From ACT to Growth Oriented Full Service Partnership (GO-FSP)

2015

GO-FSP is built upon arguably the most venerable, successful, and widely replicated of the Evidence Based Practices: ACT. In fact, ACT was one of the three initial components of the MHA-Village along with psychosocial rehabilitation and capitated funding. However, over the past thirty years several weaknesses in the standard ACT model of practice have emerged that have led us to the recovery based improvements included in GO-FSP:

1) The ACT model is based upon the medical model. It was initially described as a "hospital without walls". It focuses services on treating illnesses, reducing symptoms, and reducing psychiatric hospitalizations. Taken alone, those illness centered services didn't regularly lead to improvements in broader Quality of Life outcomes. Many programs began doing "ACT-plus" programs integrating other services into the ACT package, for example employment, substance abuse, housing, and medical services with improved outcomes in the targeted areas. Moving beyond this incremental improvement approach, the recovery model has promoted a value based transformation from "illness centered" to "person centered" services where the overt goal of services is not to treat illnesses, but to help people with illnesses have better lives. The practice that has developed as a result is integrated "**Full Service**" – a "one stop shop" where staff do "whatever it takes" pursuing Quality of Life goals.
2) The ACT model is based upon "professionally driven" relationships and services. It has been described critically at times as paternalistic and controlling. The "assertive" nature of the practice was often resented and experienced as intensive compliance monitoring. This engagement style too often leads to either overt service rejection or to passive, helpless, demoralized clients. The recovery model has promoted a value based transformation from "professionally driven" to "client driven" services where the client's individual goals and preferences drive the service selection, empowering the client and increasing the likelihood of substantial self-help efforts. A variety of practices have been developed around engagement, motivational interviewing, shared decision making, and collaboration resulting in a "**Partnership**" between clients and service providers.

3) ACT has regularly become a level of service provided on a lifelong basis. Even when clients make substantial improvements, it's usually considered necessary to maintain ACT level services for them to maintain those improvements. This has become a resource problem in many areas with long waiting lists for limited ACT slots and limited "flow" into lower intensity services. Reliance on staff based caretaking, supportive, case management services doesn't often enough lead to increased self-responsibility, self-reliance, and independence. The recovery movement has transformed us from a "deficit based" risk reduction focus to a "strengths based" resilience building focus. For wherever a client is in terms of social determinants of health, protective factors, self-efficacy, and building internal strengths by struggling we can provide specific stage based "**Growth Oriented"** services.

   Taken together these three value based transformations have led us to a substantial improvement upon the classic ACT practice – "**Growth Oriented Full Service Partnerships".**