in treatment, how well they manage their illness, how much choice

they have in treatment decisions, as well as how hopeful, satisfied, and optimistic they were. Staff and consumers completed diaries after treatment interactions to independently rate aspects of care, such as conveying hope, offering choice, fostering independence, encouraging risk/trying new things, and advancing consumer-defined goals. The two teams were compared on all of the recovery orientation variables. In addition, the researchers examined response rates of surveys and made observations regarding different assessment methods to determine feasibility of the different approaches.

RESULTS

The two teams differed in a few background areas -- the high recovery team was newer and located in an urban setting whereas the low recovery team was located in a rural setting. However, the teams did not differ in the demographics of staff or consumers, and did not differ on severity of caseload, at least in terms of consumer diagnosis or days hospitalized in the prior year. Across both teams, the survey response rate was 45% for consumers and 86% for staff. Of all the surveys, only one showed a difference between the teams, with the high recovery team staff having more positive expectations about consumer recovery. Researcher ratings of treatment plans showed substantial differences, with the high recovery team showing greater involvement of the consumer in the process, and treatment plan content that more often included individualized consumer goals and strengths. Ratings of treatment control also showed differences on several areas assessed; the high recovery team was less likely to use representative payeeship, hold the lease of consumer apartments, provide daily medication delivery, and have regular family involvement. Visit diaries had low response rates; for staff, 37% returned completed diaries, and of those visits, 79% also had a consumer diary completed. But for those that were returned, the diaries showed many differences. On the high recovery

team, both staff and consumers rated interactions as being more hopeful, offering choice, providing encouragement, and supporting independence and trying new things. Consumers on that team also rated reported greater advancement of their own goals.

DISCUSSION

In this study, survey data were not very useful in discriminating levels of recovery orientation. Although this method has relatively low burden and cost, only one survey instrument showed a difference – staff at the high recovery program had higher expectations that consumers could recover. Surprisingly, though, the consumers did not differ across the teams in their views of themselves. Consumers on both teams rated themselves similarly on their treatment involvement, degree of independence in managing their illness, and level of hopefulness, optimism, and satisfaction. With the low response rate, it may be that the higher functioning consumers of both teams were more likely to respond, and this may limit the ability to find differences. The authors suggest that lack of differences could also reflect the measures chosen, leaving open the possibility that other measures of recovery orientation might show differences. Given some lack of correspondence between surveys, interviews, and observations, the authors suggest that alone, surveys will not adequately assess recovery orientation. Treatment plan ratings were better able to discriminate between teams. However, the authors noted some difficulties in the using the ratings consistently that would need to be addressed to be useful in practice. Staff reports of treatment control practices, like holding the lease and providing daily medication delivery, appear to be a good way to distinguish high and low recovery oriented teams. The authors also suggest that not only frequency, but also the way in which these mechanisms are used, is important. A recovery-

oriented team may still use some of these practices, but usually in limited ways, and with consumer input in the planning (Salyers, Stull, Rollins, & Hopper, 2011). Finally, staff and consumer diaries provided a high level of discrimination between teams and were less likely to be affected by biases of the researchers. But, because of low response rates, other methods that are more engaging and less burdensome will be needed in order to use this method in practice.

In terms of the debate about ACT and recovery, the study's findings support the idea that ACT teams can provide services in a way that is consistent with a recovery philosophy. Both ACT teams were following the model of ACT according to the current fidelity or adherence to ACT principles and standards, but still differed on a number of important recovery indicators. High fidelity to ACT principles and standards is not inconsistent with principles of supporting consumer hope, autonomy, and personal responsibility for recovery. Yet, most ACT standards do not require recovery-oriented principles to be present. The authors point to work that is already being done to improve the way to measure fidelity to ACT to also attend to recovery principles (Monroe-DeVita, Teague, & Moser, 2011).

Although the study was limited by a small sample in one state, the authors describe some clinical implications that can arise from the work. For example, given the important differences between teams in treatment planning, ACT nurses can better support consumer involvement in this process. This active collaboration is consistent with current movements in the mental health field, and the authors describe useful approaches that can increase an active role for consumers, for example shared decision making tools (Drake, Deegan, & Rapp, 2010) or person-centered planning approaches (Adams & Grieder, 2005). Another important area for

nurses on ACT teams is the use of control mechanisms, particularly daily medication monitoring. Given the central role ACT nurses play in medication coordination, administration, and (more commonly now) prescription, nurses can support recovery by teaching consumers effective approaches to take medications independently and helping the team to integrate medications into other aspects of consumer recovery. Team members can also work on ways to ensure that treatment visits convey hope and encouragement, offer choice and independence, and focus on consumer-directed goals that are consistent with a recovery philosophy.

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