Assertive community treatment in UK practice

Revisiting... Setting up an Assertive Community Treatment Team

Andrew Kent & Tom Burns

Abstract
Since 2000 assertive outreach has been a requirement of community mental health provision in the UK. This has led to rapid proliferation of assertive community treatment teams offering a pure form of clinical case management to people with severe mental illness. The teams provide intensive support in obtaining material essentials such as food and shelter and place a greater emphasis on social functioning and quality of life than on symptoms. People with psychotic illness with fluctuating mental state and social functioning and poor medication adherence are most likely to benefit. Teams are ideally placed to monitor clozapine treatment in the community. Teams require a broad skills mix, and team members need some competence across a wide range of areas. Teams should include a psychiatrist or have regular access to one. Ideal individual case-loads are 10–12 patients. Round-the-clock availability is no longer considered essential, particularly in view of the rise of crisis resolution/home treatment teams.

Historical development

Training in community living

Assertive community treatment began with the highly influential ‘training in community living’ programme developed during the 1970s at the Mendota Mental Health Institute in Madison, Wisconsin (Marx et al, 1973). This programme sprang from a recognition by Marx and his colleagues, Stein and Test, that contemporaneous community treatments did little more than maintain chronically disabled patients in ‘a tenuous community adjustment on the brink of rehospitalisation’ (Stein & Test, 1980). Their programme was an attempt to address the imbalance of care before and after discharge, and was developed

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with the understanding that an effective community treatment programme must assume responsibility for helping patients to meet all their needs. These needs, they argued, include the material essentials of life such as food, clothing and shelter; coping skills necessary to meet the demands of community living; motivation to persevere in the face of adversity; freedom from pathologically dependent relationships; and support and education of significant others involved with the patient in the community.

The expectation that socially disabled patients would come to the clinician was replaced with the expectation that the clinician would be assertive in delivering care and go to the patient. The assumption that the patient would negotiate the difficult pathways between different caring agencies was replaced with the assumption that the clinician is responsible for ensuring coordination of inter-agency care. The role of the keyworker became pre-eminent, and key-workers assumed responsibility for delivering a greater proportion of direct care to a much smaller number of allocated patients. Care became need-led and care programmes were designed for each individual patient.

The results of Stein & Test’s original randomised controlled study of training in community living remain impressive. Over the first year, 58% of the individuals randomised to standard progressive care were readmitted to a psychiatric hospital compared with 6% of those receiving training in community living. Not only were patients on the training in community living programme more likely to live independently in the community but their clinical state improved, together with their social functioning, likelihood of employment, adherence to medication regimens and, most important of all, their quality of life (Stein & Test, 1980). These gains were achieved without additional burden on families or other informal carers and (despite the intensity of intervention) at no extra cost because of the saving on beds (Test & Stein, 1980; Weisbrod et al, 1980). These results have been interpreted to suggest that training in community living was significantly less expensive than standard progressive care. When funding for the programme was withdrawn, all of the gains were lost. This last very important finding indicated that assertive community treatment needs to be offered to patients over the longer term. This led to a change in ethos and a change in name from training in community living to assertive community treatment, reflecting a service providing continuous, longer-term support rather than one-off training.

**Assertive community treatment**

Assertive community treatment has influenced service development internationally (Marshall & Lockwood, 1998). This wider influence can be attributed in part to the rigorous manner in which Stein and Test conducted their original study, and in part to successful early replication outside of the USA. One of the most important of these early studies was a replication of training in community living in Sydney, Australia (Hoult et al, 1984).

The evidence base for assertive community treatment, although showing some attenuation since the early groundbreaking studies, has remained strong in the USA (Mueser et al, 1998). The same cannot be said of the UK, where evidence for any advantage over standard community mental health team care has not been forthcoming (Holloway & Carson, 1998; Burns et al, 2002). One possible exception has been the apparent benefit of assertive community treatment for adults with learning disability (Tyser et al, 1999). The lack of evidence for this treatment approach in the UK was not something we expected when writing in this journal 9 years ago (Kent & Burns, 1996) and it is something we shall return to later in this article.

**The key elements of assertive community treatment**

The original US model of assertive community treatment has been well described (Test, 1992). A multidisciplinary core services team (continuous treatment team) is responsible for helping its patients meet all of their needs, and does so by being the primary provider of services wherever possible. The team offers continuity of care over time and across traditional service boundaries 24 hours a day, 7 days a week. Patients are engaged and followed up assertively, and treatment is offered in the community rather than in traditional service settings. The emphasis is on helping individuals to function as independently as possible, by teaching and enhancing skills in the environment where they will be needed, rather than in day hospitals and sheltered workshops. The patient is assisted in meeting basic needs such as housing, food and work, and the development of a supportive social and family environment. Care plans for each patient are individualised and adaptable to changing needs over time. Goals such as reduced symptom severity, increased community tenure and improved social functioning are explicit. A keyworker from the team is responsible for providing and coordinating the care of each individual, helping the person to manage his or her symptoms on a day-to-day basis and overseeing medication (Box 1).

As we indicated in our previous article (Kent & Burns, 1996), assertive community treatment is a pure form of clinical case management (Kanter, 1989) and lies at the opposite end of the case management
continuum to the earlier ‘brokerage’ model (Thornicroft, 1991). Many of its underlying concepts have become emblematic of good clinical practice. Individualised, needs-led care planning coordinated by a keyworker is the cornerstone of the care programme approach (Department of Health, 1990).

In the absence of strongly identified ‘critical components’ of assertive community treatment that distinguish it from other community interventions in the UK, it is probably best to talk of indicators of good practice.

**Indicators of good practice**

**Which patients benefit?**

In order to determine who assertive community treatment is for we need to consider what it is for (Burns & Firn, 2002) (Box 2). Stein & Test repeatedly state that its purpose is to maintain regular and frequent contact in order to monitor the clinical condition in order to provide effective treatment and rehabilitation.

Accumulated clinical experience suggests that mentally disordered offenders and individuals with a primary diagnosis of personality disorder do not seem to benefit greatly. Although studies of assertive community treatment for forensic populations are ongoing, one study found that intensively managed forensic patients actually spent longer in prison (Solomon & Draine, 1995). Rather more unexpectedly, given the target population for assertive community treatment, people with predominantly negative symptoms also seem to gain little. This may well be because of a ceiling effect.

**The case manager**

Collaborative keyworking remains the dominant approach within assertive community treatment teams, with case managers tending to take a lead role with their allocated patients rather than an exclusive role. This means that, although keyworkers tend to function in a generic role that transcends traditional boundaries of professional expertise, patients get to know more than one member of the team. Consequently they should be less vulnerable to critical dependence on any one individual. It makes staff holidays and sickness easier to negotiate. It also allows staff with specialist skills to enter in and out of the care of a patient as the need arises, in a more natural and seamless way. For example, a team member with an occupational therapy background might be asked to see another key-worker’s patient to discuss vocational opportunities and remain able to cover for the lead keyworker in respect of his or her broader generic role.

There appears to be significant variation in case-loads between assertive community treatment teams in different parts of the UK; the range in London is between 5 and 14 patients per full-time staff member (Wright et al, 2003). The results of the UK 700 study raise questions about the merit of very low case-loads (Burns et al, 1999). Team leaders need to think carefully about where they set their team’s threshold. As a rule of thumb there must be

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**Box 1 Key elements of the assertive community treatment model**

- A core services team is responsible for helping individual patients meet all of their needs and provides the bulk of clinical care
- Improved patient functioning (in employment, social relations and activities of daily living) is a primary goal
- Patients are directly assisted in symptom management
- The ratio of trained staff to patients should be small (no greater than 1:15)
- Each patient is assigned a keyworker responsible for ensuring comprehensive assessment, care and review by themselves or by the whole team
- Treatment plans are individual to each patient and may change over time
- Patients are engaged and followed up in an assertive manner
- Treatment is provided in community settings because skills learnt in the community can be better applied in the community
- Care is continuous both over time and across functional areas

(Adapted from Test, 1992)

**Box 2 Features of patients who might benefit from assertive community treatment**

Agreed indicators
- Psychotic illness
- Fluctuating mental state
- Fluctuating social functioning
- Poor adherence to medication regimens
- Poor engagement
- Relapse would have severe consequences

Emerging indicators
- Belonging to Black or minority ethnic group
- Severe bipolar disorder
- Borderline learning disability

(After Burns & Firn, 2002)
capacity for patients to be seen once or twice a week on a routine basis, with less frequent visiting being the exception. Importantly, teams need to retain the capacity to work very intensively with individuals when the need arises, for example, to avoid hospital admission. A well-functioning assertive community treatment team should be able to visit patients with high needs for care on a daily basis and sustain this level of involvement for several weeks (Burns & Firn, 2002). From a purely practical perspective, case-loads greater than 15 are unlikely to allow this.

The team

Traditional assertive community treatment teams emphasise a team approach to case management, with all members getting to know all patients and pooling responsibility for their care. The aim is to avoid an ‘overinvolved’ one-to-one relationship that might lead to pathological dependency.

Advantages to a team approach include the dilution of stress by sharing anxiety during crises and the prevention of the emotional burnout associated with close one-to-one work with resentful or treatment-resistant individuals. In practice, teams manage large numbers of patients and members cannot be expected to know every single one well enough to step into the case management role, with adequate knowledge of relapse signatures, risk indicators and social networks. Engaging individuals in treatment is also more difficult if they have to deal with many staff rather than a few. Teams usually need to adopt a pragmatic approach, using the blend of team- and keyworking that best suits each individual patient. For example, some individuals successfully engage with only one or two members, whereas others get to know all of the team over time.

Skills mix

Assertive community treatment teams need to maintain the same broad mix of skills as traditional community mental health teams. Arguably the range of skills is even more important, as one of the guiding principles of assertive community treatment is that the team should provide as much direct care as possible and avoid referring externally. The importance of this is illustrated by the frequent need to work with individuals with dual diagnosis. For this reason, teams really benefit if they have someone skilled in the assessment and management of substance misuse.

Gaps in a team’s skills mix can be addressed with training. Skills in cognitive-behavioural therapy, compliance counselling and motivational interviewing, for example, can be acquired by all mental health professionals. Indeed, the value of these therapies in engaging and treating people with enduring psychotic illnesses, together with their emphasis on a collaborative and non-confrontational approach, make them important skills for all clinical case managers in assertive community treatment teams.

Assertive community treatment requires staff not only to develop new skills, but also to adopt new ways of working. It demands a lot of individual case managers, whatever their professional background, as they are continuously expected to work beyond traditional professional boundaries and develop at least a minimal competence across a range of areas. These competencies include stabilising the patient’s living situation, monitoring medication and ensuring adherence, crisis resolution, and training and supporting the individual in activities of daily living in their own environment (Burns & Firn, 2002). When the team contains a good mix of different professionals, there is much to be said for regular interprofessional training. This approach is not only cost-effective, but it also promotes team-building and helps highlight gaps in a team’s skills mix. Where there are gaps, training from external agencies can be sought.

As with all mental health teams, a real value of a diverse mix of professionals working closely together is the breadth and depth of expertise that can be brought to bear on a problem. The different perspectives and philosophies that come with a social work or nursing background, for example, can add enormously to discussions about patient management.

In the future, non-professionally qualified support workers may have a more prominent role within UK assertive community treatment teams. Indeed, there may be real advantages in employing ‘fresh’ staff unconstrained by any one professional tradition. Experience suggests that they can be very effective at engaging patients, especially when they themselves have had experience of mental health problems. ‘User-workers’ are particularly common in US teams.

Key areas of expertise that should be available within an assertive community treatment team are summarised in Box 3.

Team schedule

The team needs to meet once a day for a brief handover meeting, which should ideally last less than half an hour (Fig. 1). This is an opportunity to discuss current or emerging problems and to allocate tasks, not to conduct in-depth reviews. These should wait until the team’s weekly care plan review meeting. At handover meetings, each case manager should quickly run through all of his or her patients, flagging any concerns. Care should be taken also to look at the cases allocated to any team member who is absent.
or on leave. Monday handovers should include planning of the week’s work and Friday handovers discussion of problems that might arise over the weekend.

Weekly review meetings are an opportunity for a more in-depth review of cases (a statutory requirement in England for all patients with mental illness and complex needs). The frequency of review will depend on the patient’s need and the team’s overall case-load, but reviews should be systematic and include a summary by the case manager and risk and needs assessments. Some teams use structured clinical assessment scales to facilitate objective progress monitoring; regular contact with a patient can make it hard to spot gradual changes.

Team size

There are no hard and fast rules about the number of members in an assertive community treatment team. Experience indicates that a team needs to be large enough to maintain the right skills mix when key-workers are on leave. If too large, a team becomes unwieldy and excessive time is spent on communication. A team of 10–12 professionals seems to work well (Burns & Firn, 2002).

Patterns of care

Hours of availability

Expectations that teams will provide around-the-clock, direct-access crisis intervention derive from early descriptions of the assertive community treatment model. Closer scrutiny suggests that, for some teams at least, this was made possible by staff who were available from home on an on-call basis rather than from a ‘mobile’ crisis team working through the night. Whether they are at home or in an office, the idea of staff being immediately available at any hour is understandably attractive to service users, carers and commissioners. It certainly sits well with the notion of care that is continuous both over time and across functional areas. Increasingly, however, the need for assertive community treatment teams to provide any form of direct 24-hour care is questioned and very few offer it.

Most mature assertive community treatment services operate for extended hours, but few run throughout the night. There are good reasons for this. Operating a team safely for 24 hours a day is extremely expensive, both in financial terms and in terms of staff opportunity cost. Staff morale is inevitably more difficult to sustain if team members are required to work complex shift patterns with extended periods of relative inactivity. Professionals attracted to the assertive community treatment model

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<td>10.00–11.00 Monthly business meeting/supervision</td>
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Fig. 1 Example timetable.
Running an assertive community treatment team

Hospitalisations
A continuous and seamless assertive community treatment service should ideally manage individuals throughout their hospital admissions, exerting full control over the timing of admission and discharge. In many locations, different teams look after patients in the community and patients in hospital. In these circumstances, assertive community treatment teams can provide a continuity that is not otherwise available. In reality, many such teams in the UK have to relinquish responsibility for in-patient care. In such circumstances, close liaison with the in-patient team is essential if continuity of care and opportunities for early discharge are to be maintained. Active ‘inreach’ (visiting individuals while in hospital at least as often as one would visit them in the community) is an essential aspect of assertive community treatment work.

The role of the psychiatrist
Not all assertive community treatment teams include psychiatrists. Some liaise with psychiatrists outside of the team in adjacent local services. A recent survey of expert opinion (Burns et al, 2001) revealed a high agreement that medical involvement is a crucial component of assertive community treatment and this seems to have been confirmed by cluster analysis (see ‘The control condition’ below).

Assertive community treatment teams are not especially hierarchical and it is accepted that team members of all disciplines can take responsibility for decision-making about patients. This concept is more readily accepted in some countries and cultures than others. The relative scarcity of psychiatrists in the UK, for example, has meant that nurses are used to taking on extensive responsibility for patients. Teams working regularly with a psychiatrist appreciate the opportunity to get early medical reviews if there are problems. On the whole, prescribing medication remains the responsibility of doctors and clearly some decisions require senior psychiatric involvement.

Engagement with treatment
Assertive community treatment teams have always recognised the importance of promoting treatment adherence. The effective engagement of patients with medication regimens seems likely to have made a very significant contribution to the early success of the model. The increasing use of clozapine in the community has introduced another dimension to the work of assertive community treatment teams, as the task of promoting clozapine is especially suited to an intense and assertive outreach approach. They have a real opportunity to provide an effective intervention for individuals who might otherwise be unable to receive it. Clozapine can be delivered daily to promote adherence, and case managers are well placed either to take patients to a clinic for blood tests or even to carry them out in the patients’ homes. One team has described starting clozapine at home to avoid the need for admission (O’Brien & Firn, 2002), and the drug data sheet has been amended accordingly.

Referral to and discharge from a team
Assertive community treatment is expensive and should be reserved for people who cannot be managed effectively by routine services. Typically, these individuals will have a psychotic illness with fluctuating mental state and social functioning and poor adherence to prescribed medication. Acceptance criteria need to be clear and transparent to avoid confusion among referrers. The most likely criteria are listed in Box 4. Research is still needed to determine who is most suitably helped by assertive community treatment, but the quality of other local services will probably be a factor governing referral thresholds.

Although Stein & Test (1980) moved away from a time-limited intervention, lifelong assertive community treatment is neither necessary nor practical.
when there are good alternative services. Transferring patients back to routine services should happen in a planned way, after a long period of reduction in clinical input from the assertive community treatment team to test stability and allow an adequate handover period. If the transition to the standard service fails there should be flexibility within the system for the individual to be referred back to the assertive community treatment team.

A small minority of patients fail to engage with any team. There are no hard and fast rules about how long an assertive community treatment team should attempt to engage such individuals, but sometimes the team has to accept that it will not succeed. By the same token, the lack of proven success for assertive community treatment with individuals who have predominantly negative symptoms means that the team needs to carefully weigh the possibility of small to insignificant gains against a large amount of time and clinical effort. Discharging patients who have consistently failed to benefit will allow a degree of ‘throughput’—freeing places for individuals who may experience much greater gains.

**Current status of assertive community treatment in the UK**

As indicated, early optimism about the benefits of assertive community treatment in the UK has not been matched by reality. The studies that have been conducted have failed to demonstrate the hoped for improvements in long-term outcome, with reduced bed occupancy a primary measure (Ford et al, 1997; Holloway & Carson, 1998; Wykes et al, 1998; Burns et al, 1999). There has been no convincing evidence that assertive community treatment is better than pre-existing UK community mental health services at improving clinical symptoms, social functioning or quality of life. The lack of any impact on bed occupancy has meant that there has been no demonstrable economic benefit either (Byford et al, 2000). Given the comparable performance of the less expensive community mental health teams in UK studies, there are inevitable issues regarding the introduction of assertive community treatment services nationwide. The cautions voiced about the costs and benefits of assertive community treatment in the commentary accompanying our first article seem even wiser with hindsight (Hirsch, 1996).

The key challenges, then, are to seek to understand the UK results in a way that helps us improve our services across the board and to manage assertive community treatment teams in their local context in a creative way that ensures delivery of the very best for their patients.

**Explaining the UK results**

Three factors need to be considered to understand the results of the UK studies: model fidelity, context and the control condition.

**Model fidelity**

Much attention has been paid to the question of model fidelity—the extent to which a team describing itself as an assertive community treatment team matches the accepted definition of such a team. The question is complicated by our poor understanding of which of the described components actually matter. Attempts to operationalise the critical components of assertive community treatment have been largely self-referential, with ‘experts’ already convinced that the model works being asked what they think is most important (McGrew & Bond, 1995). A striking example is small staff case-load. Case-loads of fewer than 12 are strongly promoted as a critical component of assertive community treatment. Few would have predicted that reducing UK care coordinators’ case-loads by more than two and a half times (comparing average case-loads of 32 for standard care with 12 for assertive community treatment) would not lead to any significant differences in outcome on any measured variable at 2 years, yet this is exactly what the largest UK randomised controlled trial found (Burns et al, 1999). Not only was this result unexpected given the preoccupation with case-loads that we all share, but it is also counter-intuitive, unless one postulates some kind of ceiling effect. It also suggests that we should not blindly accept that any other single ingredient of assertive community treatment is critical to its success. How important, for example, is ‘assertiveness’?

Although it is important that we refine our understanding of which components are important for success, recent research indicates that some UK assertive community treatment services, although differing in some aspects of practice, are not significantly different from benchmark American counterparts (Fiander et al, 2003).
Context

In the USA, Stein & Test’s service was introduced against the backdrop of a large, isolated mental hospital surrounded by office-based private practitioners. The UK comparison services were far more integrated and continuous, and they had already adopted the care management model that had made the first assertive community treatment services so innovative. This raises the interesting question of whether comparative UK community mental health services, integrated as they are with well-functioning primary care and social services, have been so effective for patients with severe mental illness that American-sized differences in outcome between assertive community treatment and ‘standard care’ are unlikely.

The control condition

The third factor in the studies, and one that raises much broader questions, is the control condition. Services change over time and have always varied with location. It is possible that UK studies (as with later US and Australian studies) have failed to find differences because the control-condition standard services already contain the main effective ingredients of assertive community treatment. There is some strong evidence for this (Burns et al, 2001, 2002; Wright et al, 2004). In particular, in a review of international home-based care, Burns et al (2002) performed cluster analysis on data about actual practice obtained from the researchers who had conducted over 60 of the 91 trials that their review examined. This identified the regular clinical features of the experimental services and the authors then used regression analysis to test individual features against reduction in bed occupancy. This produced six features common to the various treatment models and two that were positively associated with reduced bed occupancy (Fig. 2). Clearly several of these are found in routine UK care and may explain, in part, the failure of studies to demonstrate substantial advantages of assertive community treatment.

Or is there no case to answer?

Although any of these three explanations may hold the key it is also possible that there is no question to answer. A detailed comparison of the in-patient component of home-based care in US and UK studies (predominantly of assertive community treatment) found that the main difference was that US control patients spent more time in hospital, whereas experimental patients in both countries spent about the same time in both locations (Burns et al, 2002). So it is still far from clear that US assertive community treatment services are that much more effective than equivalent UK services.

Despite these reservations, until we have a better understanding of the ingredients and contextual factors required for optimal assertive community treatment, the challenge for anyone running a team in the UK is not to try to replicate the American model exactly, but rather to take a local view and consider each aspect of the model an indicator of good practice. For example, geographically dispersed rural teams may have to adopt practices different from those of inner-city teams. The high quality of UK community mental health services also raises the possibility of discharging patients from assertive community treatment teams, something that seems at odds with early views on the long-term (possibly lifelong) supporting function of the model.

Conclusions

Assertive community treatment is the most wide-spread and durable model of clinical case management for the treatment and rehabilitation of people with severe and enduring mental health problems. It is established in the USA, where it has been repeatedly shown to have significant advantages over routine care, and it is increasingly being adopted in the UK and mainland Europe. Although the same advantages have not been demonstrated outside of the USA, allocation of new funding to assertive community treatment in the UK has effectively ring-fenced resources for the care of some of the patients with the greatest needs.

Assertive community treatment should be an addition to well-organised and appropriately resourced routine services; it should not be a...
replacement. It should be restricted to individuals with psychosis and complex needs, utilising evidence-based interventions wherever possible and applying indicators of good practice to local circumstances. Research continues into what the effective elements of assertive community treatment are and into how to target the most appropriate patients to benefit from this form of care.

References and related articles


MCQs

1 Assertive community treatment incorporates the following key elements:

a engagement and follow-up of patients in an assertive manner

b improved symptom management as the primary goal

c continuous care both over time and across functional areas

d training the patient to avoid seeking help with symptom management

e avoidance of the use of medication to treat symptoms.
Running an assertive community treatment team

2 The following problems are agreed indicators for assertive community treatment:
- a neurotic disorder
- b severe learning disability
- c personality disorder
- d fluctuating social functioning
- e psychotic disorder.

3 Assertive community treatment has been shown to be:
- a more effective than standard care in the UK
- b the treatment of choice for patients with bipolar mood disorder
- c less expensive than standard care in the UK
- d a good alternative to day hospitalisation
- e more effective at reducing symptoms than at reducing functioning.

4 Assertive community treatment teams should avoid:
- a managing patients during in-patient admissions
- b prescribing medication
- c pathological dependency
- d sharing their anxiety during a crisis
- e requiring case managers to work within professional boundaries.

5 Assertive community treatment:
- a developed from training in community living
- b aims to help patients live independently
- c aims to replace the total support of hospital with comprehensive support in the community
- d avoids the use of psychological therapies
- e is the most rigorously evaluated model of psychiatric community care.

MCQ answers

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NEW OUT FROM THE ROYAL COLLEGE OF PSYCHIATRISTS

Partners In Care Training Resource
Edited by Mike McClure

This training pack about carer issues is for use by mental health professionals and has been compiled following the success of the College’s ‘Partners in Care’ campaign. The training folder contains essential written information relating to carers of people with mental health problems and learning difficulties. This consists of much of the material produced for the ‘Partners in Care’ campaign (including several checklists for health care professionals, carers and service users; and leaflets on a range of mental health problems), plus, carers’ own stories, articles from the College’s journals and a preface by HRH The Princess Royal. They aim to give rise to various methods of training such as seminars, group discussions and role-play exercises.

The material is divided into six modules: carers; partnerships; young carers and families; caring for specific conditions; communication; and carers in training. Each module presents learning objectives (which fall under the categories of knowledge, skills and attitudes) and it is hoped these will later be incorporated into clinical practice. There are several self-assessment sheets that relate to the learning objectives of each module. The accompanying CD-ROM contains an electronic version of all the printed material, additional related articles, plus some MS PowerPoint presentations for use by trainers.

From June 2005, the Royal College of Psychiatrists made it mandatory to involve patients and carers in psychiatric training. This pack will help tutors and training programme directors ensure that carer issues are well covered in training programmes. It is aimed at both trainees in psychiatry and for the continuing professional development of those who have qualified. It should also be useful for allied professions including psychology, social work, nursing and family therapy; and for carers’ organisations to help promote carer issues.

Sep 2005, ISBN 1 904671 28 4, Price £45.00 – Ring-binder containing 257 pages and CD-ROM.
The last 20 years have witnessed a surge of interest in assertive community treatment (ACT) for the severely mentally ill (Drake & Burns, 1995). ACT aims to help people who would otherwise be in and out of hospital on a ‘revolving door’ basis live in the community and enjoy the best possible quality of life. Services based on the ACT model seek to replace the total support of the hospital with comprehensive, intensive and flexible support in the community, delivered by an individual key worker or core services team. They are organised in a way that optimises continuity of care across different functional areas and across time.

ACT has been most extensively deployed in the United States, where various developments have culminated in the Programs in Assertive Community Treatment (PACT) model. The origins of PACT lie with the innovative and highly successful Training in Community Living (TCL) programme developed during the 1970s at the Mendota Mental Health Institute in Madison, Wisconsin (Marx et al., 1973). The TCL programme sprang from a recognition that contemporaneous community treatments did little more than maintain the chronically disabled patient in “a tenuous community adjustment on the brink of rehospitalisation” (Stein & Test, 1980).

The concepts underpinning TCL were simple, yet revolutionary. Its architects, Arnold Marx, Leonard Stein and Mary Ann Test, realised that an effective community treatment programme must assume responsibility for helping the patient meet all of his or her needs. They argued that these needs include the material essentials of life, such as food, clothing and shelter; coping skills necessary to meet the demands of community living; motivation to persevere in the face of life’s adversity; freedom from pathologically dependent relationships, and support and education of significant others involved with the patient in the community.

The expectation that the socially disabled patient would come to the clinician was replaced with the expectation that the clinician would be assertive in delivering care and go to the patient. The assumption that the patient would negotiate the difficult pathways between different caring agencies was replaced with the assumption that the clinician is responsible for ensuring coordination of interagency care. The role of the key worker became preeminent, assuming responsibility for delivering a greater proportion of direct care to a much smaller number of allocated patients. Care became needs-led, and care programmes were designed for each individual patient.

The results of Stein & Test’s original, randomised, controlled study of TCL retain their power to impress. Over the first year of the programme, 58% of the patients randomised to progressive, standard care were readmitted to a psychiatric hospital compared with 6% of patients receiving TCL. Not only were patients on the TCL programme more likely to live independently in the community, but their clinical state improved, together with their social functioning, likelihood of employment, compliance with medication and, most important of all, their quality of life. These gains were achieved without additional burden on families or other informal carers, and (despite the intensity of intervention) at no extra cost because of the saving on beds (Test & Stein, 1980; Weisbrod et al., 1980).

These results have been interpreted to suggest that TCL was significantly less expensive than standard, progressive care. When funding for the programme was withdrawn, all of the gains were lost. Assertive community treatment needs to be offered to patients over the longer term.
The enormous influence of the TCL model can be attributed to the rigour with which the original programme was evaluated. Many other studies have followed (Olfson, 1990; Burns & Santos, 1995). One of the most influential of these was an early replication of the TCL model in Sydney, Australia (Hoult et al., 1983). To date there have been over 20 randomised controlled trials of ACT, making it the most extensively researched service development in community psychiatry. In spite of this, we still do not know exactly which components of ACT are critical for outcome.

In Britain, the largest study of an assertive community treatment to date is of the Daily Living Programme (DLP; Marks et al., 1994). The results of this were a significant reduction in duration of hospitalisation, although not its frequency. There were some modest clinical gains at 18 months and considerable benefits in terms of patient satisfaction. Like TCL, the DLP demonstrated a rapid loss of gains when the service was withdrawn. Unlike Stein & Test, however, the investigators found no financial advantage—probably because of the major start-up costs of the scheme and a focus on a more acutely ill patient group. The study was also compromised by a number of extraneous factors—a highly publicised homicide and shifts in clinical control of in-patient services.

**The key elements of ACT**

The TCL/PACT approach has been very well described (Test, 1992). A multidisciplinary core services team (continuous treatment team) is responsible for helping its patients meet all of their needs, and does so by being the primary provider of relevant services wherever possible. The team offers continuity of care over time and across traditional service boundaries 24 hours a day, seven days a week. Patients are engaged and followed up assertively, and treatment is offered in the community rather than at traditional service settings. The emphasis is on helping patients function as independently as possible, by teaching and enhancing skills in the environment where they will be needed, rather than in day hospitals and sheltered workshops. The patient is assisted in meeting basic needs, such as housing, food and work, and the development of a supportive social and family environment. Care plans for each patient are individualised and adaptable to changing needs over time. Goals, such as reduced symptom severity, increased community tenure and improved instrumental functioning, are explicit. A key worker from the team is responsible for providing and coordinating the care of each individual patient, and helps the patient manage his or her symptoms on a day-to-day basis, including overseeing medication (see Box 1).

ACT is therefore a pure form of clinical case management (Kanter, 1989) and lies at the opposite end of the case management continuum to the earlier ‘brokerage’ model (Thornicroft, 1991). Many of its underlying concepts have become emblematic of good clinical practice. Individualised, needs-led care planning coordinated by a key worker is the cornerstone of the Care Programme Approach (Department of Health, 1990).

A few authors have attempted to tease out those components of PACT which are critical for its success (McGrew et al., 1994; Teague et al., 1995). A better understanding of the critical components will facilitate precise application of the model in a greater variety of circumstances. Although there is widespread consensus on the likely components, prospective studies of programme fidelity are urgently required (Taube et al., 1990).

**What does an ACT team do?**

ACT has traditionally been delivered by discrete clinical teams operating alongside generic, locally
based mental health services. An individual team member acts as an intensive case manager (ICM) to a small group of patients (no more than 15, and usually less than 12) to help each patient meet all of their needs. Before these needs can be identified, the key worker must engage the patient in a therapeutic relationship. It is difficult to overstate the importance, and all too often the difficulty, of this task. One of the obvious strengths of the ACT model is that key worker time is protected and available for such fundamental work.

The core task of engagement is to build and foster a positive attitude on the part of the patient to both the key worker and treatment. The process of engagement pervades many other tasks, but in its purest form involves general problem solving, joint recreational activity (for example, going to see a film together), and befriending. These are generally not activities afforded high status in mental health work, often being delegated to voluntary organisations. The need for the key worker to foster a close therapeutic relationship that in all probability will last for many years lends them a new, and appropriate, priority.

Case 1.

NH is a 53-year-old isolated Irish man with a 30 year history of schizophrenia who despite several admissions has always resisted follow-up. When he had been admitted to hospital, it was always in a severely neglected state, usually under a section of the Mental Health Act. His previous compliance with medication had been very poor and he had consistently refused follow-up from a community psychiatric nurse (CPN). His intensive case manager was initially subject to the same resistance. He noted amid the general squalor of NH’s small flat that the toilet did not flush and found out that it had not for over two years. NH had regularly filled a bucket of water to flush it. It took the case manager 40 minutes and £3.60 of petty cash to fix it. NH (who had previously insisted that he did not mind the problem) was clearly delighted, allowed the case manager to visit more regularly and start to take him shopping (an activity previously inhibited by a complex set of delusions). As a consequence, he began to eat a more adequate diet.

In the midst of this, he allows his medication to be monitored and has no great opposition to taking it. There remains much still to be done – he is still refusing to seek his benefits, get a check up from his GP or improve his hygiene. He has, however, remained in contact for 15 months, which for him is a record.

Case 2.

GH is a 32-year-old man of West African descent who has suffered from schizophrenia for 9 years, with a history of multiple admissions under the Mental Health Act. His family are concerned and support him when he is well, but are excluded when he deteriorates. Despite his severe disability, he regularly seeks open employment and becomes threatening and hostile when rejected. Previous follow-up has usually been restricted to depot phenothiazines and is often characterised by suspicion and rejection of his CPN.

In the early stages of engagement, he regularly ‘sacked’ his intensive case manager. The ICM found that if he went back a few days later and did not mention the ‘sacking’, it was not brought up by the patient. The ICM has found that periods of resistance and hostility are best managed simply by changing the focus of the interview, and this is possible because they are engaged in a number of ventures – redecorating the flat and pursuing a place on a motor mechanic training course. Medication has been maintained for over one year and regular family meetings have helped the patient’s mother to understand his illness better. She has successfully adopted some of the conflict avoidance techniques she has seen the case manager use.

At an early stage, the ICM works collaboratively with the patient to identify his or her needs. This process must be systematic, and may be facilitated by the use of a standard instrument such as the Camberwell Assessment of Need (Phelan et al, 1995). ICM activity with individual patients can be grouped in the following seven broad categories: help with housing, finance, medication, occupation and leisure, daily living skills, the criminal justice system and physical health. Clear and explicit goals, derived from identified needs, strengthen collaboration between ICM and patient on a day-to-day basis. For example, the task of getting up at a reasonable hour can be linked with the goal of getting a job and earning money. American ACT services place a high emphasis on occupational rehabilitation. The motivation to earn money and be identified with a more normal role in society can be harnessed to powerful effect by a key worker who has intensive contact (at least twice a week) with the patient over many years.

Setting up a local ACT service

Establishing the local need

Assertive community treatment has been shown to benefit those patients trying to live in the community who have the highest degree of social disablement. Such patients are not necessarily those who have the highest level of contact with community mental health teams (CMHTs); many actively avoid contact. Our own experience has also
taught us that while CMHTs readily identify the small group of patients who require a disproportionate amount of care, they tend to overestimate the number of severely mentally ill patients with whom they have regular contact. This discrepancy reflects the absence of a consensus on the definition of severe mental illness. Diagnosis alone is clearly a poor indicator, but a rigidly formulaic approach to definition is impractical. We have found Bachrach’s (1988) characterisation of this group most useful, using diagnosis, duration and disability.

**Team structure**

Assertive community treatment appears to work best when the ACT team has overall clinical responsibility for all aspects of patient care – including in-patient care. The DLP study demonstrated the problems which may arise with divided consultant responsibility. The easiest, and arguably the neatest, system is for the ACT team to be self-contained, retaining consultant medical responsibility for care of the patients at all times and exercising control over a small in-patient facility. There are potential problems with this approach in the UK, where over 80% of mental health services are sectorised (Johnson & Thornicroft, 1993). The creation of additional teams may fragment the existing comprehensive service. There is a danger, too, of blunting the commitment of CMHTs to work with the severely mentally ill, by removing responsibility for the care of the most disabled. Our approach has been to integrate ACT key workers into existing CMHTs. In addition to avoiding service fragmentation, this model utilises existing patterns of vertical (primary–secondary–tertiary) and horizontal (health–local authority) service integration. A potential problem with this approach is the dilution of programme fidelity and diminished influence on in-patient care (see Table 1).

Surprisingly little is known about the ideal size of a mental health team in the UK (Onyett et al, 1994). We suggest a minimum of five intensive case managers to allow leave to be covered internally. More than eight begins to become unwieldy, making regular review, and familiarity of all case managers with all patients, difficult. ACT services in the US have successfully used both skilled mental health professionals and ‘fresh’ staff with non-vocational qualifications as case managers. Skilled staff with an accredited training in mental health work are significantly more expensive to employ, and many of the core tasks of ACT appear relatively straightforward and simple. Their skill, however, lies in achieving them with people who are profoundly disabled by severe mental illness and in maintaining a longer-term relationship. Fresh staff, on the other hand, may be unburdened by inappropriate professional attitudes, and better able to adapt to the role of intensive case manager. The arguments for and against the employment of highly skilled staff remain unresolved, although available evidence suggests that they may achieve better outcomes.

There is no evidence to indicate that any one group of mental health professionals is better equipped to act as case managers than any other. ACT is holistic in its attention to patients’ needs, and case managers must adopt a generic approach, whatever their professional backgrounds. Nevertheless, in the absence of hard data it seems logical to recommend that ACT teams retain a multi-disciplinary skill mix. Community psychiatric nurses (CPNs) have a particularly valuable role with respect to medication, and perhaps of all mental health professionals are the most skilled at promoting compliance with medication – an important vector of good outcome in ACT. Occupational therapists and social workers also have highly relevant skills, and if they can be recruited to the ACT team, this is to be particularly recommended. Clinical psychologists have been more prominent in some of the American ACT teams than they have in the UK. If it is not possible to recruit a psychologist to the team, then access to psychological skills outside the team is essential. We suggest that a team which mixes nurses and non-nurses in equal proportion is optimal.

**Team meetings**

In the US, most ACT teams meet briefly every day. A team should certainly meet at least twice a week. We suggest at least three times a week in the first year to build cohesiveness and strengthen the new
professional identity. Each meeting should include hand-over information about all patients, and a review of two or three patients in-depth each week to update individual care programmes. Time needs to be devoted on a regular basis to professional development and discussion of the new and challenging role of being an intensive case manager.

**Cross cover**

Key workers should not just cover each other for holidays and absences. Patient involvement with other case managers is essential to avoid the development of pathological and over-dependent relationships. Individual case managers can then discuss their patients with colleagues who have first hand knowledge of them. Although the concept of 'team responsibility' for all patients has been advocated by some services (Witheridge, 1991; Haringey Mental Health Group, 1994), we see a major benefit in having a clearly identified individual responsible for the care of the patient. The likelihood of confusion is decreased, and the essential benefits of case management (i.e. a clear focus for the planning, coordination and delivery of care) protected. In our opinion, a team model undervalues the essential importance of the individual therapeutic relationship in supporting the patient.

**Extent of service**

Services adhering fully to the PACT model offer access to a key worker from the team 24 hours a day. It is not apparent, however, that there are substantial advantages to 24 hour access to an ACT service in the UK, where primary care and 'out of hours' emergency mental health services are highly developed and accessible. The tasks of case management are usually most efficiently conducted during 'office hours', when liaison with other key agencies (e.g. social services, housing, social security) is possible. As few of the patients using the service are employed, most will be able to meet with their key workers between 9 am and 5 pm. Key workers will, however, need to be regularly available outside of these times – particularly when engaging a patient, supporting leisure activities or working with carers. Our own review of the literature indicates that 24 hour services in the UK may add little to an 'extended hours' service at a considerably greater cost. We piloted an extended hours ACT service (until 10 pm) in our district and found it very little used, and have subsequently disbanded it.

**Supervision and leadership**

As we gain clearer understanding of the critical components of ACT, the importance of programme fidelity is increasingly apparent. An ACT team needs to be led by someone with previous experience of the model, who can provide regular supervision and support to other key workers. Staff burnout has been perceived as a potential problem with ACT, but intensive case managers typically report high job satisfaction. Nonetheless, long-term, intensive work with a small number of seriously ill patients brings its own unique stresses.

**Team model and operational policy**

Identifying a model and drawing up an operational policy should logically come first, but experience has taught us otherwise. Although a team model has to be identified before staff are recruited, the operational policy is best evolved and regularly reviewed with the team members themselves. This leads to a greater sense of ownership and commitment.

A well written operational policy will become an invaluable document which will both guide subsequent development and implementation of the service, and also serve as a reference once the service is up and running. It needs to be written in clear and simple language and should describe the definition, philosophy and aims of the service, together with operational details such as staff skill mix, training and deployment, together with a brief, operationalised definition of patients who will be accepted by the service and broad practice guidelines. The components of the PACT model identified in this paper could usefully be used as a starting point (see Box 2).

**Resistance and problems**

Setting up a new, innovative service may generate major resistance. This has been repeatedly reported by investigators of such services in the UK and needs to be approached philosophically. The source of resistance is both external and internal.

**External resistance**

The major external resistance is professional anxiety about change. The new service may be perceived as a threat to the position and status of
part of the patient partly derive from the increased level of self-disclosure that is inevitable in such an extended key worker role. The ethics of pursuing reluctant patients was regularly debated by members of our service. This is a real issue but often served as a platform for the expression of external resistance. There is a fine line between assertiveness and harassment. Such judgements have to be made in most clinical situations, but are particularly prominent in ACT services.

**Summary**

Our service is only in its second year and is subject to an extensive evaluation. Informed judgements about its value will have to await that analysis. Some early differences can, however, be observed. After an initial period of finding the new role difficult and feeling ‘uncontained’ case managers report high levels of job satisfaction from their limited case loads and extended remit. Keeping patients engaged has undoubtedly been improved by the new approach and the sense of freedom to do what is needed to make the patient feel better (rather than to focus too narrowly on ‘illness issues’) has resulted in an improved therapeutic alliance. Medication compliance may have improved because it is no longer such an issue – just one part of a complex and generally rewarding relationship. One gratifying result has been a markedly improved uptake of benefits by the patients and an overall impression of improved material conditions. The relationship between case managers and other disciplines has steadily improved. It has been helped along by shared experience of admissions of case manager clients and a recognition that this approach is not a ‘cure-all’. Nothing succeeds like failure.

In spite of all of the potential problems that may be encountered in setting up an assertive community treatment service, the benefits are considerable. Benefits to the patients include obvious improvement in quality of life, and for many, the avoidance of episodic crises resulting in major emotional and social upheaval. There are also benefits to other clients of the mental health service – as a consequence of the more efficient use of expensive inpatient services and the liberation of these resources for CMHTs.

The gap between the outcome for patients of ACT and standard community mental health services may continue to close as the latter adopt more of the principles of the former (Burns & Santos, 1995). If so, then the pioneers of ACT have a great deal to be thanked for. There are certainly potential benefits to the various mental health professions. We experienced initial resistance from psychiatry, nursing, clinical psychology and occupational therapy, and much later on from social work. Many psychiatrists felt that the proposal for a new assertive community treatment service described nothing new, and that intensive case management was already being provided as required by CMHTs. There was also a concern that the new service could lead to confusion regarding clinical responsibility for individual patients.

Community psychiatric nurses were worried that their jobs might be threatened. For occupational therapists and clinical psychologists it appeared that the high profile of a major service development which relied heavily on their skills, but which was not under their control, contributed. Resistance from social workers developed more slowly, reflecting their generally positive view of generic functioning. The clarity of definitions in such a service (e.g. patient characteristics, case load size, regularity of contact) is unusual in NHS mental health services and can be perceived as implied criticism of the imprecision that is traditionally accepted. For example, rigorously established case loads can highlight uncertainty about workloads and skill mixes elsewhere in the system. Tight control over such a service also evokes fears of a rigid ‘medical model’.

**Internal resistance**

Within the new team there will be anxiety about the new key worker role, particularly with regard to tasks outside traditional professional boundaries. Concerns about over-dependency on the

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**Box 2. Elements of an operational policy for an ACT service**

| Definition of the service |
| Philosophy of the service |
| Aims of the service in relation to clients, social networks and other services |
| The operational definition of the target patient group |
| Pathways to and from the service |
| Composition of the core services team or equivalent |
| Team accountability |
| The definition and role of the case manager |
| The definition and role of the team leader |
| The size of key worker caseload (essential) |
| Supervision and support of key workers |
| Hours of cover |
benefits for CMHTs in the UK in terms of new learning and new practice. Greater clarity and definition of target populations and openness about activities are attributes that all teams facing the demands and challenges of the ‘new’ NHS would be served by. Such clarity is rapidly developed in ACT teams.

References


Multiple choice questions

1. Key elements of the PACT model include:
   a Individualisation of treatment between patients and over time
   b Patients are engaged and followed up assertively
   c Key worker case loads vary from 15–20
   d The avoidance of staff burnout by the regular reallocation of patients to keyworkers within the core services team.

2. The potential advantages of integrating ICMs into generic community health teams include:
   a They have small case loads and so are able to help with the work of other team members at particularly busy times
   b Responsibility for in-patient care is shared with staff who have experience of alternatives to the ACT approach
   c Skills may be shared with other team members
   d Fragmentation of existing services is avoided.

3. In general terms:
   a There is no evidence to indicate that one group of mental health professionals is better equipped to act as ICMs than any other
   b ACT teams function best of all if the ICMs are experienced community nurses
   c Clinical psychologists are too highly trained to be employed as ICMs
   d Individuals who lack a professionally accredited training in mental health work are unlikely to perform well as ICMs
   e ICMs need to adopt a generic approach to patient care.

4. Assertive community treatment:
   a Originated with the Daily Living Programme, in Madison in the 1970s
   b Aims to replace the total support of the hospital with comprehensive support in the community
   c Is more expensive than alternative forms of community care
   d Optimises continuity of care across different functional areas and time.
5. Compared to standard psychiatric care in the community, the training in Community Living Programme developed by Stein & Test helped patients to:

a. Live independently
b. Obtain employment
c. Stop medication without relapse
d. Comply with medication.

It is difficult not to be won over by the description of assertive community treatment that promises nearly total caring for the most chronically disabled mentally ill, including “the material essentials of life such as food, clothing and shelter, coping skills necessary to meet the demands of community living and motivation to persevere in the face of life’s adversity”. If we keep in mind that this approach is for patients who in previous decades would have spent their life in a mental institution, one can readily justify the transfer of expense and resources to this hopefully more humane form of treatment which allows patients to live within the context of open society, a preference they inevitably opt for when surveyed after a move from hospitalisation to community care.

Unfortunately there are serious questions as to what extent this model can meet the shortcomings of community care in modern Britain. Even 15 years after the Stein & Test (1980) original article there does not seem to be a description in the literature of any service which has been tested over a sustained period, say 5 years. The authors of this article, are only in their second year of providing such a service and they report that the Stein & Test service, and Hoult’s service in Australia were both closed down with a loss of patients’ previous benefits. Nor is it clear to me whether the division between Social Security, Social Services, Housing and Health in the UK allow for the type of total combined approach which ACT seems to require. Care management should offer such an opportunity by providing a single total budget for patients selected for such treatment so perhaps this should be combined with ACT.

It would appear that ACT should improve the quality of life and level of functioning of some patients with chronic mental illness. There is a problem in identifying which patients should receive this type of care as opposed to alternative approaches, such as the provision of a haven of supervised residential homes for patients who cannot function even when offered ACT. There are also the groups who are violent, abuse drugs, or remain resistant to assertive outreach because of their own peculiar psychopathology. These limitations should be given recognition by advocates of any single approach so that a comprehensive mental health system can be provided to replace institutional care of the past.

Purchasers and providers should keep a reasonable balance between the resources invested into the most severe mentally ill and the resources required by the rest of the population, so that they too can have decent and respectable facilities when they require acute treatment in hospital, and have access to psychologists, psychiatrists and community psychiatric nurses even when they do not fall into the most severely disabled group. Advocates for mental health services should approach assertive community treatment with some caution until knowledge of the cost and benefits and the ability to sustain such a service on a long-term basis has been well established.
Assertive community treatment in UK practice: Revisiting... Setting up an Assertive Community Treatment Team

Andrew Kent and Tom Burns

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