

Title of Presentation: Beyond Program Fidelity: The Employment of Coercion by Teams Implementing the Assertive Community Treatment Model.

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The assessment of fidelity to the assertive community treatment (ACT) model is largely focused on structure rather than process, as ACT is viewed as a way of organizing services rather than a prescribed set of services. Several key process variables may be overlooked when fidelity is the sole focus of program administrators and policy makers. In Indiana, 28 of the 31 community mental health centers (CMHCs) are implementing ACT. Currently, the majority of teams exhibit high fidelity to the model and recently implemented teams are more rapidly obtaining high fidelity than earlier teams. Although teams are becoming more homogeneous with regard to ACT fidelity, appreciable differences remain across teams.

The promotion of client empowerment is a key aspect of high quality mental health services. Empowerment has been identified as a key factor in the recovery process and is characterized by having decision-making power, access to information and resources to make informed choices, and a range of options (Chamberlin, 1997). Coercion is a process of exercising control or power over another to bring about change (Carroll, 1991) and is conceptualized as falling along a continuum of restrictive practices (Lucksted & Coursey, 1995; Neale & Rosenheck, 2000). Coercion may at times be necessary to facilitate treatment of some individuals with severe mental illness (SMI). Excessive use of coercion may suggest indiscriminate use, which arguably counters client empowerment.

ACT has been criticized as being coercive (Fisher & Ahern, 2000; Gomory, 1999). Surprisingly, there is very little literature on the prevalence of coercion in outpatient mental health services, particularly ACT. Characteristics of both the ACT model itself (e.g., use of assertive engagement and high frequency of community-based contacts) and the clients targeted for ACT services (e.g., difficult to engage in less intensive treatment programs) heighten the potential for coercion (Diamond, 1996).

The presenter will argue that while the potential for coercion is present in ACT, it is not a necessary condition of well-implemented ACT teams. New data and preliminary findings from a study examining the use of coercion in teams implementing ACT within

Indiana will be presented. Practices indicative of coercion are examined using three novel measures that were pilot tested in this study. These practices include involuntary commitment to treatment, control of valued resources (e.g., housing and money), monitoring of medications and substance abuse, and withholding of information. Although some of these practices may be inherently coercive (e.g., involuntary commitment), others only indicate the possibility that coercion may be occurring (e.g., control of valued resources). The relationship between fidelity to the ACT model and employment of coercion are examined, along with other possible correlates.

It is critical to identify, measure, and reduce coercion in mental health services. As ACT is increasingly being disseminated nationally and internationally, it also is important to determine the validity of claims that the ACT model is inherently coercive. Examining the rate with which these practices occur can serve as a proxy for measuring coercion and guide training and program level interventions to assist system level transformation toward recovery and client empowerment.