

# Implementation of Assertive Community Treatment Teams in Norway

## - Preliminary results

## Presentations

- Implementation of Assertive Community Treatment in Norway  
by/ Hanne Kilen Stuen, sociologist, Centre for Addiction Issues
- National Evaluation of Assertive Community Treatment Teams in Norway  
by/Anne Landheim, PhD, Sociologist, Centre for Addiction Issues
- Preliminary Results from the patient assessment Evaluation of ACT- teams  
by/ Hanne Clausen, physician, PhD- student, Akershus University Hospital Trust
- Recovery among Patients in Norwegian ACT- teams  
by/Henning Pettersen, PhD- student, Centre for Addiction Issues



## **Report to the national government in 1997. Mental health services were lacking at all levels.**

De-institutionalisation. The services had not kept pace

- Preventive measures were insufficient.
- The services provided by the municipalities were too few.
- Not sufficient accessibility to specialised health services. The inpatient stays were often too short and there was a lack of sufficient coordination and monitoring at discharge.
- Lack of competence on the planning, organisation and integration of services

## The National Action plan 1999-2008

Major increase in the funding, as well as an expansion and reorganisation of the services.

- Strengthening the users position
- Information campaign to increase the public awareness
- **Strengthening community based services provided by the municipalities**
- **Expanding and restructuring the specialised services**
- Improving labour marked services
- Assisting with accomandation and housing
- Stimulating education and research

# The mental health care system

## Three service levels

1. GPs and mental health teams in primary care settings (municipalities) have an important role within the mental health care system. Some municipalities have residential or sheltered accommodation.

The municipalities play a key role in the provision and co-ordination of services for people with mental health problems.

## **Four regional health authorities, responsible for providing specialised health services.**

### **2. District Psychiatric Centres (75 CMHC)**

Outpatient treatment (individual/groups). General units/teams: psychosisteam, rehabilitation teams, ambulatory teams, acute teams, drug/alcohol teams and dual diagnosis team.

Some DPC provide inpatient treatment.

And there is now established 12 ACT – teams.

### **3. Psychiatric hospital wards, including acute wards**

## Report 2008: The Directorate of Health Assessment of need and planning of services

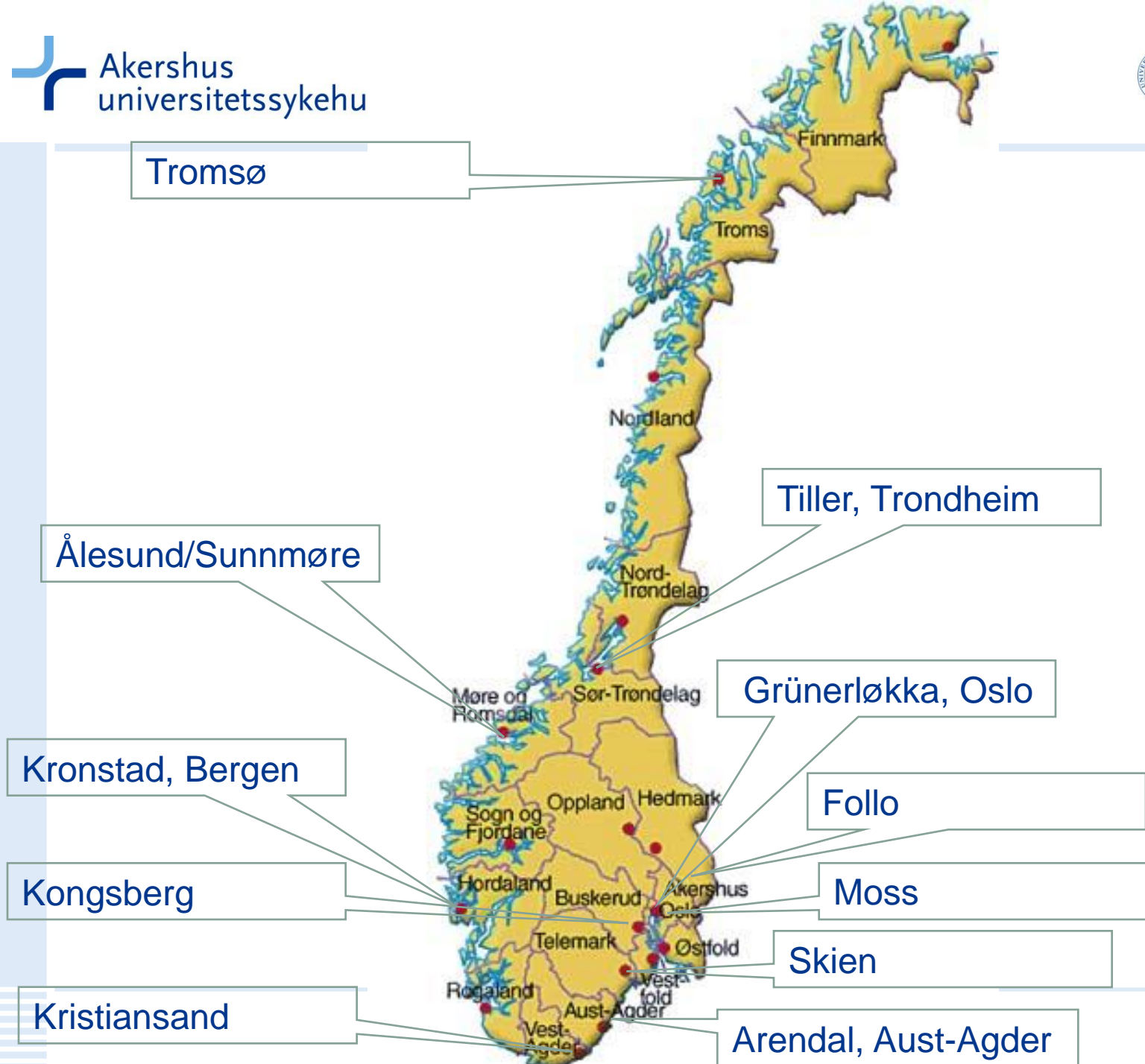
- How many persons with SMI are in need of inpatient treatment and continuent and co-ordinated services?
- Most patients are receiving services.
- **BUT** Everyone isn't receiving sufficient services
- Many patients need a more stabil housing situation and there is a lack of continuity and collaboration
- 4000 persons - persistent and continuent services.
- Many are falling outside the established services
- ACT recommended.



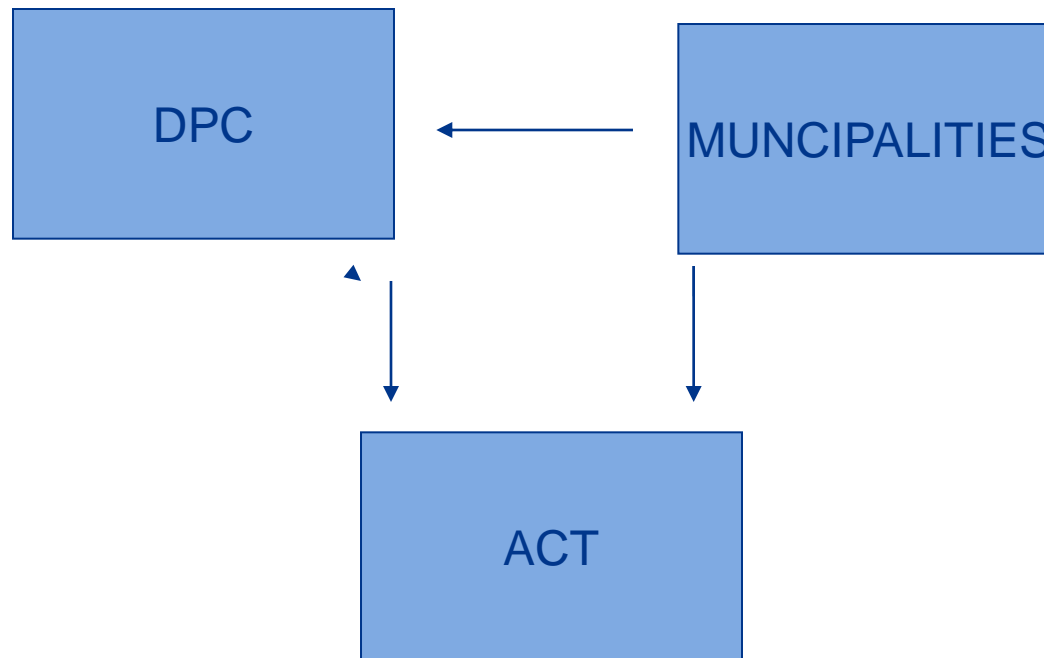
## Continuity of care – ACT a well known model for service delivery

**ACT is a well known model for service delivery for:**

- patients with severe mental illness with strong needs for services who are difficult to engage
- the "high users" of inpatient treatment
- patients with severe mental disorders and substance abuse



## How are the ACT- teams organised?



Team leader  
Psyciater  
Psychologist  
(specialist in  
psychology)  
Nurses  
Social worker  
Vernepleier  
Priest/philosopher  
Merkantil ansatt

# A National Research - Based Evaluation of 12 Assertive Community Treatment Teams in Norway

## Background

- National evaluation of 12 ACT- teams in Norway
- The evaluation is funded by the Directorate of Health
- Evaluation period from 2010- 2013

## Research Team

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# Project Objectives

- The purpose of the research project is to evaluate the treatment benefit of a model of Assertive Community Treatment in Norway
- How the model actually function in Norway and what aspects are important for developing a Norwegian model

## Primary Research Questions

1. Do the ACT teams include the target group?
2. How are patient outcomes two years after inclusion in the ACT-team?
3. What Characterizes services provided by the ACT- teams?
4. What are the experiences with implementing the ACT- team model (team members, community agencies, users and relatives)?



## Do the ACT teams include the Target Group?

1. What characterize patients included in the ACT teams (primary and secondary diagnoses, psychiatric symptoms, use of substances, functional status, earlier use of services)?
2. Are the patients included in the ACT teams in accordance with the model and directives from the Department of Health in Norway?
3. Are there persons in the target group, that is not included in the ACT- teams?

## Patient Outcomes

1. Has the patient a better course (mental health, substance abuse problems, crime, physical health, employment, housing, practical and social functioning, quality of life) at follow-up?
2. To examine whether patients receive a reduction in inpatient stay compared with the previous two years, and whether they get more continuity of contact with health services?
3. How are **patients' experiences and satisfaction** with the ACT team, and are there variations in this between the teams?
4. How does a selected sample of patients explain their own recovery process?
5. To what extent can variation in patient outcomes be explained by patient variables, the services received, degree of implementation of the ACT model and local conditions in the catchment area?

# What Characterizes Services Provided by the ACT Teams?

1. What services (scope and content) receives patients from the teams and from other service providers, and how much does this vary between the ACT-teams?
2. To what extent do the team members follow the ACT model (measured by TMACT) and are there variations between the teams?
3. How are the ACT teams organized (catchment area, anchoring, location, team composition, internal duties, cooperation with other services) and how much variation are there between the teams?

## Experiences with the ACT Model?

1. What experiences have the team leaders and members with the implementation of the ACT model (internal cooperation, collaboration with other services, and how the model is suitable in Norway)?
2. How do the team members explain and justify whether they follow the fidelity criteria of the ACT model or not?
3. What experience (contact, awareness, cooperation) have key partners with the ACT team? To what extent have ACT teams led to changes in other services? Do they see the ACT team as an appropriate model in relation to the defined target group?
4. How are the patients and relatives' experiences with the ACT team?

## Sample

- 12 ACT- teams included in the evaluation  
(Start- up period: December 2009- March 2011)
- Patients and the teams are followed up to years after the team started up
- Approximately 400 patients included in the teams one year after start up
- Written consent from patients is required
- Number of patients in the evaluation ?

## Data Collection

- **Assessment of Patient**

T0: At intake

T1: Two years after intake

- **Evaluation of model fidelity (TMACT, 2011)**

Two times: 12 months after the team started up and 2 ½ years after

- **Registration of each contact the team have with the patients**

Continuously during two years

Weekly assessment form

## Data Collection

- **Interviews with users and relatives about experiences and satisfaction with the ACT teams**  
*Two years after the team started up*
- **Interviews with service providers in the community and specialist health services**  
*Two years after the team started up*
- **Interviews with team members**  
*Two years after the team started up*

## Data Collection

- Registration of patients who stop treatment or drop- out for other reasons

Separate questionnaire

- Registry Data (Norwegian Patient Register)

Continuity of contact and in-patient care



# Patient Assessment

- Data were collected by team members
- Team members were trained by the evaluation team

## Assessment at Baseline and Follow- up

| Areas:                               | Instruments:  |
|--------------------------------------|---|
| Demographics, Life Situation, Health | Questionnaire   |
| Symptoms mental illness:             | Brief Psychiatric Rating Scale (BPRS)   |
| Substance use:                       | AUDIT<br>DUDIT  |
| Functioning:                         | Global assessment of functioning-split version (GAF-Symptoms and GAF-Functioning)<br><br>Practical and social functioning (PSF) |
| Engagement and acceptance:           | Homeless Engagement and Acceptance Scale (HEAS)   |
| Quality of life:                     | Manchester Short Assessment of Quality of Life (MANSA)  |

# Characteristics of Patients at Intake

## Demographics

- Age
- Gender
- Residential Status
- Marital Status
- Education
- Employment
- Main income
- Criminality

# Patient Characteristics at Intake

## Clinical variables:

- Primary psychiatric diagnosis
- Secondary diagnosis (both Axis I and II disorders)
- Somatic health
- Use of substances
- Use of services the last 12 months
- Days in hospital the last 12 months
- Use of compulsory mental health care

## Social participation

- With family
- With friends
- Activities in the community

## Outcome Measures

- Psychiatric symptoms (BPRS)
- Substance abuse (Audit, Dudit)
- Housing (Questionnaire)
- Employment (Questionnaire)
- Functional Status (GAF, PSF)
- Quality of life (MANSA)
- Satisfaction by users and relatives (interview)
- Use of services (Questionnaire, Registry Data)

# Evaluation of Model Fidelity

To what extent do the team members follow the ACT model (model fidelity)?

## **TMACT: Tool for Measurement of Assertive Community Treatment**

- Developed by Maria Monroe-DeVita og Gregory Teague (DACTS).
- Developed in 2007-2010, tried out in several states, completed in January 2011
- Consists of 47 items divided in seven areas
- Made available for use in evaluation of ACT teams in Norway
- The research team in Norway (2 persons x 3) trained four days in August 2010 and several internal work shops

## Fidelity Measurement with TMACT

- Two researchers are visiting the team in 2-3 days
- Received written information about the team and the patients
- Interviews with team leader, the core staffing, specialists in the team and some patients
- Observing a daily team meeting and a treatment planning meeting about a patient
- Going through a random sample of patient records
- Have a final meeting about the preliminary assessments and clarifications
- A written report with comments from the fidelity assessment are given to the teams





## What have we done so far?

- Fidelity Assessment (TMACT) in 7 ACT- teams
- Assessment of Patients: N= 80
- Weekly Assessment Form about contact with patients:  
Continuously
- Questionnaire about patients who stop treatment or drop- out for other reasons (graduation, deseased, "given up", not in the target group)

# Recovery in Patients with co-morbid Substance Use Disorder and Severe Mental Illness included in ACT-teams

Persons with co-morbid substance use disorder (SUD) and severe mental illness (SMI) are suffering from complex problems, and are in need of services from different agents and levels of the social- and health care system.

In consideration of this group of patients needing services that are well coordinated and comprehensive, ACT-teams should be a relevant offer for these patients.

Most addiction programs share an acute-care model of intervention, focusing on symptom reduction and delivered within a short timeframe.

A crucial question is whether persons with high personal vulnerability, high problem complexity and low recovery capital will benefit from sustained and assertive forms of monitoring and support.

The evaluation so far indicates that above 50% of patients included in the Norwegian ACT-teams also have a substance use disorder.

## Integrated Dual Disorder Treatment

Integrated dual disorder treatment (IDDT) is a crucial aspect of the ACT-model.

Several researches (Mueser et al. 2006, Joannette et al. 2005, Swofford 1996) have showed that an integrated treatment approach in ACT are more efficient than other kind of treatments (parallell or sequenciel) for these individuals.

Reported advantages with IDDT in ACT:

- Better effect than standard treatment concerning user satisfaction and stable housing (Fletcher et al. 2008)
- Better effect than standard case management in reducing substance abuse (Bond et al. 1991, Essock et al. 2006)

## The Recovery Concept

- Clinical Recovery (Warner 1985)  
vs.
- Personal Recovery (Topor 2001, Borg 2003, Slade 2009, Davidson 2010)

Concepts that can be seen as belonging to the same «family» as personal recovery and an antidote to the individual oriented psychiatry in the scope of the natural sciences:

- Rehabilitation
- Self help
- Salutogenesis
- Resilience
- Person centered care

## The Recovery Concept

Focus on resources instead of problems, meaning and quality of life before symptom reduction.

Puts weight on the knowledge of the users through their insight into symptoms, treatment and their experiences of the recovery process.

Focus on the users own reports on getting better even if the symptoms prevails.

## Why the Recovery perspective?

Most studies in psychiatry and addiction treatment focus on diagnoses, symptoms and problem solving from the view of the professionals.

There are few studies examining the experiences of those offered different treatment programs in the field of comorbid severe mental illness and substance abuse.

It is important to focus on the stories to those who get better, why and what they themselves point to as significant.



## Why is the Users Perspective important?

- It should be of great value for professionals to gain knowledge of how people experience psychotic symptoms.
- Reasons for readmission to hospitals is often regarded to be substance abuse or refusing to take medication.

By asking the patients: «Readmission had nothing to do with relapse – more a matter of convenience» (Davidson 2010).

# Aim: What Stimulates Recovery from the Patients Perspective?

## Research questions:

### **How will the use of substances influence personal recovery?**

The pros and cons of substance abuse

Manage the craving and how to recover from substance abuse

The differentiating between medication and substance abuse

The meaning of friendship in- and outside substance abuse environment

### **What are the possible dilemmas for stimulating personal recovery in ACT?**

The relevance of personal responsibility when the patient do not see the need for treatment

Professionals focusing on empowerment versus compliance

The importance of one-to-one relationships versus relationship to a team

## Method

A retrospective cohort study design with qualitative interviewing of selected persons (N=10). A phenomenological/hermeneutic approach with data analyses through Grounded Theory (Charmaz 2006).

Inclusion criteria:

Persons with simultaneous SUD and SMI included in ACT-teams, who have gained recovery (as defined by both the patient and the team) after minimum 12 months of treatment in ACT-teams, concerning;

- increased quality of life, or
- increased level of functioning, or
- a decrease in substance abuse

Before the interviews the team offered information concerning:

- Name, gender and age
- Diagnoses
- Duration of treatment in ACT

The interviews have been conducted in:

- Patients home
- Meeting room at the ACT-team
- Institution

## Conducting the Interviews

The team leader made all appointments with the participants, but I was flexible concerning time and place.

- All interviews tape recorded
- Duration 40 – 80 minutes
- 1-2 pauses in all interviews except one
- All participants agreed to be re-interviewed later in the process

One question is used to initiate the interview process:

***”What has been the most important issues for your recovery process after you were included in the ACT-team?”***

Depending on the informants varying ability of verbalizing their own experiences, follow-up questions have been used to illuminate the research questions:

- How does substance use effect your life today?
- How does substanse use influence your relation to other people?
- What are your dreams?
- How is your relationship to the team?

## Reflections on the Interviewing Process

The intention is to meet participants with an open mind without too many preconceptions.

Even if the participants so far have similar psychiatric diagnoses, their substance use is different.

The participants have a certain degree of fatigue that are challenging concerning:

- Creating an atmosphere of trust and cooperation
- Focusing on the research role versus a therapist role
- Efforts to emancipate personal experiences from individuals who find it hard to communicate

Thank you for your attention