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ORIGINAL ARTICLE

ACT and Recovery: What We Know About Their Compatibility

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Abstract While assertive community treatment (ACT) is a widely implemented evidence-based practice, the extent of its recovery orientation has been debated. A literature search identified 16 empirical articles studying recovery and ACT. These 16 studies were classified as involving stakeholder perceptions, interventions, or fidelity measurement. Stakeholders generally viewed ACT as being recovery oriented; research on both interventions and fidelity measurement showed promising approaches. Overall the literature yielded encouraging findings regarding ACT and recovery, though there remains a dearth of research on the topic. We discuss future directions for research and practice to ensure that ACT programs skillfully support recovery.

Keywords ACT · Recovery orientation · Person-centered · Fidelity

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Introduction

Findings across many studies have demonstrated the robust effectiveness of Assertive Community Treatment (ACT) for improving the lives of people with severe mental illness. Specifically, controlled studies have found ACT programs to be effective at reducing psychiatric hospitalizations, increasing stable community housing, improving treatment retention, fostering positive consumer and family satisfaction, and, to a lesser extent, decreasing psychiatric symptoms and improving overall quality of life (Bedell et al. 2000; Bond et al. 2001; Burns et al. 2007; Burns and Santos 1995; Coldwell and Bender 2007; Gorey et al. 1998; Herdelin and Scott 1999; Latimer 1999; Marshall and Lockwood 2000; Ziguras and Stuart 2000; Mueser et al. 1998). Consequently, ACT has been identified as an evidence-based practice (EBP) (Kreyenbuhl et al. 2010; Lehman and Steinwachs 1998; President's New Freedom Commission on Mental Health 2003; Torrey et al. 2001), and has been widely disseminated, becoming a cornerstone service program in many public mental health systems. It has been implemented in 45 states (Aron et al. 2009) and a half-dozen countries internationally. Despite its empirical support and popularity, however, ACT programs have not been without criticism and controversy. One of the most important issues has been the degree to which ACT is compatible with and promotes recovery.

Recovery has quickly become one of the most important movements in mental health, even though it is still a relatively new construct. First person accounts by consumers in the 1980s (e.g., Deegan 1988; Lovejoy 1984) were instrumental in raising professional and public awareness that people living with severe mental illness can live with hope and possibilities for meaningful and positive lives, despite the hardships imposed by schizophrenia and other

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major mental health disorders. By the early 1990s, Anthony declared in a now classic article that the emerging concept of recovery will become "the guiding vision of the mental health service system" (1993, p.11). Indeed, early within the twenty first century, national political and governmental groups promoted recovery as a central goal for mental health policy (President's New Freedom Commission on Mental Health 2003; SAMHSA 2011). Similarly, numerous state and local mental health agencies have also promoted recovery as a primary goal (Halvorson and Whitter 2009).

Despite the importance of recovery as a philosophical value and policy goal, observers have noted that there is uncertainty in the field as to precisely what recovery means (Morse 2000; Salyers et al. 2011b). Various definitions have been offered. Deegan, a consumer and psychologist, described the concept succinctly: "Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability" (1988, p. 11). Anthony, meanwhile, described recovery "as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, and/or roles. It is a way of living a satisfying, hopeful, contributing life even with limitations caused by illness" (1993, p. 15).

The construct of recovery emphasizes the potential for people with mental illness to experience personal growth and a range of positive change; thus recovery can also be considered as an outcome itself. Further, the literature suggests that recovery involves multiple associated outcomes, including the development of personal meaning, well-being, hope, a positive self-identity separate from their mental health diagnosis, improved symptom management, and functional improvements in a wide range of social roles and activities (Anthony 1993; Morse 2000; Salyers et al. 2011b).

Longitudinal studies on the course of schizophrenia provide empirical support for some of the key features of the concept (e.g., Harding et al. 1987). However, additional research is still needed on how people progress in their recovery, the measurement of recovery, and the methods by which providers can best support recovery (Farkas et al. 2005; Morse 2000; Salyers et al. 2011b). Although additional research is needed, policy makers, researchers, and consumers have cogently argued that community mental health services must be recovery oriented (Farkas et al. 2005)–a requirement that has sometimes brought criticism to the ACT model.

Some of the earliest and strongest criticisms regarding the extent to which ACT is consistent with recovery have come from consumers. Fisher and Ahern (2000), active in the consumer movement, argued that ACT programs are both intrusive to consumers' lives and coercive because at times ACT providers use involuntary treatment mechanisms and leverage money and housing resources to gain consumer cooperation. In Fisher and Ahern's view, ACT violates the basic rights of consumers and fosters dependency while promoting a medical "maintenance" model of lifelong support for people with severe mental illness. Gomory (1999), writing from an academic position, made similar strong criticisms of ACT, as did Knight (2004), a managed care executive. A very different opinion has been offered by another consumer, Fekete (2004), who suggested that ACT is recovery oriented as compared to traditional outpatient programs by virtue of the "side-by-side" working relationship between ACT staff and consumers and the in vivo nature of service delivery.

A more balanced assessment of the strengths and weaknesses of the ACT model for supporting recovery came from a frequently cited article by Salyers and Tsemberis (2007), who noted there was actually little empirical data at that time examining the recovery orientation of ACT teams. They also noted that ACT may be prone to criticisms of being coercive by design, since these teams are often intended to serve people with severe mental illness who are disengaged from traditional services but often suffering poor outcomes in terms of hospitalization, homelessness, and criminal justice offenses. Salyers and Tsemberis focused their study on a conceptual analysis of the recovery orientation of ACT by examining the theorized nature of the program, as measured by the Dartmouth Assertive Community Treatment Scale (DACTS), which was the first fidelity instrument for ACT (Teague et al. 1998) and recovery-oriented service approaches. Salyers and Tsemberis noted that nine of the ACT fidelity items are at odds with a recovery perspective. However, they suggested that these fidelity items could be modified to better support recovery, and that the other 19 fidelity items were compatible with or facilitative of consumer recovery. They concluded that "Even with some of these liabilities, ACT can still be particularly well suited to a recovery orientation" (p. 635). The importance of this possibility for ACT was underscored by Drake and Deegan's (2008) rhetorical reply to Salyers and Tsemberis: "Is ACT compatible with recovery? It had better be" (p. 77).

A number of other researchers and policy-makers believe that ACT is a useful program for facilitating recovery (e.g., Chandler et al. 1999; Corrigan 2006; Furlong et al. 2009; Latimer 2005; Lehman et al. 2003; Mueser et al. 2003), or even a critical ingredient in a recovery-oriented system of care (e.g., Padgett and Henwood 2011). Increasingly, recovery is specified as a core principle defining the ACT model (Morse and McKasson 2005) and it has been a topic of major interest at the Annual ACT Association meetings, with 16 (8.9 %) of all conference workshops focused on recovery and ACT during the three recent years of the annual meetings (from 2009 through 2011).

Despite these developments, there remains controversy in the field as to whether or not ACT is a recovery-oriented service program (see, for example, Johnson 2011; Salyers et al. 2010; Salyers et al. 2011a). Much of this controversy and uncertainty stems from a paucity of theory and research describing how ACT programs operationalize and support the recovery of the people they serve. Drake and Deegan described the recovery orientation of ACT programs as “unspecified” (2008, p. 75), and there have been precious few attempts since then to specify the ACT elements and practices that support recovery.

The field needs to advance beyond debate on the basic question as to whether or not ACT is recovery oriented. Programmatic experience suggests that ACT can indeed support recovery, and it is clear from a values and policy perspective that it must do so. The literature, however, needs to provide data-based information about the positive–and any negative–recovery aspects of ACT and the ways by which ACT programs can best support recovery. Toward these ends, this paper will systemically review the empirical literature to examine the question: What do we know about ACT and recovery? The discussion will both comment on the results of the literature search and outline future directions for research and specific practice approaches to ensure that ACT programs do indeed skillfully support the recovery of the people they serve.

Methods

The authors conducted a literature search of the databases CINAHL, Family & Society Studies Worldwide, PsychINFO, MEDLINE, Social Work Abstracts, and SocINDEX for publications using the keywords “assertive community” AND “recover*” in the title or abstract during March of 2012 and then conducted an updated search in November 2014. The search term “assertive community” was used as a search term after preliminary searches showed this term garnered more articles relevant to ACT with fewer false positives than “ACT,” and that use of “ACT” as a single search term was redundant in tandem with the term “assertive community” (this was found by running preliminary searches both ways and discovering that relevant articles consistently used the term “Assertive Community Treatment” whereas ACT often was frequently used in reference to unrelated concepts). The term recover* was used given that recovery is the prevailing term used in the field to address the concept we set out to examine in relationship to ACT. As of November, 2014, the search yielded a total of 191 results[1] with 99 results remaining after removal of duplicates. All authors independently reviewed the 99 abstracts to further determine whether each article addressed recovery specifically within the context of ACT; sources that happened to mention ACT and recovery within the same article but without a meaningful connection between these two concepts were dropped from further review. Two results were deemed to be irrelevant to ACT upon review of the abstracts by all three authors. The authors further reviewed each of the remaining 97 articles to determine if it was an original study concerning ACT and recovery that involved empirical methods—that is, a study that used quantitative, qualitative, or mixed research methods to investigate one or more research questions; single case study reports were excluded from our results. When at least one author determined that an article appeared to empirically address the connection between ACT and recovery from a reading of the abstract, at least one author then reviewed the entire manuscript to verify whether its inclusion in the review of ACT and recovery was warranted.

Results

From the pool of 97 citations that were yielded through the literature search, the authors found a total of 16 articles where quantitative ($n = 8$), qualitative ($n = 6$), or mixed methods ($n = 2$) were used to study recovery in the context of ACT. The authors determined upon review that these citations could be classified into three categories of studies: 1) perceptions and experiences of ACT and recovery by various stakeholders ($n = 8$); 2) original research on interventions to improve recovery orientation of ACT ($n = 5$); and 3) measurement of fidelity and recovery orientation of ACT ($n = 3$).

Perceptions and Experiences of Recovery by Stakeholders

The first area of research we explore concerns the nature and extent of recovery orientation within ACT programs, especially as assessed through the experiences and perceptions of various stakeholders ($n = 8$). Specifically, seven articles investigated the perspectives of ACT participants to better understand the relationship between ACT and recovery (Barrett et al. 2010; Chinman et al. 1999; Cunningham et al. 2005; Kidd et al. 2011a; Milbourn et al. 2014; Salyers et al. 2011b; Yasui 2009). Four studies also included perspectives of ACT providers (Chinman et al.

[1] The numbers of articles found per database are as follows:PsychInfo (85), Medline (51), CINAHL Plus with Full Text (38), SocINDEX

Footnote 1 continued
with Full Text (9), Family & Social Studies Worldwide (6), Social Work Abstracts (2)

1999; Felton et al. 2006; Kidd et al. 2011; Salyers et al. 2011b) and one study assessed views of families (Kidd et al. 2011). The methodology was quantitative in two of the studies (Barrett et al. 2010; Kidd et al. 2011) and qualitative in six publications (Chinman et al. 1999; Cunningham et al. 2005; Felton et al. 2006; Milbourn et al. 2014; Salyers et al. 2011b; Yasui 2009). Findings from these studies are discussed below.

Barrett et al. (2010) found that participants in a modified ACT program considered services to be recovery oriented. They found that ACT participant scores on a recovery measure, the Recovery Self-Assessment (RSA; O'Connell et al. 2005), were no different from recovery measure scores from demographically similar individuals served by a community mental health center. They also found that the relationship between recovery orientation and satisfaction with services was mediated by empowerment (Barrett et al. 2010). In a larger study of 67 ACT teams where recovery orientation was measured using the RSA from the perspectives of staff, ACT participants, and families, Kidd et al. (2011) also found that each of the stakeholder groups rated ACT teams as having a moderate to high recovery orientation.

A qualitative study by Cunningham et al. (2005) compared the illness management strategies of a convenience sample of current ACT participants and former ACT participants who were receiving less intensive case management services. Cunningham et al. (2005) found that those who graduated from ACT and were receiving case management were more engaged in their communities and had more understanding and acceptance of their illness compared with those currently participating in ACT. Though the authors did not investigate the relationship between recovery and ACT as an intervention, they assumed that ACT participants who graduated were further along in the recovery process compared with ACT participants who had not yet graduated. In a series of qualitative interviews with four individuals on an ACT team, Yasui (2009) investigated definitions and extent of community integration, and found that participants considered their experiences with the ACT team to be integral to the process of being part of a community. Another qualitative research study (Milbourn et al. 2014) recruited "hard to engage" participants ($n = 11$) in two ACT teams in Australia and found different results. Specifically, they concluded that while just over half ($n = 6$) of respondents had a personal definition of recovery, all participants expressed feeling that their choices were not honored with respect to their goals and treatment preferences, and all participants appeared to experience daily routines that centered upon receiving services (Milbourn et al. 2014). While no comparison was made with other ACT participants who were more engaged in services or individuals receiving other services, Milbourn et al. (2014) found that participants seemed to feel they were passive recipients rather than active partners in their ACT services.

Felton et al. (2006) observed recovery perspectives expressed by ACT providers in the context of a 19-session training on ACT. Specifically, they documented and qualitatively analyzed comments made by ACT providers over the course of the training and found that overall trainees expressed positive attitudes regarding recovery but that there were some providers who continued to express the idea that some ACT participants may not be appropriate for recovery-oriented services due to substance use or being in a state of crisis. Similarly, Felton et al. (2006) found that some trainees saw ACT participants' denial of their mental health status as a barrier to developing relationships and providing recovery-oriented services.

Some studies have indicated notable differences in the perspectives of different stakeholders regarding the recovery orientation of ACT (Chinman et al. 1999; Kidd et al. 2011). Chinman et al. (1999) conducted a qualitative study where ACT staff and a small sample of ACT participants were asked to share their perspectives on what aspects of ACT facilitated their recovery. They found that staff and participant perspectives differed; the staff emphasized adherence to medications and treatment in general while participants focused on their relationships with the staff and their willingness to help with important practical tasks such as finding housing or buying groceries. Kidd et al. (2011) investigated the relationship between recovery orientation and ACT outcomes such as legal involvement, hospitalization, housing and employment status, and involvement in formal education. They found differing associations between recovery-orientation scores and ACT outcomes across stakeholder groups including ACT participants, ACT team leaders and other providers, and family members.

Salyers et al. (2011b) took a unique study approach, using qualitative methods to identify features that distinguished an ACT program rated as "high" in recovery orientation from another ACT team rated as "low" in recovery. Salyers et al. reported that the two teams could be distinguished by differences on four main dimensions: environment, team structure, staff attitudes, and expectations of consumers. Specific findings suggested that the ACT team that was high in its recovery orientation differed from the team low in recovery by critical ingredients that included visual cues of recovery in the program environment (e.g., posters about recovery), a specific orientation to providing recovery, the integration of peer specialists, the provision of illness self-management services, an accepting and normalized view of consumers, positive expectations for consumers, the use of strengths-based language, collaborative treatment decision-making, and minimal use of

mechanisms of control (e.g., outpatient commitment). Further, Salyers et al. characterized the team high in its recovery orientation as using a "coaching" rather than "parenting" approach in working with consumers.

Research on Interventions

Despite the central importance of recovery to the ACT model, there has been very little research on approaches that ACT programs can use to systematically and explicitly enhance the recovery outcomes of clients. This review of the literature identified only five empirical studies in this area, two of which employed randomized control trial (RCT) designs. One of the first investigations was an RCT study by Barbic et al. (2009) on the effectiveness of a modified Recovery Workbook intervention (Spaniol et al. 1994). Barbic and colleagues randomly assigned 33 ACT participants to either treatment as usual or an adjunct experimental group that provided ACT clients with a shorter (12-session) version of the Recovery Workbook program. Post test assessments showed that ACT clients had significantly better scores than control participants on measures of hope (the Herth Hope Index; Herth 1991), empowerment (Empowerment Scale; Rogers, Chamberlain, Ellison et al. 1997), and recovery (RAS), though not on quality of life (Quality of Life Index, Ferrans and Powers 1985). This study had positive findings and manifested several methodological strengths, but the findings were also limited by the absence of a follow-up assessment, a small sample size, a low participation rate for eligible clients, and the exclusion of persons with co-occurring substance abuse disorders.

Salyers et al. (2010) conducted a RCT study of a specialized recovery intervention within ACT. Their study randomly assigned two of four Indiana ACT teams to the illness management and recovery (IMR) (Gingerich and Mueser 2005) program. As part of the experiment, IMR was delivered in weekly groups to ACT participants by peer specialists and at least one other team clinician trained as ACT+IMR specialists. The experimental ACT+IMR teams demonstrated moderate fidelity to the IMR program, but relatively few ACT clients actually received the intervention over a two-year test period. Specifically, only 25.7 % of clients participated in any IMR sessions and, more concerning, only 3.8 % of clients actually completed the IMR program. Not surprisingly, given the low penetration rates, there were no main outcome effects for adding IMR in this study. However, secondary analyses found that those clients who actually received some IMR services within ACT experienced reduced hospitalization rates over time; in addition, clients with substance abuse diagnoses in the ACT+IMR condition showed better substance abuse recovery on the Substance Abuse Treatment Scale (SATS, Mueser et al. 2003) at the 2 years follow-up period. Salyers and colleagues also noted several challenges to implementing IMR within ACT, including role conflicts for staff (i.e., having adequate time to provide IMR versus responding to case management and crisis responsibilities) and staff turnover. They also provided several useful recommendations for improving the implementation of IMR within ACT (e.g., clear job descriptions, defined and gradually increasing caseloads of IMR participants, opportunities for continuous learning on IMR).

Two other empirical studies have been conducted on recovery interventions exclusively within ACT. Both of these uncontrolled studies were conducted by Salyers and colleagues and involved the use IMR within ACT. Salyers et al. (2009) conducted an uncontrolled pilot study on providing IMR within ACT using peer specialists. Over a 6 month period, 11 ACT participants who completed individual IMR, often during home visits, showed a significant pre-post improvement on a measure of recovery (RAS) and also a trend toward improvement in their knowledge of mental illness (IMR Scale, Gingerich and Mueser 2005). Qualitative interviews with ACT staff and consumers indicated other positive changes, including increases in consumer hope and motivation. In a separate investigation, Salyers et al. (2011a) conducted a retrospective, multivariate analyses of IMR within ACT on hospitalization and emergency room use. The analyses, conducted on Medicaid claims data for 498 service users from five ACT teams in Indiana, found that those who received some IMR services had fewer days hospitalized than ACT participants who did not receive IMR services. In addition, graduation from the IMR program predicted lower rates of emergency room use for ACT clients.

Finally, MacDonald-Wilson et al. (2013) conducted an interesting study to support recovery and other outcomes using a web-based and peer-supported intervention (CommonGround, Deegan 2010). The study was not specific to ACT, however, being conducted acress ten medication clinics and one ACT team, and subanalyses by program type were not reported. The open clinical trial found significant improvements over time for the 5,583 persons in the study on several measures constructed for the project, including self-ratings on health functioning, symptoms, illness self-management strategies, medication side effects, and perception of benefits from medications.

Fidelity and ACT Recovery

Three articles focus on measurement of recovery orientation within ACT, two of which focus specifically on fidelity (Kidd et al. 2010; Monroe-DeVita et al. 2011), and one of which focuses on other methods of measuring recovery orientation within ACT (Salyers et al. 2013). Research on

identifying components of recovery-oriented ACT and incorporating them into fidelity measurement is an evolving area. As described earlier, Salyers and Tsemberis (2007) began this work by conducting a conceptual crosswalk between the original ACT fidelity tool, the DACTS (Teague et al. 1998) and recovery-oriented approaches to service provision, and a few subsequent studies have incorporated empirical methods.

Kidd et al. (2010) empirically examined recovery-oriented practice, as operationalized in the RSA (O'Connell et al. 2005) in 67 ACT teams in Ontario, Canada. They found that while those ACT teams embraced a moderate to high degree of recovery-based practice, there was no significant relationship between ACT fidelity as measured by the DACTS (Teague et al. 1998) and consumer and natural supports' moderate to high ratings of the teams' recovery orientation. The authors suggest that such a lack of clear association indicates the need for a fidelity measure that captures and holds ACT teams accountable to recovery-oriented service provision.

A newer ACT fidelity tool, the Tool for Measurement of Assertive Community Treatment (TMACT; Monroe-DeVita et al. 2013) addresses many of the recommendations laid out by Salyers and Tsemberis (2007) and Kidd et al. (2010) to promote more recovery-oriented practice within ACT. For example, the TMACT includes a subscale, Person-Centered Planning and Practices focused on recovery-oriented practices; items on this subscale examine the extent to which: (1) the ACT team assesses and applies consumers' personal strengths and resources into treatment goals, (2) consumers take the lead in collaboration with the team in determining their treatment goals and the treatment planning process, (3) interventions target a broad range of life domains (e.g., personal relationships, work, health), and (4) the team promotes consumer self-determination and independence. Further, the tool places an emphasis on team provision of psychiatric rehabilitation and other EBPs known to facilitate an increase in independent functioning, personal recovery, and community integration. The TMACT also delineates the roles that team members play in facilitating wellness, self-determination and independence. Similarly, the fidelity item on assertive engagement was revised from the original DACTS version to reflect a range of strategies from collaborative, motivational interventions to therapeutic limiting-setting; these strategies should then be evaluated for effectiveness and modified when necessary while promoting a goal of maximizing consumer independence.

Initial pilot research on the TMACT is promising, indicating that it is a more sensitive tool than the DACTS, and captures elements that facilitate evidence-based and recovery-oriented practice (Monroe-DeVita et al. 2011). Another study found higher TMACT scores to be associated with a decrease in use of state psychiatric hospitals, as well as local inpatient psychiatric and crisis stabilization services (Cuddeback et al. 2013). Further, an earlier version of the TMACT was also found to correlate with another measure of recovery orientation, the Recovery Oriented Practices Index (ROPI; Mancini and Finnerty 2005) when used with 29 ACT teams in New York State (Teague et al. 2009), showing promise for future directions in research and practice.

Salyers et al. (2013) used a mixed-methods evaluation approach in order to empirically examine the best and most feasible approaches to measuring recovery orientation with two ACT teams in Indiana, one of which was pre-identified as low fidelity and the other as high fidelity. They compared the use of team member and client surveys [e.g., IMR Scales (Mueser and Gingerich 2005), Adult State Hope Scale (Snyder et al. 1996), an adapted version of the Housing Choice Measure (Srebnik et al. 1995)], team member and client diaries of treatment contacts, interviews with clients and team members, independent observer ratings of treatment plans, and team leader-report on the degree of control consumers on their team have of their own treatment. Findings suggest that treatment plan reviews by independent observers, team member and client visit diaries, team leader-reported treatment control mechanisms, along with team member and consumer interviews best differentiated the two programs and yielded the least amount of burden to respondents and assessors. These findings suggest that mixed-methods approaches such as these are a feasible approach to measuring ACT teams' recovery orientation, which has implications for further enhancing ACT fidelity measurement.

Discussion

What do we know about ACT and recovery? Unfortunately, our knowledge remains limited, given the small number of empirical studies on the topic and the use of relatively weak research designs and methods; in particular, many of the existing studies relied on small samples, samples of convenience, uncontrolled comparison groups, qualitative methods and cross-sectional designs with correlational analyses. The existing empirical literature is not sufficient in the quality of research methods or the quantity or strength of findings to unequivocally resolve the controversy concerning ACT and recovery. Still, it is possible to draw some preliminary and tentative conclusions about our current knowledge of ACT and recovery.

First, it is a positive substantive finding that most if not all studies have reported that people served by ACT services do indeed view the program as recovery oriented (Barrett et al. 2010; Yasui 2009; Kidd et al. 2011), as do ACT service

providers (Barrett et al., 2010; Kidd et al. 2011; Felton et al. 2006). Various stakeholder groups differ somewhat, however, in their perspectives regarding the ways and extent to which ACT is recovery oriented (Kidd et al. 2011); this finding may reflect the fact that different stakeholder groups emphasize different aspects of ACT and the elements that are essential to recovery (Chinman et al. 1999). In future research, it will be important to assess multiple stakeholder perspectives, given varying perceptions.

A second important substantive development comes from recent research on ACT fidelity and recovery. In particular, this research (Monroe-DeVita et al. 2011) has begun to define and measure specific elements of a recovery orientation within ACT (e.g., assessing and incorporating consumers' personal strengths into treatment planning, a collaborative treatment planning process, the promotion of consumer self-determination) while empirically examining this recovery service approach with consumer measures of recovery (Teague et al. 2009) and with service system outcomes (Cuddeback et al. 2013). We should also note in passing that stakeholder perceptions of recovery and fidelity measures represent only two areas of research concerning a recovery orientation. Additional topics still need to be investigated, and our knowledge about ACT and recovery will be improved as future researchers employ stronger research methods and designs, including larger samples, matched control groups, longitudinal designs, and multivariate analyses for descriptive studies.

Third, it is encouraging that there is some empirical support for the proposition that ACT teams consciously facilitate recovery by incorporating specific recovery-oriented interventions, including IMR (Salyers et al. 2010; Salyers et al. 2011a; see also Barbic et al. 2009). Still, the controlled research in this area is very limited, with only two, small-sample RCTs having been conducted (Barbic et al. 2009; Salyers et al. 2010). Additional research in this area using rigorous experimental methods is critical for the further development of ACT as a treatment program that supports the recovery of persons with severe mental illness. Given the importance of this topic, we continue the discussion below with recommendations of promising means by which ACT programs can further improve their service approaches and better support people in their recovery journey.

Recommendations to Improve Recovery Through Practice Approaches

Undoubtedly, ACT programs—like other EBPs and community mental health programs in general—can improve their approaches to better support and facilitate the recovery of the people they serve. As described below, it is likely that a number of activities—in the areas of service interventions, team operations, staffing, and even discharge planning—can lead to better recovery outcomes. Each of these strategies, however, must be grounded in a core set of program service principles. Most fundamentally, the ACT team must embody a culture of recovery—i.e., shared values, beliefs, and attitudes about the possibilities and promise of recovery for people with severe mental illness (Drake and Deegan 2008; Salyers and Tsemberis 2007). The inclusion of recovery as a key ACT principle (Morse and McKasson 2005) and the increasing attention to recovery issues within the ACT community (e.g., at ACTA conferences) are encouraging signs of progress toward recovery in this critical area. Recovery needs to be promoted not only through words, but also through human interactions; perhaps the most important activity is the development of a caring, trusting, understanding and respectful relationship between ACT staff and the persons they serve (Chinman et al. 1999; Salyers and Tsemberis 2007; see also Fisher and Ahern 2000). As others have noted, however, the development of such relationships can take years (Fisher and Ahern 2000; Salyers and Tsemberis 2007). It is also important to recognize that individuals may be at different stages of recovery, which may therefore require different service approaches (Salyers and Tsemberis 2007; Shetty 2010). People in early stages of recovery may require more frequent contact (Salyers and Tsemberis 2007), often for developing a positive working alliance and helping with basic treatment and resource needs; meanwhile those further along in their recovery may need more assistance with recreational needs and social inclusion (Shetty 2010) as well as employment. In any case, it is important that ACT staff recognize the recovery potential of each person, celebrating the gains of each person over time, while acknowledging that recovery may occur more gradually for some individuals than others (see also Salyers and Tsemberis 2007).

Services to better promote recovery start with a person-centered approach. Of particular importance are strengths-based assessments and person-centered treatment planning approaches (Brun and Rapp 2001; Claes et al. 2010; Cox 2006; Rashid and Ostermann 2009; Tedeschi and Kilmer 2005; Tondora et al. 2010; Stanhope et al. 2013), which must be incorporated with the comprehensive assessment traditionally emphasized in ACT (Allness and Knoedler 2003). Person-centered treatment planning takes a collaborative approach that identifies the participant's dreams, strengths, and resources, as well as traditional areas of need and concerns—service approaches that the revised ACT fidelity measure assesses (Monroe-DeVita et al. 2011).

ACT teams can also facilitate recovery by incorporating other EBPs into their service delivery regimens. As noted in the review of empirical studies, IMR offers particular promise with its emphasis on symptom management,

functional skills, and personal recovery goals. Unfortunately, less attention has been directed to date toward the social outcomes of ACT for consumers, including supported employment, but the integration of the Individual Placement and Support (IPS) practice should be effective for helping ACT participants obtain competitive jobs (Bond et al. 2008; Gao and Dolce 2010; cf. Waynor and Pratt 2011), and to accrue the secondary benefits that come from working, such as greater social inclusion and improved self-esteem. Cognitive behavioral therapy (CBT) is another EBP that could be integrated into ACT to help participants decrease symptoms and improve functioning; preliminary research suggests the integration of CBT for Psychosis within ACT is feasible (Pinninti et al. 2010). Other best practices—including motivational interviewing (Miller and Rollnick 2013; Lundahl and Burke 2009), shared decision making (e.g., Deegan and Drake 2006; Drake et al. 2010; Joosten et al. 2008), and wellness recovery action planning (Cook et al. 2009, 2010, 2012; Copeland 1997; Fukui et al. 2011)—should also be integrated into ACT programs to further support consumer recovery (Salyers and Tsemberis 2007). Although the integration of these other practices into ACT programs may potentially improve recovery for consumers, an important caveat should be noted. Specifically, prior research (Salyers et al. 2010; Blajeski and Monroe-DeVita 2011) has found it is often difficult to successfully implement other EBPs into ACT on a large scale. Additional implementation research is needed to determine how to truly integrate other practices into ACT without simply layering them on top of the model; this includes identification of core ACT structures and processes that facilitate uptake of these practices across multiple team members. Future studies also need to consider workforce issues, such as the busy schedules and high clinical productivity demands commonly experienced by many ACT staff that can create barriers for the integration of other EBPs.

While the integration of EBPs and best practices will be one effective means for ACT teams to better support the recovery of the people they serve, additional services are also needed in order to improve other social outcomes for consumers served within ACT. In particular, social relationships, recreation and leisure activities are important aspects of community life and personal happiness for most people (Layard 2005), but few ACT participants engage in recreation and leisure activities (Krupa et al. 2003) and teams need to target assistance in these areas. While developing treatment plans, ACT teams can better support personal recovery by being more mindful of what contributes to a satisfying life. ACT teams should also provide skills training (Bellack et al. 2004) and social networking interventions (especially for persons with co-occurring disorders—see Drake et al. 2001) to help participants find life-enhancing activities and develop greater social support and more meaningful relationships.

ACT programs can further support recovery through general team operations and regular service activities. For example, staff can regularly ask clients about their ideas for personal recovery, their level of satisfaction with the team's recovery services, and their sense of progress toward their personal recovery goals. Staff should also be taught to report on and consider the person's recovery—not just clinical status—during daily team meetings. Recovery can also be reinforced by using collaborative documentation, a method that empowers clients in the documentation process and helps to ensure that services are aligned with the consumer's preferences (Stanhope et al. 2013).

The human resource component of ACT teams is another avenue for supporting recovery. Many ACT programs now employ a peer specialist and this inclusion of consumers as peer specialists can provide a helpful model for the recovery of other consumers who are being served by the team (Salyers et al. 2009; Wright-Berryman et al. 2011). Further, a few studies provide at least partial support for improved outcomes when ACT or case management programs include peer providers, especially for client engagement and, to a lesser extent, for reducing hospitalizations (see Wright-Berryman et al. 2011).

One final recommendation for improving ACT services to foster recovery: ACT teams need to facilitate and support "graduation" from the program. Early proponents of the model advocated lifelong membership in ACT, in large part because of research and experience showing poor outcomes for people who had been discharged, often too quickly, from ACT (Test et al. 1992). Expecting that most or all clients should be served for the rest of their lives by ACT programs runs counter recovery premises that people grow in independence from mental health services over time. In addition, recent research shows that many people with severe mental illness can function well after discharge from ACT, especially if they are supported through the transition period and are provided with less intensive or "step-down" services and/or are linked to other supports in the community (e.g., less intensive case management programs, medication clinics, other community resources) (Rosenheck and Dennis 2001; Rosenheck et al. 2010; Salyers et al. 1998). Teams may benefit from using measures developed to assess participant readiness for transition or graduation from ACT programs (Cuddeback 2011; Donahue et al. 2012). While Critical Time Intervention (e.g., Herman and Mandiberg 2010) currently appears to be one promising strategy for helping with the transition from ACT while securing needed follow-up supports and services (Finnerty et al. 2009; Finnerty, 2013 [personal communication]), further research and development is needed on the most effective ways to help participants graduate from ACT programs.

The preceding discussion suggests that there are multiple ways to further improve the recovery orientation of ACT teams and the recovery outcomes of the people they serve. This statement is not meant to imply that ACT teams are now failing in these objectives, but only that there is room for further innovation and improvement. A related question may arise as to whether teams that incorporate these additional recovery-oriented practices should still be regarded as fidelity-based ACT programs that are supported by a large body of research evidence. In large part, the answer should be affirmative, given that these changes will not alter the fundamental program characteristics of ACT, nor many of the critical variables that mediate positive outcomes; rather, they are useful and necessary enhancements to the model's guiding philosophical underpinnings and to selected aspects of ACT's comprehensive service approach. Further, the theoretical model of ACT and its practice in community settings has been evolving over the years to become more recovery oriented, and some of these adaptations have already been captured by the most recent ACT fidelity measure (Monroe-DeVita et al. 2011). Further improvements, such as those outlined in this paper, can continue this trend in the field to enhance recovery practices. Future research on ACT outcomes will also be important as the model continues to evolve in its recovery orientation, but we predict that future outcomes will continue to be positive even as consumers advance further in their personal recovery journeys.

Some of the issues discussed here are not exclusive to ACT. Many of the practices suggested here are applicable to other EBPs and other community mental health programs. Indeed, as Anthony and colleagues (Anthony et al. 2003; Farkas et al. 2005) have noted, other EBPs are also in need of future research and development concerning their recovery orientation. Further innovations in recovery practices may also raise the need for additional research on other EBPs, but these efforts are worth pursuing as the mental health system continues to discover ways to best support the recovery of persons with severe mental illness.

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