EDITORIAL

Specialisation and marginalisation: how the assertive community treatment debate affects individuals with complex mental health needs

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Summary The growth of specialism in a field can be considered a healthy response to emerging evidence, technology and skills, yet it risks creating unhelpful barriers to collaborative working and fragmented patient pathways. Mental health services in England have experienced this tension in recent years through the national implementation of local specialist community teams that aim to reduce the need for in-patient admission through a focus on crisis resolution, early intervention and assertive community treatment (ACT). In response to the results of studies assessing its effectiveness, there has been disinvestment in ACT. This risks marginalising people with severe and complex mental health problems by depriving them and their families of the intensive support they need for successful community living, as well as discouraging researchers from undertaking further high-quality studies that can inform the intelligent evolution of the ACT model within different contexts.

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In 1945, 3 years before the National Health Service (NHS) was established in England, *The Lancet* published an article entitled 'Clinical specialism',[1] which explored the tensions between medical generalists and specialists. It suggested that specialisation evolved as an appropriate consequence of 'the growth of knowledge and the mastery of technique', but warned of its potential to limit the cross-fertilisation of ideas and collaborative working, and to generate areas of expertise that were more focused on the self-serving needs of the clinician than on the needs of patients. It advocated more specialised services where needed, with a better balance between generalised and specialised services, while fostering collegial, congenial and collaborative relations between them all. The article probably reflected widely held anxieties about the consequences of the radical reorganisation of health services in the UK at the time and the shift from a private to a publicly funded system. In the current international context of economic turbulence, where health priorities compete for investment within different public/private funding systems, the generalist *v.* specialist debate remains highly topical.

Specialisation of psychiatric services

Psychiatry in many countries has seen an increase in specialisation over recent years. In England, the National Service Framework for Mental Health[2] led to the implementation across the country (from 1999 to 2005) of prescribed specialist community mental health services whose job was to work alongside the established, generic, community mental health teams (CMHTs) to address the needs of people in acute crisis (crisis resolution teams), those experiencing their first episode of psychosis (early intervention teams) and those with longer-term psychoses who had recurrently disengaged from services, resulting in frequent relapse and readmission to hospital (assertive community treatment teams). The pros and cons of this increased specialisation in contemporary mental health services are still hotly debated. Protagonists argue that specialisation reflects an evolving evidence base for delivery systems that are most effective, whereas generalists cite the risks of specialisation to continuity of care and therapeutic relationships.[3–6] In this editorial we use the example of assertive community treatment (ACT) to explore the challenges of importing models of specialist care into different socioeconomic contexts and health systems at the international level.

Can ACT work in a European setting?

Assertive community treatment provides flexible and intensive home-based treatment to people with severe mental health problems. Originally developed in the USA, it has evolved into an internationally recognised model which has been extensively researched through randomised controlled trials in the USA, Canada and Australia. These trials have provided robust evidence of its clinical efficacy and cost-effectiveness, particularly when targeted on high users of in-patient care.[7] However, trials in European countries with well-established community mental health

services, such as the UK[8] and The Netherlands,[9] have failed to replicate these findings when comparing ACT with standard, individual case management delivered by generic CMHTs, and thus cost-effectiveness has not been established in these settings.[10] Nevertheless, all trials have consistently found ACT to be more acceptable to patients, who engage better with it than with standard care.[7,8]

What might explain the discrepancy in findings? A meta-regression of trials comparing standard care with intensive case management, which included some trials of ACT, identified seven specific components associated with greater effectiveness in reducing the use of in-patient care: (1) being based in a community setting; (2) operating an extended hours service; (3) the team manager having clinical as well as managerial responsibilities; (4) the team having full clinical responsibility for their patients; (5) holding daily team meetings to agree work priorities for the day; (6) adopting a 'shared case load' whereby all staff work flexibly with the team's patients, rather than using an individual case management approach; (7) offering a 'time unlimited' service that avoids discharging patients because of disengagement.[11] A separate systematic review that investigated aspects of care associated with greater efficacy in trials of home-based treatment (including crisis resolution services, ACT and intensive case management) identified two factors: integrated management of health and social care staff; and the degree to which staff made contacts with clients outside of healthcare settings (so-called '*in vivo*' contacts, at home or elsewhere in the community).[12] Inadequate implementation of these key components could therefore explain the lack of effectiveness found in the European trials.

A national survey of English ACT teams in 2003, repeated in 2007, found that most did not offer extended hours or maintain clinical responsibility when their patients were admitted to hospital.[13] A comparison of ACT in London and Melbourne found that the London teams delivered fewer '*in vivo*' contacts.[14] It therefore does appear that the UK ACT teams lacked key components. In addition, CMHTs in England provide some of these components (community based, team manager with clinical responsibilities, integrated health and social care staff, provision of some *in vivo* working), reducing the chance that trials comparing intensive case management or ACT with standard CMHT services might discern differences in outcomes. Another possible explanation is that in-patient mental health services in inner cities of the UK operate with such high threshold criteria for admission that a kind of ceiling effect prevents ACT from making any further impact on this.[15] Consequently, it has been suggested that ACT is more likely to be effective at reducing in-patient service use where there is high availability of in-patient beds, yet this was not borne out in The Netherlands, a country with one of the highest proportions of psychiatric beds per population in Europe.[9] However, one could argue to the contrary – that perhaps the easy availability of in-patient beds in this study may have reduced the impetus on the ACT teams to reduce admissions.

UK specialist services for people with complex mental health problems: the future

Whatever the reasons for the differences in findings in international trials of ACT, what seems clear from the evidence trail is that importing models of care that have an evidence base in one setting will not necessarily result in the same benefits elsewhere, particularly if the intervention is diluted. So how does this help us in our thinking about specialisation? The ACT story in the UK has prompted initially healthy but now repetitive debate about whether investment in specialist community mental health services should ever have happened.[3–6] The result from the only trial of ACT to be carried out in the UK[8] is used to support the case made by protagonists of standard care to stick with the generic CMHT case management model.[3,5] On the other hand, early intervention services, which incorporate similar key components to ACT, are seen as central to current mental health policy in England.[16] This is despite the fact that evidence for their longer-term effectiveness has not yet been clearly established in the UK literature,[17] although encouraging longer-term results are emerging elsewhere in the world.[18,19] Similarly, on the basis of only one UK trial showing their ability to reduce the need for hospital admission,[20] crisis resolution services have not undergone the pillorying that ACT services have endured.

With regard to the impact of specialisation on continuity of care and therapeutic engagement, these are complex constructs and their relationship to clinical outcome is not clear.[4] Nevertheless, early intervention and ACT teams are specifically designed to amplify relational engagement functions, something that ACT in particular has been consistently shown to be more successful at achieving than generic approaches.[7,8] Furthermore, staff turnover may occur less in these teams, prolonging therapeutic engagement with an individual, and the use of shared case-loads (where more than one member of staff works with an individual) reduces the impact on therapeutic engagement when a team member leaves. Transfers, where they occur, should also be purposefully phased to preserve continuity.[6]

The economic downturn and cuts to NHS resources in the UK have led to major disinvestment in ACT.[21] Many have been closed or reconfigured into more 'diluted' forms despite a lack of rigorous evidence for the effectiveness of these models.[22] Some would argue that there has been a similar dilution of the evidence for ACT through reporting negative outcomes of trials of models that do not deliver the key components, or ones that focus on a different target client group as though they are trials of ACT.[6] One is left wondering whether ACT's fall from grace in the UK is a re-enactment of the historic marginalisation of those with the most severe and complex mental health problems, left to languish in the back wards of the old asylums. Across Europe there has been a recent rise in the number of longer-term psychiatric beds in private nursing homes, hospitals and forensic units, a process of so-called 'reinstitutionalisation',[23] which suggests adequate support for individuals with more complex mental health needs is not available in the community. The recent report by the UK Schizophrenia Commission called for investment in high-quality services to deliver evidence-based treatments for

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people with long-term psychosis.[24] They specifically recommended extension of the successful principles of early intervention to support people experiencing second and subsequent episodes of psychosis. Since these principles are the same as those of ACT, and we now know which specific aspects of the ACT approach are effective, investment in community mental health services must deliver these key components if we are to give people with complex and longer-term psychoses the best chance of recovery and successful community living. At the same time, this report was curiously silent about the need to invest in ACT teams.

In relative contrast, the value of specialisation to address the needs of people with the most severe and complex mental health problems is increasingly recognised throughout the Asia-Pacific region, including in low- and middle-income countries. Although there are undoubtedly many contributory factors, the establishment of policy and guidelines to move from institutional care to community mental health services is an important driver.[25] Assertive community treatment is one of the specialised models being introduced for this purpose[26,27] in recognition of the need for assertive engagement of a subgroup of patients.[28] However, 'diluted' models are also appearing here due to scarce resources and, given the lack of evidence for these models, their implementation may turn out to be a false economy. At the same time, it may be appropriate to modify direct application of Western-based community mental health models of care in favour of more culturally appropriate and sustainable models, such as those placing greater emphasis on family support.[25,29]

While noting the necessity for contextually appropriate adaptations of imported healthcare models, policy makers and clinicians must ensure that the evidence-based, critical ingredients are not lost. Researchers must be resourced to rigorously evaluate emerging approaches to inform investment in the most clinically and cost-effective models that 'best fit' different settings. The current disinvestment in ACT in England runs the risk of depriving many individuals with severe mental illness and their families of the intensive support they need, as well as discouraging researchers from undertaking further high-quality studies that can inform the intelligent evolution of the ACT model within different contexts. People in England with severe mental health problems who require ACT are currently experiencing the worst of both worlds; ACT teams are disappearing without any coherent strategy (or investment) to ensure the active components of the model are incorporated into the work of generic CMHTs. Elsewhere in the world, and particularly in Europe, diluted, less intensive, hybrid models are being implemented, so far without robust evaluation. In the end, the debate is much more complex than simply specialism *v.* generalism; it is about the content of complex interventions in different contexts – what works best for whom and where. The unquestionable need to reconfigure services to deliver optimal benefits for individuals with severe and persistent psychiatric disorders and their families should not be allowed to be derailed by recycling a flawed discourse. Clearly, the urgent call to reconfigure these services should not merely lead the debate but follow the evidence.

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