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# The Limits of Evidence Based Medicine and Its Application to Mental Health Evidence-Based Practice. (Part Two): Assertive Community Treatment assertively reviewed

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# The Limits of Evidence Based Medicine and Its Application to Mental Health Evidence-Based Practice (part two): Assertive Community Treatment assertively reviewed[1]

Ethical Human Psychology and Psychiatry, Volume 15, Number 2, 2013

http://dx.doi.org/10.1891/1559-4343.15.2.73

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[1] The present article in part relies on prior research by the author published in several articles (Gomory 1999; 2001; 2002a; 2002b; 2009), a chapter (Gomory, 2005) and a 2013 book coauthored with two colleagues Drs. Stuart Kirk and David Cohen titled *Mad Science: Psychiatric coercion, diagnosis, and drugs.*

**Abstract:**
This article is the second of two published in EHPP, the first appeared in the current spring 2013 volume. The first article argued the very serious limitations of Evidence-Based Medicine (EBM) and its very popular mental health offshoot Evidence-Based Practice (EBP)(Gomory, in press). The present article is meant to be a consolidation and update of a 1999 analysis of Assertive Community Treatment (ACT), the best "validated" mental health EBP according the National Institute of Mental Health (NIMH) and academic researchers. The present analysis reconfirms the failure of ACT as a treatment modality and a platform for successfully reducing hospitalization its touted consistent effect accept when ACT can apply administrative coercion to keep its clients out of the hospital or quickly discharge them. When ACT fails to have such administrative coercive control it does no better than other community mental health delivery systems. The use of ACT coercion begun over forty-years ago, the article further argues, set the table for conventionalizing psychiatric coercion as evidence-based best practice.

Keywords: Coercion, Evidence-Based Practice, Clinical Social Work, Mental Health, Psychiatry, Clinical Practice, Assertive Community Treatment

Although there are no absolute criteria for assessing the validity of scientific evidence, it is still possible to assess the validity of a study. What is required is much more than the application of a list of criteria [such as done for evidence-based practice]. Instead, one must apply thorough criticism, with the goal of obtaining a quantified evaluation of the total error afflicting the study. This type of assessment is not one that can be done easily by someone who lacks the skills and training of a scientist familiar with the subject matter … Neither can it be applied readily … by scientists … who do not take the time to penetrate the work.

Kenneth J. Rothman, Boston University, School of Public Health, Department of Epidemiology and Sander Greenland, UCLA, School of Public Health

**Introduction**

This article is the second of two published in ISEPP, the first appeared in the current spring 2013 volume. The first article argued the very serious limitations of Evidence-Based Medicine (EBM) and its very popular mental health offshoot Evidence-Based Practice (EBP)(Gomory, in press). It should be noted that the popularity of the phrase “evidence-based” and its apparent power to convince that effective science is being referenced merely by its incantation when attached to almost any social science enterprise, for example the law (Rachlinski, 2011), or education (Biesta, 2007), has spread like wildfire. Academia now has “evidence-based” anything and everything that you could call social science and even beyond, such as evidence-based art (Baum, 2001). All of this has happened as demonstrated in the first article without any rigorous test of the superior efficacy of EBM or EBP over alternative approaches utilized before and after EBM/EBP was invented in medicine and distilled to other domains such Evidence-Based Mental Health.

The present article is meant to be a consolidation and update of my analysis of Assertive Community Treatment (ACT), the best “validated” mental health EBP according the National Institute of Mental Health (NIMH) and academic researchers

published in *Ethical Human Sciences and Services*, (Gomory, 1999), which concluded that:

> Although [Program of Assertive Community Treatment] PACTs (sic) are packaged by institutional psychiatry and its various supporters as a discrete, well tested modality of effective treatment, a critical review of the conceptual framework and the controlled experimental research reveals negative findings as well as possible harmful effects. Why PACT remains aggressively marketed may be explained by the failure of institutional and biopsychiatric treatment efforts in general … . It is consistent with current trends to resort to increasingly coercive approaches. (p. 160)

These conclusions as I show in the present article hold just as true today as they did then, even though hundreds more articles on ACT have been published over the fourteen years since that publication and the EBP marketing rhetoric for it has only increased.

**ACT History**

The routine claim is that Assertive Community Treatment is "widely recognized as an evidence-based practice for adults with severe mental illness" (Bond, Drake, Mueser, and Latimer, 2001, p. 155). ACT appears to be well-credentialed, having built its credibility more than a decade ago on "a research base includ[ing] 25 well-controlled studies" (Bond, Drake, Mueser, and Latimer, 2001, p. 155). The National Alliance On Mental Illness (NAMI)[2] states that ACT is the most widely replicated and frequently used community treatment for SMIs throughout the world. Only five states in the US do not

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[2] NAMI the most powerful "grassroots" mental health lobby turns out to have pharmaceutical companies as it largest funding source and although claiming to represent some 500,000 "members and supporters" has less than 10,000 paid members (for the sordid details see (Kirk, Gomory, & Cohen, 2013, chapter 1).

have ACT teams, while 43 states make their Medicaid funds available for its reimbursement (Aron, Honberg, Duckworth et al., 2009). ACT is without question the leading community treatment for that particular group of the mad:

> Since the deinstitutionalization era began nearly 50 years ago, several models of community-based care for persons with severe mental illnesses have been developed. Of these models, the assertive community treatment (ACT) program has by far the strongest empirical support. (Essock et al., 1998, p. 176)

In addition, social work, the "helping" profession with the largest number of professionals in mental health practice enthusiastically promotes ACT. In a recent text, *Social Work Practice in Mental health* (2002), Sands and Angell (2002) call ACT an "exemplar program" which "demonstrate[s] how effective mental health teams work" (p. 272).

Let's scrutinize the veracity of these claims and the allegedly convincing evidence for ACT's effectiveness that has lead to both NIMH and the Cochrane Collaboration to certify it as one of 6 community mental health EBPs. Originally called Training in Community Living (TCL), ACT was one of those mental health programs developed during the late 1960s and early 1970s to respond to the federal mandate for shifting the locus of care and control of psychiatric patients from isolated institutions into the community (Stein & Test, 1985). It was considered to be an immediate success: soon after its first randomized controlled study (Marx, Test, and Stein, 1973), receiving the Gold Achievement Award in 1974 from the American Psychiatric Association. Its developers stated that ACT fit closely the prevailing psychiatric disease model and its

concomitant reliance on psychiatric drugs: “Congruent with our conceptual model, we tell our patients that indeed we believe they are ill, otherwise we would not be prescribing medication for them” (Stein & Diamond, 1985, p. 272). ACT has continued to be lauded for the past forty years by most mental health researchers on its impact on mental health treatment research very much along the lines discussed by long-time ACT researchers, Bond et al. (2001):

> They … hypothesized that … community programs needed to replicate the array of medical, residential rehabilitation and other services provided by the hospital. That is, community programs needed to create a “hospital without walls.” … Stein and Test’s initial study involved *deflecting* patients presenting for hospitalization at a state hospital. One group received PACT services, whereas the comparison group received the standard community services. *Results clearly demonstrated the advantages of the PACT program across a range of clinical and social outcomes* … The study by Stein and Test … is probably the single most cited study in the literature on psychosocial treatment of mental illness in the twentieth century. (p. 146, emphasis added)

The quote in passing identifies what I believe is the chief mechanism of ACT activity. Not any putative ACT specific clinical approach but rather the programmatic administrative “deflecting,” that is the coercive administrative activity of preventing the patients from entering the hospital and forcing their treatment to take place in the “community” which results in the only consistent outcome in all the ACT research literature, the “successful” reduction of patient

hospitalization. When “deflecting” is not done, as will be addressed in the analysis ahead such reductions are not attained.

**The Origins of ACT’s Methods**

ACT originated at Mendota State Hospital in Madison, Wisconsin in the 1960s and 1970s. Key protagonists in the hospital at the time were: (1) psychiatrist Arnold M. Ludwig, the hospital’s director of research and education (2) the creators of ACT, psychiatrists Arnold J. Marx, Leonard I. Stein, and psychologist and Professor of Social Work Mary Ann Test, and (3) less directly, clinical social worker Frank Farrelly and psychologist Jeff Brandsma. Farrelly and Brandsma at that time together fashioned and tested at Mendota State a therapeutic approach they called “provocative therapy” (Farrelly & Brandsma, 1974) and influenced the treatment approaches of those involved with ACT. Examining the then contemporary research publications of these professionals helps us gain some insight as to their understandings of the patient populations under their care and the best practices they promoted for their care.

**Patient Descriptions**

The Mendota State researchers despite their view that their patients are medically ill (a perspective that ordinarily does not hold the patient responsible for the consequences deemed to flow from having an illness) appeared to have entertained, if not hostile, at least negative attitudes toward patients. Patients in a locked ward (the STU) at Mendota State Hospital are not described in medical terms, but as adversaries:

> Professionals have overlooked the rather naive possibility that schizophrenic patients become “chronic” simply because they choose to do so … If he so desires, he can defecate when or where he chooses,

> masturbate publicly, lash out aggressively, expose himself, remain inert and unproductive or violate any social taboo with the assurance that staff are forced to "understand" rather than punish behavior. (Ludwig & Farrelly, 1967, p. 737-741)

These two authors wrote an earlier article (in 1966) which is entitled "The Code of Chronicity." The discovered code, according to them, is employed by the mad, along with other "weapons of crazyness" (p. 565).

They concluded that these patients were:

> formidable adversaries who were "pros" and who had successfully contended with many different staffs on various wards in defending their title of "chronic schizophrenic." (Ludwig & Farrelly, 1966, p. 566)

As a result, Ludwig and Farrelly felt that the only medical cure was to coerce the patients to mimic the "sane" behavior of the staff:

> To become well patients would have to think, feel, and behave … similar to staff. The concept of normality and sanity as therapeutic goals …would have to [be] deliberately concretize[d] …by insisting that patients employ staff persons as models for behavior. … Furthermore, … health and sanity, *as defined by staff*, would rule. (1966, pp. 566-567, emphasis added)

The psychiatric commitment to use coercion to cure could not be better illustrated than by these experts' efforts to force their inmates to conform in order "to become well." The similarity to the later ACT approach, as described by ACT insider, psychiatrist Ronald J. Diamond, is uncanny:

> Paternalism was to a large extent accepted with little question. … *Staff were assumed to know what the patient "needed."* Even the goal of getting patients paid employment *was a staff-driven value* that was at times at odds with the patient's own preferences. Current assertive treatment programs continue to be influenced by traditions … from this … history. (Diamond, 1996, p. 53)

**Punishment as Treatment**

Leonard Stein, after replacing Arnold Ludwig as the Director of Research and Education at Mendota State Hospital, co-authored a study with "provocative therapy" advocate Brandsma, entitled "The Use of Punishment as a Treatment Modality: A Case Report" (Brandsma & Stein, 1973). The study examined the value of using involuntary electric shock to reduce the "unprovoked" assaultive behavior of a "retarded, adult, organically damaged" (p. 30) 24-year-old woman. This publication appeared during the time that TCL/ACT community research was already well on its way (see Marx, Test, & Stein, 1973) and was apparently part of a line of research focused on force and violence as treatment, begun earlier at Mendota State. Ludwig, Marx, Hill, and Browning (1969) had previously published a single-case study on a paranoid schizophrenic patient, titled "The Control of Violent Behavior through Faradic Shock." The authors justified this study by its "uniqueness," including because "this procedure was administered *against the express will* of the patient" (p. 624, emphasis added). They used an electric cattle prod as the "aversive conditioning agent" because it was "an excellent device for providing a potent, noxious stimulus … capable of producing a faradic shock spike of approximately

1400 volts at 0.5 milliamperes, the resulting pain lasting … as long as the current was permitted to flow" (p. 627).

The methodology of Brandsma and Stein's experiment reveals what can only be termed sadism. To obtain a "baseline" measure (a requirement of single-subject design research) of this patient's assaultive behavior, she was baited and ridiculed so she would respond aggressively:

> During the base rate week the staff quickly developed a consistent provocative approach in order to ensure a high frequency of behavior from the patient … This consistently involved: 1) ignoring the patient in conversation; 2) refusing to give the patient candy or snacks when others were eating them; 3) denying all requests, for example, during the session if she asked if she would be able to go for a walk that afternoon, she was immediately told, "No you can't."; 4) refusing to accept her apologies or believe her promises of good behavior; 5) The … female sitting next to her often leading the provocation; 6) using provocative labels for her behavior, i.e., "animalistic, low grade"; 7) discussing family related frustrations … . … [T]hroughout the program the patient was kept in a seclusion room at all times except when involved in a baseline or treatment session. (Brandsma & Stein, 1973, pp. 32-33)

Brandsma and Stein's research exemplifies mental health science at its worst, by daring to torture an imprisoned, non-consenting subject and by publishing an article full of scientific misinformation and distortion. Brandsma and Stein cited the classic behavioral study by Azrin and Holz (1966) to support their use of punishment, stating that "our

clinical reports back up the more controlled animal studies on punishment. For example … Azrin and Holz ...” (Brandsma & Stein, 1973 p. 36). In fact, the cited authors argued that punishment is *ineffective* as a method of behavioral change, especially for human subjects, (Azrin & Holz, 1966, p. 441)

Despite the clear refutation of their brand of behavioral treatment in the article Brandsma and Stein cited to support their own therapeutic use of an electric cattle prod, they falsely concluded that “the extant literature now supports the assertion that ‘punishment therapy’ is a useful tool to modify certain behaviors” (Brandsma & Stein, 1973, p. 37). Their research instead demonstrated that “punishment therapy” was not effective. As they report about their subject, “[u]nfortunately the intensity of her now low frequency, occasional attacks was still sufficient to relegate her to a life of relative social isolation” (p. 36) and even a year after the intervention “the punishment contingency continues … in seclusion with only a few hours out per day when accompanied by a male aide” (p. 35). The patient was not better off after the coercive treatment, and was relegated to permanent solitary confinement.

What is noteworthy in this publication is how easily actions like baiting, punishment, and torture could be applied to a difficult patient by “doctors” and be described as scientific research on “treatment.” The early transformations of control and punishment as treatment at Mendota State appear to have influenced research on ACT over the next several decades.

**What is ACT?**

According to Test (1992), ACT has four essential characteristics:

> [1.] Core Services Team [made up of 3-5 members, with at least a primary case manager, psychiatrist, and backup case manager per patient]: The team's function is to see that all the patient's needs are addressed in a timely fashion. ... Having one team provide most of these services minimizes the ... fragmentation of ... care systems and allows for integrated clinical management….
>
> [2.] Assertive Outreach and In Vivo Treatment: An essential ingredient ... is the use of assertive outreach. … [staff] reaches out and takes both biological and psychological services to the patient[in the community]….
>
> [3.] Individualized Treatment: Because persons with serious mental illnesses … are greatly heterogeneous and both person and disorder are constantly changing over time, treatment … must be highly individualized….
>
> [4.] Ongoing Treatment and Support: It must be concluded that even very intensive community treatment models do not provide a cure for severe mental illness, but rather provide a support system within which persons with persistent vulnerabilities can live in the community and grow. It appears these supports must be ongoing rather than time limited. (1992, pp. 154-156)

**ACT Clinical Treatment Effect or Administrative Control and Coercion?**

A 2001 article in the journal *Psychiatric Services* claimed that ACT was to be deemed an EBP because it had shown superiority over alternate treatments:

> Research has shown that assertive community treatment is … more satisfactory to consumers and their families. Reviews of the research consistently conclude that compared with other treatments under controlled conditions, such as brokered case management or clinical case management, assertive community treatment results in a greater reduction in *psychiatric hospitalization and a higher level of housing stability*. (Phillips, Burns, Edgar et al., 2001, p. 771, emphasis added)

The clinical effectiveness of any treatment is usually measured in symptom reduction, reduced disability, better functioning, or improvements in behavior, self- or other-rated. What is noteworthy about the quote above is that keeping people out of a hospital or in a community residence is used as the markers of success. It might come as a surprise then that an award winning "treatment" program made few claims that it improved patients' clinical condition. In fact, Philips et al. admit that "[t]he effects of assertive community treatment on *quality of life, symptoms, and social functioning* are similar to those produced by these other treatments" (p. 771, emphasis added). In other words, ACT does *not* reduce the troubled/troubling behavior or improve the functioning of the severely mentally ill any more than any other approach. Decades earlier the ACT inventors admitted: "a change in the site of treatment [from the hospital to the community] says nothing about whether the patient's clinical status or functioning has improved. Some would argue that only the place of a person's suffering has changed" (Test & Stein, 1978, p. 360).

Nonetheless, ACT aspired to do more. In 1992, Mary Ann Test indicated that they always "target[ed] goals for the model … going far beyond the reduction of time in

hospitals. Additionally, improvements in patients' psychosocial functioning and quality of life are sought" (Test, 1992, 164). But over time, the ACT model simply failed to achieve these clinical outcomes that would be routinely expected of any treatment in medicine. If traditional clinical effectiveness was not achieved by ACT, what was the basis for its purported success? Let's examine five core claims of success.

**ACT's "Successes"**

**1. *Claim.*** ACT significantly reduces hospitalization when compared to alternate treatments.

***Evidence.*** Reduced hospitalization and inpatient treatment costs are the only consistent outcomes found across studies. On the surface, reducing hospitalization rates can be mistaken as reducing symptomatic behaviors and therefore the need for hospitalization. But, in fact, ACT specific therapeutic methods have no direct bearing on reducing symptoms or the need for hospitalization. They simply reduced hospital stays by using a fairly strict *administrative* rule not to admit or readmit any ACT patients for hospitalization regardless of the psychiatric symptoms, but to carry out all treatment in the community. The comparison group of troubled patients at the same time could be freely readmitted.

Test and Stein (1978) provided an early clue to the importance of program control over hospitalization and discharge: "Community treatment results in less time spent in the hospital. This finding is certainly not surprising since experimental patients were usually not admitted to hospital initially and there were subsequent concentrated efforts to keep them out" (p. 354). Many ACT articles acknowledge that reduced hospitalization in ACT is the result of administrative rules, not clinical treatment. An early treatment program for

SMIs named “The Bridge” (Witheridge, Dincin, & Appleby, 1982) claiming inspiration from the Madison ACT program in listing what differentiates it from the Madison model notes that “[u]nlike the Madison group … we would have no formal control over the channels of readmission or the course of inpatient treatment” (p. 10). One of this paper's authors, Jerry Dincin, in 1999 reiterates that “[i]mportant attributes of the [ACT] model included an explicit mission to prevent the use of psychiatric hospitals” (Wasmer, Pinkerton, Dincin, Rychlik, p. 26). Hoult, Reynolds, Charbonneau-Powis, Weekes, & Briggs, 1984) in a well know early Australian ACT replication state “the project group patients were not admitted if this could be avoided” (p. 161). Columbia University psychiatrist Mark Olfson in a report on ACT to NIMH cautioning against interpreting reduced hospitalization found in ACT research as a result of clinical treatment writes “[t]he clinical significance of the observed decrease in inpatient service utilization is difficult to assess. Restricting the clinical criteria for hospitalization is an explicit tenet of assertive community treatment. Under such conditions reducing hospitalization utilization becomes … an independent … variable.” (1990, C-75). An English replication puts it this way, “[Daily Living Programme] DLP was modeled on the experimental intensive community care services developed in Madison (Stein & Test, 1980) and Sydney (Hoult et al, 1983) … with inpatient admissions avoided if possible” (Knapp, Beechham, Koutsogeorgopoulou, Hallam, Fenyo, Marks. Connolly, Audini & Muijen, 1994, p. 195). These researchers found that “removing DLP responsibility for discharge from any in-patient phase of care prolonged admission. … Removing responsibility trebled the length of admissions” (p. 185). Scott and Dixon (1995) examining the impact of case management and ACT programs observe, “the effectiveness of ACT models in

reducing hospitalization may be a function of their capacity control hospital admissions, length of stay, and discharge" (p. 659). Two English researchers referencing Stein and Test along with John Hoult of the Australian ACT replication mentioned earlier explain "[i]n contrast to other case management models, ACT teams have direct control over hospital admission and discharge with a brief to minimize hospital admissions … Several studies have noted that the length of hospital stay returned to pre-intervention levels when ACT team … control of discharge was blocked by hospital authorities" (Craig & Pathare, 1997, pp. 111-112). Finally Minghella, Gauntlett and Ford (2002) discussing the failure of some Assertive Outreach teams in England to reduce hospitalization write that "[w]hile the teams partly adhered to the ACT model, there were major areas of deviation. The teams had little influence over admissions and discharge" (p. 27).

In short, if one doesn't allow particular people to be hospitalized, they won't be.

A crucial point to be made here is that the identical type of psychiatric administrative activity is used to force people into hospitals for treatment (Involuntary Civil Commitment) the historically oldest tool of psychiatric coercion, or to prevent them from entering hospitals, or to force people out of them into the community for treatment (ACT). All these approaches are coercive: they don't consider whether any of the patients being forced into the hospital want out, or those being kept out want in. Client choice is not an option.

**2. *Claim***. ACT is more cost effective than standard interventions.

***Evidence***. Since hospitalization is by far the more costly treatment, the cost savings are not dependent on specific ACT clinical interventions but on keeping people away from hospitals, which, as we have just reviewed, is a by-product of the ACT

administrative coercion. Cost reduction could occur with any other treatment rigorously pursuing the same objective.

***3. Claim***. ACT provides significantly greater patient satisfaction.

***Evidence.*** Most people prize their freedom; few prefer to be confined in hospitals. ACT's clients are the same, but patient satisfaction appears to be independent of distinct ACT activity. The greater autonomy provided by *any* community treatment (as compared to locked hospital ward or outpatient commitment procedures), not the particular interventions of ACT, would explain increased satisfaction. In an Australian ACT replication study the patients were surveyed at a 12-month follow-up: "The majority (80%) of experimental group patients who were not admitted to the hospital were pleased and grateful about it; only 30% of control group patients were pleased and grateful about being admitted to hospital, whereas 39% were upset and angry" (Hoult, 1986, p. 142). Stated differently, "Treatment preference was explored by asking *all* patients whether they prefer admission to the institution Macquarie Hospital or treatment at home by a community team. "The majority of the project (87%) and control (61%) patients preferred community treatment" (Hoult et al., 1983, p. 163, emphasis added). Evan a majority (61%) of the group that *did not* experience the ACT treatment still preferred community treatment rather than incarceration in an institution. In fact, the experimental group reported that the most important elements of the ACT treatment were the availability of staff for frequent caring, supportive, personal contact and the enhanced freedom, therapeutic elements not specific to ACT (Hoult et al., 1983, p. 163).

Lending further support, a survey of "patient perspectives" on ACT "ingredients" (McGrew, Wilson, & Bond, 1996) identified in order of preference: "helping

relationship, attributes of therapist, availability of staff, and non-specific assistance" as what patients liked most (p. 16, table 1). These attributes are not ACT specific; they apply to all forms of "helping." The least liked of the 25 elements associated with ACT was "intensity of service"—the component most representative of ACT's intrusive philosophy. The survey's authors, themselves longtime ACT experts, admit, "[s]omewhat surprisingly, non-specific features of the helping relationship emerged as the aspects of [ACT] most frequently mentioned as helpful" (McGrew et al. 1996, p. 190).

***4. Claim***. ACT increases [independent community] housing stability (Bond et al., 2001, p. 149).

***Evidence.*** I conclude, in agreement with most other reviews, that the evidence supports this claim. ACT patients, but *not* control group patients, are more likely to find rooms and apartments in the community, rather than using many specialized residential settings. But just as ACT patients are not allowed to be hospitalized, ACT patients are administratively directed *only* to "independent" housing. Increases in independent community housing appears to be accomplished by helping ACT, but *not* control "clients find rooms and apartments in the community rather than using …specialized residential settings" (Test, Knoedler, Allness, Kameshima, et al, 1994, p. 4). So, what is achieved is not an ACT clinical treatment success, as much as a paternalistic assertive administrative rule to help ACT patients find independent living settings exclusively while the control patients were given supportive options as well as independent ones.

Finally and most importantly:

**5. *Claim.*** "The assertive community treatment approach never was, and is not now, based on coercion" (Test & Stein, 2001, p. 1396).

***Evidence.*** One of the rationales which the ACT inventors cited to explain the shift from psychiatric institutional care to community care was the reduction of coercive management and the promotion of autonomy to improve the social functioning of the SMI (Marx et al., 1973). Another was the desire to reduce the harmful effects of institutional living. Test and Stein's unequivocal rejection of accusations that ACT is coercive (as quoted above) was in response to an article in APA's community psychiatry journal, *Psychiatric Services.*

The historical record suggests that the Test & Stein denial is open to debate. For example, here is how Stein (1990) describes the role of the ACT team:

> [S]erves as a fixed point of responsibility... and is concerned with *all* aspects of…the patients' lives that influence their functioning, including psychological health, physical health, living situation, finances, socialization, vocational activities, and recreational activities. The team sets no time limits for their involvement with patients, is assertive in keeping patients involved…In addition to the day work ... the team is available 24 hours a day, seven days a week. (p. 650, emphasis added)

This methodology appears highly intrusive. ACT activities may include such coercive moves as becoming the representative "financial payee" of the patient, providing opportunities to blackmail the patients by enforcing medication compliance or threatening to withhold monies belonging to the patient (Stein & Test, 1985, pp. 88-89). Even bribery may be appropriate ACT treatment: "it might be necessary to pay a socially withdrawn patient for going to the movies in addition to buying his ticket" (Test & Stein, 1976, p. 78).

The ACT researchers rely on only two studies, one of which is their own (Test, 1981, p. 80) to validate their approach. The other study is by Beard, Malamud and Rossman (1978), who describe their Fountain House outreach program as follows: "phone calls, letters, and home and hospital visits [were] made by both staff and members. Through such contacts, subjects who dropped out were provided with further information…. In those ... instances when an individual requested that no further contacts be made, his wishes, of course, were respected" (p. 624). Respect for the wishes of people who choose not to be involved in the Fountain House program contrasts with the coercive methods used by Test and Stein (1976):

> A staff person attempting to assist an ambivalent patient to a sheltered workshop in the morning is likely to receive a verbal and behavioral "no"…. If … the staff member approaches the patient with a firm, "It's time for you to go to work; I'll wait here while you get dressed," the likelihood of compliance increases. The latter method allows less room for the patient to "choose" passivity. (p. 77)

Coercion and control, despite Test and Stein's denial, appear to be integral parts of the ACT model when it appears to be effective. According to the candid admission of Diamond (1996), a close associate of the original ACT group in Madison:

> Paternalism has been a part of assertive community treatment from its very beginning.... Paternalism continues to be reinforced by mandates from the community to "control" the behavior of otherwise disruptive patients... A significant number of patients in community support programs … have been assigned a financial payee.... This kind of coercion

> can be extremely effective.... Obtaining spending money can be made … dependent on participating in other parts of treatment. A patient can then be pressured by staff to take prescribed medication…. [T]he pressure to take medication … can be enormous.... While control of housing and control of money are the most common … methods of coercion in the community, [and] other kinds of control are also possible. This pressure can be almost as coercive as the hospital but with fewer safeguards. (pp. 53-58).

So ACT's ability to reduce hospitalization is not due to any supposed clinical treatment effect but the result of administrative forceful manipulation of ACT clients. One very recent naturalistic cohort study (Boden et al., 2010) even found potential harm by being treated with ACT if undergoing first episode of psychosis, "Contrary to our hypothesis, patients in the mACT group, compared to those in the non-mACT group, had a borderline significant increased risk of having a poor 5-year outcome regarding positive psychotic symptoms" (p. 665).

The failure of both the NIMH sponsored mental health EBP approach or the EBM sponsored systematic review process on ACT RCTs to uncover what is easily uncovered by a thorough analytic review as demonstrated here (and in article one of this two-part article series) speaks to the severe limitations of any textbook approach to getting at the best evidence. After all, the textbook on EBM is now in its fourth edition (Straus, Glasziou, Richardson & Haynes 2011) and still after two decades there is nothing empirically to show regarding whether or not EBM trained practitioners provide better health or mental health care than those in the various fields of practice who are trained

otherwise despite all these authors' hard promotional work for EBM as laid out in these best-selling manuals. Only excuses regretfully delivered why the EBM recommended RCT methodology is too difficult to implement for such a trial. Evidence Based Practice apparently means "just trust us."

**Conclusion**

The discussion of ACT coercion that is routinely found throughout the psychiatric literature as one mode of contemporary psychiatric evidence-based practice means that coercion is now apparently considered to be just another normative therapeutic intervention.

A large body of literature now addresses the "therapeutic" value of community-based coercion of mental health patients, an ongoing discussion which can be tied directly to the existence of ACT. A 1996 edited book legitimated the study and use of such coercion with the title specifically identifying ACT and its coercive approach: *Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law* (Dennis & Monahan, 1996). More recently, the importance of conventional psychiatric coercion research has been further validated by a major new book published in 2011, also coedited by John Monahan, *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects* (Kallert, et. Al., 2011). While some psychiatric experts are busy asking "Is Assertive Community Treatment Coercive?" (Appelbaum & LeMelle, 2007), ACT experts acknowledge that "assertive engagement" or "assertive outreach" is a core element of ACT. These concepts are included in the most popular scale for evaluating ACT program replications' fidelity to the original Madison model, the *Dartmouth Assertive Community Treatment Scale* (DACTS). Assertive engagement is measured (in

DACTS) primarily by counting the frequency of formal coercive legal mechanisms (i.e., mandated outpatient treatment or appointed financial payees). Its developers state transparently that "[i]t should be noted that the criterion for assertive engagement was operationalized in such a way that it emphasized use of legal mechanisms" (Teague, Bond, & Drake, 1998, p. 229). A report prepared in 2000 for the Federal Health Care and Financing Administration and the Substance Abuse and Mental Health Services Administration devotes a whole section to ACT coercion. The report notes that "[w]ithin the context of ACT programs, coercion can include a range of behaviors including, friendly persuasion, interpersonal pressure, control of resources and the use of force. … Research generally suggests that coercion may be harmful to the consumer" (LewinGroup, p. 43). It is noteworthy that "friendly persuasion" is included as an example of "coercion" in a federal report on psychiatric treatment. This appears like a simple error. Or is it in fact part of a strategic effort to broaden the meaning of coercion? Is the inclusion of non-coercive interpersonal activity (friendly persuasion appears to be an essential ingredient of *voluntary* talk therapy) in the preceding list of coercive activities an effort to domesticate externally imposed force as effective treatment?[3]

Unfortunately, as a final cautionary note regarding the current state of the helping professions and their interventive skills things may be far gloomier as Gomory and colleagues note:

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[3] This attempt to rebrand coercion as a benign and helpful mental health treatment by attempting to classify among "coercive" techniques a patently voluntary technique "friendly persuasion" is reminiscent of other deceptive efforts in psychiatric "science." The most common examples of this are the linguistic efforts to authenticate "mental illnesses" as physical diseases by lumping together in the psychiatric research literature problems like depression and schizophrenia within lists of common neurological disorders or "brain-based disorders" that have identifiable neurological signs, such as Parkinson's Disease or Alzheimer's Disease, though neither depression or schizophrenia have any such identifiable signs (for example Andreasen, 1997).

The very small number of dissenting voices concerning the legitimacy of psychiatric coercion doesn't indicate the rightness of the approach, only the numbing of our moral and critical faculties. The historical role of punishment of those people society calls mentally ill remains imbedded in the medical model because of the ways in which control and coercion easily slip into the benevolent rubric of treatment for the relatively powerless and vulnerable, and because of the ways that, outside hospital walls, control and coercion have been chopped up into bits, each of which is echoed by various professionals and institutions in society, and each of which seems like a relatively small price to pay to ensure proper "medical" treatment of widespread distress and misbehavior.

Coercion is the only intervention in the management of the mad to have endured since the birth of the discipline of psychiatry, over 200 hundred years ago. We suggest that coercion and the threat of coercion persist in psychiatry because coercion is all there ultimately is. (Gomory, Cohen, & Kirk, in press)

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