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Staff and Consumer Perspectives on Defining Treatment Success and Failure in Assertive Community Treatment

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Abstract

Objective—Although Assertive Community Treatment (ACT) has been consistently recognized as effective, there has been little research on what constitutes success in ACT. The purpose of the current study was to 1) understand how ACT consumers and staff define treatment success and failure and 2) examine whether definitions varied between staff and consumers.

Methods—Investigators conducted semi-structured interviews with 25 staff and 23 consumers from four ACT teams.

Results—Across perspectives, success and failure were most clearly related to consumer factors. Other themes included having basic needs met, being socially involved, and taking medications. Reduced hospitalizations were mentioned infrequently. Consumers were more likely to identify level/type of treatment as defining success and failure, while staff discussed substance abuse more often when defining failure and improved symptoms when defining success.

Conclusions—Success in ACT should be viewed more broadly than reduced hospitalizations and include domains such as social involvement.

Assertive Community Treatment (ACT) is a widely investigated treatment model for persons with severe mental illness and is recognized as an evidence-based practice (1). Typical outcomes include reduced dropout rates, reduced hospitalizations, increased housing stability, and higher client and family satisfaction (2, 3). However, there is little evidence that ACT improves symptomatology, quality of life, and social functioning or impacts recovery-oriented domains, such as employment, education, and relationships (4).

Although ACT is effective, it does not work for everyone. One way to understand this variability is to explore client successes and failures. Such an exploration provides information about mechanisms that underlie an intervention, ways to perfect or add to existing procedures (5), and clarifies what is being done well, what is not being done well and with whom. Currently however, there is no consensus definition of what constitutes treatment success or failure in ACT. Although research typically has operationalized success as decreased hospitalizations, this narrow outcome does not capture important recovery-related domains such as hope and meaningful activities (6, 7). Thus, one important step is to determine how success and failure is defined in ACT. Second, given that staff and consumer perspectives often differ (8, 9), we also chose to compare staff and consumer definitions of success and failure.

Methods

Sites were four ACT teams in Indiana participating in a larger study of recovery in ACT. Six staff members representing the major disciplines on each team were targeted for recruitment: team leaders (n = 4), psychiatrists (n = 2), nurses (n = 5), case managers (n = 5), substance abuse specialists (n = 4), and employment specialists (n = 3). One team had no employment specialist, one psychiatrist was unavailable and another refused. Additionally, a therapist (n = 1) and peer support specialist (n = 1) participated; these are optional positions in Indiana. In total, six staff from three teams and seven staff from the fourth team participated (n = 25). Most were Caucasian (23, 92%), female (19, 76%), and middle-aged (43.6 ± 11.4).

All staff members were asked to identify the most and least successful consumers on their teams. Consumers were rank-ordered based on the number of staff nominations. On each team, consumers identified as most (n = 3) and least successful (n = 3) were contacted for interviews. Six consumers nominated as less successful could not be included due to incarceration (n = 3), not currently receiving services (n = 2), and refusal to participate (n = 1). In each case, the next ranked consumer was notified and participated. One consumer nominated as more successful declined, but could not be replaced because it was the end of the study. In total, 11 more successful and 12 less successful consumers participated (n = 23). Most were Caucasian (20, 87%) and female (12, 52%). The average age was 42.7 ± 12.0 .

Data were collected during the fall and winter, 2007. Researchers attended the team's morning meeting to invite staff participation. After obtaining informed consent, the consumer nominations were solicited and compiled. ACT staff contacted consumers first to determine their willingness to talk with a researcher. Researchers met individually with willing consumers to obtain written informed consent. Interviews were audiotaped and transcribed. Participants were compensated \$50 for completing interviews. The Indiana University-Purdue University Institutional Review Board approved the study procedures.

To assess how staff view success and failure, staff reflected on the six exemplar consumers. Staff first rated the overall success of each consumer (1 = completely unsuccessful; 5 = completely successful). We then asked: "What would make [consumer's name] a five?" Or,

“What would make [consumer’s name] a one?” Consumer interviews followed a similar process. Consumers first rated their own success in ACT using the same five-point scale. We then asked: “What is it that would make you (or makes you) a five?” and, “What is it that would make you (or makes you) a one?” For both staff and consumers, additional probes were used for clarification. Interviews lasted 90 minutes and included questions from the larger study. Qualitative analyses followed a grounded-theory approach (10, 11). Three researchers separately and then jointly analyzed themes common across interviews. The labeling and organization of themes was aided by qualitative software (ATLAS.ti 5.5.9). Themes are listed in Table 1. We discuss differences in rank order (of at least four places), rather than frequency to account for varying verbosity between staff (average word count = 76.2 ± 22.2) and consumers (average word count = 24.0 ± 11.0).

Results

Rankings of staff and consumer definitions of success were correlated, $r = .79$, $p < .01$. There were several areas of strong agreement. First, for both, the top ranked definition of success was consumer-specific factors (e.g., behaviors—more assertive, less impulsive, and attitudes—feeling happy, increased confidence). For example, one consumer stated, “I feel successful because I am independent, I am more assertive. I’m having a ball just meeting people.” Staff and consumers also defined success according to consumers’ social involvement (e.g., reuniting with family, connecting with others) and meeting basic needs (e.g., housing, food). Surprisingly, neither staff nor consumers emphasized reduced hospital use when defining success (staff ranked 10th, consumers ranked 12th).

There were some notable differences between staff and consumer perceptions of success. Consumers described less need for ACT treatment when defining success (ranked 3rd) (“They’d say ‘you are probably doing so good, we’re going to let you go’”), whereas staff ranked this relatively low (ranked 11th). Consumers also described processes that support success, such as getting needed help from the team (e.g., help with finding housing). In contrast, staff mentioned improved mental health more often (tied for 7th) than consumers (ranked 13th). For example, staff described improvement in symptoms (“She’s not as delusional and doesn’t seem to be having the hallucinations”) or broader mental health (“[The consumer] is just living his life and doing the things that he enjoys, and being able to cope when he feels stressed”).

Rankings of definitions of failure were correlated, $r = .67$, $p < .05$. Similar to success, the top-ranked theme defining failure identified by both consumers and staff was consumer-specific factors (e.g., undesirable behaviors—stealing, lying, negative attitudes, not progressing in treatment). For example, one staff member noted, “[The consumer] just makes a lot of bad decisions, really...it’s just really poor judgment overall” and one consumer stated, “Because I haven’t always tried and I haven’t always done my best, and I sometimes yell at people and have a negative attitude.” Staff and consumers also defined failure according to poor social involvement (e.g., lack of family support, isolating).

Surprisingly, when defining failure, not taking medications ranked 2nd among consumers but only 8th among staff. One consumer stated, “So if I missed a few doses and pretty soon I

would be sick and I'd be not wanting to take it you know." Other consumers described failure as having to receive more medication supervision or not taking medications as prescribed. In contrast, staff ranked substance abuse higher (2nd) than did consumers (tied for 6th). For example, one staff member stated, "She's very much into her substance abuse right now, and that affects both her mental and physical health." In general, staff frequently linked substance abuse to difficulties with other areas of life (e.g., "(he) lost his job, probably because of the substances.").

Finally, when discussing failure, consumers ranked the presence of negative aspects of ACT treatment higher (3rd) than staff (tied for 9th), which included ACT not helping and controlling everything. For example, consumers stated "I think they'd kick you out of the program" and "Well for me, it would be them controlling my money."

Discussion

Consistent with prior research comparing staff and consumer perspectives (e.g., 8, 9), we found similarities and differences in perspectives regarding success and failure. First, success and failure were defined most frequently by both groups in terms of consumer-specific factors. That is, both success and failure were viewed most often in terms of specific changes (e.g., more assertive) or lack of changes (e.g., not progressing in treatment) in consumer attitudes and behaviors.

Across both staff and consumers, successes were more likely than failures to reflect client growth. That is, themes related to client growth (e.g., relationships, employment, independence) were ranked more highly as definitions of success than as definitions of failure. Success seemed to be viewed not just as the opposite of failure, but embedded within it aspects of growth. The results also fail to support concerns that ACT is inherently and narrowly focused on medical/symptom change.

Curiously, consumers were more likely to mention not taking medications when defining failure, whereas staff mentioned taking medications more often when defining success. Consistent with Deegan's work (12), consumers viewed not taking medications as an undesirable outcome, but identified other types of "personal medicine" (i.e. wellness strategies and activities) as indicators of success. That staff viewed taking medications as indicative of success, corroborates previous literature in which case managers rated medication management as an extremely beneficial mechanism of action in ACT (13). Another difference was that consumers were more likely to discuss helpful and unhelpful aspects of the ACT team. Consumers seemed to internalize external factors related to treatment, such as the need for and types of treatment received, in self-definitions of success and failure. In contrast, staff members were more likely to mention factors internal to the client, such as substance abuse when defining failure and improved symptoms when defining success.

One striking finding was that hospitalizations were mentioned infrequently by staff and consumers, despite the emphasis within the ACT model on reducing hospitalizations. ACT programs have consistently demonstrated reduced hospitalizations over time (2) and

compared to other treatments (3), suggesting that one critical indicator of ACT success is decreased hospitalizations. The current findings, however, suggest that ACT staff and consumers view treatment success and failure more broadly. Although reasons for the lower rankings were not clear, we speculate that hospitalization would be more salient to both groups if ACT was not successful in addressing this issue.

Staff and consumers emphasized social aspects of treatment. The impact of consumers' social relationships, both good and bad (e.g., reuniting with family, isolating), was mentioned frequently when defining success and failure. This is consistent with findings that consumers view relationships as an important ingredient of ACT (14, 15). However, the effectiveness of ACT in helping develop friendships and family relationships has received little support (4). These findings suggest that social relationships are valued within ACT, and further work should examine how ACT teams are facilitating or supporting these relationships.

Critically, our findings suggest that researchers need to broaden the view of success in ACT beyond hospitalizations to include other important aspects of treatment, such as medication adherence, relationships, consumer growth, and consumer-specific factors. Research reviews typically focus on hospital use and engagement rates, with some studies examining housing, employment, legal activity, symptoms, or QOL (1–4). Our sample described a much richer view of treatment effectiveness.

Strengths of our study were the inclusion of both staff and consumers from several ACT teams and the use of open-ended interviews. We used the same coding scheme for staff and consumer interviews. Although different themes may have emerged if staff and consumers had been analyzed separately, we wanted to directly compare the presence/absence of each category. Further analyses could also compare extreme groups of consumers or staff from different roles. One limitation is that themes reflect a broad level, resulting in several fairly heterogeneous themes (e.g., consumer-specific factors) that could be broken down further in future analyses. In addition, future studies could benefit from examining a more ethnically and culturally diverse group, as well differences in as prior hospitalizations and length of community tenure.

Conclusion

Understanding treatment success and failure helps identify the beneficial ingredients of ACT and aspects that could be modified to improve services. Based on 48 staff and consumers, the critical factors in defining success and failure within ACT were most clearly related to consumer characteristics. Staff and consumers also identified broad aspects of treatment as critical to success and failure, including having basic needs met, being socially involved with others, and taking medications. There were differences between staff and consumers in their definitions of success and failure. Researchers should broaden their view of success in ACT beyond reduced hospitalizations to include domains like social relationships and medication adherence.

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Table 1

Definitions of success and failure by perspective

Definitions	Definitions of Success						Definitions of Failure					
	Consumers (n = 23)			Staff (n = 25)			Consumers (n = 23)			Staff (n = 25)		
	Rank	n ^a	% ^b	Rank	n ^a	% ^a	Rank	n ^a	% ^b	Rank	n ^a	% ^b
Consumer-Specific Factors (e.g., feel happy, more assertive, lying, negative attitude)	1	19	83	1	24	96	1	12	52	1	24	96
Basic Needs (Not Met) (e.g., meeting or not meeting needs regarding housing, food)	2	13	57	4	23	92	4	8	35	3	21	84
ACT Team (e.g., get help that need from ACT, team not doing everything, needs team less, ACT not helping)	3	12	52	11	11	44	3	9	39	9	9	36
Social Involvement with Others (e.g., socially involved, isolated, poor relationship with family)	4	11	48	1	24	96	6	6	26	4	20	80
Medications (e.g., take meds, get on own, not taking medications)	5	10	44	1	24	96	2	11	48	8	13	52
(Absence of) Employment/Education/ADLs	5	10	44	4	23	92	10	3	13	9	9	36
(Lack of) Independence	7	9	39	6	19	76	13	1	4	13	5	20
Relationship with ACT Team (e.g., getting along, able to trust each other, not getting along or connecting)	8	8	35	11	11	44	10	3	13	9	9	36
(Not) Participating in Treatment	9	6	26	7	16	64	8	5	22	6	19	76
(Lack of) Substance Abuse	9	6	26	9	13	52	6	6	26	2	23	92
Other (e.g., get off disability, accomplish goals, do things didn't used to do, unresolved issues)	9	6	26	15	6	24	N/A	N/A	N/A	14	2	8
(Fewer) Hospitalizations	12	4	17	10	12	48	8	5	22	7	18	72
(Poor) Mental Health (e.g., reduced symptoms, hallucinating)	13	3	13	7	16	64	4	8	35	4	20	80
(Decreased) Legal Involvement	14	1	4	14	7	28	12	2	9	12	7	28
Wants/Desires (Not Met) (e.g., get a car, a dog)	15	1	4	13	10	40	13	1	4	N/A	N/A	N/A
Taking Small Steps/Breaking Down the Goal	15	1	4	16	1	4	N/A	N/A	N/A	N/A	N/A	N/A

^a Number of consumers or staff who mentioned the specific definition of success or failure.

^b Percentage of consumers or staff who mentioned the specific definition of success or failure.