

ACT Conference 2012
5/16/12

Session 14

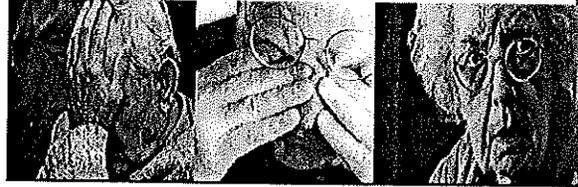


ACT for the elderly (ACTE)
in Rotterdam the Netherlands

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In view of the specific problems of elderly people with Severe Mental Illness a specialist ACT team for the elderly (55 years and over) was started



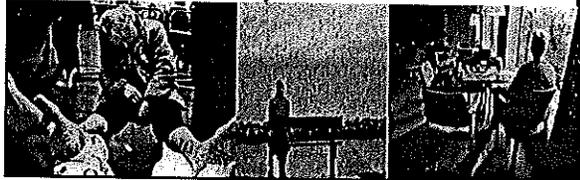
ACTE in The Netherlands

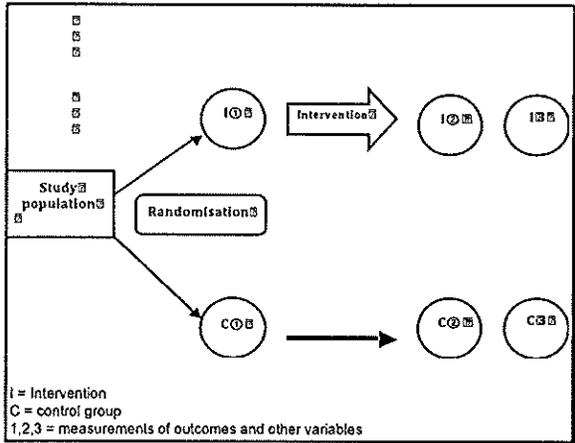
But also because mental health services for the elderly delivered fragmented care with barriers across mental, somatic & social health-care



The ACT program for elderly is studied. The inclusion of patients started July 2008 and was closed on 1 August 2010

Data collection ended in march of this year





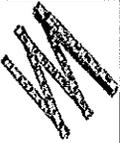
AIM of the study 

Compare effects of ACT for the Elderly
with effects of Treatment as Usual
(TAU)




hypothesis

ACTE better engage patient
in care and will improve
patients psychiatric, somatic,
and social symptoms more
than TAU

Measurement instruments 

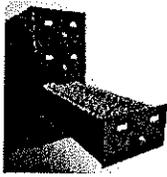
Dutch version of the Health of Nations
Outcome Scale for elderly people (HoNOS
65+)

The short Dutch version of the Camberwell
Assessment of Needs for the Elderly (CANE)

Data collection

Three measurement moments

At baseline at 9 months and at 18 months



Intervention and control group

This study compared one intervention group: ACTE,

and one control group: consisting of three community mental health elderly teams (treatment as usual)



ACTE TEAM

Community mental health nurse specialized in elderly

Psychiatric and somatic nurse

Social worker

Psychiatrist specialized in elderly

Rehabilitation worker



ACTE

The intervention ACTE comprise the working method of the ACT model

Team members received training in ACT features and the team started April 2008.



TAU

Community mental health nurse specialized in elderly

Psychiatrist specialized in elderly

Psychologist



Tau

outreach services, pharmacotherapy, individual therapy and group therapy

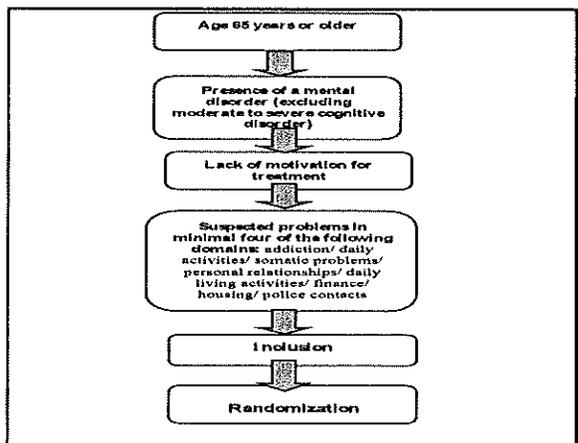
The TAU teams provided only psychiatric care (but rehabilitation programs for elderly were available)

Disciplines are individually responsible for the patients and their treatment plan

high caseload



Model Fidelity (2010) DACTS	ACTE	GP North	PG team	GP South
Score DACTS	3,6 Moderate implementation	2,4	2,4	2,4

Referred by Hospital SWs, family members, police, etc.

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 facilities, & ADL activities.

Problems



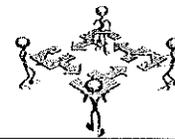
Fewer patients than expected were announced to the ACTE team, causing financial problems for the team and power problems for the study.

Solutions

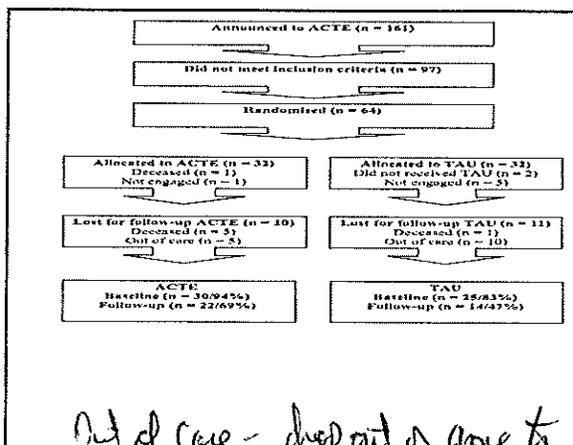
We broadened our inclusion criteria in five steps



- 1.) we prolong the inclusion period with one year,
- 2.) we lowering the minimum age to 60 years and
- 3.) We expanding the work area of ACTE
- 4.) to limit the number of problems in several domains to two instead of four and finally
- 5.) we let loose of criterion the number of problems in several domains.



Research outcome



Out of care - drop out or gone to DNF



Analyses



We handled missing data with the 'last observation carried forward' method

Differences in socio-demographic characteristics' and dropout, between ACTE and TAU, were analyzed using standard statistical tests



Characteristics	Total N 36	ACTE n=22	TAU n=14
Median (mdn) age (range)	74 (60-90)	74 (60-90)	72 (61-87)
Mdn age 1 st contact mental health (range)	66 (28-87)	65 (28-81)	66.5 (36-87)
<i>Previous</i> Psychiatric admission (%)			
Yes	11 (30.6)	6 (27.3)	5 (35.7)
No	25 (69.4)	16 (72.7)	9 (64.3)



Characteristics	Total N 36	ACTE n=22	TAU n=14
Gender (%)			
Male	16 (44.4)	9 (40.9)	7 (50)
Female	20 (55.6)	13 (59.1)	7 (50)
Marital state (%)			
Unmarried	12 (33.3)	9 (40.9)	3 (21.4)
Married	13 (36.1)	6 (27.3)	7 (50)
Divorced	5 (13.9)	3 (13.6)	2 (14.3)
Widowed	6 (16.7)	4 (18.2)	2 (14.3)
Living situation (%)			
Independent	31 (86.1)	18 (81.8)	13 (92.9)
Other	5 (13.9)	4 (18.2)	1 (7.1)
Nation of birth (%)			
The Netherlands	28 (77.8)	18 (81.8)	10 (71.4)
Other	8 (22.2)	4 (18.2)	4 (28.6)



Diagnosis AXIS I	Total N 36 (%)	ACTE n=22 (%)	TAU n=14 (%)
Schizophrenia spectrum disorders	13 (36.1)	9 (40.9)	5 (35.7)
Cognitive disorder	8 (22.2)	3 (13.6)	5 (35.7)
Mood disorder	8 (22.2)	5 (22.7)	3 (21.4)
Other disorders	6 (16.7)	5 (22.7)	1 (7.1)



*Most were referred w/ Y problems
but later became clear that
were cognitive disorders even though*

Other diagnosis

22.2% had an Axis II diagnosis
(mostly personality disorder not otherwise specified)

Most Axis III diagnosis:

19.4% Diabetes

8.3% Hypertension



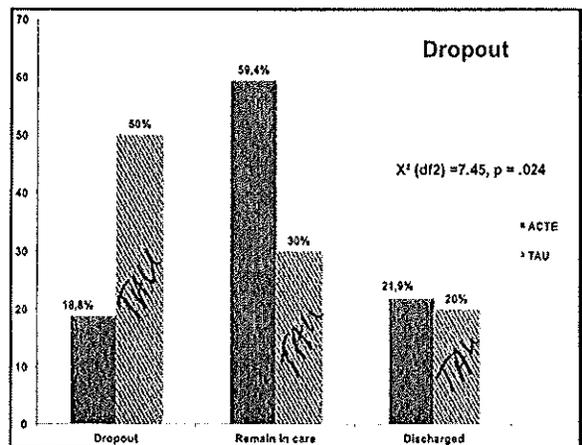
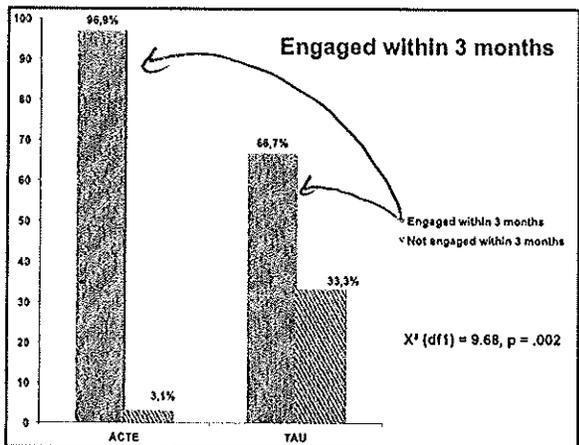


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Characteristics	Total N=36	ACTE n=22	TAU n=14
Treatment motivation (%)	7 (19.4)	6 (27.3)	1 (7.1)
Motivated	19 (60.6)	16 (72.7)	13 (62.5)
Not motivated			
Caregiver (%)	9 (25)	4 (18.2)	5 (35.7)
Yes	27 (75)	18 (81.8)	9 (64.3)
No			



Primary Outcome
 Engagement
 # of dropout
 Pt's psychosocial outcome over time

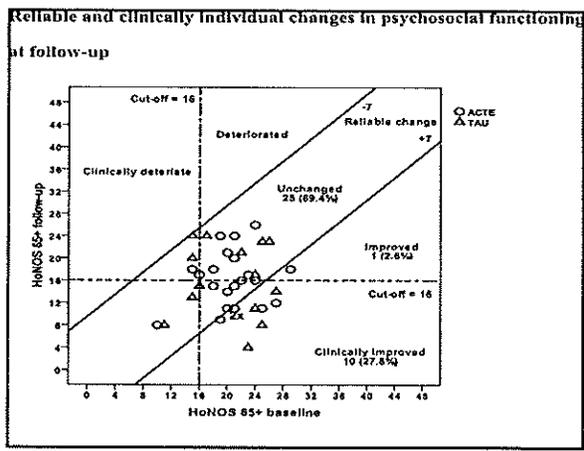
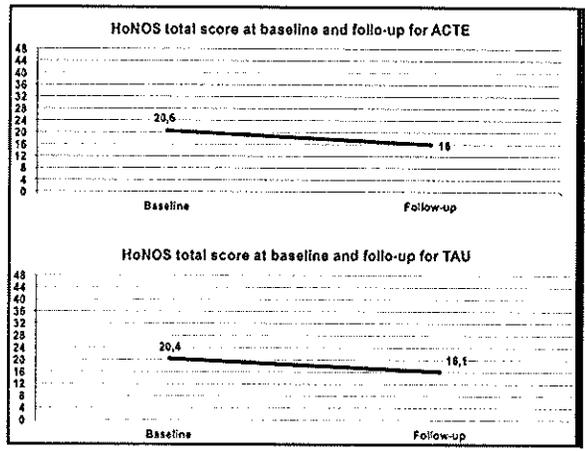
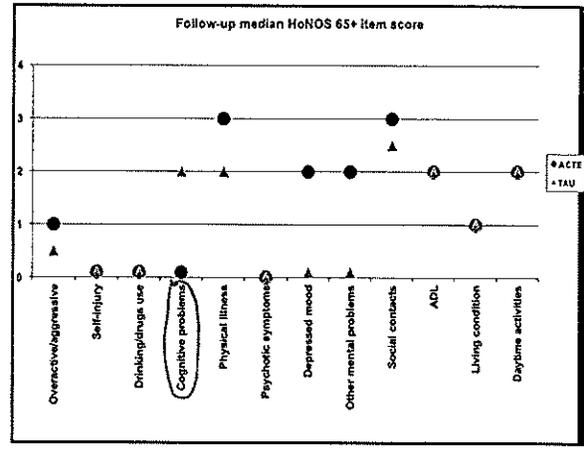
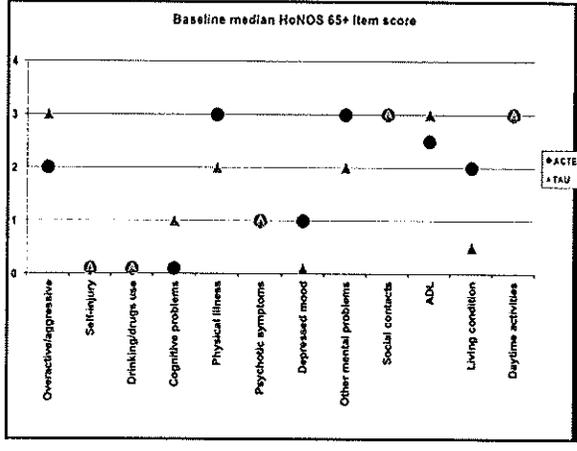


Missing home

Most Disruptive
 Women (66.7%)

Avg age 74

Schizophrenia spectrum d/o

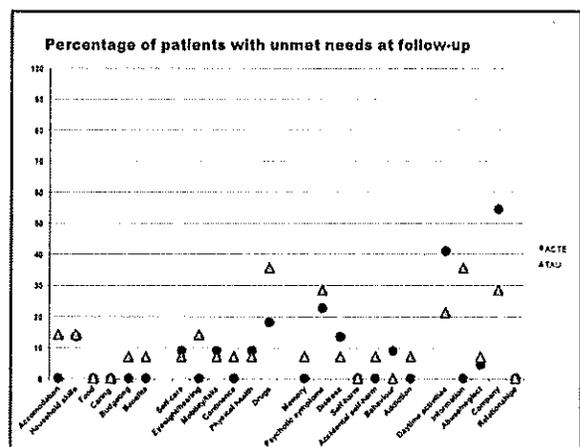
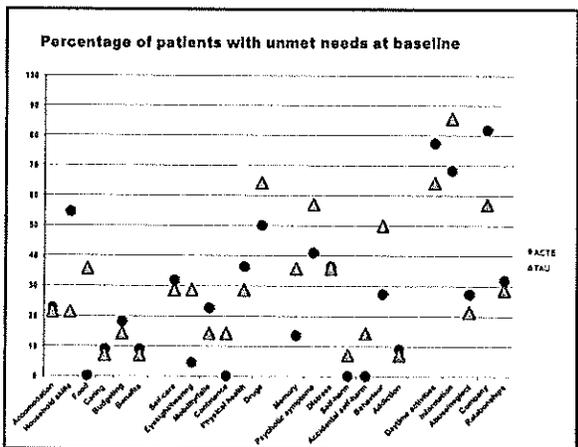
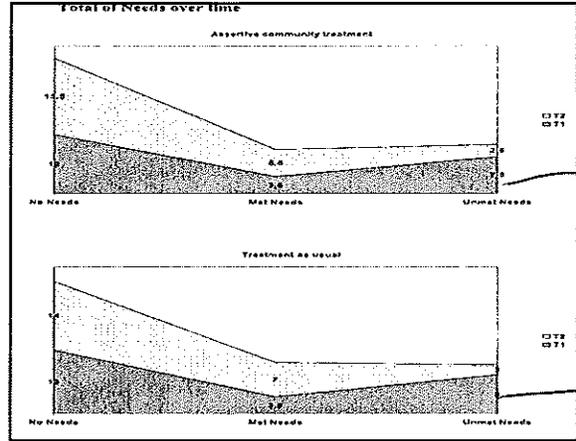


Secondary Outcomes
↓

Models of significant change from baseline to follow-up. Data presented as n (%) in ES

Intervention group (HoNOS 65+)	Threshold	Significant deterioration	No significant change	Significant Improvement
ACTE n 22 (%)				
ES medium	4	1 (4.5)	9 (40.9)	12 (54.5)
ES Large	6	0	14 (63.6)	8 (36.4)
TAU n 14 (%)				
ES medium	4	3 (21.4)	6 (42.9)	5 (35.7)
ES large	6	2 (14.3)	7 (50)	5 (35.7)

ES: effect size, RCI: reliable change index



No significant differences

Slower pace of contacts

Mobility problems

Don't like psychiatric practitioners

Cognitive impairments
somatic problems

Exclusion criteria is severe cognitive impairment

Admission days and crisis contacts

There were hardly admissions and crisis contacts 2 years before and after randomization in the study

Due the small numbers of patients with admission (days) and, with crisis contacts these variables were not analyzed



Summary

Despite the lack of power of the study, the results showed that:

ACTE patients better engaged in care within 3 months after announcing, and

ACTE also was more able to sustain contact with patients, compared with TAU.

Our results demonstrate no differences between TAU and ACTE in change in psychosocial functioning and unmet needs over time.

Also seen in a Dutch study in 2007

Is adding a geriatric specialist to an ACT Team enough to effectively treat?

Elderly with severe mental illness who are difficult to engage can benefit from ACT

Conclusion



Thank you for your attention



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ACTE in Orange County, CA + Michigan

Things seen - less inpt & hoops but
↑ police contacts, 911 calls, + ER visits

Handling a big problem of elderly. Netherlands have "clean up teams" to clean up