Assertive outreach: what can we learn from the evidence?

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Assertive Community Treatment

- Most intensive form of case management
- Focus on home based treatment and engagement to reduce need for admission
- Evolved from Training in Community Living Project, Madison, Wisconsin

Stein & Test (1980), *Arch Gen Psych*, 37: 392-397

 Assertive community treatment
Dartmouth ACT Scale

- Maximum case load 10-12 per FT worker
- Full MDT (incl. vocational, substance misuse, SU expertise)
- Team manager has caseload
- Extended hours (24 hours)
- “In vivo” contact (2 hours per week, >5 contacts per week)
- “Assertive” engagement
- “No drop-out” policy – time unlimited (<5% d/c per year)
- Team based approach
- Regular and frequent team meetings - daily plans
- Use skills of team rather than outside agencies
- Family/carer support and liaison
- Own beds, responsible for admissions/discharges
- Emphasis on social needs: accom, leisure, occupation
- Medication management
Assertive community treatment for people with severe mental disorders

Marshall M and Lockwood A (Feb 1998)
Cochrane Schizophrenia Group, Cochrane database of systematic reviews. 1, 2003

- SR of 75 RCTs of ACT vs standard care
  (17 included in meta-analysis: 15 US, 1 Swedish, 1 UK)

ACT clients:
- less likely to be lost to follow up
- less likely to be admitted and shorter admissions
- improved employment, accommodation stability & patient satisfaction
- no increase in adverse events
- no improvement in symptoms or social function
Cochrane conclusions

“ACT is clinically effective approach to managing the care of severely mentally ill people in the community. If targeted correctly on high users of inpatient care it can reduce the cost of hospital care whilst improving outcome and patient satisfaction. Policy makers should support the setting up of ACT teams.”
Evidence re. intensive models of community care in England

1) Intensive case management for SMI

2) PRiSM Study

3) UK700 Study
   Burns et al. (1999), *Lancet*, 353: 2185-2189

4) Heavy users of acute psychiatric beds: RCT of enhanced community management
   Harrison-Read et al. (2002), *Psychological Medicine*, 32: 403-416
Summary results UK studies

- Increased contact/engagement w. intensive intervention
- Greater participant satisfaction w. intensive intervention
- No differences in admissions
- No differences in other clinical or social outcomes
- Cost more or no difference in cost effectiveness
Problems w. ACT evidence in England

- No trial of “pure” ACT with high model fidelity
- UK 700 was not trial of ACT but of small case loads
- PRiSM was not RCT, two groups differed at baseline and not aimed at “difficult to engage”
- Good standard care from CMHTs in UK so control group different to US, particularly when considering older trials

*PRiSM Psychosis Study: Design limitations, questionable conclusions*
Mental health policy in England


- By 2003:
  - 220 Assertive outreach teams
  - 335 Crisis resolution teams
  - 50 Early intervention services
NSFMH implementation

- National Service Framework for Mental Health – 5 years on (DH, 2005):
  - 263 AOTs (< 3,000 staff)
  - 168 CRTs (2,000 staff)
  - 41 EIS (174 staff)
Mental Health Policy Implementation Guide for AO

As per DACTS except:

- Extended hours 8am-8pm, 7 days per week and telephone cover overnight

- No mention of specialist vocational or dual diagnosis staff or service user employees
Pan London AO Studies: PLAO I: Models of Operation
Wright et al. (2003), Br J Psych, 183: 132-138

- 7/24 voluntary sector
- 8/17 statutory teams not integrated (health and social services)
- 5/24 own beds
- 6/24 full medical responsibility
- 80% contacts within office hours
- 70% contact face to face, 63% in vivo

- Cluster A (14/24) = integrated, CPA, psychiatrist, own beds
- Cluster B (4) = integrated, CPA, no psychiatrist, no beds
- Cluster C (6) = voluntary sector, no CPA, no psychiatrist, no dedicated inpatient beds

- Only 3/24 DACTS > 4 (= ACT), 8/24 DACTS < 3 (13/24 ACT like = 3 to 4)
- < 24 hours, vocational rehab, substance misuse experts, SU employees
REACT: A randomised evaluation of assertive community treatment in North London.

- RCT “pure” ACT vs. usual CMHT care
- 2 AOTs, 13 CMHTs
  Camden and Islington
- 1999 to 2004
- SMI, high users of inpatient care, difficult to engage
- Outcomes at 18 months: clinical and cost-effectiveness
Staffing and training

- 1 team manager (half case load)
- 0.5 psychiatrist
- 3 CMHNs
- 1 social worker
- 0.5 psychologist
- 1 OT
- 2 support workers
- 1 junior doctor

- Trained by Sainsbury Centre for Mental Health in ACT model
ACT model fidelity

- PLAO (Wright et al., 2003) 2 years into study
- Cluster A
  (statutory, dedicated inpatient beds, psychiatrist, integrated team, CPA responsibility)
- High/moderate model fidelity (DACTS 4.1, 3.4): missing substance misuse specialist, vocational specialist, 24 hour service, users on team.
251 patients randomised

127 ACT
90 consented to baseline interview
1 out of contact

3 died within 18 months

124 CMHT
78 consented to baseline interview
2 out of contact

4 died within 18 months
1 emigrated

124 with hospital admission data at 18 months
0 out of contact

119 with hospital admission data at 18 months
4 out of contact

23 refused
9 did not respond
1 emigrated

91 interviewed at 18 months

75 interviewed at 18 months

28 refused
16 did not respond
REACT participant demographics

- 59% male
- Mean age 39 years
- 89% unemployed
- 54% white, 36% black african/caribbean
- 83% scz/sczaff, 5% BPAD
- 25% dual diagnosis
- 46% recruited as inpatients
Characteristics at recruitment

- Mean length of illness 10 years
- 8 admissions/lifetime, half under MHA, lasting around 2 months
- 21% homeless last 2 years
- 21% prison ever
- 28% significant violence last 2 years
- 39% DSH ever
- No differences between AOT and CMHT patients in these or symptoms, clinical/social function, quality of life, unmet needs
## Results: primary outcome

<table>
<thead>
<tr>
<th></th>
<th>ACT</th>
<th></th>
<th>CMHT</th>
<th></th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=124</td>
<td></td>
<td>n=119</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>mean (SD)</td>
<td>median</td>
<td>mean (SD)</td>
<td>median</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>IQR</td>
<td></td>
<td>IQR</td>
<td></td>
</tr>
<tr>
<td>Total days</td>
<td>162 (162)</td>
<td>121</td>
<td>144 (140)</td>
<td>130</td>
<td>0.53</td>
</tr>
<tr>
<td></td>
<td>27-231</td>
<td></td>
<td>14-215</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days per admssn</td>
<td>65 (91)</td>
<td>27</td>
<td>52 (66)</td>
<td>27</td>
<td>0.51</td>
</tr>
<tr>
<td></td>
<td>0-95</td>
<td></td>
<td>0-86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days to dischrge</td>
<td>158 (177)</td>
<td>70</td>
<td>141 (159)</td>
<td>61</td>
<td>0.81</td>
</tr>
<tr>
<td></td>
<td>29-272</td>
<td></td>
<td>14-215</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Secondary outcomes

- No differences on any measure of inpatient service use (any admission, number, MHA, PICU)
- No differences in symptoms, social function, needs, quality of life, substance misuse, adverse events, medication adherence
- ACT participants had 3x more face to face contacts with staff than CMHT participants but this was less than weekly
- ACT recipients better engaged, less likely to be lost to follow-up and more satisfied with service
## Engagement

<table>
<thead>
<tr>
<th></th>
<th>AOT n=124</th>
<th>CMHT n=119</th>
<th>Mean diff (95% CI)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD) engagement</td>
<td>9.1 (3.3)</td>
<td>8.0 (3.8)</td>
<td>1.1 (0.1 to 1.9)</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>n = 124</td>
<td>n=115</td>
<td>Chi squared</td>
<td>P</td>
</tr>
<tr>
<td>Lost to follow up</td>
<td>2 (2%)</td>
<td>10 (8%)</td>
<td>5.96</td>
<td>0.01</td>
</tr>
</tbody>
</table>
## Satisfaction with services

<table>
<thead>
<tr>
<th></th>
<th>AOT n=91 Mean (SD)</th>
<th>CMHT n=75 Mean (SD)</th>
<th>Mean diff (95% CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Info about illness</td>
<td>4.9 (1.8)</td>
<td>4.2 (1.9)</td>
<td>0.71 (0.14 to 1.28)</td>
<td>0.02</td>
</tr>
<tr>
<td>Influence over Rx</td>
<td>4.0 (2.3)</td>
<td>3.2 (2.3)</td>
<td>0.79 (0.08 to 1.5)</td>
<td>0.03</td>
</tr>
<tr>
<td>Conversation helped</td>
<td>5.4 (1.5)</td>
<td>4.9 (1.9)</td>
<td>0.55 (0.35 to 1.07)</td>
<td>0.04</td>
</tr>
<tr>
<td>Overall rating</td>
<td>5.4 (1.6)</td>
<td>4.7 (1.9)</td>
<td>0.75 (0.22 to 1.3)</td>
<td>0.01</td>
</tr>
<tr>
<td>Total satisfaction score</td>
<td>79.4 (19.1)</td>
<td>71.7 (19.1)</td>
<td>7.6 (1.8 to 13.5)</td>
<td>0.03</td>
</tr>
</tbody>
</table>
Why are ACTT's better at engaging clients and why is client satisfaction greater?

- Investigated content of care delivered to REACT study participants (20 AOT, 20 CMHT)
- Purposive sampling of clients
- Each client under care of team > 6/12
- Qualitative, semi-structured interviews with care co-ordinators (37 nurses and social workers)
Main findings

- Engagement – AOT staff more informal, flexible, less “coercive”, more help with practical matters, more responsive
- Patterns and place of contact – both doing “in vivo” work, but AOTs doing more
- Medication adherence and monitoring
- Contact and support to carers and family
- ACT staff found two aspects of model particularly helpful: team approach and small case loads
ACT less coercive than standard care

- Very little use of coercive approaches e.g. outpatient commitment, financial control
- Evidence of wide range of collaborative approaches that promoted psychoeducation and engagement

- Service users’ perceived coercion reduced more for ACT than CMHT clients
- Fewer coercive strategies used by ACT than CMHT staff

- ACT clients ratings of intrusiveness of service were lower than CMHT clients, despite having three times the number of contacts and most in vivo

- Service users reported that a poor therapeutic relationship was most important factor associated with disengagement from ACT

- Engagement was promoted where there was not a focus on medication and where service users felt they were in an authentic partnership and being listened to
Does engagement matter?

- Therapeutic alliance is one of the most powerful predictors of outcome in psychotherapy
- Outcomes include social functioning, global improvement, drug use
- Meta-analyses suggest around 25% of outcome can be attributed to therapeutic alliance

- Paucity of literature on therapeutic alliance in schizophrenia
- Most measures used to assess therapeutic alliance developed for psychotherapy clients
- Measures generally assess single relationship
- Associations found with: medication adherence; satisfaction; self-rated symptoms and social functioning; quality of life; inpatient service use (increased or decreased)
Association between therapeutic alliance and outcome doesn’t necessarily mean therapeutic alliance is the “active ingredient”. It may simply be a vehicle for delivery of interventions that are effective.

<table>
<thead>
<tr>
<th>Inpatient service use</th>
<th>AOT N=120</th>
<th>CMHT N=117</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Median</td>
</tr>
<tr>
<td>Total inpatient days</td>
<td>290.9 (280.8)</td>
<td>209.0</td>
</tr>
<tr>
<td>Number of admissions</td>
<td>2.0 (1.8)</td>
<td>2.0</td>
</tr>
<tr>
<td>Days per admission</td>
<td>107.8 (151.7)</td>
<td>55.5</td>
</tr>
<tr>
<td>Involuntary admissions</td>
<td>1.4 (1.3)</td>
<td>1.0</td>
</tr>
</tbody>
</table>
Other outcomes at 36 months

- No differences in any measure of inpatient service use except AOT clients more likely to go to MSU ($10/120$ vs $2/117$, $\chi^2 = 5.40$, $p = 0.02$)
- No differences in adverse events (violence, arson, DSH, homelessness)
- No difference in use of supported accommodation
- Continuing AOT clients less likely to be lost to follow-up ($3/95$ ACT vs $11/89$ CMHT, $\chi^2 = 5.53$, $p = 0.019$)
## REACT 36 month: contacts

<table>
<thead>
<tr>
<th></th>
<th>AOT n=88</th>
<th>CMHT n=89</th>
<th>Mean diff (95% CI)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD) days since seen</td>
<td>17.7 (55.1)</td>
<td>40.0 (80.9)</td>
<td>22.2 (-42.8 to -1.67)</td>
<td>0.03</td>
</tr>
<tr>
<td>Mean (SD) face to face contacts last 3 months</td>
<td>12.6 (10.1)</td>
<td>6.6 (10.0)</td>
<td>6.0 (3.05 to 8.96)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
The REACT Study: Cost-Effectiveness of Assertive Community Treatment in North London.


- At recruitment: equal costs

- At 18 months:
  - More staff contact costs for ACT (mean diff. £1272, 95% CI £913 to £1670)
  - More inpatient costs for ACT at 18 months but not stat. sig. (mean diff. £3160, 95% CI -£3305 to £9772)
  - Total costs higher for ACT but not stat. sig. (mean diff. £4031, 95% CI -£2592 to £10,690)
Cost effectiveness

- Incremental cost-effectiveness ratio based on difference in total satisfaction rating of 7.6 = £3592/7.6 = £473 per unit of satisfaction

- If societal value of one unit of satisfaction = £0 then 21% chance that AO more cost-effective than standard care. If valued at £1000 then 78% chance

- Satisfaction would have to be valued very highly (> £2500) for AO to have 95% chance of being more cost-effective
Crisis resolution/home treatment teams and psychiatric admission rates in England.

- National Mental Health Service Mapping Exercise and NHS routine admission database
  - From 1998 to 2004 admissions reduced across country by 11%
  - Areas with CRTs showed greater reductions than areas without
  - Areas with AOTs showed no additional reduction in admissions. Only 65% offered extended hours service
Why are intensive models of case management, including ACT not more effective than standard care in England?

- Inadequate ACT model fidelity?
- Overlap in ACT and comparison services?
- Overlap in content of care/interventions delivered?

- What are the critical components?
Critical components of home based treatment


- Most effective teams provided integrated health and social care and offered high proportion of home based ("in vivo") treatment


- US teams made more contacts than European, but European intensive teams and comparison teams did more "in vivo" work than US intensive teams
Critical components of ACT


**Active ingredients of ACT:**
- community based
- manager w. case load
- full clinical responsibility
- meeting daily
- shared caseload
- time unlimited service
- extended hours
Areas with less developed standard community services and greater levels of inpatient resource show more benefits from ACT.

Inpatient mental health services in inner cities in the UK operate at a very high admission threshold and interventions aimed at reducing admissions are therefore unlikely to succeed.

(Burns, 2009).
Overlap of ACT and CMHT in UK

- Same context
- Integrated health and social care
- Community based
- Manager w. case load
- Full clinical responsibility
- In vivo work
## Comparison of AOTs in London and Melbourne

Harvey et al., *Epid Psich Soc, In Press*

<table>
<thead>
<tr>
<th></th>
<th>% or mean across all London teams (range)</th>
<th>Cluster A</th>
<th>Cluster B</th>
<th>Cluster C</th>
<th>Melbourne Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of teams</td>
<td>24</td>
<td>14</td>
<td>4</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Age of team (months)</td>
<td>40 (4-120)</td>
<td>39</td>
<td>36</td>
<td>44</td>
<td>90</td>
</tr>
<tr>
<td>Statutory status</td>
<td>71%</td>
<td>100%</td>
<td>75%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Responsible for CPA*</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Integrated health and social care*</td>
<td>71%</td>
<td>93%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>FTE psychiatrists per 100 clients*</td>
<td>0.6 (0.0-2.3)</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Number of professional disciplines</td>
<td>3.5 (2.0-5.0)</td>
<td>4.0</td>
<td>3.0</td>
<td>2.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Number of FTE clinical staff</td>
<td>7.7 (3.1-15.1)</td>
<td>8.4</td>
<td>7.7</td>
<td>6.2</td>
<td>8.0</td>
</tr>
<tr>
<td>Mean individual caseload</td>
<td>9.5 (5.0-14.0)</td>
<td>8.7</td>
<td>10.4</td>
<td>10.8</td>
<td>6.3</td>
</tr>
<tr>
<td>% of team leader’s time in clinical work*</td>
<td>29% (0-90%)</td>
<td>30%</td>
<td>58%</td>
<td>6%</td>
<td>44%</td>
</tr>
<tr>
<td>&gt; 70% of client contacts in vivo*</td>
<td>41% (16-67%)</td>
<td>36%</td>
<td>31%</td>
<td>45%</td>
<td>75%</td>
</tr>
<tr>
<td>Routinely operates outside office hours*</td>
<td>38%</td>
<td>57%</td>
<td>25%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Has 24 hr responsibility for psychiatric crises*</td>
<td>1.9 (1-4)</td>
<td>1.79</td>
<td>2.5</td>
<td>1.8</td>
<td>2.5</td>
</tr>
<tr>
<td>Has dedicated inpatient beds*</td>
<td>21%</td>
<td>36%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
London and Melbourne AO model fidelity

<table>
<thead>
<tr>
<th></th>
<th>Cluster A (range)</th>
<th>Cluster B (range)</th>
<th>Cluster C (range)</th>
<th>Melbourne teams (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DACTS total score</td>
<td>3.6 (3.1–4.1)</td>
<td>3.4 (3.1–4.0)</td>
<td>2.9 (2.3–3.3)</td>
<td>3.7 (3.4–4.0)</td>
</tr>
<tr>
<td>DACTS - H</td>
<td>3.7 (3.1–4.6)</td>
<td>3.4 (2.9–3.7)</td>
<td>2.5 (2.0–3.2)</td>
<td>3.7 (3.2–4.2)</td>
</tr>
<tr>
<td>DACTS - O</td>
<td>4.1 (3.3–4.6)</td>
<td>3.9 (3.0–4.6)</td>
<td>3.4 (3.0–4.4)</td>
<td>4.0 (3.3–4.6)</td>
</tr>
<tr>
<td>DACTS - S</td>
<td>3.2 (2.6–3.9)</td>
<td>3.2 (2.7–4.0)</td>
<td>2.9 (2.2–3.5)</td>
<td>3.4 (3.0–4.0)</td>
</tr>
</tbody>
</table>
AOT clients in London (439) and Melbourne (189)

- London cluster A/B teams only
- No differences in demographics or diagnoses
- 48% Melbourne clients had 10+ admissions vs 21% London clients
- 75% Melbourne and London clients had at least one admission previous 2 years
- Median admissions last 2 years: Melbourne 2; London 1
- Median bed days last 2 years: Melbourne 40; London 70
Why differences in admissions in Melbourne and London?

- Melbourne: more psychiatrist time; more extended hours; smaller caseloads; more in vivo work
  - More “anticipatory response”? (Weaver et al., 2003)
  - CTOs?
  - Services very focussed on brief admissions?
Interventions and support that AOTs (and CMHTs) should provide (MHPIG, DH, 2001)

- managing tenancy
- claiming appropriate welfare benefits
- daily living skills
- social/family networks
- community activities (education, leisure, work)
- medication management
- CBT, family interventions
- promotion of physical health
National AO survey 2002-3.
Wright et al (Br J Psych, In Press)

- 222 teams
- Wide range of model fidelity (186 [84%] stand alone, 36 [16%] integrated within CMHT)
- Only 12% operating with high model fidelity
- Many missing components (operates 24 hours a day; meets daily; team manager has case load; primary therapist for clients) were those later identified as being associated with greater efficacy
- Average case load - 5 clients
- Average service user contact - 2 hours per week
- Minimal provision of specialist psychosocial interventions (only 2/3 had OT, very few had psychologist)
- Only half had a psychiatrist hence medication was not prescribed or reviewed by the team
- Few had substance misuse or vocational rehabilitation specialist
Sustainability of AOTs


Teams didn’t change in staffing or model fidelity over time
- > 50% no psychiatrist, > 60% no occupational therapist, > 80% no psychologist at both time points
- No change in missing components

- Teams continued to work with target population
National Survey of ACT Services in England in 2007

- Postal survey
- Response rate 104/187 (56%)
  - 93 (89%) “stand alone” teams
  - 31 (30%) “rebadged”
  - 48 (46%) urban, 11 (11 %) rural
- Mean team caseload 70 (11 per case manager)
- 18% own inpatient beds
Staffing of AOTs in England in 2007

- 36% had no consultant psychiatrist (rest 0.5 FTE)
- 22% had no Dr
- 52% had psychologist (0.4 FTE)
- 65% had OT (0.9 FTE)
- 92% had social worker (1.7 FTE)
- 99% had support workers (2.7 FTE)
- 100% had nurses (4.6 FTE)
- 16% employed service users
- 29% had substance misuse specialist
- 49% had vocational rehabilitation specialist.
Managers’ ratings of most important activities/interventions

<table>
<thead>
<tr>
<th>Activity</th>
<th>Rating (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>9.82 (0.60)</td>
</tr>
<tr>
<td>Support with finances</td>
<td>9.14 (8.10)</td>
</tr>
<tr>
<td>Support with accommodation</td>
<td>8.92 (1.21)</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>8.30 (1.66)</td>
</tr>
<tr>
<td>Supporting carers</td>
<td>8.21 (1.31)</td>
</tr>
<tr>
<td>Medication management</td>
<td>8.21 (1.61)</td>
</tr>
<tr>
<td>Activities of daily living</td>
<td>8.17 (1.40)</td>
</tr>
<tr>
<td>Social support</td>
<td>7.97 (1.43)</td>
</tr>
<tr>
<td>Developing structure</td>
<td>7.88 (1.38)</td>
</tr>
<tr>
<td>Practical support</td>
<td>7.71 (1.63)</td>
</tr>
<tr>
<td>Psychological interventions</td>
<td>7.28 (1.87)</td>
</tr>
</tbody>
</table>
Threats to AOTs in 2007

- 65% reported no proposed changes to their service
- 6% - team being disbanded
- 5% - integration with another team (CMHT, rehab)
- 21% - non-specific review of services
Conclusions: lack of effectiveness of AO

- AOTs in England have not been able to impact on admission rates for “difficult to engage” clients beyond the effect of CRTs plus standard CMHT care
  - CMHTs able to prevent admissions as effectively as AOTs using fewer face to face contacts and higher case loads
  - No advantage of AO over standard CMHTs on any measure of clinical outcome except satisfaction
  - AO not been shown to be cost-effective
  - AO style is more acceptable to “difficult to engage” clients and less coercive than standard approaches
Conclusions: why not more effective?

- Majority of AOTs not operating with high model fidelity
- Extended hours of operation, % “in vivo” work and having full clinical responsibility appear to be key
- Delivery of evidence based interventions hampered by lack of appropriately skilled staff
Survival tips for AOTs

- Improve implementation to include key elements of model
- Focus for professionally trained members of team needs to shift from engagement to delivery of specific, skilled interventions
- Retain the collaborative approach that engages clients
- Retain team based approach that supports staff
Current challenges for AO

- Can elements of AO which engage and improve client satisfaction be incorporated into standard approaches?
- Could more intensive team based approach and extended hours be incorporated into standard services given variety and size of caseloads?
  - Service line management (rebadged as community rehab teams?)
  - HoNOS clustering models
  - Hybrid models
FACT (Function-ACT)

- Dutch hybrid model, or diluted ACT
- Combines intensive and standard care within the same team
- Tentative reports of benefits for severe psychosis (Drukker et al., 2008)
- No trials comparing FACT with ACT nor reports of its effectiveness across sites, despite widespread implementation in the Netherlands
The problem with research....
Thank you for your attention