# Exploring Barriers to ACT Program Fidelity in Ontario

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## Outline

- Background
- Research Objectives
- Methodology
- Results
  - Respondents
  - Rural vs. Urban vs. Mixed
  - Funding and Staffing
  - Standards: Perceived Compliance and Importance
  - Barriers to Compliance
- Discussion Questions
- Conclusions and Implications



## Background: Mental Health Reform

- 1970s – Consumer movement / growth in community-based services
- 1988 – Graham Report
  - Stressed need for an integrated and coordinated system
- 1993 – "Putting People First"
- 1999 – "Making it Happen"
- 1999 – Hospital Restructuring Commission recommended divestment of provincial psychiatric hospitals
- 2003 – 9 regional Mental Health Implementation Task Forces



## Background: Assertive Community Treatment (ACT)

- 1972 – First use of (P)ACT model, Madison, Wisconsin
  - Goal: shift to community-based services
  - Multi-disciplinary community support treatment model for severely mentally ill individuals
  - Focus on client empowerment and involvement in care decisions
- Evidence of:
  - Increased client and family satisfaction
  - Reduced inpatient hospitalization days
  - Cost effectiveness



## Background: ACT in Ontario

- 1990's – trial of ACT programs in Ontario
- 1998 – formal endorsement of ACT programs with program standards
- 2004 – revised ACT program standards

## Research Objectives

1. To what extent have Ontario's ACT programs adopted the 2004 program standards?
2. What barriers exist to meeting the new standards?
3. What is the perceived importance of each standard (how essential)?



## Methodology

- Selection of Fidelity Measures
  - Dartmouth ACT Scale (DACTS)
    - Standards missing or only superficially addressed
      - E.g. role of advisory committee
      - E.g. client involvement in decision-making
      - E.g. skills training and job placement
    - Use of categories does not provide flexibility
      - Does not accommodate urban / rural differences
      - Limited opportunity to explain why
    - Teague is in process of revising the DACTS
  - Examples of other scales
    - Index of Fidelity of Assertive Community Treatment (IFACT)
    - Critical Components of ACT Interview (CACTI)



## Methodology continued…

- Development of Our ACT Fidelity Tool Allowed us to:
  - Focus specifically on the Ontario standards
  - Obtain both quantitative and qualitative data
  - Obtain feedback on the challenges which prevented standards from being attained
  - Obtain feedback on the perceived importance of each standard
- The Survey Instrument
  - Section A – details of specific ACT Program
  - Section B – perceived compliance with new Program Standards and information on why standards were not met
    - *Extent to which each program meets standard*
    - 10-pt. scale: (1 = Not at all, 10 = Completely)
  - Section C – ranking of importance of Program Standards (33)
    - *Extent to which each standard is essential* for effective functioning
    - 10-pt. scale: (1 = Not important, 10 = Essential)
  - Section D – profile of respondent



## Program Standards for ACT Fidelity Tool

1. Intake
2. Admission Criteria
3. Discharge Criteria
4. Staff-to-Client Ratio
5. Staff coverage
6. Frequency of Client Contact
7. Qualifications
8. Team size
9. Required Staff
10. Hours of Operation
11. Place of Treatment
12. Staff Communication & Planning
13. Continuity Mechanisms
14. Staff Supervision
15. Initial Assessment
16. Comprehensive Assessment
17. Individualized Treatment/ Service Planning
19. Crisis Assessment & Intervention
20. Psychiatric Treatment
21. Concurrent Disorders
22. Work-Related Services
23. Activities of Daily Living
24. Social/Interpersonal and Leisure Skill Training
25. Peer Support Services
26. Support Services
27. Family-Centered Services
28. Client Record
29. Client Rights & Complaint Resolution Procedures
30. Barrier-Free Services
31. Performance Improvement & Program Evaluation
32. Community Advisory Bodies
33. Accountability



## Example of Question

**14. Staff Supervision:** *Each team coordinator and/or psychiatrist shall supervise the clinical performance of staff by: (1) accompanying staff during client visits; (2) observing staff at daily meetings and treatment/service planning meetings; and (3) reviewing clinical documentation.*

a. What is your opinion of the extent to which your ACT program currently meets this standard?

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑩

Not at all — Completely — Not Sure

b. What challenges prevent the Program from reaching a 10 on the scale?

_____

_____

_____



## Data Analysis of Open-ended Questions: Challenges (Barriers) to Compliance

- Six Primary Coding Categories:
  - Human Resources (6 sub-codes)
    - Recruitment; on leave; lack of right qualifications
  - Communication (2 sub-codes)
    - Intra and inter-organizational sharing of information
  - Client-Related (4 sub-codes)
    - Scheduling; language; willingness; complexity of care
  - Organizational (5 sub-codes)
    - Lack of motivation; structural barrier (unions, ODSP)
  - Standard-Related (6 sub-codes)
    - Unnecessary; unattainable; needs modification; not a priority
  - External (7 sub-codes)
    - Funding; lack of support; geography

## Methodology continued…

- Pilot of survey
  - 5 mental health professionals and 2 ACT programs
- Data collection
  - Personal letter to respondents with copy of the survey instrument
  - Telephone call to set appointment for survey
  - Completion of survey over telephone (1-2 hours each)
  - Data was collected in April – July 2005 but respondents were asked to answer questions based on March 31, 2005
- Sample population – all ACT programs in Ontario
  - Census sample (N =66)
  - Program Coordinators or designee



## Methodology continued…

- Data Analysis
  - Quantitative data
    - SPSS
  - Qualitative data
    - Excel database
    - Content analysis of comments (i.e., challenges that prevent the Program from reaching a 10 on the scale)
    - Established categories and sub-codes
    - Three judges and assessment of inter-rater reliability



## Results

- 85% participation
  - 56 of 66 ACT programs
  - Non-participants were evenly distributed geographically
  - 66% urban, 21% rural, 13% mixed
  - First program established in 1990
  - Only 17 (30%) existed prior to 1998
- Respondents
  - Average of 19.5 years in field (4 to 33 years)
  - Average of 4.2 years in their current position (4 weeks to 17 years)
  - 34% held a Masters degree
  - 51% nursing; 29% social work; 10% occupational therapy; 10% other



## Results continued …

- **Review of new standards**
  - 87% reviewed the new ACT standards with their staff & sponsoring agency
    - Unaware that there were new program standards
    - Too busy to review with staff
  - 38% reviewed the new ACT standards with their advisory committee
    - Did not have an advisory committee
    - On the schedule for the next advisory committee
    - The advisory committee has never met or is on hiatus



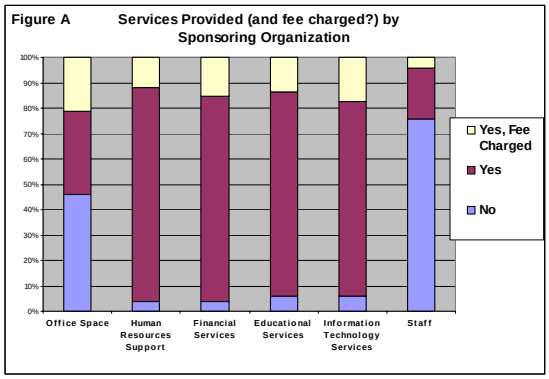
## Results continued …

- **Client admissions and capacity**
  - Average target capacity: 73 clients
  - Average current clients: 59 clients
    - Range from a minimum of 11 to a maximum of 125 clients
  - Average waiting list: 1-2 per month
  - Average new admissions: 1.6 - 2 per month
    - Range from 0-15 inquiries per month
    - Range from 0-6 admissions per month
  - 14% (8 of 56) of Programs meet or exceed target capacity



## Results continued …

- **Funding of ACT Programs**
  - ACT programs reported receiving an average of $1.06 million/year
    - Range $.65 million - $1.5 million from Ministry of Health and Long-Term Care
    - Some programs are only funded through hospital global budgets
  - 27% (15 of 56) have additional sources of funds
    - Hospital global budget
    - United Way
    - Donations
    - Health Accord funding






## Results continued …

- **Funding agency provides funds for**:
  - Additional professional and support staff
  - Human resources department
  - Financial services
  - Information technology
  - Education services
  - Office space / rent
  - Maintenance and housekeeping
  - Car maintenance and gas



## Results continued …

- **Funding agency charges a fee for:**
  - Additional professional and support staff
  - Human resources department
  - Financial services
  - Information technology
  - Education services
  - Office space / rent (some only charge a percentage)
  - Maintenance and housekeeping
  - Purchasing services fee
  - 5% of budget for IT/HR/financial services
  - 15% for all administrative services



## Results: Rural, Urban, Mixed

- MOHLTC funding per client per year was an average of $21,400 (n = 47)
  - Rural (n = 9)
    - Average of $23,458 (Min. $15,000 - Max. $37,500)
  - Urban (n = 32)
    - Average of $17,613 (Min. $7,968 - Max. $30,769)
  - Mixed (n = 6)
    - Average of $33,253 (Min. $16,667 - Max. $101,818)



## Results: Rural vs. Urban vs. Mixed

| Description | Rural (n=11) Mean | Urban (n=35) Mean | Mixed (n=7) Mean | Sig. Level Diff. in Means (ANOVA) |
|---|---|---|---|---|
| **Number of Current Clients** | **42.64** | **65.23** | **52.29** | **.002** |
| Target Service Capacity | 59.50 | 75.80 | 68.07 | .090 |
| Approximate Wait Time (weeks) | 14.33 | 15.13 | 29.00 | .119 |
| Average Referrals per Month | 2.25 | 3.09 | 3.29 | .311 |
| Average # Admissions per Month | 2.00 | 1.61 | 1.99 | .371 |

(Sig. at p > or = .05)



## Rural vs. Urban vs. Mixed

| Extent to Which ACT Program Meets Standard for: ( 1=Not at all to 10 = Completely) | Rural (n=11) Mean | Urban (n=35) Mean | Mixed (n=7) Mean | Sig. Level Diff. in Means (ANOVA) |
|---|---|---|---|---|
| **B22. Work Related Services** | **7.68** | **7.97** | **9.57** | **.036** |
| **B32. Community Advisory Bodies** | **7.45** | **4.57** | **7.14** | **.026** |

(Sig. at p > or = .05)

## Rural vs. Urban vs. Mixed

| " How Essential" is the ACT Program Standard (1=Not important to 10=Essential) | Rural (n=11) Mean | Urban (n=35) Mean | Mixed (n=7) Mean | Sig. Level Diff. in Means (ANOVA) |
|---|---|---|---|---|
| **C1. Intake** | **9.30** | **8.24** | **5.14** | **.000** |
| **C22. Work-Related Services** | **8.22** | **8.07** | **9.57** | **.036** |
| **C32. Community Advisory Bodies** | **6.30** | **5.57** | **6.29** | **.026** |

(Sig. at p > or = .05)

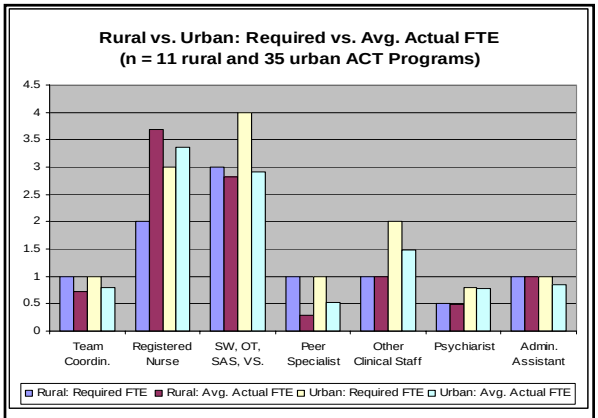


## 9. Required Staff *(focus is on specific disciplinary mix / requirements)*: *Each **urban and rural** team shall follow the following specified staff requirements.*

| Position | Urban/Full | Rural/Smaller |
|---|---|---|
| Team Coordinator | 1 FTE | 1 FTE |
| Registered Nurse | 3 FTE | 2 FTE |
| Social Worker | 1 FTE | 3 FTE* |
| Occupational Therapist | 1 FTE | |
| Substance Abuse Specialist | 1 FTE | |
| Vocational Specialist | 1 FTE | |
| Peer Specialist | 1 FTE | 1 FTE |
| Other Clinical Staff | 2 FTE | 1 FTE |
| Psychiatrist | 0.8 FTE | 0.5 FTE |
| Administrative Assistant | 1 FTE | 1 FTE |
| **Total** | **12.8 FTE** | **9.5 FTE** |

* On a rural team, 1 of these staff may serve a dual role.








## Current Staffing Levels: Average Actual FTE Rural vs. Urban vs. Mixed

| Staff Position | Rural (n=11) Mean FTE | Urban (n=35) Mean FTE | Mixed (n=7) Mean FTE |
|---|---|---|---|
| Team Coordinator | 0.75 | 0.80 | 0.73 |
| Nurses | 3.68 | 3.37 | 3.30 |
| SW, OT, SAS, VS | 2.83 | 2.90 | 3.13 |
| Peer Specialist | 0.29 | 0.52 | 0.43 |
| Other Clinical Staff | 0.98 | 1.47 | 1.50 |
| Psychiatrist | 0.67 | 0.77 | 0.63 |
| Administrative Assistant | 0.99 | 0.86 | 0.94 |
| Team Size | 10.19 (9.5) | 10.68 (12.8) | 10.66 |



## ACT Standards with Greatest Perceived Compliance

(Scale: 1 = Not at all, 10 = completely)

| Program Standard | Compliance Mean | How Essential Mean | Gap Between Means | Sig. Level Diff. in Means |
|---|---|---|---|---|
| **28. Client Record** | **9.980** | 9.650 | 0.330 | **.010** |
| **18. Service Coordination** | **9.930** | 8.910 | 1.020 | **.000** |
| **23. Activities of Daily Living** | **9.750** | 9.330 | 0.420 | **.005** |
| **23. Place of Treatment** | **9.700** | 8.670 | 1.030 | **.000** |
| 26. Support Services | 9.610 | 9.270 | 0.340 | .142 |
| 33. Accountability | 9.600 | 8.660 | 0.940 | .071 |
| **3. Discharge Criteria** | **9.571** | 7.450 | 2.121 | **.000** |

(Sig. at p > or = .05)



## ACT Standards with Lowest Perceived Compliance

(Scale: 1 = Not at all, 10 = Completely)

| Program Standard | Compliance Mean | How Essential Mean | Diff. in Means | Sig. Level Diff. in Means |
|---|---|---|---|---|
| 4. Staff-to-Client Ratio | 8.163 | 7.920 | 0.243 | .396 |
| **16. Comprehensive Assessment** | **7.940** | **8.490** | **-0.550** | **.016** |
| 1. Intake | 7.900 | 7.920 | -0.020 | .911 |
| 9. Required Staff | 7.570 | 8.060 | -0.490 | .251 |
| **21. Concurrent Disorders** | **7.480** | **8.210** | **-0.730** | **.039** |
| **25. Peer Support Services** | **6.180** | **8.080** | **-1.900** | **.000** |
| 32. Community Advisory Bodies | 5.680 | 5.960 | -0.280 | .658 |

(Sig. at p > or = .05)

## The Five "Most Important" Standards

(Mean Scale: 1 = Not at all, 10 = completely
Ranking Scale: 1 = Most important)

| Program Standard | Compliance (Mean) | How Essential (Mean) | Importance Rank (1-5) | Sig. Level Diff. in Means |
|---|---|---|---|---|
| **17. Individualized Treatment/ Service Planning** | **8.400** | **9.510** | **1** | **0.000** |
| 20. Psychiatric Treatment | 9.460 | 9.760 | **2** | 0.182 |
| 12. Staff Communication and Planning | 9.400 | 9.590 | **3** | 0.207 |
| 2. Admission Criteria | 9.268 | 9.390 | **4** | 0.683 |
| 7. Qualifications | 9.020 | 9.280 | **5** | 0.229 |

(Sig. at p > or = .05)



## The Five "Least Important" Standards

(Mean Scale: 1 = Not at all, 10 = completely,
Ranking Scale: 1 = Least important)

| Program Standard | Compliance (Mean) | How Essential (Mean) | Importance Rank (1-5) | Sig. Level Diff. in Means |
|---|---|---|---|---|
| 32. Community Advisory Bodies | 5.680 | 5.960 | 1 | .658 |
| **15. Initial Assessment** | **8.890** | **7.290** | **2** | **.000** |
| 9. Required Staff | 7.570 | 8.060 | **3** | .251 |
| **10. Hours of Operation** | **8.550** | **7.860** | **4** | **.038** |
| **13. Continuity Mechanism** | **9.160** | **8.320** | **5** | **.005** |

(Sig. at p > or = .05)



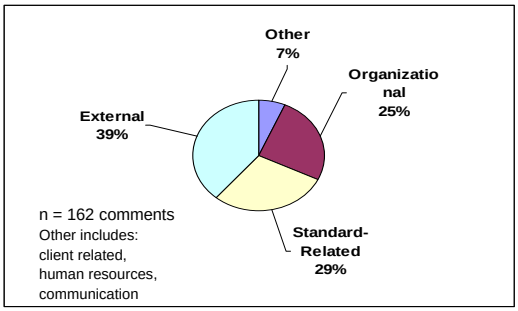
## **Example 1:** Barriers to Compliance

32. **Community Advisory Bodies:**

*Each team shall have a Community Advisory Body which makes recommendations on the annual operating plan and budget, promotes fidelity to program standards, and reports directly to the Board of Directors of the sponsoring agency.*



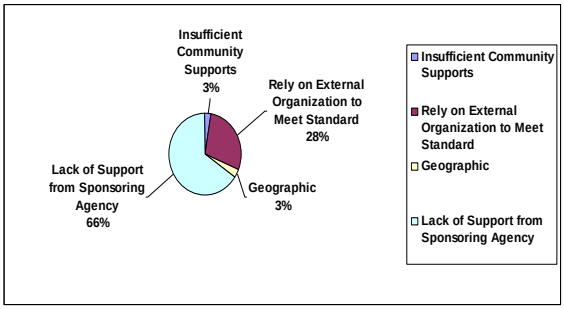
## Example: B32. Barriers to Meeting Standard for Community Advisory Bodies






## B32. Community Advisory Bodies: Sub-Category *External Barriers*

(n=64 comments; 39% of barriers)

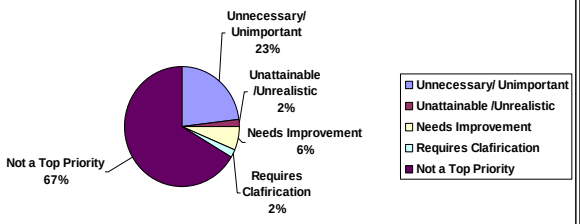





## Sample Comments: ***External Barriers*** to Meeting Standard for Community Advisory Bodies

- "Support from the sponsoring agency is required."
- "We need direction from the agency to say we have to have one. Don't have one that's necessarily specific to the program."
- "There was a community advisory body, and that has been disbanded. Sponsoring agency is transitioning and the community advisory is falling to the wayside."
- "Host organization has a number of advisory bodies who all function in an advisory capacity for mental health services . . . didn't create another just for ACT."

## B32. Community Advisory Bodies: Sub-Category ***Standard Related Barriers***
**(n = 48 comments; 29% of barriers)**



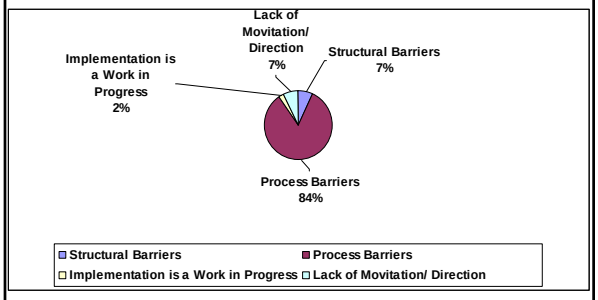



## Sample Comments: ***Standard-Related Barriers*** to Meeting Standard for Community Advisory Bodies

- "The community advisory board was disbanded."
- "Hospital has one, not specific to ACT. I don't think we need one."
- "We have a committee…it is the bane of my existence. We struggled with their mandate…role of sharing information between teams…3 teams share advisory committee. It doesn't work.."
- "The standard is written for small community agencies, not large corporate hospitals."



## B32. Community Advisory Bodies: Sub-Category ***Organizational Barriers*** (n =42 comments; 25% of barriers)



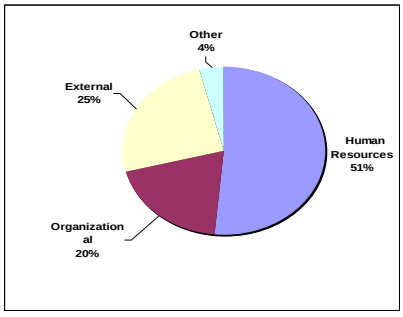



## Sample Comments: ***Organizational Barriers*** to Meeting Standard for Community Advisory Bodies

- "Persons on community advisory boards are not permanent. Within a year they are off and doing something else."
- "Our community advisory group does not report to our hospital board but they are in communication with the Ministry of Health."
- "Advisory body meets irregularly…lack of direction and goals. Being reviewed and reassessed."
- "Not getting around to it."
- "Problems with quorum…lack of clear roles and responsibility for Advisory Board."



## Example 2: B9. Barriers to Meeting Standard for Required Staff




n= 172 comments
(90 concerned staff shortages)



## Barriers to Meeting Standard for Required Staff

- Human Resources (92 comments)
  - Staff shortages due to recruiting difficulties, illness/maternity leave, turnover, lack of qualified staff
  - Lack of peer specialist
- External (45 comments)
  - Lack of funding
  - Rely on external organizations to meet standard
- Organizational (35 comments)
  - Structural/process barriers
    - Unions
    - Team coordinators managing many programs or too much clinical time
    - Clinical workload of team coordinators average 21% (0-80%)

*Why the discrepancy between actual staffing levels and perception of staff shortages given that most programs are operating below capacity?*

## Discussion Questions

- Why the discrepancy between actual staffing levels and perception of staff shortages given that most programs are operating below capacity?
- Why are respondents' ratings so low for:
  - "perceived compliance" for standards for
    - Community Advisory Bodies (5.68 out of 10)
    - Peer Support Services (6.18 out of 10)
    - Concurrent Disorders (7.48 out of 10)
    - Required Staff (7.57 out of 10)
  - "how essential" they regard the standards for
    - Community Advisory Bodies (5.96 out of 10)
    - Initial Assessment (7.29 out of 10)
    - Required Staff (8.06 out of 10)
- Why the discrepancy between actual funding and perceived funding shortages



## Conclusions

- No program is perceived as being fully compliant
- Significant variation in standard compliance
- Overwhelming number of standards
- Differences on opinion regarding importance of standards
- Weak MOHLTC introduction of revised standards, e.g.
  - Not all ACT coordinators aware of existence
  - Not clearly understood by coordinators
- Variation in resources available (funding and services)
- Respondents felt that some standards are:
  - Unrealistic / unattainable / unimportant / not needed
  - Beyond the program's control



## Implications

- Some standards require modification
- Funding variations should be examined
- There should be more specific/consistent requirements for sponsors' support (e.g., services provided vs. fee for services)
- Standardization of governance may be needed
- Level of compliance to standards should be monitored by MOHLTC.
  - Is there a need for accreditation to monitor standard compliance?



## Thank You!

Questions?

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