What is the future of assertive community treatment?

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Although the trend towards community care for psychiatric patients has been apparent now for over fifty years, we still do not have a satisfactory model of community care that all can aim for as the target to be achieved. To an outsider this may seem curious. It seems fairly obvious that hospitals are necessary for patients when they are severely ill, that good care given outside hospital when patients have made some improvement is better than continued hospital treatment, and that the more resources there are available in the community to treat patients early in the course of illness or at times of relapse, the better the service. When one learns that by far the largest proportion of costs spent on the treatment of mental illness is concerned with in-patient treatment (around 85% in most countries) (Knapp et al., 1994), it is also easy to see why such a policy is attractive to planners and managers of mental health services as well as governments who have to foot the bills.

This was the climate in which assertive community treatment (and its synonyms such as assertive outreach and intensive case management) was born. The approach pioneered by Stein & Test (1980) involved a psychiatric team taking over responsibility for all parts of life, and so it was no exaggeration that those involved in training and treatment were primarily concerned with training for ‘daily living’. Since the original report there have been many other randomised controlled studies carried out between 1980 and 1991 which have confirmed that assertive community treatment is more effective than ‘standard care’ in the treatment of severe mental illness (Hoult & Reynolds, 1985; Merson et al., 1992; Muijen et al., 1992; Burns et al., 1993a; Creed, 1995). Although only a small number of studies have shown superiority of assertive community treatment in terms of clinical outcome (Stein & Test, 1980; Merson et al., 1992), almost all have shown superiority in terms of cost (mainly because admissions to hospitals are reduced) (Weisbrod et al., 1980; Muijen et al., 1992; Burns et al., 1993b; Merson et al., 1996). Patients also are much happier with this type of care than conventional hospital-orientated care and this too is a universal finding.

It might therefore be thought that assertive community treatment was here to stay and would become standard practice in most countries of the world. Certainly, in the United Kingdom this approach has now suddenly been discovered by managers in mental health services the length and breadth of the land and, like Paul’s conversion on the road to Damascus, the new dictum is ‘assertive community treatment for all’. Against this background of enthusiasm and commitment it may seem churlish to introduce negative findings. Unfortunately for these enthusiasts, such findings are now beginning to appear. Two major studies have been carried out in the United Kingdom in the past five years that throw into doubt some (but certainly not all) of the tenets of assertive community treatment. The first, reported in a comprehensive set of articles in the British Journal of Psychiatry, the PRiSM Psychosis Study, supervised by Graham Thornicroft and his colleagues, has demonstrated that assertive treatment in one borough of London shows no superiority over standard community treatment in another similar borough of London with equivalent levels of socio-economic deprivation (Thornicroft et al., 1998).

The study showed no difference in terms of admission rates and duration of admission, clinical outcome, quality of life and overall satisfaction with treatment, although in general patients in the assertive service had more of their needs met than the standard service (Leese et al., 1998; Taylor et al., 1998; Wykes et al., 1998). Costs were, as expected, higher in the intensive care borough because of higher staff
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Stein L.I. & Test M.A (1980). Alternative to mental hospital treat-


