# How effective is Assertive Community Treatment (ACT) in improving mental health transitions?

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**November, 4th, 2014**

# Presentation Outline

- Overview of Assertive Community Treatment (ACT) Services
- Target Population
- Effectiveness
- New Developments
- Management Issues
- Conclusion

# Overview of ACT Services

- Introduced in the 1970s - Wisconsin (Stein, Test, & Marx)
- Objective: To successful engage severe mental illness (SMI) clients in treatment
- Outcomes:
  - Substantially reduces use of psychiatric hospital and emergency department; increases housing stability
  - Moderately improved psychiatric symptoms
  - Improved vocational outcomes and quality of life
- Extensive evidence base:
  - Over 30 RCTs
  - No more expensive than traditional care
  - Replicated in Canada, UK, Australia, Europe, Asia

# ACT Structure, Function & Approach

**Comprehensive, Multidisciplinary Approach**

- Team includes psychiatry, nursing, social work, occupational therapy, psychology, addictions medicine, primary care, peer support
- Shared caseload
- Integrated dual diagnosis treatment - substance use
- Attention to primary health care needs

**Accessible and Assertive Approach**

- 24 hours/7 days per week
- Crisis interventions - 24 hours
- Long-term services – no arbitrary time limits
- Rapid Access
- 75-80% delivered in the community – out of the office
- Community Treatment Orders

# ACT Structure, Function & Approach Cont.

**Intensive, Individualized Supports**

- Intensive (1:10 staff/client ratio )
- Support 85-100 clients per team
- Highly individualized services

**Recovery-Focused**

- Treatment, rehabilitation and support – recovery focused - Strength based model (Rapp et all)
- Emphasis on vocational expectations – Individual Placement and Support Model (IPS) (G Bond)

**Continuity of Care**

- Hospital, Emergency Dep't, Police, Corrections - integrated care approach
- Scattered Housing - private market housing (At Home Chez/Soi)

**Evidence-Based and Community-Informed**

- Fidelity Scale – Dartmouth ACT Fidelity Scale (DACTS)
- Community advisory committee

# ACT Target Client Population

**Diagnosis and Health Status**

- Severe mental illness - primarily recurring psychoses
- Often with substance use and physical health care needs
- Significant cognitive impairment

**Socio-Economic Factors**

- Poor social, employment, money management skills
- Poor housing stability (frequently homeless)

**Service Use and Needs**

- Frequent extensive use of hospital emergency, in-patient psychiatric (75 days +) and community emergency services
- Frequent contact with criminal justice (Police, Corrections)
- Don't do well in transitions (hospital-community; corrections-community; housing transitions; transfer to less intensive services)
- Do not respond well to less intensive (office-based) mental health and substance use services

# ACT Target Population Cont.

- Targeted to key populations with high service costs and poor outcomes
- Tripartite Target Populations
  1. Long stay/institutionalized mentally ill
  2. “Revolving door syndrome” (“heavy users” of ER, and hospital….50 + bed-days )
  3. “High profile” homeless, high criminal justice system users
- Collectively, these patients are amongst the most ill and cost the state the most amount of money, often without positive outcomes to show …

# High Fidelity ACT Teams

- US, UK, rest of Europe, Australia, Asia
- 80 teams in Ontario
- 25 teams in Quebec
- 19 teams in BC (4 under development)
- Several teams in Western provinces and Atlantic Canada

# Research Results: Significant Impact on Service Use & Quality of Life

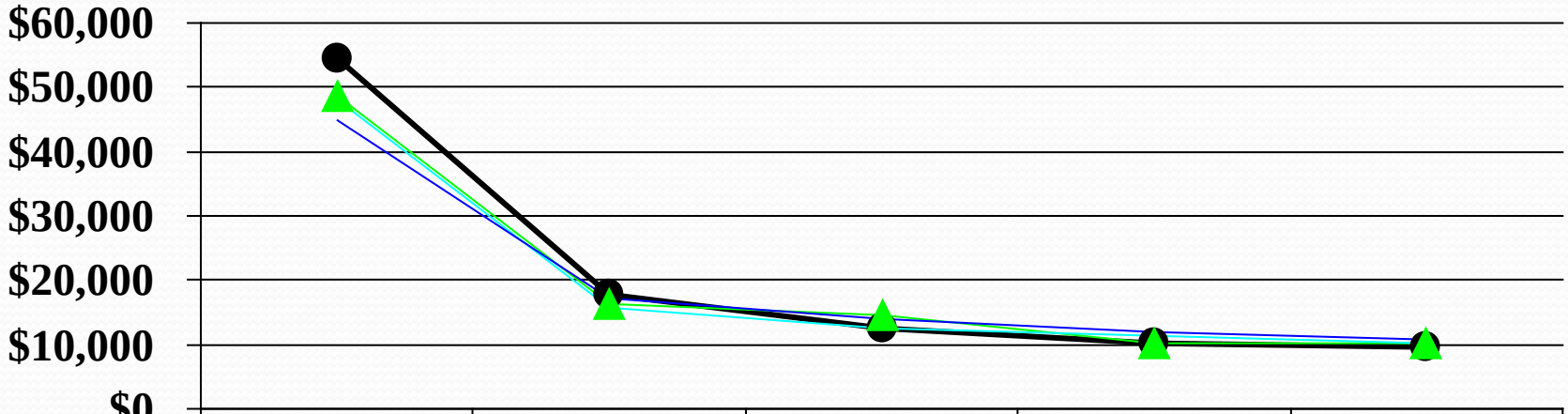
- Over 30 RCT results across many jurisdictions (Cochrane Reviews)
  - Significant reductions in hospital and ER use (both long stays and acute care recidivism) compared to regular case management
  - 50 - 70% average reductions in bed days after 12 months
  - Increased housing stability
  - Increased vocational outcomes - IPS place-train approach
  - Increased satisfaction of client, family, community
- Different outcome results in UK/Europe

# Research Results: Significant Reductions in Hospital Use

- Oklahoma - **73 % decrease in hospital inpatient care** (2006/07)
  - From 9,583 to 2,612 days after 1 year
- Ontario - **82% reduction** (2006/07)
  - based on 4,525 clients supported by 72 teams
  - In the year prior to ACT enrolment, service recipients spent an average of 67 days in hospital.
  - Post-ACT reductions in inpatient days:
    - After 1 year: 24 days
    - After 4 years: 13 days
    - After 6 years: 12 days

# Ontario Results: Significant Health Care Savings due to Reduced Hospital Bed Utilization

***Value of an Individual ACT Client's Reduced Hospital Bed Utilization***

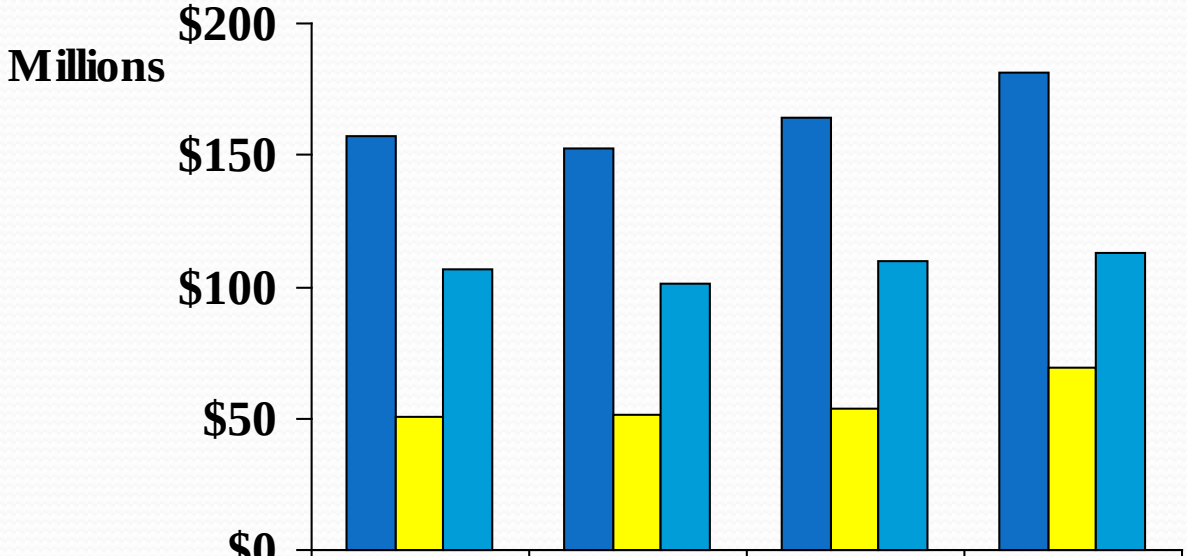



| | 1Yr Pre | 1 Yr Post | 2Yr Post | 3Yr Post | 4Yr Post |
|---|---|---|---|---|---|
| 2002-03 | $54,352 | $17,696 | $12,640 | $10,112 | $9,480 |
| 2003-04 | $48,664 | $16,432 | $14,536 | $10,112 | $10,112 |
| 2004-05 | $48,032 | $15,800 | $12,640 | $11,376 | $10,112 |
| 2005-06 | $44,872 | $17,064 | $13,904 | $12,008 | $10,744 |

Avg. Bed Day Cost = $632†

† Source for Average Bed Day Cost:
*Forchuk, Cheryl, RN, PhD., "Therapeutic Relationships: From Hospital to Community" (June 2002)*

# Ontario Results: Value of Reduced Hospital Bed Utilization Projected at $112.6 million over 4048 Clients




| | 2002-03 (2887 clients) | 2003-2004 (3130 clients) | 2004-2005 (3414 clients) | 2005-2006 (4048 clients) |
|---|---|---|---|---|
| Pre-ACT | $157,350,000 | $152,319,000 | $163,982,000 | $181,642,000 |
| Post-ACT | $50,716,000 | $51,433,000 | $53,941,000 | $69,075,000 |
| Cost Avoidance | $106,634,000 | $100,886,000 | $110,041,000 | $112,567,000 |

4048 clients: Pre-ACT averages 71 Bed Days; declines to 27 Avg. Bed Days after 1 year in ACT

N.B. - #'s rounded off to the nearest thousand

Using Average Bed Cost of $632†

† Source for Average Bed Day Cost:

*Forchuk, Cheryl, RN, PhD., "Therapeutic Relationships: From Hospital to Community" (June 2002)*

# New Developments

- Increased focus on other SMI client populations:
  - Homeless
  - Severe Substance Use
  - Forensic
  - Developmental Disability
  - Elderly
  - Aboriginal

# New Developments Cont.

**Flexible Assertive Community Treatment model (FACT) – Netherlands**

- Multidisciplinary team - 11–12 FTEs monitor 200 clients.
- Optimal staff/client size 1-25; combination of individual and team care
- Target group - SMI 20% for whom ACT is indicated and 80% who need less intensive treatment and support.
- Strength-based model (Rapp et al.), family intervention, integrated dual diagnosis treatment, vocational support (IPS)
- To combine care for these two groups, the FACT team employs a flexible switching system - no client transfers
- Integrated community and hospital care
- Fidelity scale created in 2007 (R. van Veldhuizen, M. Bahler)
- 2013 - 200 FAC T teams in the Netherlands (150 certified)
- Plans to expand to 400 teams - Interest in Belgium, UK, Norway, Sweden

# Management Issues

- Fidelity of the model of care - not uniformly implemented
- Transition to less intensive services
- Urban/Rural
- Recovery/Community Treatment Orders
- Adequate funding - significantly under developed
  - ACT teams: 1 team 75-100,000 adult population
- Need for ongoing research – adaptations of ACT in terms of new client populations and mixed service models such as FACT highlight the need for further research
- Up-to-date standards, fidelity reviews/certification, outcome reviews, community of practice support are essential to established fidelity requirements

# Conclusion

- Effectiveness of high fidelity ACT is well established including impacts on patient outcomes and health care costs
- ACT successful addresses the  community tenure and health transitions of the vast majority of complex SMI clients
- In the absence of ACT, client trajectories would generally involve long-stay hospitalization, acute care revolving door syndrome and/or homelessness