“GETTING IT RIGHT”

OAAF Discussion Paper

Ontario Association for ACT & FACT

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Introduction

Ontario (population 14,297,160) has one of the lowest inpatient bed ratios in the world: 33 per 100,000.

- Total inpatient psych beds: 4,578 (33 per 100,000)
- Short term beds: (10 day average stay) 1,818 (13 per 100,000)
- Long-term beds: 2,760 (20 per 100,000)

Sampling of other countries

Inpatient beds per 100,000 population:

- Barbados 196
- Belgium 168
- Czech republic 93
- Germany 85
- Estonia 54
- Spain 37
- US 35 (+ prisons)
- Ontario 33
- United Arab Emirates 1

Our bed numbers have been steadily and substantially reduced over several decades. The province needs to actively support the parallel development of the necessary community mental health service structures in support of a committed philosophy of deinstitutionalization and community tenure with dignity. We must not be satisfied with a false sense of accomplishment that follows from trans-institutionalization (multiple short term admissions rather than true and sustained community integration).

ACT - Assertive Community Treatment

The need for ACT Teams is clear, experientially validated, and evidence based; it is one of the best researched and data supported psychiatric service models in the world. With the reduction in centralized Ministry of Health oversight and the concomitant advent of the 14 LHIN regions, the proper funding of existing ACT Teams has lagged, the maintenance of program fidelity and respect for the provincial ACT standards has slipped, and proper attention to flow through and stepped care service levels is quite variable. Without proper ACT team fidelity and an adequate number of teams, the emergency and inpatient systems are unduly burdened, and human beings who can live in the community with adequate support are instead suffering the indignity of traumatic recurrent admissions.

FACT - Flexible ACT

Experience has also accumulated across a variety of jurisdictions (Netherlands, Quebec) showing that **team based** intensive case management (ICM), that uses **ACT operating principles** as needed, meets the needs of a long neglected service level, namely those persons with serious and persistent mental illness (SPMI) who often need more than case management (CM) and usually less than ACT level care to support them through cycles of illness; these are the people in the **complex ICM service range**. FACT teams help fill this critical service gap in urban centres, and show particular merit in bringing secondary and tertiary care service to smaller communities. They also substantially reduce hospital admission days when compared to existing CM/ICM service models.

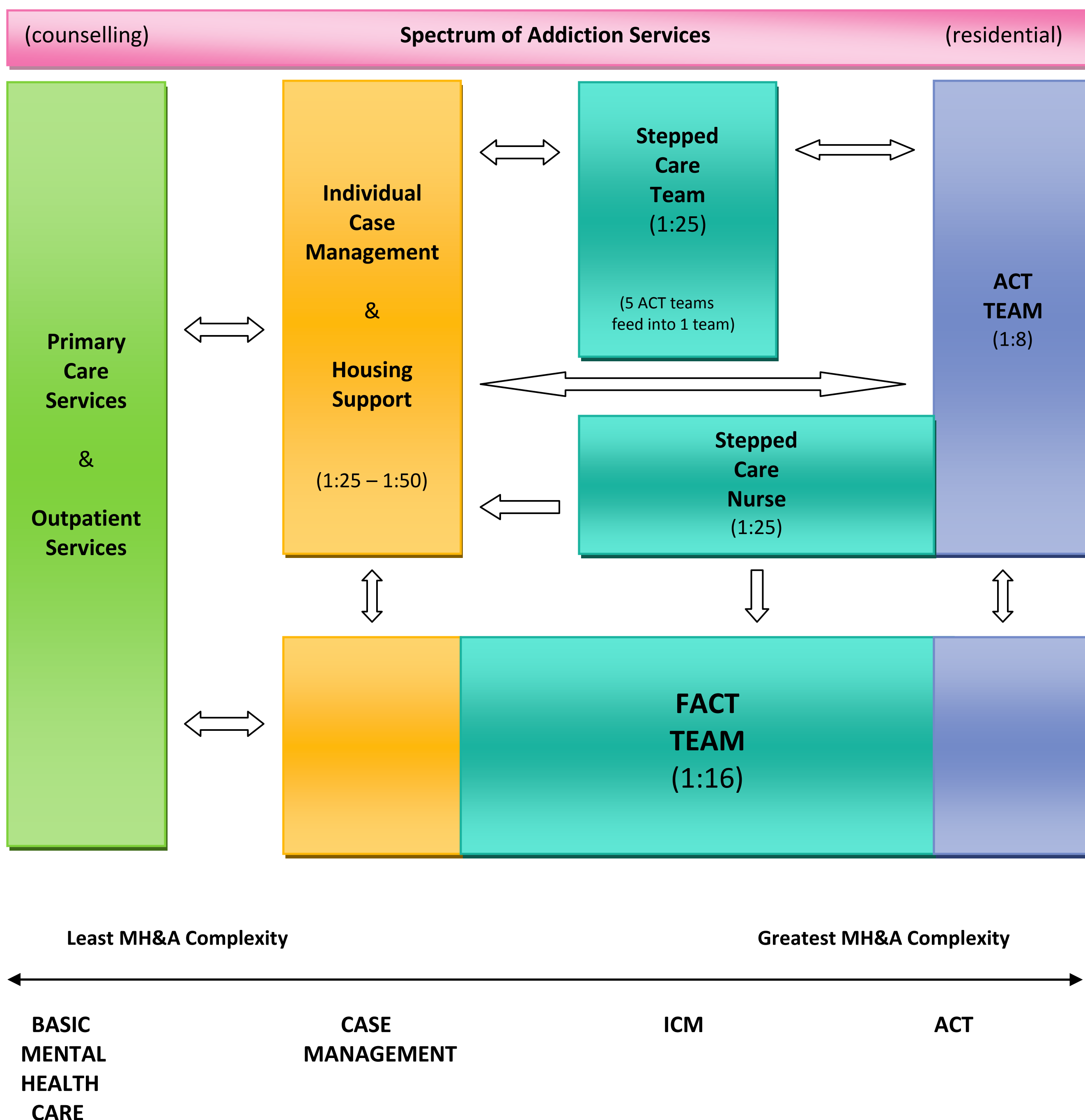
We Know What Works

- Proper funding matters.
- Model fidelity matters.
- Staff - client ratios matter.
- Service saturation matters.

Recent Central East LHIN data and experience reaffirm 3 things: many people who are heavy bed users are needing and waiting for ACT services, that Stepped Care is a simple solution for opening up ACT spaces, and that ACT teams definitively and drastically reduce hospital days.

Ontario needs to commit to the systematic development and proper support of the ACT and FACT service structures. To do so is absolutely cost effective, as well as being an ethical and clinical imperative.

ONTARIO MENTAL HEALTH & ADDICTION COMMUNITY SERVICE LEVEL FRAMEWORK



The CM-ICM-FACT-ACT Service Continuum in Ontario

1) **Current Service Models:** Case management (CM); housing support; hospital and community agencies; primary care services.

   Currently Serving: the seriously mentally ill (SMI) who constitute 1% of the general population.

   Service Providers: Individual caregivers working through primary care services, hospital and community agencies; supported housing/case management services (1: 25-50 staff/client ratio); non-team based intensive case management (1: 25 staff/client ratio).

   Significant Service Gaps: funded CBT services; proper personality disorder programs; adequate number of housing subsidies; ER to home diversion/extramural hospital/crisis resolution services.

2) **Current Service Models**: ICM (Intensive Case Management – individual & teams); FACT (Flexible Assertive Community Treatment) Teams.

   Currently Serving: the seriously and persistently mentally ill (SPMI - 30% of the 1% of the general population) needing more intensive and/or team based case management.

   Service Providers:

- Existing ICM services and teams
- Currently only 3 FACT teams in Ontario, with 3 other CM/ICM services transitioning into FACT Teams. FACT Teams have 12.5 FTE staff; 1:16 staff/client ratio; max 160 clients; 80% CM/ICM level clients; 20% intermittent (shorter term) ACT level clients; high volume flow through; and they provide rural areas with secondary and tertiary service levels.
- There should be 1 Rural FACT Team per 50,000-80,000 population for rural (smaller city/town) regions.
- There should be additional Urban FACT teams in urban areas serving as adjuncts or partners with ACT Teams.

   Significant Service Gaps: adequate number of FACT Teams

3) **Current Service Models**: FACT and/or transitional Stepped Care services (In regions where discharge options are limited, backlogged or inadequate, FACT and Stepped Care improves flow through, increases ACT capacity, and helps sustain client recovery. ACT teams should have admission and discharge/transition wait times of less than 6 months.)

Currently Serving: the SPMI no longer needing long term or sustained ACT level support.

Service Providers:

- FACT Teams
- ACT Stepped Care Nurse: 1 extra nurse on an ACT team who cares for the 25 most stable clients, and thereby makes room for 25 additional new clients on the ACT team (8 ACT teams in the Central East LHIN use this model)
- ACT Stepped Care Team: 5 ACT teams feed into one smaller Stepped Care Team; 5.5 FTE staff, 125 clients; 1:25 staff/client ratio (Ottawa is the only area with this service model at present)

Significant Service Gaps: adequate number of FACT Teams; many ACT Teams lack adequate stepped care/flow through capacity

4) **Current Service Models**: ACT

Currently Serving: the seriously and persistently mentally ill requiring longer term, sustained intensive supports (10% of the 1% of the general population).

Service Providers:

- 1 ACT Team per 80,000-100,000 population (currently 79 ACT teams in Ontario); 12.8 FTE staff; max 85 clients; 1:8 staff/client ratio

Significant Service Gaps: funding lag for existing ACT Teams; adequate number of ACT Teams; targeted care and monitoring of the most dangerous clients

Cost Effectiveness of ACT Teams

Cost avoidance for 1 ACT Team through bed day reductions:
(based on Ontario 2002-2006 data, corrected from $632/bed day to $650/bed day)

Pre ACT costs:	$4.5 million per year
Year 1 savings:	$3.0 million per year
Year 4 savings:	$3.7 million per year

1 ACT team at a cost of $1.3 million per year produces cost avoidance of $3.7 million.

This figure excludes ER visits, quality of life and productivity measures, and the reduction in community violence and court/jail costs.

(Recent Central East LHIN data has once again dramatically validated the benefits of ACT services as an incredibly effective means of reducing in-patent bed days. See Appendix A)

Funding

Funding per Ontario ACT team varies widely from $800,000 - $1,700,000
(properly funded British Columbia teams get $1.7 million each)

Each **community agency** based ACT Team in Ontario should receive:

i) base funding of:	$1,300,000	
ii) housing subsidies:	+ $100,000	(for 40 clients)
iii) if stepped care needed:	+ $70,000	(for 1 FTE RN)

Each **hospital based** ACT Team in Ontario should receive:

i) base funding of:	$1,600,000	
ii) housing subsidies:	+ $100,000	(for 40 clients)
iii) if stepped care needed:	+ $90,000	(for 1 FTE RN)

Number of ACT & FACT Teams Needed in Ontario

2018 Ontario population: 14,297,160

ACT Teams: (current need without parallel FACT team development)	168	(79 currently)
ACT Teams: (projected need with parallel FACT Team development)	128	(79 currently)
Urban FACT Teams*:	241	(6 currently)
Rural FACT Teams*:	25	(0 currently)
Specialty FACT Teams:	?	(1 currently)

*These are estimates. Existing case managers, housing support workers, and ICM services from geographically proximal agencies and hospitals can be transitioned into cohesive and effective FACT Teams.

Proposed Initial 5 Year Implementation Plan for Ontario

10 ACT Teams per year
(priority goes to regions with longest wait times presently)

3 Urban FACT Teams per year
(priority goes to areas where existing services can be most easily integrated and transitioned)

1 Rural FACT Team per year
(priority goes to areas with service gaps and challenges)

The experience gained with the cautious introduction of urban and rural FACT Teams into the Ontario mental health service structures will help guide subsequent 5 year implementation plans.

ACT & FACT Ontario: Implementation & Technical Centre (ITC)

A new, centralized technical centre is essential for fidelity support and best outcomes. This is now a standard approach in many countries and jurisdictions (e.g. Netherlands; Columbia University/New York State; Quebec National Center of Excellence in Mental Health http://www.douglas.qc.ca/section/cnesm-298?locale=en).

Funding: Ministry of Health
Staffing: 2 ACT Consultants, 2 FACT Consultants, 1 Admin Assistant
Responsibilities:

- Team placement analyses & recommendations
- Team development assistance
- ACT & FACT Team Fidelity Reviews
- Fidelity remediation monitoring and enforcement
- Funding monitoring
- Capacity monitoring
- Flow through assistance
- Team process assistance
- Team orientation and education
- Trouble shooting advice
- Mediation assistance

Rural (Smaller City/Town) FACT Teams

On the ground local knowledge and service variations are critical factors to evaluate for FACT Team locations:

- total population served (50,000-80,000)
- LHIN/city/county/ hospital catchment area boundaries
- ICM and ACT level service deficits in a given region/LHIN
- long admission or discharge wait times in a given region/LHIN
- regions where existing ACT Teams are already split across sites

Appropriate rural team locations:	Catchment under 80,000
1. South Georgian Bay (Collingwood/Wasaga Beach)	60,000
2. Leamington-Kingsville-Amherstburg	75,000
3. Cochrane, Smooth Rock Falls, Iroquois Falls	80,000
4. City of Kawartha Lakes/Haliburton	80,000

Probable rural team locations:

5. Innisfil
6. Kapuskasing, Hearst and area
7. Haldimand Norfolk
8. Muskoka

Possible rural team locations:

9. Midland/Penetanguishene
10. Orangeville/Alliston
11. Bradford/West Gwillimbury
12. Caledon
13. Aurora
14. Fort Erie
15. Georgina
16. Halton Hills
17. Port Colborne
18. Welland
19. Whitechurch-Stouffville
20. Others?

Specialty FACT Teams

Specialty FACT Teams may be developed in urban areas to serve clients with serious and persistent mental illness complicated by other challenges [e.g. intellectual delay (such a Dual Diagnosis team already operates in Ottawa), forensic issues (Forensic ACT Teams operate in Toronto), or geriatric needs (a Geriatric ACT Team currently operates through Southlake)].

Implementation of Specialty FACT Teams require case by case/LHIN by LHIN analyses.

1.Dual Diagnosis (intellectual delay) FACT
   - Ottawa (already established)
   - Other locations require needs assessments.

2.Forensic FACT
   - Operating out of all forensic hospitals?
   - Community based mental health and justice/support court teams?
   - Forensic youth?

3.Geriatric FACT
   - All large cities?
   - Integrated with or evolving out of existing psycho-geriatric services?

4. Others?
   - EPI?
   - Youth?

APPENDIX A

Excerpted from the Executive Summary of the Central East LHIN ACTT Quality Initiative (2012-2017):

"In 2012, the Assertive Community Treatment Team (ACTT) Quality Improvement Initiative originated […] over concerns regarding access to ACTT services, with several of the Central East LHIN ACTT teams at full capacity with extensive waitlists and what appeared to be significant deviations from team to team in the model of care employed. The Central East LHIN initiated a Quality Improvement Initiative to review the ACTT model and provide recommendations with the aim to increase flow within ACTT and standardize consistent practices across the 8 Central East LHIN ACTT teams."

"Implementation of recommendations […] began in April 2014 across all eight Central East LHIN ACTTs."

"As a result of the project [*and the addition of Stepped Care*], 364 new clients have been admitted to the eight Central East LHIN ACTT teams over the course of the 3-year implementation phase. The total capacity of active clients in Stepped Care is 170 and, since the inception of the Stepped Care program, a total of 240 clients have been admitted into the program. The 364 new clients admitted into ACTT between April 1, 2014 and March 31, 2017 had a combined total of over 58,302 hospital bed days in the two years prior to their admission into ACTT. **The first 204 clients that entered regular ACTT since the implementation of Stepped Care had 36,064 combined beds days the previous two years before entering ACTT. Two years into ACTT treatment, those same 204 clients saw a reduction in bed days by 90% to a total of 3,497 bed days for a total bed savings of 32,567 days."**

"Continued client satisfaction with the Stepped Care program was tracked through ongoing surveys throughout the duration of client involvement with the ACTT team. Increased freedom (i.e. fewer visits with ACTT staff) was highlighted by clients as a very important and positive feature of Stepped Care. Continued assistance with other ACTT staff as necessary, and continued inclusion of Stepped Care clients in ACTT social groups/outings was also seen as important**.** Of the 240 clients admitted into Stepped Care, only 11 required re-entry into the full ACTT services."

APPENDIX B

Guide for Planning ACT & Urban FACT Team Distribution in Ontario

By Population	ACT and FACT Teams needed	ACT level care (max capacity)
50,000 - 80,000	1 FACT Team	32
80,000-100,000	1 ACT Team & 1 FACT Team	85 + 32 = 117
100,000-150,000	1 ACT Team & 2 FACT Teams	85 + 64 = 149
150,000-200,000	1 ACT Team & 3 FACT Teams	85 + 96 = 181
200,000-250,000	2 ACT Teams & 4 FACT Teams	170 + 128 = 298
250,000-300,000	2 ACT Tams & 5 FACT Teams	170 + 160 = 330
300,000-350,000	3 ACT Teams & 6 FACT Teams	255 + 192 = 447
350,000-400,000	3 ACT Teams and 7 FACT Teams	255 + 224 = 479
400,000-450,000	4 ACT Teams & 8 FACT Teams	340 + 256 = 596
450,000-500,000	4 ACT Teams & 9 FACT Teams	340 + 288 = 628
500,000-550,000	5 ACT Teams & 10 FACT Teams	425 + 320 = 745
550,000-600,000	5 ACT Teams & 11 FACT Teams	425 + 352 = 777
600,000-650,000	6 ACT Teams & 12 FACT Teams	510 + 384 = 894
650,000-700,000	6 ACT Teams & 13 FACT Teams	510 + 416 = 926
700,000-750,000	7 ACT Teams & 14 FACT Teams	595 + 448 = 1,043
750,000-800,000	7 ACT Teams & 15 FACT Teams	595 + 480 = 1,075
800,000-850,000	8 ACT Teams & 16 FACT Teams	680 + 512 = 1,192
850,000-900,000	8 ACT Teams & 17 FACT Teams	680 + 544 = 1,224
900,000-950,000	9 ACT Teams & 18 FACT Teams	765 + 576 = 1,341
950,000-1,000,000	9 ACT Teams & 19 FACT Teams	765 + 608 = 1,373