Jan 2020

Dear Colleagues,

We have over 40 years of worldwide ACT research and clinical experience. We know what works and what matters:

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

PROPER FUNDING

- Funding for Ontario ACT teams varies dramatically ($800,000 - $1,700,000).
- Quebec teams get 1.3 million each. British Columbia teams get $1.7 million each.
- Unfortunately, some hospitals and agencies redirect part of their ACT funding to other service areas within the organization.
- You simply can't follow the provincial operational standards and you can't provide good clinical service if you are underfunded.
- Each of the 21 community agency sponsored ACT teams in Ontario should be receiving a minimum of $1.3 million annually.
- Each of the 60 hospital sponsored ACT Teams in Ontario should be receiving a minimum of $1.6 million annually.
- ACT teams save money; it is one of the most well researched and cost effective mental health service models in the world.
- For every $1 million dollars invested in ACT teams there is at least over $4 million in savings.
- Between 2014-2017 the Central East LHIN tracked 204 clients admitted to ACT. Result: 90% bed day reductions; $20 million net savings.
- To underfund ACT Teams is extremely unsound health care policy.

MODEL FIDELITY

Why do we need Version 3.1 of the Ontario ACT Standards?

- to clarify grey areas in the 2005 standards
- to reflect current best practices
- to prevent service erosion and fidelity drift
- to clarify discharge protocols and improve flow-through
- to support stepped care service approaches
- to protect teams from misguided (and well meaning) intrusions by hospitals/agencies that do not understand the importance of fidelity and appropriate client numbers for both cost and service efficacy

As conscientious care providers we need a provincial technical centre, fidelity support resources, a collegial fidelity accreditation process, and clear direction from the Ministry of Health that all teams are expected to abide by the provincial operational standards and thereby provide the best care possible.

STAFF-CLIENT RATIOS

ACT	1:8
FACT	1:16
ICM	1:25
CM	1:25-50

There is a clear service objective: the right client, at the right service level, for the right amount of time, with easy and timely transition across service levels. Modifications to these ratios quite simply result in poorer care and poorer outcomes. The pressure to see more clients with fewer staff reflects a lack of appreciation for the complex work and the necessity of frequent crisis management.

SERVICE SATURATION

- We estimate there are over 7000 heavy service users in Ontario who meet ACT admission criteria but do not have ACT services available.
- There are 2 to 5 year waits for ACT services in some regions. (see OAAF waitlist study)
- There are 81 ACT Teams in Ontario. Given our population, we need 130 ACT Teams (50 more teams would produce additional net cost savings of over $600 million).
- There are 6 FACT Teams in Ontario. Given our population, we need to reorganize our services into 265 FACT Teams.
- We need to properly develop these critical mental health service levels, otherwise we have a huge volume of inappropriate admissions, hundreds of millions in wasted tax dollars, service logjams that increase cost and service burdens at all levels, and most importantly, people living with serious mental illness suffer needlessly.

We hope that collectively we can join our voices in the shared expectation that funders and policy developers will understand, support, and implement all of the elements that we know work best. It is unethical and represents poor fiscal and civic policy to do otherwise.

With warm regards,

John Maher MD FRCPC
President, OAAF