INTRODUCTION
In England Assertive Outreach (AO) was mandated and funded nationally in 2000. Over 250 teams were established to provide intensive home-based care for people with severe and enduring psychosis and a history of high hospital use and disengagement from services. Their introduction, using 7 day teams with small caseloads, was popular but English studies were disappointing. Indeed English RCT studies (Killaspy et al. 2006, 2014) have not shown that AO reduces bed use or improves clinical outcomes when compared to standard community mental health teams (CMHT). We tested an alternative standard care model adopted and adapted from the Netherlands (Van Veldhuizen & Bähler 2013). This Flexible Assertive Community Treatment model (FACT) uses locally teams working office hours and standard caseload sizes, but allows for two levels of care for all patients with more complex and long term needs as shown in Fig. 1.

AIM
We aimed to demonstrate non-inferiority of the new model in clinical effectiveness and thereby show cost efficiencies for local CMHTs reinforced with FACT through a series of service level evaluations. The FACT2 study then aimed to test generalisability of the FACT1 findings through replication in a second locality and to additionally compare patient experience with the two treatment models.

METHODS
Observational mirror-image studies of the closure of three AO teams with service utilisation data comparisons spanning up to 4 years. We used routinely collected data taken from the electronic patient record (socio-demographic, number of admissions, bed days, use of crisis and home treatment, number and type of contacts and missed appointments).

RESULTS
The FACT1 study with 112 patients, was published at 12 month follow up (Firm et al. 2013) and 4 year follow up (Firm et al. 2016) showing a significant reduction in bed use following AO closure (Fig. 2). Median bed days reduced (significant to p = 0.05) for each CMHT year compared to AO.

Figure 2. FACT1 days in hospital and in Home Treatment Team (crisis) with AO and at 1 year follow up in CMHT

There was no significant change in the use of crisis services as an alternative to admission (Fig 2). Understandably for a less intensive model the decrease in patient contacts was highly significant (p < 0.001 or less) for each year after AO closure (Fig.3). However, there was a significant increase in the missed appointment (DNA) rate ranging from a median of 5.4 % during AO to 7.9 % in FACT, (p = 0.002).

Figure 3. FACT1 contacts and missed appointment rates

We conducted an economic cost-consequence analysis of the change for each locality. In the FACT2 study we were also able to conduct service user reported experience pre and post team closure (Table 1). Qualitative feedback of service user perceptions of benefits and disbenefits (Table 2) was collected pre and post for which ethics approval was granted.

Table 2. FACT2 comparative patient reported experience

Table 2. FACT2 themes from qualitative questions and illustrative quotes

CONCLUSIONS
Reinforcing community mental health teams can provide an integrated service model that is clinically effective and equally acceptable to patients. This makes FACT a viable and affordable alternative to orthodox AO teams.

AO patients, particularly those who have been in AO care for some time, are remarkably resilient to significant reductions in the intensity of care and this holds for up to 4 years. AO had a tendency to keep patients in specialised high intensity teams for many years, thereby overproviding care and nurturing dependency.

BIBLIOGRAPHY