

The effectiveness of Assertive Outreach in Europe

*Back to basics or further
improvement?*

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AO across Europe (inventory Mulder et al)

	Practice			Research	
	National	Some regions / cities	Pilot/no	Several studies	(N)one, local report, ongoing
UK	X (fall)			X (incl trials)	
Netherlands	X (rise)			X	
Denmark	X				X
Norway		X			X
Lithuania			X		X
Switzerland		X			X
Bulgaria		X			X
France			X		X
Spain		X			X

ACT/CM results in Europe

Country	Example	Main conclusion
UK	DLP, Prism, UK700, React, PLAOS, national, etc	Slight differences with care as usual
Netherlands	Winschoten, Amsterdam, Maastricht, national	Modest
Sweden	Björkman, Aberg-Wistedt, Bodén	2 positive, 1 negative
Denmark	OPUS (Copenhagen), Aagard (rural)	Positive
Norway	Grawe (Integrated early treatment)	Positive
Germany	Hamburg ACCESS	Very positive
Switzerland	Bonsack (Lausanne, observational)	Positive
France	Robin ERIC (mobile crisis team, observational)	Positive
Spain	Alonso Suarez (Madrid, observational)	Positive

Mishmash of AO practices in European trials

- Intensive Case Management
- Assertive Community Treatment
- Strengths Case Management
- Assertive Outreach
- Social Services Case Management
- Community Psychiatric Nurse Teams

(Dieterich et al. (2011) Cochrane review of intensive case management, 38 trials, 12 European trials, 8 in UK)

Explanations for (modest/diverging) results

- Baseline differences in hospital use
- Lack of contrast with 'care as usual' (early studies had more contrast)
- Fidelity, treatment integrity
- First pilot is successful, pioneering
- Model (broker model vs integrated treatment)
- Program lacks specific interventions for desired outcomes (ACT as an organizing platform with insufficient content)
- Long term intensive assertive treatment may be handicapping

ACT and CMHT in React study (Killaspy et al. 2006)

Characteristic	Assertive community treatment teams ¹⁶	Community mental health teams ¹⁷
Total team case load	80 to 100	300 to 350
Maximum individual case load	12	35
Availability	Extended hours (0800 to 2000 every day)	Office hours only (0900 to 1700 Mon-Fri)
Locations for appointments	Not office based ("in vivo"): meet client at home, in cafes, parks, etc	Office based appointments and home visits
Contact with clients	Assertive engagement: multiple attempts, flexible and various approaches (for example, befriending, offering practical support, leisure activities)	Offer appointments at office or make home visits
Commitment to care	"No drop-out" policy: continue to try to engage in long term care	Discharge if unable to make or maintain contact
Case work style	Team approach—all team members work with all clients	Case management—little "sharing" of work with clients between team members
Frequency of team meetings	Frequent (up to daily) to discuss clients and daily plans	Weekly
Source of skills	Team rather than outside agencies as far as possible	"Brokerage": referral to outside agencies for advice (for example, social security benefits, housing)

Killaspy:

“Inadequate implementation of the ACT model, inadequate delivery of evidence-based interventions, and similarities between key elements of ACT and standard care therefore appear to explain the variation in its effectiveness reported in the international literature. In the UK, ACT teams need to be staffed appropriately and operate with the critical components likely to result in improved outcomes. Otherwise, their lack of cost-effectiveness will make them vulnerable to closure.”

AO: A double mission?

- Survival in the community, combating social breakdown, a safety net
 - Engagement, readmissions, homelessness, debts, suicide risk, detention, stabilization (with outreach, psychiatric treatment, practical support)
- Quality of life and perspective
 - self-esteem, cognitive skills, quality of life, employment, social contacts, social functioning, personal goals (with psychological training/therapy, (vocational) rehabilitation, peer support)

Issues in the double mission

- Specific outcomes need specific components (IPS for work)
- Some components will be useful for only a minority of the users
- These components (and respective specialists) can enrich integrated team work
- But: implementation difficult; switching between problem oriented and recovery oriented care

What about cognitive therapy?



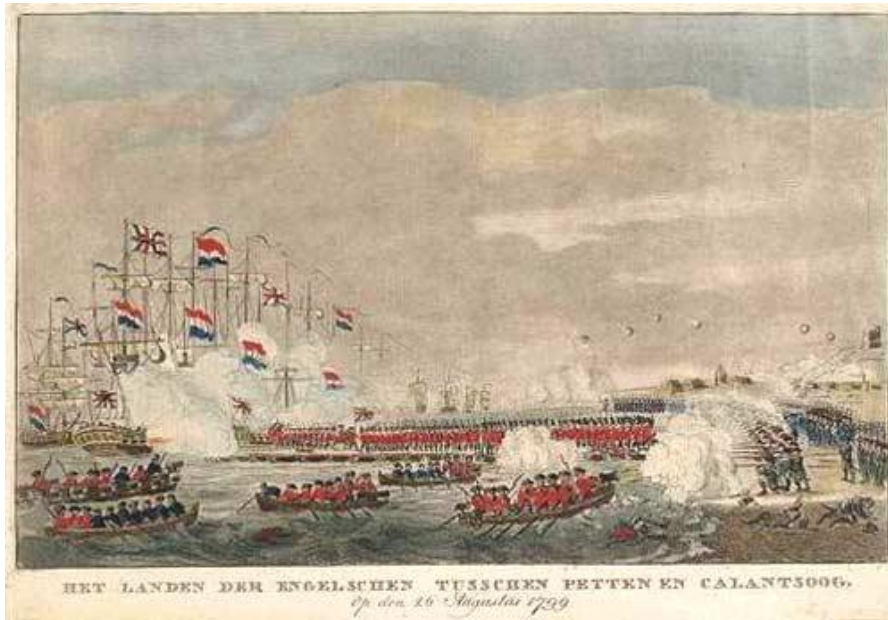
Examples of 'more'

- Boston psychiatric rehabilitation
- Strengths model
- Wellness Recovery Action Planning
- Illness Management and Recovery
- Shared Decision Making
- Individual Placement and Support
- Cognitive therapy
- Cognitive training
- Motivational interviewing
- Contingency Management
- Peer specialist, peer support
- Work with family/support network
- E-mental health

Outcomes of AO (Cochrane review)

- Favourable results compared to standard care: hospitalisation, engagement, accommodation status, satisfaction with services, general functioning (GAF) → **first mission**
- Compared to non-intensive CM: only higher follow-up rate
- Conclusion: let's do AO (NI) or let's do non-ICM (UK)

England vs Holland



England

- Government: every region should have AO teams
- NICE Guideline: Assertive outreach teams should be provided for people with serious mental disorders (...) who make high use of inpatient services and who have a history of poor engagement with services leading to frequent relapse and/or social breakdown (as manifest by homelessness or seriously inadequate accommodation)
- Experts: let's stop with AO teams and return to (less costly but equally effective) community mental health teams
- So: top-down, "not invented here"

The Netherlands

- Government: says nothing
- Guideline: same conclusion as UK
- Experts advocate for implementation of assertive outreach with fidelity
- So: Bottom-up and expert-based

Predicting outcome of assertive outreach across England

T. S. Brugha · N. Taub · J. Smith · Z. Morgan ·
T. Hill · H. Meltzer · C. Wright · T. Burns ·
S. Priebe · J. Evans · T. Fryers

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Conclusions Characteristics of AO teams do not explain long-term patient outcomes. Since recommended team characteristics are not effective new models of care should be developed and the process of care tested. Managing teams to implement evidence-based psychological interventions might improve outcomes.

Assertive Community Treatment in the Netherlands: Outcome and Model Fidelity

Maaïke D van Vugt, MSc¹; Hans Kroon, PhD²; Philippe A E G Delespaul, PhD³;
Fred G Dreef, MD⁴; Annet Nugter, PhD⁵; Bert-Jan Roosenschoon, MSc⁶;
Jaap van Weeghel, PhD⁷; Jeroen B Zoeteman, MD⁴; Cornelis L Mulder, MD, PhD⁸

Results: High ACT model fidelity was associated with better outcomes on the HoNOS and less homeless days. Among all of the ACT ingredients, team structure was associated with better outcomes. No associations were found between ACT model fidelity, number of hospital days, and CANSAS scores.

Conclusions: Our evidence supports the importance of model fidelity for improving patient outcomes.

Can J Psychiatry. 2011;56(3):154–160.

Same studies, different conclusions

Brugha, England

- Multi-site correlational study of AO team characteristics and outcome
- Team characteristics do not predict time in hospital or re-admissions →
- New models of care should be developed and tested

Van Vugt, Holland

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- Team characteristics do not predict time in hospital or re-admissions
- Our findings support ACT, shared caseload is important

Same studies, different conclusions

Brugha, England

- Multi-site correlational study of AO team characteristics and outcome
- Team characteristics do not predict time in hospital or re-admissions →
- Recommended characteristics are not effective (especially joint health and social care management) →
- Our findings call into question the AO model →
- New models of care should be developed and tested

Van Vugt, Holland

- Multi-site correlational study of AO team characteristics and outcome
- Team characteristics do not predict time in hospital or re-admissions
- ACT fidelity (team structure) predicts better outcomes on HONOS and homeless days; SA specialist predicts SA outcomes →
- Our findings support ACT, team work is important

Question

- Cochrane reviewers recommend review of comparison of non-ICM with standard care
- What if no differences in effectiveness will be found?

AO in the Netherlands



Models (theory and practice)

	ACT (USA)	FACT (NI)	AO (UK practice)	CMHT (UK)
case load	1:10	1:20	1:10/15	1:25/30
total team case load	100	200	100	300-350
target group	SMI +	SMI	SMI +	SMI
daily team meeting	yes (all pat discussed)	yes (15% pat discussed)	yes (all pat discussed)	no
in vivo contact	80%	80%	33%	<20%
assertive	yes	yes	to a certain extent	no
psychiatrist	100% (aim)	100%	50-64%	yes
psychologist	0% (no aim)	100%	20-50%	?
integrated health/social care	yes	yes	majority: yes	some brokerage
vocational, SA specialist	100%	100%	0-10%	?
specific treatment (voc rehab, subst abuse, CBT, etc.)	yes	yes (moderately implemented)	no	no
research focus	hospital use	functioning	hospital use	hospital use
team work, shared caseload	yes	yes	yes	no

Issues in fidelity: IFACT

- Staff/patient ratio
- Team size
- Psychiatrist, and nurse on team
- Team is primary service provider
- Own office
- Shared case load
- Daily team meetings
- Team leader sees patients
- 24 hour coverage
- Time unlimited services
- In vivo contacts
- Low % office contacts
- Number of contacts / month

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Question: what if the main task of team members was to screw in light bulbs?

Issues about fidelity

Successful program in Madison, Wisconsin
Multifaceted program. No program theory

Operationalization in fidelity instrument.
High scoring original teams had better outcomes.

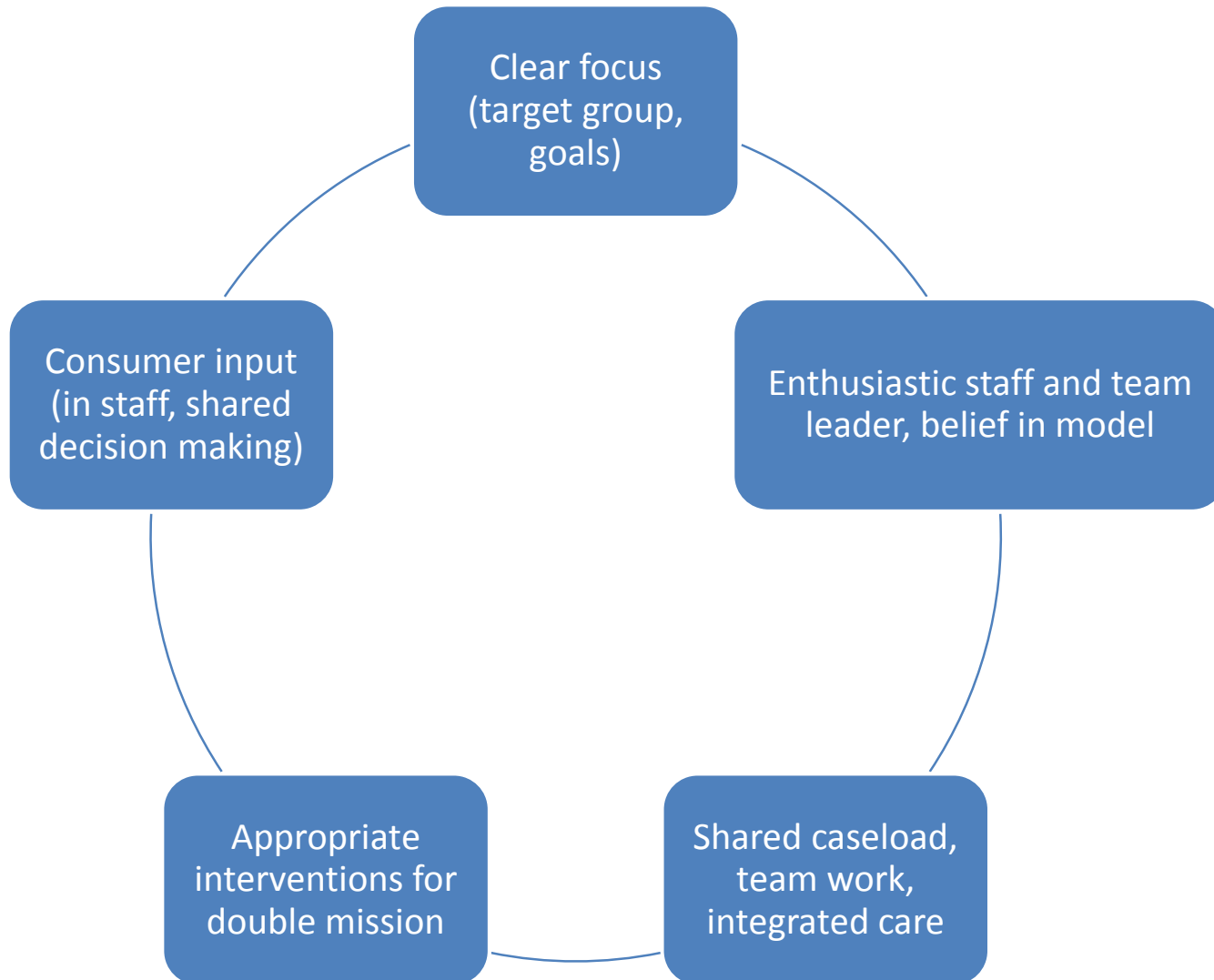
New teams copy what's in the fidelity scale

Threat: drift from what really works. Lack of positive outcomes

IFACT, DACTS, TMACT

- IFACT 1994: ACT as an organizing platform (no processes and services)
- DACTS 1998: ACT as an organizing platform (with some attention to processes and services, for instance substance abuse treatment)
- FACTS and TMACT 2011: specification of “provider of all the services that (F)ACT consumers need”, including evidence based practices, rehabilitation, treatment planning/process.
 - TMACT and FACTS are the first to address the double mission
- Probable next step: basic modules and choice of relevant, specific modules

Ideal AO



Conclusion

- Only a few European countries with broad implementation and research
- The higher the contrast with standard care, the larger the difference AO makes
- AO has a double mission but tends to emphasize the first (safety net)
- Diverging insights about the way to go: less or more

Research needs

- Study of enhanced ACT versus CMHT (UK), AO studies outside of UK
- Trials of specific ingredients (cf UK700): for instance cognitive training
- Trials for specific target groups: for instance personality disorders, substance abuse, intellectual disability, forensic
- “Golden” alternatives to the RCT
- Development and testing of new models (before abandoning AO)
- “It’s not about models, it’s about people”
→ Staff competencies

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- Hospital use should not be the primary outcome of assertive outreach
 - Positive outcomes of AO are a result of enthusiasm, not of a good model