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Assertive Community Treatment Teams in the Canadian Multicultural Context

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ABSTRACT

The Assertive Community Treatment (ACT) model of care for individuals suffering from severe mental illness has proven to be successful in affecting a range of positive psychosocial outcomes such as reduced hospitalizations and improved access to suitable housing and vocational opportunities. As evidenced by a team in inner city Toronto, an encouraging recent trend has been to adapt ACT design and models of care delivery to the needs of the increasing cultural diversity that is seen in the Canadian context. That particular model of best practice utilized various strategies for tailoring care to the needs of the culturally diverse population in Toronto including linguistic pairing between staff and patients, offering culturally specific psychosocial rehabilitation, and assessing patients' acculturation status. Adaptability and responsiveness to the culturally diverse population should be given more priority as a criterion against which the design and performance of mental health services in general are evaluated.

Key Words: Assertive community treatment; Canada; Cultural diversity

One of the principal aims of assertive community treatment (ACT) teams as set out in Stein and Test's seminal paper from 1980 was to reduce hospitalizations for individuals with severe and enduring mental illness (That mostly refers to individuals with schizophrenia) [1]. In a worldwide context, several studies attest to the fact that ACT teams have been successful in achieving that aim. This brief communication focuses on and overviews research done on psychosocial outcomes in ACT teams in the Canadian multicultural context. A growing body of research attests to the fact that ACT teams can improve various parameters of psychosocial functioning including housing and vocation. Recent scholarship has begun to focus on the issue of ACT teams' ability to respond and adapt to cultural diversity in the population.

An important paper in the Canadian context was that by [2]. That paper reported data in relation to 295 individuals in Edmonton, Alberta, with chronic mental illness (covering the period April 1993 to April 1995). The 365 day period after ACT team intervention was compared to the 365 day period before ACT treatment and improvements were demonstrated on several measures. For example, in the one year period after ACT intervention, the average number of days of hospitalization for each patient was reduced by 39%. As well, in the year after the ACT intervention, visits to the Emergency Room declined by 30%. Since then, the research base in Canada attesting to the fact that ACT teams reduce hospitalizations has grown significantly [3,4].

15 to 20 years ago, researchers' focus began to shift, with the question of ACT teams' possible role in improving various psychosocial outcomes particularly housing becoming front and center. One of the major studies in this regard was that by [5]. That study reported on 7 RCTs of ACTs in which housing had been studied as a psychosocial outcome. Out of the 7 studies examined 6 demonstrated favorable outcomes in relation to housing. With respect to pragmatic suggestions, Kirsch and Cockburn ventured to speculate that housing outcomes could be improved or enhanced among those populations whose ACT teams have either good access to vocational services or

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have vocational counselors embedded within their teams. That observation was given a lot of weight by researchers who were concerned with the fact that unemployment rates among patients in Ontario's ACT teams was "Stuck at 77%" (p. 161) [6]. Their conclusion was that vocational resources had not been accorded a high enough priority within Ontario's ACT teams. As they put it: "The CMHA-Toronto experience shows that having employment specialists on ACT teams may lead to significant employment outcomes when the whole team develops a mindset that sees employment as possible and desirable, and sets employment as a clinical outcome" (p. 170).

An area that has started to attract the attention of Canadian mental health services researchers is that of cultural diversity [7]. For a long time, it has been known that immigrants in Canada as well as ethnic minorities access mental health services at lower rates than the mainstream population [8]. As well, drop-out rates from mental health services are high in these populations. To date, there is only one documented example of an ACT team in Canada which has sought to modify its practices in order to better serve ethic minorities. This is a team in inner city Toronto affiliated to Mount Sinai Hospital [3,4]. First, that team, which serves patients hailing from a broad range of backgrounds (China, India, Vietnam, Caribbean, Indigenous, and so forth) was successful in meeting the aims of reducing hospitalizations for patients. Second, that team was able to tailor its services and interventions to cater to the needs of its culturally diverse patient base. Examples of the way in which that was done include multi-family psycho-educational groups conducted in patients' native tongues, routine assessment of patients' acculturation status, cultural and linguistic pairing (between staff and patient), culturally specific psychosocial rehabilitation activities, and so forth. In fact, the authors consider (rightly so) their team to be an example of best practice when it comes to delivering culturally adapted mental health services.

Canada wide, it is unfortunate that there is, as a rule, a dearth of literature looking at how mental health teams could be modified to meet the needs of our increasingly diverse society. The authors of a recent paper write that the "EI (early intervention) movement has yet to fully integrate knowledge about the needs of immigrant and ethno-cultural minority clients into its models of service provision" (p. 740) [7]. This is an astute observation but it applies not only to EI teams but to all mental health services, including ACT teams. Cultural adaptability and responsiveness ought to be given more importance as a criterion against which mental health teams in Canada not least ACT teams are evaluated. There also needs to be more user and family participation in the design and evaluation of ACT teams, one that, again, reflects our diverse society and gives priority to such outcomes as satisfaction, access and engagement.

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COMPETING INTERESTS

The author declares that he has no competing interests

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