

Manual

Flexible Assertive Community Treatment

Vision, model, practice and organization

by J.R. (Remmers) van Veldhuizen
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Foreword

Assertive Community Treatment (ACT) was introduced in the 1970s by Stein, Test and Marx (Test and Stein, 1978) in the United States. In ACT a multidisciplinary team consisting of 10 FTE cares for about 100 clients with a shared caseload, so that all the members of the team know all the clients. The approach focuses on outreach and on providing persistent and very intensive care and treatment. ACT is indicated for the most severely ill 20% of persons with SMI in the community, in particular hard-to-engage patients at risk of hospitalization, homelessness or neglect. ACT has been implemented very frequently. Broad impact research has been carried out and fidelity scales have been developed. ACT is internationally recognized as an EBM (Evidence-Based Medicine) intervention.

What can the Flexible Assertive Community Treatment model developed in the Netherlands add to such a widely-acclaimed model? Why are we presenting the Dutch version of ACT to an international public in this manual? The reason is that FACT contains beneficial innovations. These innovations first become apparent at the team level, in the daily operation of FACT teams. However, the FACT model also creates opportunities for innovation in a broader field, namely the organization of community mental health care services for SMI individuals in the community.

On average, a multidisciplinary FACT team of 11–12 FTE monitors 200 clients. The target group is the broad group of all individuals with SMI in a catchment area: both the 20% for whom ACT is indicated and the other 80% of the group, who need less intensive treatment and support. To combine care for these two groups, the FACT team employs a flexible switching system. The group requiring the most intensive care is discussed daily and for this group the team adopts a shared caseload approach. The names of these clients are listed on the digital FACT board. For the clients requiring less intensive care, the same team provides individual case management with multidisciplinary treatment and support. When clients become more stable, they do not have to be transferred (as in ACT, through ‘graduation’) to a different team; they stay with the same FACT team. This flexibility to switch between the two modes of service delivery in the same team enhances continuity of care and reduces drop-out.

This system also provides better opportunities for recovery, recovery support and rehabilitation. As soon as a client receiving individual case management is at risk of a recurring psychosis or hospitalization, the same team immediately switches to intensive ACT. This combination of flexibility and continuity ties in well with the natural course of SMI with its recurring episodes and relapses.

When the FACT teams started to operate, this also led to a rethinking of the broader mental health care system. We developed the FACT model with the aim of combining

- * recovery-oriented care
- * evidence-based medicine and best practices
- * integrated community and hospital care.

Within FACT, the Strengths model (Rapp et al., 1998), Family Interventions, Integrated Dual Diagnosis Treatment (IDDT) and Individual Placement and Support (IPS) are all incorporated into a system which treats clients in accordance with the guidelines for schizophrenia.

FACT teams are district-based: a FACT team provides care for all individuals with SMI in a particular neighbourhood or district of approximately 40–50,000 inhabitants. This facilitates collaboration with other social services and with GPs. They operate in accordance with the typically Dutch model of ‘transmural care’¹. The FACT team is not only a gatekeeper for the hospital, but also stays in touch with the client during his or her admission and retains the overall coordination of the client’s treatment.

Up till now Dutch mental health services have been relatively well funded and the availability of these services has been ensured. It was in this favourable environment that we were able to develop FACT, which is now a complete model. While FACT care is relatively expensive, it also generates psychiatric, social and economic benefits. Clients, family and partners are positive about FACT. As a result of FACT, neglect and nuisance issues are addressed, more people with SMI have a chance to obtain paid work and the number of hospital beds can be reduced. People with SMI can function in the community, outside psychiatric institutions, provided they receive sufficient support and treatment.

The FACT model was developed in the Netherlands by J.R. van Veldhuizen (psychiatrist) and M. Bähler (psychologist). The first FACT teams were set up at the GGZ Noord-Holland Noord (Northern North-Holland Mental Health Service) in Alkmaar from 2003 onwards. Based on real-life experience, the FACT model was developed further. Now, in 2013, there are about 200 teams in the Netherlands and in some areas the FACT model has been fully implemented. Growth to 400–500 FACT teams is predicted².

A fidelity scale was created in 2007 (Bähler et al.) and in 2008 a Dutch FACT manual was published (edited by Van Veldhuizen, Bähler, Polhuis and Van Os). The Certification Centre for ACT & FACT teams (www.ccaf.nl) has already certified 100 teams. By the end of 2013 there will be 150 certified teams. Teams are also starting in Belgium. In Hong Kong, Norway, Sweden and the UK, mental health service practitioners and organizers are looking into the possibilities of integrating the principles of FACT into their existing systems.

Apart from one publication in English (Van Veldhuizen, 2007), no description of the model in a language other than Dutch has appeared previously. The present manual provides a compact account of FACT’s vision, the model itself and the way it is used in the day-to-day delivery of care, and the model’s organization. Policy makers and experts who want to start using the FACT model will find all the information they need here. It is a practical book, with only limited research data and references. We will discuss the key models set out in the Dutch FACT manual and also cover new developments.

This manual is intended for international mental health care practitioners. Specific Dutch situations are explained, but they are not the main focus. Comparisons are made with other countries. We hope that this will make the FACT approach accessible for our international colleagues.

We would like to thank Margaret Kofod for her translation.

¹ ‘Transmural’ care is a Dutch concept which will be explained in further detail in the following chapters. The core of the concept is that admission to a clinic or partial hospitalization is always regarded as ‘time out’ in the broader framework of outpatient care provided by a FACT team.

² The Council for Public Health and Care (an advisory body to the health minister).

Due to financial contributions from four mental health care organizations in the Netherlands, this manual can be downloaded free of charge from several websites. We would like to thank these four organizations:

- * GGZ Noord Holland Noord
- * GGZ Breburg
- * GGZ Mondriaan
- * VNN (North Holland Addiction Services)

These four organizations will also be happy to provide information for international contacts. The names and email addresses of the contact persons are listed at the front of the manual.

The same applies to the Certification Centre for ACT and FACT (www.ccaf.nl) and to the association of practitioners working in ACT and FACT in the Netherlands: F-ACT-Nederland.

This manual was presented at the second international conference of the EAOF (European Assertive Outreach Foundation) in Aviles (Spain) in June 2013. (www.eaof.org)

The authors hope that it will benefit many people and we are keen to hear your feedback. We hope you enjoy reading it and that you will draw inspiration from it for the ongoing improvement of care for people with SMI, wherever they may be in the world.

J.R. van Veldhuizen, psychiatrist

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Prologue A: FACT in a nutshell

FACT teams provide long-term care for people with severe mental illness who are not in psychiatric hospitals. In addition to psychiatric problems, these people have many limitations in their social functioning, for instance in relation to housing, self-care, employment and finances. It is difficult for them to participate in society, to 'belong'. Their support systems and contacts are often limited. Family is very important, but sometimes family is kept at a distance.

FACT is a broad biopsychosocial model, providing (a) management of illness and symptoms (treatment), (b) guidance and practical assistance with daily living, (c) rehabilitation and (d) recovery support. One integrated team provides all of this.

FACT aims to ensure continuity of care, to prevent admissions to psychiatric hospitals and to stimulate inclusion, so that clients can participate in society.

A FACT team provides care for 200–220 clients in a particular district or region of 40,000 to 50,000 inhabitants. This is why we refer to 'district' or 'neighbourhood' teams. The team tries to establish close contacts with the family and with other services in the district. The team is multidisciplinary, with members from a wide variety of disciplines (including a psychiatrist, nurses, a community psychiatric nurse, a psychologist, an employment specialist (IPS), an addiction specialist and a peer support worker); approximately 10-11 FTE.

The multidisciplinary team can switch back and forth between two modes of care delivery:

- 1. Individual case management by a member of the team*
- 2. Intensive (ACT) team care, which involves the clients having contact with several team members; these clients are listed on the FACT board and the team discusses them every day to decide which form of care should be provided and by which team members.*

In both situation 1) and 2) the care is provided at the client's place of residence. As a result, the care is more personal and the client's care needs become more specific. For instance, better use is made of sources of help in the family and possibilities in the neighbourhood. For most clients, individual supervision (1) suffices. But if a psychosis recurs (or threatens to recur), if hospitalization is imminent or if an individual needs extra care for some other reason, the care is stepped up (2). This may be long-term, but it may also be short-term. Once the crisis is over, the team switches back to individual care (1). This flexible switching seems to be the response needed for the natural course of severe mental illness with its remissions and relapses.

- 1. Clients receiving individual support are not listed on the FACT board. They always have a case manager and a psychiatrist. Other team members can also be called upon for specific components of treatment or support (for instance the addiction specialist or the psychologist for CBT).*
- 2. The names of clients receiving intensive team care are listed on the FACT board, which is an Excel spreadsheet beamed onto the wall. Every morning the team meets to discuss the FACT board and decide which team members will visit and supervise the clients.*

At least once a year the multidisciplinary team discusses each client's treatment plan (including crisis and rehabilitation plans) with the client, using up-to-date information from the HoNOS and MANSA or similar instruments. FACT teams work during office hours. Some teams also visit clients at home during weekends. Every region in the Netherlands has a readily accessible psychiatric emergency service, available 24/7. FACT teams work in close conjunction with regional inpatient clinics.

Prologue B: A personal story

I am 40 years old, I live alone and I have suffered from psychoses since I was 20. The first time was terrible. I didn't understand what was going on. I became alienated from my family. Eventually I was forcibly admitted to hospital on a court order. After that I was admitted several more times. That was very hard for me, being on a ward with other people who also have a lot of problems. You see all sorts of things, including suicides.

Over the years they explained about my illness and how to cope with it. That helped me to accept that I need medication, even though I really don't like it. The first 10–15 years of my illness I had very little perspective. Everything revolves around your illness. I dropped out of my studies, first lived in shared accommodation, but often had relapses and was admitted again. Support outside the hospital was not very intensive. I went to the outpatient clinic once every 4 to 6 weeks to talk to my doctor about my medication. Apart from that I had a nurse counsellor. Usually I went to see her at the surgery, but if I got confused again she came to see me, often to arrange for an admission.

Over the past eight years the support has changed. I'm now looked after by a FACT team. They come to see you more at home, they want to talk to you in your own environment. And they now help me at home to tackle things properly, to really make something of it. I have a treatment plan which includes appointments with the peer support worker and the IPS worker.³ The peer support worker is a patient himself, but also a member of the team. Everything is a bit more familiar to him. It helped me a lot to talk to him about those hospital admissions. Then the team psychologist gave me EMDR therapy and those images didn't bother me nearly as much any more. The peer support worker also set up a recovery group – a small group of clients where we can talk about things you can do to make your own life more worthwhile.

The IPS worker helped me to get a job, 3 hours a day, 4 days a week, with a regular company. That was tough at first, but he really trained me to do it and now I can. It doesn't pay very much, but it feels much better than the activities I used to do at the day centre. I still go there occasionally, but more for the company or for a meal.

The nurse is still my case manager. I've set up my treatment plan with her and the psychiatrist. She also has contact with my family and my neighbours. That's handy, because if I'm in danger of becoming confused again, I have some noticeable habits. I keep the curtains closed the whole day and don't say hello to anyone any more. If the neighbours see this, they ring the team and someone comes. Last year, due to various circumstances (my sister was ill and I'd been robbed) I got pretty confused again. I also started taking drugs again. Then

³ IPS stands for Individual Placement and Support, a method of active assistance for vulnerable people to find and keep paid work.

people from the FACT team came around every day, to bring medication, to talk about my sister and to report the theft to the police. They also told my work I wasn't coming for two weeks. The psychiatrist came to see me at home too. He also met my mother.

It really makes a big difference if there's a whole team of people around you. If you need a lot of care, it's almost like being in hospital at home. But it's in your own environment, and you know all the people. I got out of the bad patch very quickly. Now I'm only seeing the case manager and the recovery group. Soon we're going to do a project with neighbourhood community work. All in all I'm quite content now.

Prologue C: A morning FACT team meeting

Every working day at about a quarter past eight the team members arrive for the FACT board meeting. They get a tea or coffee, chat for a while and then sit down around the table with their diaries. Every day you work, you start here – it's part of the job.

Nurse Rick starts up the digital FACT board. The beamer projects the Excel sheet onto the white wall. Today Rick is the FACT board chair. He and two other team members, Anna and Hans, have had training to chair the meetings. Today Anna is sitting at the PC and making notes in the Excel sheet, so that all the team members can immediately see on the FACT board on the wall what has been agreed.

Rick starts. The names of about twenty people are listed on the FACT board; these people are discussed every day. They are divided into groups which show why they are on the board: a group who need short-term intensive care, a group who need very long-term, almost daily care, people who have been admitted to a psychiatric hospital or an ordinary hospital, people who avoid treatment and new clients.

For each client, the board lists the name, a short diagnosis, the reason why they are on the board, the client's goals, what action the team is going to take, who the contact person or family member is, and who is going to visit the client at home.

Client Ella is discussed. She has been receiving intensive team care recently. She has a severe bipolar disorder and has been very busy the last week. She has been doing risky things, getting upset with people she otherwise gets on well with and is in danger of becoming exhausted. The team visits her every day. Fortunately she accepts her medication and is now settling down a bit. Today the psychiatrist and the case manager are going to see her at home to see what else she needs. Tomorrow another nurse will visit her, and today her own case manager will ring the family. She needs to have lithium injections. Normally she has them at the lab, but now it's better for her to have them at home. The psychologist asks: do we actually know why she suddenly lost the plot again? A discussion arises. The peer support worker heard from another client that Ella had been badly hurt. She had an internet date who pulled out when he heard she had psychiatric problems. That might have something to do with it; the team members visiting her at home will ask about it. It also turns out her lithium blood levels were too low over the past few weeks. This also requires attention: her medication packs should be checked. Rick summarizes the tasks, Anna puts them on the FACT board. Tomorrow the team will check that the tasks have been carried out.

Over the past week client Jeanne has had intensive care for a recurring psychotic depression, with suicidal thoughts and a tendency to neglect herself. Yesterday morning the FACT team admitted her (with her consent) to the psychiatric clinic. Even two home visits a day was not enough to guarantee her safety. The risk that she would get worse was too great. In the past, not only Jeanne, but also the team have postponed admission in a situation like this. This resulted in danger, suicide attempts and often ultimately compulsory admission. Now things are done much more in consultation. The 'support system' box after her name is empty – which is not a good sign! The team makes appointments for treatment at the clinic. The psychiatrist will talk to the clinical psychiatrist about medication and about what lab tests are needed. The community psychiatric nurse will talk to Jeanne again about whether she has any family or other sources of support. Perhaps contact can be reestablished while she is in hospital. The case manager will visit her twice a week at the clinic and will make sure her house is clean again. The team thinks she will probably stay at the clinic for 2 to 3 weeks. Anna records the arrangements on the FACT board, including a note for two weeks later: discharge from clinic?

Tom is a new client, passed on yesterday by the Centrum Geestelijke Gezondheidszorg (CGG - Mental Health Care Centre), which provides treatment for a variety of diagnosis groups. The CGG tried for two years to get Tom into treatment. The diagnosis was personality problems and anxiety. The treatment was not a success: Tom often missed appointments, there were signs of substance abuse, and now things also seem to be going wrong on the social front – eviction due to rent arrears was imminent. It was impossible for an outpatient clinic to deal with all these problems. The FACT team makes arrangements. Tom is assigned a case manager, who will identify and list the problems and if necessary consult the community psychiatric nurse. The psychiatrist will talk to him at home, the psychologist will invite him to make an appointment and the peer support worker will visit him (and will look for his strengths and for possible ways to motivate him). This is all recorded on the FACT board and in 3 weeks' time there will be a multidisciplinary team meeting to develop a treatment plan. Twenty 'board clients' are discussed along these lines.

Then Anna opens the 'cases to discuss' worksheet. Rick asks the team if they have any cases to discuss and four team members each mention the name of a client. These are people who are not on the FACT board, but are monitored by the team. They do not require daily discussion. Their treatment is provided by their case manager in conjunction with the psychiatrist, the psychologist or the IPS worker. Their treatment plan is evaluated and updated once a year (at the treatment plan meeting). But sometimes a team member thinks the team needs to be told about something that has happened and sometimes the case manager needs help from someone from another discipline. These are the 'cases to discuss'.

The IPS worker mentions client Max: Max is going to start a paid job this week. He is proud of this, but he's also a bit tense about it. If team members bump into him, please wish him good luck!

Client Bart, a young man who experienced a great deal of loss after a first psychosis, is on the right track. He talks to the psychologist about the changes in his expectations for the future and about his loss. His former friends and fellow students are about to graduate, whereas he... The psychologist says it's on the cards that he may send out a distress signal. She indicates what should be done if this happens. This is heard and noted.

A case manager mentions another young man. He is reasonably stable, but drugs seem to be playing an increasingly prominent role. The case manager wants the team's addiction specialist to visit this man and she wants a meeting with the psychiatrist in 3 weeks' time to determine the best strategy. This is arranged.

The last client is a woman with schizophrenia and alcohol abuse. The case manager reports that there have again been incidents. Neighbours have called the police. Rick says: 'This woman was one of the "cases to discuss" a couple of times last week as well. In view of all these reports, it seems better to put her on the FACT board. Let's visit her every day and make sure several people speak to her. Then we'll discuss next week whether the strategy should be adjusted'. This is agreed. Anna records the decisions and the names of the team members who will visit this woman over the next few days.

Finally Rick asks if there is any other business. One of the case managers mentions that she is taking a short holiday. Team care for her clients on the FACT board is already guaranteed, but she would like someone else to visit a few other people. This is arranged. There are new community work leaflets offering various activities. The team mentions the names of people who could sign up for these; their case managers will give them the leaflets. Management has sent an email to say that certain forms must be handed in within a week. The team members sigh and write it down in their diaries. No-one else has any other business, and after exactly half an hour Anna shuts down the PC. All the arrangements and appointments have been made, the building empties; most of the team members are off to do home visits.

Chapter 1: An initial exploration: patients with SMI, their needs, their care

1. 1. For which groups of patients do ACT and FACT provide care?

FACT is a further elaboration of Assertive Community Treatment (ACT), which was developed by Stein and Test (Test and Stein 1978) in the United States. Stein and Test's ACT model focused on the most vulnerable 20% of people with severe mental illnesses. This group had a very high percentage of people with psychotic disorders, usually combined with addiction problems (dual diagnosis). Many of them had recently been in hospital (sometimes for a long time) and were caught in the 'revolving door' between the hospital and the community. Many of them had major housing and financial problems. Often they had little contact with their families. Care for the remaining 80% of severely mentally ill people was not discussed in detail in the ACT model, but the point of departure was that it would be provided by other, less intensive teams.

With FACT (Flexible ACT) we opted to provide services for 100% of people with SMI; in other words, FACT teams deliver care and treatment for the *whole* group of people with SMI.

In the Netherlands, the group of people with SMI has been defined in a consensus document. To be included in the target group of the severely mentally ill, an individual must meet the following five criteria:

- has a psychiatric disorder which requires care and treatment (\approx is not in symptomatic remission)
- has severe limitations in social and community functioning (\approx not in functional remission)
- these two criteria are related to each other (the limitations are the cause and consequence of the psychopathology)
- these problems are not transient in character (they are systematic and long-term)
- coordinated care provided by care networks or health care practitioners is needed to implement the treatment plan.

In terms of the DSM-IV: 'severe' diagnosis on axis 1, frequently also personality disorders (axis 2). On axis 3, complicated medical and neurological problems often play a role. On axis 4 there are psychosocial and environmental problems. Patients with SMI have low scores on functioning (axis 5). The limitations are systematic and long-term, so that coordinated care is needed. The SMI population varies as regards age, background, problems, life course and social and economic circumstances.

The largest group have psychotic disorders. Other common disorders are affective disorders (depression, bipolar disorders), personality disorders, organic disorders, autism, ADHD, developmental disorders, addiction problems and combinations of these.

The individuals in question have severe problems in several areas of life such as physical health, keeping or finding work, obtaining training, functioning in the community and maintaining personal relationships.

1.2. What do SMI patients' problems mean for their care needs?

People with SMI vary just as widely as people without SMI. However, many of them not only have recurring psychoses or depression and addictions, but also characteristic limitations. Sometimes they have problems with organizing things, sometimes they are slack, and sometimes they find it more difficult to understand things. Often they have weaker social skills and are vulnerable. Sometimes they have problems with domestic and physical hygiene. They go through periods of anxiety or mental problems. Their contacts with their family or support system are often not so stable. They have fewer social contacts and close friends. They are less often married. Few have paid jobs. They have major questions about the meaning of life. They have more contact with fellow sufferers. Partly due to this, they have more experience with loss (acquaintances who become psychotic again, hospitalizations, suicides, etc.) It is difficult for people with SMI to function in society; they often have problems with employment, money and housing.

Whoever reads the above definition will understand that the medical and psychiatric problems of people with SMI lead to problems in practically every area of social functioning. People began to realize this from the beginning of the nineteenth century onwards and started to put such individuals in institutions. The institutional environment was supposed to provide solutions to all the social problems: housing, hygiene, financial management and control of substance abuse were all dealt with by the institution. Doctors and nurses could focus on the 'medical' treatment of medical symptoms. Institutionalization was seen as a 'salutary exclusion from society'.

At first this seemed like a humane solution; but in the long run the people with SMI in mental hospitals turned out to be exclusively 'patients' in medical total institutions. The institution's social roles (those of landlord, employer, family member, neighbour) disappeared. Although psychiatric hospitals continued to develop in the next century and old treatments were replaced by medication and occupational therapy, the tendency for the hospital to take on many social roles and responsibilities remained. Within the hospital the patients did not learn any skills that would help them to cope in society after they were discharged from the hospital. This was why admission became the strongest predictor of readmission.

Around 1920 -1930 there was a growing body of opinion that psychiatric care should be provided in a more social context. In Amsterdam, Arie Querido set up a crisis team which showed how hospital admissions could be prevented or curtailed. But it was actually not until 1975 that a real alternative to hospitalization became available for people with SMI. It was then that Stein and Test (Test and Stein 1978) started their 'Training in Community Living' programme in the United States. They helped the patients not only with medication, but also with housing, finances, maintaining their support system and family contacts etc. It became clear that helping patients in their own environment (outreach) was an essential criterion. In addition, the help had to be assertive: the care practitioners had to actively look for the patients, actively help them to find solutions and actively work with support systems. In many cases the patient's motivation was not strong enough, so care workers had to be persistent and persuasive. This was how 'assertive outreach' was born. Later Stein and Test developed the Assertive Community Treatment (ACT) model on the basis of this project. It became clear that the delivery of care could not focus only on medical and psychological aspects. It really did need to involve 'training in community living' and providing active support in a wide range of social and community activities.

1.3. What does community care for people with SMI require?

The development of the FACT model was mainly inspired by American, British and Australian literature from the 1980s onwards. Intagliata (1982) described the components of case management that is personal and links clients to services. Bachrach (1993) discussed the importance of continuity of care, including the continuity of outpatient care during a hospital admission. Stein and Test (1978) stressed the importance of working with shared case loads, with the whole team knowing the client. Bond and Drake (2001) discussed the formation of models, drew attention to the importance of helping clients to find paid jobs, of integrated addiction treatment and of social interventions.

From 2000 onwards work was done in the Netherlands on the development of the first *Multidisciplinaire Richtlijn* (Multidisciplinary Guideline) (2005, revised in 2012) for the treatment and care of people with schizophrenia. This guideline set out evidence-based interventions and best practices based on scientific analyses. It became clear that any form of care for people with SMI (therefore including FACT) would have to be able to provide the interventions set out in the guideline. This meant for example that not only a psychiatrist was required, but also a psychologist for interventions such as cognitive behavioural therapy. Clearly, FACT had to be able to deliver not only care, but also treatment.

Around the same time, health care practitioners in the Netherlands began to focus on recovery, recovery-oriented care and the Strengths Model. In the Netherlands, recovery refers to a stream in the client movement, according to which people should work towards their own recovery. The aim is not recovery from the disorder, but recovery with the person's limitations; clients give their own meaning to their limitations, learn to cope with them and develop their own strengths. These are processes which care practitioners should not take over or take away. Care practitioners should support clients who are finding their own way, in conjunction with other clients and peer support workers. The recovery vision has become a leading vision for Dutch mental health services and has also been incorporated into FACT.

In other words, a FACT team must be able to provide recovery-oriented care. An important step towards achieving this was the decision to include a peer support worker in every team. This is a person who can provide the team and the clients with information based on their own experience with mental illness and recovery. They work as full team members.⁴

1.4. The seven C's: care requirements for people with SMI outside psychiatric units

The FACT model was developed with inspiration drawn from ACT, the Dutch multidisciplinary guideline and the recovery approach. The practical implementation of FACT reveals which interventions and which therapeutic and support activities need to be deployed. When the first 20 to 30 FACT teams were developed, it became clear which factors were essential in the care for and treatment of people with SMI in the community. We have summarized these requirements in an overview of categories which all start with C: the 'seven C's'.

⁴ In the Netherlands, a peer support worker is a paid member of the team, in a regular position, who contributes to the team on the basis of his or her own experience with mental health services. Other terms with the same meaning are 'experiential expert' and 'consumer consultant'.

Table 1.

	The seven C's:	Care requirements for people with SMI outside psychiatric hospitals (community treatment)
1.	Cure	<ul style="list-style-type: none"> • Evidence-based treatment, focused on cure, stabilization or making the situation tolerable, in keeping with the multidisciplinary guidelines which have appeared in various countries • Treatment by doctors or nurses • Psychological treatment (cognitive behavioural therapy, metacognitive therapy, EMDR⁵, etc.) • Addiction treatment; IDDT⁶ • Somatic screening/treatment (metabolic screening)
2.	Care	<ul style="list-style-type: none"> • Daily support, guidance • Nursing guidance, assistance with daily living, preventing self-neglect, attention for hygiene • Rehabilitation • Recovery-oriented care • Continuity of care; preventing drop-out
3.	Crisis intervention	<ul style="list-style-type: none"> • Intensive supervision and care at the client's home with a shared caseload • 24/7 accessibility • Crisis intervention, risk assessment • Emergency admission, short-term, 'bed on request' • Involve family/support system
4.	Client expertise	<ul style="list-style-type: none"> • Use the client's experiential expertise • Shared decision-making (SDM) • Recovery-oriented care • Empowerment (Strengths Model) • Interventions of the peer support worker
5.	Community support	<ul style="list-style-type: none"> • Family contacts • Community support system • Support regarding housing, work and well-being • IPS: individual support in finding and keeping a job • Promote inclusion of clients • Prevent nuisance
6.	Control	<ul style="list-style-type: none"> • Risk assessment and safety management for client and environment • Prescribe and implement compulsory mental health care interventions on court orders in the event of danger • Sometimes forensic care (at the request of the court)
7.	Check	<ul style="list-style-type: none"> • Evaluation of the effects of the treatment • Routine Outcome Monitoring • Evaluation of the care and treatment strategy • Certification

⁵ Eye Movement Desensitization and Reprocessing.

⁶ Integrated Dual Diagnosis Treatment.

The 'seven C's' are an ambitious set of requirements. All interventions must be available at all times. However, they are not offered to one client at the same time. For each client a treatment plan is developed with a selection of the various components of the seven C's. Choices have to be made, by the clients themselves and by the treating practitioners. This requires needs assessment, coordination and planning. The selection process is supported by information from rating scales which have been completed partly by the client and partly by the case manager. The most commonly used scales are the HoNOS,⁷ the Mansa⁸ and the Canzas.⁹ They supply information about the various areas of life and the client's symptomatology and satisfaction regarding the care service delivered. Along with the goals towards which the client wants to work, these outcomes contribute to the treatment plan. These scales are completed once a year; this is referred to as Routine Outcome Monitoring (ROM).

An interesting feature of the seven C's is that some of the requirements seem to be almost incompatible. For instance, recovery support seems to be at odds with compulsory treatment. This does in fact lead to difficult decisions. It also sometimes happens that the client's wishes run counter to the wishes of that client's family or environment. These clashes must be discussed with the client and the family. In such situations it is of great value that the various disciplines in the team can look at the problems from different angles and perspectives. The perspectives of the peer support worker, the psychologist and the social worker complement the views of the doctors and nurses, which can be helpful in finding solutions.

The seven C's show that we have to determine *what* we are going to do, *when* we are going to do it, and *who* is going to do it. To some extent these are long-term decisions made when the treatment plan is developed, but often it is also necessary to respond to changes and to modify the *who*, *what* and *when* almost every day. This means that a team has to meet several organizational criteria, which are set out below.

1.5. Requirements for teams delivering the seven C's

1.5.1 Good coordination

The FACT model is a service delivery model. The model enables a team to deliver the seven C's, but that team must be well coordinated. Decisions have to be made about various interventions; what should be done first, what should be done later. In the FACT board, the FACT model has a mechanism to effectively coordinate the various activities within one team. Coordination takes place at the daily morning FACT board meetings and at the regular treatment plan meetings (once or twice a year per client). Good coordination is essential not only for treatment and supervision, but also for the many external contacts the team has to maintain: ringing up family members, making contact with neighbourhood bodies, etc.

1.5.2 Integrated team, not a brokerage model

With FACT, most of the interventions are carried out by members of the team. As few services as possible are provided by other teams or agencies. This is why the team is called an 'integrated team'. This vision is based on important lessons learned in the United States in the 1990s: it turned out that the 'brokerage model', in which one care manager arranges for

⁷ Health of Nation Outcome Score (Wing et al. 1998).

⁸ Manchester Short Assessment of Quality of Life (Priebe et al. 1999).

⁹ Camberwell Assessment of Need Short Appraisal Schedule (Phelan et al. 1995).

assistance to be provided for each client by various bodies, was not as effective as an integrated team.

In an integrated team the interventions needed are divided among the team members. This happens at the FACT board meetings, which saves many telephone calls and time spent on coordination with other services. Moreover, the individual who is going to carry out an intervention has attended the meeting and therefore knows what the intention is.

Monodisciplinary teams, individual case management and brokerage

In the 1990s nurses also worked in the Netherlands as individual case managers for people with SMI in many regions in the Netherlands. Their case loads were high (1: 40–60). The nurses worked in teams, but within a team everyone worked individually. If a client had a crisis, the individual case manager could only visit the client at home twice a week at the most, and no team care was provided. The teams were monodisciplinary. The psychiatrist worked at the outpatient clinic. A referral to the psychiatrist (for assessment or medication) often took too long. When case managers thought extra care was needed, they had to arrange for it to be provided by other services. This meant a lot of time was spent coordinating. In many cases, eventually patients' need for more intensive care led to hospitalization or sometimes acute day care (partial hospitalization).

In this situation there was insufficient coordination and continuity between outpatient and inpatient care. The outpatient practitioners were not involved in treatment while the patient was hospitalized and only came on the scene again when follow-up treatment had to be arranged.

The brokerage model was abandoned, because it did not work well. The nurses who were placed in the role of broker often spent more time on the telephone with other services than they did visiting patients. Moreover, they were in a difficult position because there was little room for consultation or mutual support.

1.5.3 Multidisciplinary teams

The seven C's can only be delivered to the patient by an integrated, multidisciplinary team. The psychiatrist, the nurse, the social worker, the psychologist, the IPS worker and the peer support worker each have their own expertise and perspective. Because they work together and meet every day, they also develop a joint vision and style. The different disciplines represent different kinds of solutions for daily problems; at the morning meetings, the team discuss the various interventions in relation to each other and decide on the order in which they will be offered.

1.5.4 If necessary, a shared caseload

Working with a shared caseload was developed in the ACT model. Instead of having individual caseloads, the whole team shares cases, so that several members of the team visit clients at home or support them in other ways. This team care means that the client receives intensive care and treatment from several or all members of the team. Thanks to the morning meetings, these different people and disciplines can develop and implement the treatment plan consistently together, each making his or her own personal contribution. FACT has adopted the shared caseload model for the group of clients who need stepped-up care at some point.

1.5.6 Flexible switching

Not all clients need the shared caseload model. For many clients individual contact with their own case manager is enough, supplemented by the occasional meeting with the psychiatrist, contact with the peer support worker or assistance from the IPS worker.

This is why we have divided the clients into two groups: (1) the intensive care group and (2) the less intensive care group. The division into these two groups corresponds *to some extent* with the division made by ACT into a 20% group (the most severe cases) and an 80% group (less severe cases). The difference is that with FACT (a) both groups receive care from the same team and (b) clients are sometimes in one group and sometimes in the other; that is, depending on the situation, a client may be in group 1 or group 2, but will still receive care from the same team.

To serve both groups well, a single team must be able to deliver both individual case management and ACT. To do this, FACT has a switching mechanism between less intensive and very intensive care. The team meets every day. The clients who need intensive care (\approx the 20% group) are listed on the digital FACT board. They are discussed daily and receive team care on the basis of a shared caseload. Every day the team can check whether at that particular point a client should be included in the 20% group or the 80% group. If it is the latter, the client will not be listed on the board and their own case manager will provide most of their care. This switching mechanism is the crucial element of ‘Flexible ACT’.¹⁰

1.5.7 Working with a clearly-defined model

The FACT model provides a consistent system and working procedures. However, the model is not a straitjacket. It has proved that within this system teams have enough room to develop their own style. This is in keeping with the high regard held in the Netherlands for ‘self-guided’ teams, with plenty of room for development within a clearly-defined model.

The consistency of the model is also important in connection with administration and funding, because often one organization has several FACT teams. On the other hand the distinctive identity of the team is also important: it means that the specific expertise and strengths of the team members are better utilized. A FACT team must also be able to connect with the community or region in which they are working; they have to be willing to respond to local problems and able to collaborate with local services.

Teams can assess their model fidelity by using a scale: the FACTs (FACT scale), which has 60 items about the members, working procedures and organization of a team. This is described elsewhere in this manual.

1.6. The strength of outreach

We can safely say that FACT has rediscovered the strength of outreach counselling and treatment. Outreach means care outside of institutions or surgeries; it means home visits, care or counselling relating to social activities, visiting the client at a police station and if necessary caring for homeless people on the streets.

¹⁰ Initially FACT stood for ‘Function ACT’, meaning that the same team could have more than one function. It turned out that this name was difficult to explain internationally; we therefore later opted for ‘Flexible ACT’.

While counselling based in the office of the mental health service or in an outpatient clinic is outpatient care, it is not outreach care. In the Netherlands, until recently outreach care was provided mainly in crisis situations: an assessment was made at the client's home as to whether or not hospitalization was necessary. When clients were not in a crisis, they usually saw practitioners at an outpatient clinic or a day centre.

Within the FACT model, outreach (visiting the client at home) is the standard procedure for contact with the client; that is, not only when clients are in crisis, but also to monitor and support them in more stable phases. More than 80% of case managers' and peer support workers' contacts take place outside the team's office. Psychiatrists are at least familiar with the client's home situation and regularly accompany case managers on home visits. The psychologist can provide on-the-spot training and the IPS worker usually works on an outreach basis with clients and their employers.

Inspired by ACT and the Strengths Model, FACT has made home visits standard procedure. This applies both in crises and for individual longer-term supervision of clients who are not in crisis. This has proved to have a major impact on contacts between practitioners and clients.

Diagnosis and other assessments are changed by outreach. The practitioner talks to the client in the client's own environment and is more likely to meet the client's family, and there is a lower threshold for neighbours to ask something or say something. In their own environment, clients can show more clearly what they can and cannot manage, and what assistance they need. It is easier to see what their talents and hobbies are, where their strengths lie and what support is available in their environment. In turn, this makes it easier to help the client find solutions that tie in with their environment. There is evidence from research that on-the-spot training is more effective than training at a day centre.

Home visits and outreach also mean a lot for the relationship between client and practitioner. Care practitioners have to 'blend in' with the client's territory. They are no longer in charge (as they are at the hospital); they have entered the other person's territory, which helps them to accept that other person as they are and which leads to different dialogues.

Outreach also provides information about the client's strengths; care practitioners can see how the client is coping – with life in general, with housing, with the social environment, what contact they have with neighbours; they see what the client likes, what their interests are, perhaps signs of talents that have been neglected, but can be revived. They can respond to these things in the care they provide.

An important new development is the 'self-reliance' approach, in which clients set new goals in relation to their environment and work – with the support of care workers – on tasks they themselves have formulated.

2. Interlude: a summary of FACT in building blocks

2.1 The building blocks of FACT

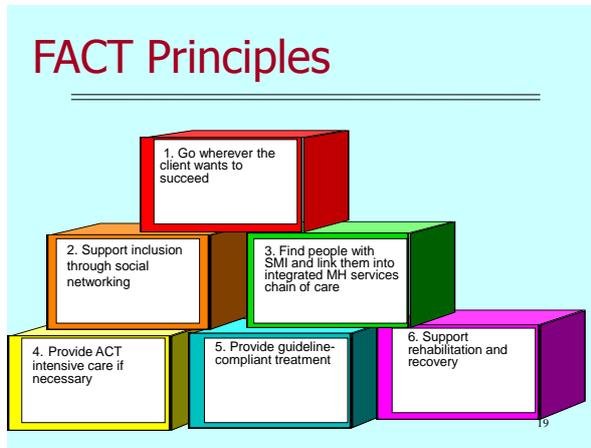


Figure 1.

FACT is sometimes difficult to explain, because so many different components are combined in the FACT model. The diagram above – ‘The building blocks of FACT’ – shows the most important components:

block 1: Go wherever the client wants to succeed

We aim to chime in with the client’s wishes and goals. We go to the client’s home, work, family, or anywhere else where the client wants to participate successfully in society. By focusing on success, we show our confidence in people’s strength and their recovery. This block is consistent with Test and Stein’s observation that training skills in the artificial environment of a hospital has little effect.

block 2: Support inclusion through social networking

FACT aims to contribute to the social inclusion of psychiatric patients. They need to not only live outside the hospital, but also participate in the community. For that purpose, each client needs his or her own social support system. In building this up, the focus is on the client and what he or she thinks is important. Family plays an important role, but so do neighbours, or volunteers and various organizations in the community – welfare organizations, social teams, landlords, the police in the area. The FACT team cannot take the lead in the inclusion process; it has to make use of the existing social networks and collaborate with them. The FACT teams must be well integrated into the community; they must be reliable partners and must meet their commitments. This also involves being aware of safety issues and using compulsion if necessary; if there is any nuisance behaviour or threat to safety, acceptance in the community will soon be lost.

block 3: Find people with SMI and link them into the integrated MH services chain of care

‘Finding’ clients is very important – especially since people with SMI sometimes have little understanding of their own illness and do not seek help themselves. The names of clients are passed on not only by GPs, but also by the police or by community services. FACT can make an initial low-threshold contact to find out what is possible and assess what is needed.

The next step is linking these people in. It cannot be taken for granted that clients will remain in care; often they do not see the need. Many clients find the medication we recommend unpleasant. We therefore have to make sure that some element of the care we offer is attractive; that people find something in it that appeals to them, such as support for their rehabilitation goals. We try to provide care that the clients will be motivated to accept.

FACT aims to prevent hospital admissions or keep them as short as possible, but we also know that sometimes admissions are helpful and necessary. In those cases we collaborate closely with the clinic. In the Netherlands the mental health services are integrated; outpatient care and inpatient care are linked in a system with clearly-defined rules and commitments. An admission is always regarded as an incident in an outpatient treatment programme. This is why the outpatient practitioners remain involved in treatment in the clinic and in determining the date of discharge. We stay in touch with client and if possible take them home from hospital every so often. In this integrated system there are arrangements for short-term part-time treatment and very short admissions.¹¹ Because collaboration with the hospital is so close, 24/7 accessibility can be organized. These days video calls are also used for this; the client has a touch screen at home so that they can have direct contact with the FACT team in the daytime, and with the hospital in the evening, at night and in the weekend.

block 4: Provide ACT if necessary

Once the client's name has been put on the FACT board, the team can immediately start providing intensive team care with a shared caseload. Clients are 'admitted to the FACT board' instead of to an acute psychiatric ward, as used to be the case. This happens 'if necessary': there are criteria for stepping up to intensive care and – after stabilization – stepping back down again to individual, less intensive care. The fact that all this integrated care is delivered by the same team is a crucial element of FACT.¹² FACT does away with the 'revolving door': in good times and in bad, the client has contact with the same team, the same case manager and the same psychiatrist. This is continuity of care.

block 5: Provide guideline-compliant treatment (evidence-based and best practices)

In the Netherlands we have a *Multidisciplinaire Richtlijn* (Multidisciplinary Guideline) for schizophrenia. Internationally the NICE and for example the SAMHSA (toolkits) are known. These sources provide indications as to which forms of treatment should be provided. Many of these treatments are difficult to implement at a traditional outpatient clinic, because clients sometimes drop out again, forget appointments, suddenly have a bad week, etc. With outreach and continuity of care the chance is higher that these treatments will be fully completed. Recently FACT teams started to use 'shared decision-making', an approach in which clients and treating practitioners make joint decisions about the client's treatment on the basis of the client's own knowledge, the psychiatrist's expertise and structured information.

block 6: Support rehabilitation and recovery

¹¹ In the Netherlands we work with a concept called 'bed on request'. There is a very low threshold for a patient to be admitted for one night, and then make further arrangements with their own outpatient practitioner the next morning.

¹² In ACT teams in the United States it is customary for a stabilized patient to move on to a less intensive form of care. This is called 'graduation'. The patient is assigned new treating practitioners, with new ideas and new contact situations (usually consultations at the surgery instead of home visits). This leads to more relapse and drop-out (the patients abandons care altogether). Or the patient is registered again for ACT; this is a form of revolving door psychiatry.

FACT aims to support recovery and focus on recovery goals. The peer support worker in the team can make an essential contribution from his or her perspective. He or she can organize recovery groups such as the WRAP groups (Wellness Recovery Action Plan, Cook et al. 2012) and stimulate peer contact. The teams also include rehabilitation expertise, and the specific task of the IPS worker is to stimulate paid work.

2.2 Composition of a FACT team

The composition of a FACT team is intended to cater for approximately 200 clients. This means that it must at least include enough case managers and a psychiatrist. The team also includes a psychologist, an addiction specialist, an employment specialist and a peer support worker. This results in the following ideal team composition:

- 1 FTE psychiatrist
- 0.5 FTE team leader (not necessarily working in client care)
- 7 FTE case managers, including:
 - o 4–5 FTE psychiatric nurses
 - o 1–2 FTE community psychiatric nurses
 - o 0.8 FTE social worker/ welfare rights adviser
- 0.8 FTE psychologist
- 0.6 FTE peer support worker
- 0.5 FTE employment specialist / IPS (Individual Placement and Support)

Expertise required within this team

- * Addiction expertise within the disciplines referred to above (at least 2 FTE)
- * Broad expertise relating to rehabilitation and recovery
- * 2-3 FACT board chairs

with the optional addition of:

- * Many FACT teams also provide care for individuals living outside the hospital in sheltered accommodation; the independent living supervisors in those facilities can be members of the FACT team.
- * Sometimes other specialists are added to the team, such as a systemic therapist in teams for people with first-episode psychosis.

The role of individual case manager can be taken on by team members from a variety of disciplines (nurse, social worker, sometimes also psychologist).

Many nurses work in the Dutch FACT teams. In Great Britain more social workers and employment specialists work in teams of this kind. In the United States many case managers are social workers. This is usually a result of history. That Dutch teams opt for nurses is partly due to the major role of nurses in former psychiatric hospitals. Many of them were trained in hospitals and switched to outpatient work after supplementary FACT training.

As well as psychiatric nurses, each team includes at least one community psychiatric nurse (CPN). A CPN's additional expertise in comparison with a psychiatric nurse includes areas such as diagnosis and assessment of care needs, crisis intervention and dealing with complex systems and personality disorders.

FACT teams in other countries will have to decide for themselves from which disciplines in the team the case managers will be sourced. A good mix of nurses and social workers (and addiction specialists) seems to be important.

In optimal teams, a case manager's average caseload per FTE is around 25 clients. The case manager is the first contact person for the client and the client's support system. The case manager regularly visits and monitors the client and makes sure they have an up-to-date treatment plan. The case manager can involve other team members in the treatment, for example the psychiatrist for medication or the employment specialist for work. Every client also has a 'shadow case manager' who also knows the client well and is familiar with the current situation, so that they can take over if the case manager is sick, on holidays, etc.

For clients receiving intensive team care via the FACT board, all team workers work together and share the caseload; in other words, at this stage all members of the team are deployed to provide additional care. The psychiatrist is directly involved regarding medication issues, preventing admissions, etc. The psychologist and the peer support worker also share the caseload.

A FACT team as a whole has a wide variety of expertise. As well as the medical perspective, the social work perspective is also very important. The social workers and rehabilitation specialists contribute an important perspective to the team. All team members are expected to be able to support rehabilitation processes.

The peer support worker plays an important role in recovery and rehabilitation processes. An increasing number of peer support workers have permanent paid jobs in FACT teams. They have been trained to utilize their experiential expertise in the direct care process. Often they make contact with clients in a different way. Sometimes they can act as interpreters between client and care practitioner. Usually they do not have a caseload of their own, but are active participants in shared-caseload care, help to find people with SMI and link them to the care system and, for example, help with recovery activities.

The fact that both psychiatrists and psychologists work in FACT means that together they can make good diagnoses and treatment plans. It means that medication, awareness of physical problems and metabolic screening can go hand in hand with cognitive behavioural therapy.

The team must include at least two individuals with up-to-date addiction expertise. In the Netherlands we increasingly work with the Integrated Dual Diagnosis Treatment (IDDT) model. Team members from various disciplines, for instance case managers and the psychiatrist or the psychologist, receive IDDT training which they can use in the team. Many FACT teams have now attended training sessions in motivational interviewing as a team.

The daily coordination of care provision requires special attention. This is why more and more often FACT teams have with two – or if possible three – FACT board chairs. They are not formal managers or leaders of the team, but simply team members who have been trained to chair the FACT board meetings. They operate the digital FACT board, they coordinate daily care for clients and are in charge of making notes in the electronic patient files.¹³ This model has proved to work well. It means that in each team there are three individuals who are very familiar with the FACT model and who have been trained to chair the meetings. These

¹³ Some Australian teams work in a similar way with a 'shift manager' for each shift.

three individuals can also support each other; one of them is always present, including in the holiday season.

A FACT team should not have too many members. We have to take care there are not too many members with small part-time jobs in the team. Ideally, most of the members should have substantial positions (4 days a week, for example). If there are too many members with small part-time jobs in the team, it is more difficult to make arrangements and handing things over takes up too much time. We have also observed that there is also an optimal maximum number of clients a team can care for: this is about 180 to 220 clients. Teams that have to take care of more than 250 clients cannot customize care as well.

CHAPTER 3: The FACT working procedure

3.1. Outline of a situation: so many clients, so many needs

The FACT team in a neighbourhood in Amsterdam has 210 clients. A large proportion of them are reasonably stable. A few have jobs, many visit a drop-in facility and join in activities at an activities centre. Some take part in a recovery group with the peer support worker. Others are actively looking for better accommodation with the help of their case manager. The psychologist is running a training group in conjunction with a colleague from another FACT team; she also talks to people and sometimes uses EMDR to treat traumas from the past. The psychiatrist sees all clients who are stable at least once a year, but she sees many of them once a month or even once a week, especially clients on complicated medication (such as clozapine) with risks of side effects. About 25 of the team's clients are in touch with the employment specialist (IPS). Some of them work with her every day when they start a new job. All clients have an individual case manager, usually a nurse, who visits the client at home at least two or three times a month. The case manager sometimes accompanies clients to social service agencies and is often also in contact with the family. Apart from their contacts with the clients, many team members also have contact with various agencies in the area, with the GP, with landlords, with the police, etc.

Most of the clients have a case manager, occasional contact with the psychiatrist and sometimes also contact with an addiction specialist, peer support worker or psychologist. The care practitioners work individually with the client. They coordinate their activities on the basis of the client's treatment plan, which is updated at least once a year. But if additional coordination is needed, it can also take place at the morning team meeting. Short-term interventions from other disciplines can also be requested. In other words, care for these clients consists of individual supervision and treatment with fairly easy access to other disciplines.

Of the 210 clients, about 20-25 receive much more intensive team treatment. This is because they are not doing very well at a particular point, or because they require extra attention or even intensive care. When the team becomes aware of this, the client's name is put on the FACT board. From that point onwards the team discusses that client every day and can provide intensive care as a team.

The group of clients on the FACT board is very heterogeneous. At present three individuals on the board are there because they were only recently registered with FACT. The team wants to get to know them; this is why they are discussed every day for three weeks and information is provided by several team members who visit them. Nine individuals have been on the board for a long time. These are people with disorganized schizophrenia and substance problems. They can only continue to live at home with daily support from the team. Two of them have compulsory medication (there is a court order requiring them to take medication every day and for this to be monitored). Three others have compulsory depot medication. More than ten others are on the board because things are threatening to go wrong at the moment. One is in crisis because he did not take his medication. Another is suffering a relapse manic episode. Another has a severe malignancy which he regards as a 'health bump' and for which he refuses treatment. A woman with a severe borderline problem has recently got into conflict with everyone again, stopped taking her medication and given notice on her house. The group on the board also includes several people who have been admitted to the psychiatric clinic and

two people who are in detention. Finally, several treatment avoiders are on the board: while these people clearly need care, they do not feel they are ill, they do not believe treatment is necessary and they cut themselves off from all contact. The team nevertheless keeps an eye on them from a certain distance for several weeks or months, talks to the police about information coming from the neighbourhood and if a dangerous situation arises, the team will also actively (forcibly) administer treatment.

The people 'on the board' need much more intensive care than the others. Their care cannot be organized by one individual; they must be visited every day or more often, care workers depend on a wide variety of information from the community (especially as regards treatment avoiders), someone has to meet with service agencies, families and the hospital, major decisions have to be made: this requires teamwork.

Working with a shared caseload

For the people on the FACT board – clients who need intensive care, we work with a shared caseload. Home visits – every day if necessary – are carried out by several team members. Sometimes these daily visits are short, for instance to deliver medication and to watch the client take it. Sometimes they are longer, for instance to bring some order into the client's house or paperwork or to make contact with the neighbours. Working with a shared caseload requires clear daily coordination of goals; otherwise each team member will have their own agenda and recommendations. Peer support workers also share the caseload; they will often talk about different aspects, but they are well-informed about the client's overall treatment and care. The impressions of the various team members are conveyed at the morning FACT meeting; again and again we find that different people from different disciplines of expertise see completely different possibilities and impossibilities in a situation.

3.2. The FACT board procedure: FACT's great strength

The FACT board is the mechanism which enables integrated care to be delivered by the same team.

A FACT team has two methods of monitoring and supporting clients:

- 1) individual supervision and
- 2) intensive team care with a caseload shared by the whole team.

Re 1) Most clients are individually supervised by their own case managers, who focus on treatment, rehabilitation and recovery support. In the course of this individual supervision the case manager may also involve other disciplines from the multidisciplinary district team in the client's treatment or rehabilitation. Members from several disciplines including at least the psychiatrist are always involved in drawing up and establishing a client's treatment plan, but the client does not see different care practitioners every week or every day.

Re 2) For a fluctuating group of 10–20% of the clients in the team's total caseload this individual supervision is not intensive enough. They need more help than one case manager can provide. For these clients on the FACT board the team provides team care according to the ACT principle of 'shared caseload'. This means that all members of the team have been informed about the client and that he or she is monitored and counselled by several care

In the first column (red) each client is placed in a certain category. These (fairly rough) categories reflect the reason why the client has been placed on the board. A client who is put on the FACT board is placed in one of the categories defined below. Over time the client may be placed in a different category; for example, someone who was first admitted to hospital and then goes home will be moved from the 'admission' category to the 'intensive short-term' category. These changes can be kept up to date in a database, which may be helpful when the team's working procedures are evaluated.

The categories on the FACT board are as follows:

1. Crisis prevention: for clients who are showing the first signs of a possible relapse into psychosis or addiction or if there are signs of increasing social problems. Also interventions to prevent admission.
2. Intensive short-term: clients with temporary worsening of psychiatric symptoms or crisis; also clients who have just returned home after an admission or after detention.
3. Intensive long-term: clients who need long-term stepped-up care, for example due to prolonged decompensation or permanent vulnerability (low GAF score); some need *permanent* daily support and will therefore remain on the board.
4.
 - a. Treatment avoider: patient wants no contact with mental health services, but the situation is not of serious concern; contact is offered but not forced (team presence); a possible support system is identified.
 - b. High-risk treatment avoider: patients who do not want any care from mental health services, but who are neglecting themselves and/or their environment or are causing a nuisance. The FACT team will provide assertive care for these people and if there is danger will use pressure or compulsion.
5. Admission: client has been admitted to a psychiatric unit or has been sent to prison. The team keeps in touch with the client and treating practitioners and prepares the client's return.
6. New: new client recently registered with the team; three weeks to get to know the client and for assessment.
7. Court orders: clients with court orders for involuntary treatment or monitoring.

At the morning meetings with the FACT board beamed onto the wall, 20–40 individuals on the board are discussed every day. The FACT board chair names a client. Then the case manager tells the team what the situation was like yesterday. The client may also have seen another team member or spoken with the psychiatrist. Some information may have been passed on by the family, or the client may have requested something. This is discussed briefly and the actions for today are discussed: who will visit the client, who will assist the client with an application for housing, who will make sure the client makes an appointment with the GP, etc. With some clients there is little news, others are discussed for 2 or 3 minutes. But the intention is for the meeting to last no longer than 30–45 minutes.

Within that time there is also room every day for a brief discussion of clients who are not on the board, but who need to be mentioned because there are some new developments. They are put on the 'cases to discuss' list. A case manager might want to discuss a client to call in extra expertise, for instance to ask for medication monitoring or a psychological intervention. Client successes (client started a job, finished a course) are also reported at this point. The team also needs to celebrate its successes.

Sometimes a client turns up on the 'cases to discuss' list several times in a few weeks, for instance in connection with things that are unclear, an imminent crisis or life events. If this happens several times, the team will soon decide that it is better to put the client on the FACT board, so that things will become clear in a few weeks due to the daily discussions.

The FACT board is crucial for the coordination of activities and for sharing information. In community-oriented work, team members will also run into clients without an appointment, on the street or in a shop. They hear clients' stories about other clients and receive information from community liaison workers. As a result, the team obtains a broader picture of how clients are functioning. This can be especially important with treatment avoiders: although they refuse contact, team members know them, sometimes have a chat with them and can work much more effectively if treatment avoidance becomes a real concern (for instance due to the client's self-neglect).

The board also functions as a reminder: clients who are in hospital or in detention remain in the spotlight. In collaboration with the hospital, the FACT team provides support to facilitate a quick and safe return home for the client.

New clients are regularly passed on to the team. These people are always put on the FACT board for the first few weeks. The procedure is that during the first three weeks at least four team members, preferably from different disciplines, talk to the client and visit him or her at home. This enables the team to make a good assessment of this individual's care and treatment needs. An initial contact with family or support system can also be organized. After three or four weeks an intake interview takes place and the team draws up a treatment plan in conjunction with the client.

Some clients are subject to conditional court orders: if they stick to the rules, they can stay outside hospital. For instance, they may be obliged to talk to care workers and to accept depot medication. These clients are also on the FACT board so that their supervision can be coordinated and information can be gathered for the purpose of risk management. The FACT board then also functions as a reminder about dates by which the court order must be extended or for other procedural formalities.

In practice, the daily FACT board meetings have proved to play another important role: they provide transparency and enable the team to share knowledge, since the team members discuss specific actions and the team's approach to the most difficult clients. Often these are also the clients whose situations involve contradictory interests and risks. Sometimes strategies have to be devised and modified nearly every day, since additional information may surface every day. At the FACT board meetings, team members learn from each other and the FACT team's vision and mission is made clearer in a pragmatic way to the members among themselves every day. This is also beneficial for new team members and for trainees.

When the first FACT teams were set up, we were convinced that the FACT board meetings would play a very important role in the daily coordination of care. This proved to be correct. However, the morning meetings have also proved to be crucial because team members from different disciplines with their specific focal points look for possible ways to support the client. As a result, the team makes it clear every day which disciplines can make which contributions. It also makes it clear that care for the most problematic clients is never just one team member's problem: the whole team can tackle it. Because team members share their solutions, the team is not likely to

follow the inclination of some members to wait too long or to ignore problems that are difficult to solve. The morning FACT board meetings sharpen the team's thinking and show that together you can achieve more. For the meetings to be successful, it is compulsory (!) for all team members who are working that day to attend the FACT board meeting.

FACT teams have a clearly-defined procedure for the FACT board meetings:

- The clients on the FACT board are discussed by the team every working day
- A client's case manager or any other team member can ask for a client to be put on the FACT board at any time
- As soon as there is any indication from a client, their family or fellow clients, or from the neighbourhood that the client's medical or social situation is worsening, the next morning someone will say: 'shouldn't Mr J. go on the board for a couple of weeks?'
- Then there is a step-by-step plan:
- The personal supervisor of the client who has been put on the board outlines the client's background and lists the actions required
- The crisis plan prepared in advance is put into action
- Additional agreements are reached regarding shared caseload and intensive care
- The psychiatrist is responsible for making a risk assessment (or having it made) within 24 hours and must be aware of the patient's medication within 24 hours.

Working with the FACT board means that team members have to keep spaces open in their diaries to be able to respond to new care needs flexibly. When a client is put on the board, the psychiatrist must decide within 24 hours whether he or she should examine the client personally in the short term to optimize their medication and to assess safety issues.

If a client is put on the FACT board, that client's care switches from individual care to team care with a shared caseload. This means that several team members will visit the client at home. It has proved helpful to explain this procedure to the client and their family in advance, so that they understand that several care workers will be coming to provide extra care together.

The team works in office hours. However, we consider whether additional arrangements with the psychiatric emergency service or the hospital are necessary for outside office hours.¹⁴ Sometimes several teams together (sometimes in conjunction with the hospital) also provide additional nursing care on Saturdays and Sundays in the daytime. One nurse then visits several teams' clients. This is mainly for medication monitoring and to provide structure. This 'weekend FACT' helps the clients to get through the weekend. It reduces the number of admissions on Friday afternoons and also enables the hospital to discharge patients on Fridays, because initial care and support for them is guaranteed.

Team care is terminated when a client no longer belongs to one of the groups that are supposed to go on the FACT board. The client's name is then removed from the board. Once again, there is a standard procedure for this:

- The client can only be removed from the board at the daily FACT board meeting
- This must be approved by the team

¹⁴ The Dutch mental health services have well-organized psychiatric emergency services in all regions of the Netherlands. These services can be contacted through the GP. In most cases the emergency service can now access the patient's electronic file, which contains a separate module with the patient's crisis plan.

- This must include approval by the psychiatrist – if the psychiatrist is not present at the meeting, the client cannot be removed from the board
- Afterwards the case manager evaluates the period of intensive care with the client and their family. Was the care provided helpful, did it deliver the client and family what they wanted, did we forget anything or do something that was not helpful?
- On the basis of this evaluation, the client's crisis plan may be adapted for the next time.

3.3 Criteria for putting people on the FACT board

We have already listed the categories of reasons why clients are put on the board. We will now discuss these categories in greater detail.

- Crisis prevention
 - This is a relatively 'mild' group; extra attention is paid to certain clients in anticipation of predictable stressors, guided by the relapse prevention plan (for example, imminent loss resulting from illness of housemate or the threat of problems due to legal proceedings)
 - This group also includes clients who have shown the first signs and early symptoms of possible decompensation; the aim is to prevent admissions if possible
 - For this group, in many cases the care has not yet been stepped up, but it is important for the team to be aware of clients' vulnerabilities. Then if something happens while a client's own case manager is away, the team can still respond adequately.
- Intensive short-term
 - Worsening of psychiatric symptoms / crisis, addiction problems
 - It is desirable for certain treatment and/or care to be stepped up
 - Clients with life events
 - Threat of admission
 - Suicidality, risky behaviour towards others, imminent eviction
 - Clients who have recently been admitted
 - Follow-up care, prevention of revolving door admissions
 - Neglect, signs of nuisance or danger
 - When stepped-up care for this category begins, it often has to be all hands on deck: the diagnosis has to be clarified, the crisis must be brought under control as quickly as possible, arrangements must be made with the client's environment and possibly also for a 'bed on request' (very short-term admission)
- Intensive long-term
 - This is a group of very familiar clients who need long-term or even permanent daily care to be able to cope outside the hospital; these are usually clients with a GAF < 40 and with little in the way of a social network, in spite of attempts to build up a social support system.
 - These are also the clients who without daily care are at risk of neglect, non-adherence to medication, causing nuisance etc.
 - Many of these are patients who in the past were admitted frequently – the 'revolving door' patients. For them, the aim is to reduce the number of admissions and the number of days per admission. Sometimes they also spend a small part of

- the day in the hospital's day programme or in an acute part-time treatment programme.
 - To a large extent this group coincides with the classic group of ACT patients.
- Treatment avoiders
 - Patients with whom contact is unsatisfactory, who do not stick to agreements, but who do not have neglect, nuisance or danger issues: with these people, the focus is on the presence approach, motivation and gathering information
 - See text in italics
- High-risk treatment avoiders
 - Patients who avoid treatment and who are in danger or at considerable risk of suffering severe harm. At that point the team cannot wait any longer and has to intervene, providing care assertively; possibly in conjunction with the family or with the community police officer, the team will insist on making contact in order to inform the patient that treatment is needed and that if necessary pressure and coercion will be used to avert danger or nuisance.
- Admission group
 - All clients admitted to a psychiatric hospital; these clients are visited weekly in the context of integrated ('transmural') care
 - All clients admitted to a regular hospital; they are also visited; their discharge is prepared, help at home is arranged.
 - All clients in detention are visited; contacts are made with judicial authorities, specifically regarding discharge from prison, possible parole conditions and starting detox and medication while in detention.
- New clients
 - Always 2–3 weeks, so that several team members get to know them
 - See elsewhere in manual.
- Forensic clients
 - All clients subject to community treatment orders (involuntary treatment)
 - All clients subject to court orders such as Forensic Psychiatric Supervision or Conditions for Provisional Release.

This summary shows that being put on the board does not always lead to significant stepping up of care. Sometimes it has more to do with sharing information (sometimes from other agencies and from the community). Working in a community-oriented way generates a lot more information about a client from many different contacts and encounters in the area. Team members often receive information casually (also from other clients) about how people are doing. This is then shared at the FACT board meeting. It means that each case manager has extra ears and eyes.

The FACT board is also used as a calendar: interventions that have been arranged are recorded on the digital FACT board – such as the three-weekly appointments for depot injections for certain clients. Two days before the depot appointment a reminder will appear as a pop-up on the board. If the depot injection is not recorded, this box will be highlighted in red the day after the date of the appointment.

Extensions of court orders are also monitored in the same way; the board provides a reminder well before the expiry date.

Clearly there are many reasons why a client can be put on the FACT board. The aims team members have when placing a client on the board also vary widely:

- 1) to enhance treatment
For instance, stepping up contact in connection with grief or psycho-education, but also often delivering medication or arranging lab tests
- 2) to enhance care
For instance, providing support, structure, a daily rhythm, personal and home hygiene
- 3) to enhance intensive rehabilitation or recovery support
For instance, recording on the board that a client is about to take a major step, such as moving house or starting a paid job
- 4) to organize better monitoring
For instance to prevent nuisance, to channel substance use as much as possible, possibly to monitor adherence to parole conditions
- 5) to assist a client who is going back home
For instance, guiding and counselling a client after a longer-term admission or after detention; the first few weeks of this period are often crucial for preventing relapse
- 6) to organize better 'linking'
For instance by providing assertive treatment and searching as a team for ways to stimulate the client to cooperate with treatment.

These are all objectives which are difficult for one care worker to achieve; but the short daily team meeting sometimes generates surprising perspectives.

3.4 Integrating treatment, care, rehabilitation and recovery within FACT

FACT is a special model because it focuses on the combination of several elements: (1) guideline-compliant treatment, (2) care and rehabilitation, (3) recovery support and (4) working with support systems in the family and the community.

The book *Classics of Community Psychiatry* (Rowe et al., 2011) is a volume of the fifty most important articles in social psychiatry of the last hundred years. Browsing through these articles, we see that authors often emphasize one or two important elements, such as case management, continuity of care, treatment or the importance of recovery. FACT's point of departure is that many different important elements are necessary. The challenge is to integrate all these different aspects. For each individual, FACT tries to find a carefully balanced combination of all these elements. The daily FACT board meeting helps to coordinate interventions and, in response to the information received, to decide what is necessary, desirable and possible at that particular point. For the individuals receiving individual supervision, a treatment plan meeting is held at least once a year.

The Dutch Multidisciplinary Guideline for Schizophrenia (like similar guidelines in other countries) sets out which treatments can be used, such as medication, psychological interventions, psycho-education and family therapy. These interventions must also be explained to clients and their families and sometimes offered proactively.

In FACT the rehabilitation aspects are integrated into the treatment plan. Treatment goals are formulated by the client and recorded in a personal and comprehensible way, in the client's

language. Clients can be supported in reaching those goals by their own case manager or by specialized rehabilitation workers, such as employment specialists.

FACT aims to support the clients in their recovery process. The goal is for clients to function optimally and to participate in society in a way that appeals to them and that is safe.

Recovery (Ridgway et al. 1999) means:

1. Regaining a positive self-image in spite of the struggle with a mental illness. This involves a journey from surrender to hopeful and realistic optimism, from alienation to meaning and purpose, from psychiatric patient to a personality for whom the illness is not in the foreground.
2. Active self-management by the client of their life and mental illness. This involves a journey from being a passive patient to being an active client, from stress vulnerability to active self-management, from self-neglect to a development focused on a positive lifestyle, self-care and well-being.
3. Regaining a life outside mental health services. This entails changing from a life mainly lived in a mental health services programme to a life in a community environment, from withdrawal and passivity to active participation in meaningful activities, and from social isolation to relationships and involvement in society.

FACT also focuses on the interaction between clients and their environment. For FACT, the client's family members play a very important role. They often provide support, are concerned and have known the client for much longer than the care worker has. Sometimes relationships have broken down, but the need is felt to build them up again. Guideline-compliant treatment includes psycho-education and other interventions with the family.

Since FACT aims to support the client's inclusion in the community, FACT must be a reliable and accessible partner for the community and for agencies. The client's ultimate integration into the community depends on a wide range of other agencies and services. Between these services and FACT there is an overlapping area in which they will have to find each other as partners.

Treatment avoiders

There is also a group of patients who refuse to have contact with the team or care workers. Lack of awareness of being ill or lack of insight into their illness sometimes play a role, but so do lack of trust or previous negative – sometimes very negative – experiences with care workers and psychiatrists. We refer to these patients as 'treatment avoiders'. We try to establish contact with them, for instance by offering practical social support. But if they want nothing, we will respect that. We also distinguish 'high-risk treatment avoiders'. How 'high-risk' these people are depends on the extent to which they are seriously disadvantaging themselves or are even a danger to themselves or their environment, and the extent to which this is caused by their mental illness.

We see people who live very reclusive lives, with very few contacts, but are not severely neglecting themselves, as 'treatment avoiders'. We try to make contact with them in an informal way. We try to offer 'attractive', 'linking' care, for instance by have a short chat on the street or by offering people support in the

form of accompanying them to various services and agencies. We look for an opening, but do not force ourselves on them. Peer support workers can play an important role in establishing contact.

If patients are mentally incompetent due to their illness and – for example – are severely neglecting themselves or severely disrupting their environment, we see them as ‘high-risk treatment avoiders’. The team then tries to establish contact assertively. Team members coordinate treatment with the family and where applicable with social services. The team then provides ‘assertive treatment’ to get patients into care (case finding) and keep them in care (linking). Sometimes this can lead to a court order for involuntary treatment, which will also be administered by the team. The goal is then to guarantee safety.

3.5. Treatment plan and treatment plan cycle

To keep track of treatment and supervision with so many different components, a treatment plan is essential. In the Netherlands there are clear agreements about the standards with which a treatment plan must comply:

- 1) each client must be in possession of a treatment plan in writing, in comprehensible language.
- 2) The plan must be drawn up in consultation with the client (and the family).
- 3) The treatment plan must contain the client’s own goals, in the client’s own, personal wording, along with the treatment and the support and rehabilitation activities proposed by the team.
- 4) A crisis plan or relapse prevention plan is often part of the treatment plan.
- 5) The treatment plan must be evaluated and updated regularly, at least once a year.

In a FACT team the case manager is responsible for ensuring that the requirements set out above are met. In other words, the case manager must make sure every year that the plan is evaluated and if necessary updated in good time.

- 1) The case manager schedules the next treatment plan meeting in ten months’ time.
- 2) The case manager prepares the plan in conjunction with the client (and possibly the client’s family).
- 3) Prior to the meeting, the case manager fills out some forms with the client, for example for the HoNOS, the MANSA or the IDDT scale.
- 4) The case manager gathers data from somatic screening.
- 5) The case manager discusses the preceding year with the client and evaluates to what extent the previously formulated goals have been reached.
- 6) In consultation with the client, the case manager may also approach a family member to evaluate the preceding year.
- 7) In consultation with the client, the case manager prepares a draft treatment plan which addresses all areas of life and also monitors the client’s physical condition
- 8) The next step is the multidisciplinary discussion of the draft treatment plan by the team. The psychiatrist and other team members involved in the treatment attend the meeting. Many teams invite the client to this meeting to discuss the treatment plan. Other teams prefer to invite the client to talk about the treatment plan in a smaller group (for example, only the client, a family member, the case manager and the psychiatrist).
- 9) The treatment plan is then adjusted in consultation with the client. The plan includes the client’s wishes and various arrangements with the treatment team (about

treatment, medication, guidance, looking for work, possible interventions in the event of a crisis).

10) Finally the client signs the plan (if he or she wants to) and the psychiatrist signs on behalf of the team.

11) Once the plan has been adopted, the client may have a copy if he or she wants one.

Chapter 4 The hourglass model

4.1 The different roles of care workers

In a FACT team the care workers have to switch roles all the time. A case manager who supervises a client individually often has a personal approach. He or she knows the client well and can talk about practical matters, household affairs, finances or medication, but also about personal matters such as intimate relationships or coping with grief. Case managers supervising clients during intensive team care are less likely to have in-depth personal conversations with clients; they come mainly to provide support and structure, to help activate the client, etc.

In individual supervision case managers also have many different roles; a case manager is sometimes a confidential counsellor, sometimes a practical consultant regarding other agencies and services, and sometimes also the person who has to administer compulsory treatment in compliance with a court order.

This variety of roles also applies to the psychiatrist (sometimes confidential counsellor, sometimes the supplier of medication that is often found very unpleasant, and sometimes also the person who asks the court to make treatment compulsory) and the psychologist. For practitioners in FACT teams that are just starting, this continual switching has often proved to be challenging, particularly for nurses who trained in a hospital. In the course of talks with these practitioners, we developed the 'hourglass model'.

4.2 The hourglass model

FACT teams provide different kinds of care. From the point of view of care workers, we distinguish three processes:

1. Dealing with destabilization
2. Treatment
3. Recovery.

We should not see these three processes in a rigid way, as 'phases' which succeed each other. Often a client is receiving treatment, but at the same time working towards recovery, and often treatment is essential in dealing with destabilization. The processes can coincide or alternate. However, each process requires different activities and a different attitude on the part of the care worker, who has a different role in each case.

Re 1) Dealing with destabilization

The term destabilization refers to a situation of crisis, with the threat of relapse, or increased symptoms or substance use. When there is a threat of recurring psychosis, clients need all the energy they have just to keep going. Often social problems also arise and we see that self-care and care for the environment are deteriorating. In this situation we will provide optimal crisis intervention to enable the client to overcome the episode safely, if possible without a relapse and without readmission.

Destabilization may also be a permanent characteristic of people with chronic disorganized psychosis. These clients are no longer able to keep their lives on track, even if they wanted to. Then FACT's task is to deal with long-term destabilization by providing permanent daily care and structure.

Re 2) Treatment

Treatment includes not only medication, but also psychological interventions or interventions focused on addiction problems or skills training. The process whereby an IPS worker works with a client and guides them towards finding paid work is also seen as a form of treatment, since the client is working with the assistance of a care worker in accordance with methods used by the care worker to improve the client's functioning and reduce their symptoms.

Re 3) Recovery

This is the domain in which the client is working on his or her *self*-guided recovery process, supported by the team with rehabilitation.

The care worker assumes different roles for each process:

Destabilization requires a problem-oriented, directive and action-oriented approach. Team care is needed and team members can take over some of the client's daily activities.

Treatment processes revolve around collaboration with the client. Treatment serves to support the goals formulated by the client. On the basis of shared decision-making, the team tries to reach agreements with the client regarding optimal treatment. Sometimes treatment is prescriptive in nature (medication, recommendations), and sometimes the client and the care worker are looking for solutions together (psychotherapy). Case managers have a stimulating and supporting role in treatment. They provide information and counselling regarding treatment, or they motivate clients to take part in a certain treatment programme, for example the pre-contemplation group for clients with addiction problems.

In the *recovery process* the individual case manager or treating practitioner supports the client more individually and it is the client who controls the process. The relationship of trust between the client and the case manager is crucial in this process.

We have summarized the above in a diagram – the hourglass:

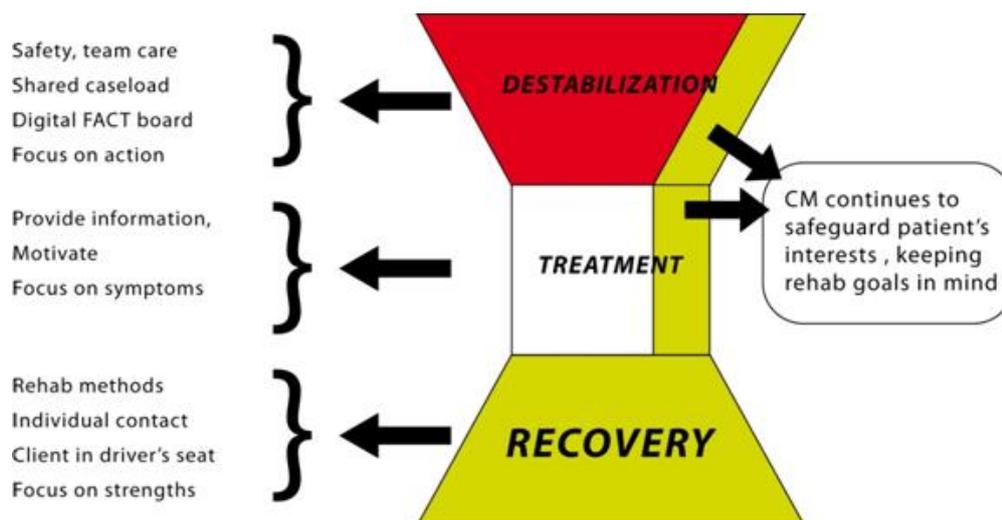


Figure 3.

4.3. Working with the hourglass model

The hourglass shows that the role of the case manager (and other team members) is different for each process. For each process, the left column lists:

- the goal
- the working procedure
- who is in control
- the care worker's attitude.

We will examine these aspects in more detail, focusing on the case manager:

Destabilization requires a problem-focused, crisis-solving approach. This may entail supervision, counselling, support, or arranging extra assistance for personal care. But it may also mean taking over, protection and if necessary (if the situation is dangerous) using pressure or ultimately force. The client is on the FACT board. The case manager is now working as a member of a team and making team arrangements for joint, united action. The case manager will direct the joint team care. The case manager will also keep the client's file up to date and maintain contact with key individuals in the client's network.

As regards *treatment*, the role of case managers is to provide information, motivate the client and provide group treatment in the form of psycho-education, Liberman skills training etc. The case manager collaborates with the psychiatrist or psychologist or with another care practitioner. As the client's personal supervisor, he or she evaluates the treatment with the client. The client must be offered the appropriate treatment at the right time. This requires diagnostics – the team has to assess which interventions might help. The next step is to explain that treatment to the client and the family and stimulate the client to accept it. The case manager can ask the psychologist or psychiatrist to make an appointment or to accompany them on a home visit. Many treatments are carried out by members of the team, so that referrals can take place more quickly and without high thresholds.

As regards *recovery*, the case manager's role is individual; the case manager creates conditions that are conducive to recovery and follows the process with interest. The case manager is present and attentive, and focuses on increasing the client's autonomy. This is the role of a coach, guide or travel companion. With recovery, the client is the driver and the care worker is an interested passenger, sitting beside the client or taking a back seat. The one-to-one relationship is important in this context. The care worker's role as a 'clinical expert' shifts to that of a partner (Salyers et al. 2007). If necessary, the care use rehabilitation techniques/methods to help the client to formulate their own goals or to take charge again. The Strengths Model (Rapp and Goscha 1998) also provides specific tools and methods for support. Although the case manager's role is individual and entails creating conditions, experience has shown that in fact several team members are involved in providing support, such as the peer support worker, the IPS employment specialist, the psychiatrist for updating medication, etc.

This approach, which is referred to as recovery-oriented care, is an essential component of FACT. It is important both for individual clients and for the team's general attitude. It offsets the sometimes highly prescriptive and directive aspects of FACT. In the past there has been considerable criticism in the United States of overly assertive ACT teams, which in their

enthusiasm and focus on reducing admissions sometimes lost sight of the clients' own goals. The introduction of recovery-oriented ACT restored the equilibrium.

Switching roles – an example

Before the morning meeting at 9am, case manager Anja goes to see Mr De Jager at 8.10am. Mr De Jager lives alone and recently started a volunteer job for which he is expected to be present at 9am. Starting so early is very difficult for him and he has asked for help for a few weeks to get into this daily rhythm. One of the case managers comes to see him every day. Anja checks that he has got up on time, gives him his medication and reminds him to pack his lunch box. Then Anja goes to the FACT team's office. That day she has four more appointments with clients from her own caseload.

At the morning FACT board meeting the clients on the board are discussed briefly to see if there is any news. Anja has nothing in particular to report about Mr De Jager, but the employment specialist reports that Mr De Jager is very proud that he has managed to get into the daily rhythm. A new client, Ms Langerdam, has been registered; she is put on the board. She is a possible treatment avoider; as yet there is little clarity as regards her problems. It is agreed that Anja and the psychiatrist will visit her at 11.30am to observe the situation and see whether medication is needed. At 10am Anja has a meeting with Merel, a client who recently completed the MANSA (Manchester quality of life) scale. They discuss Merel's satisfaction and dissatisfaction in various areas. The main question is in which areas Merel would like to change things. Where do her ambitions and aspirations lie? It turns out that Merel is dissatisfied with her limited social network; she is considering doing a course on 'working with your own experience'.

At 11.30am Anja is at Ms Langerdam's front door. The psychiatrist arrives. Anja rings the doorbell and they go inside together. It soon becomes apparent that this woman is not really averse to receiving care and has already been in treatment somewhere else. She appreciates receiving support, but does not want to be admitted. It is agreed that over the next few weeks Anja will talk through Ms Langerdam's problems with her and that she will start taking her medication again. Anja will also arrange for a psychologist to meet her and for her physical condition to be assessed via the GP.

In one morning Anja has assumed all the different roles: organization and guidance, diagnostics and crisis intervention, motivating a client to accept treatment and talking about recovery. This means a whole morning of switching.

4.4. The right-hand column in the hourglass model

Many care practitioners tend to think sequentially: 'the client needs to stabilize first, only then will there be room for rehabilitation'. Care practitioners are also often unnecessarily pessimistic about recovery and rehabilitation. These are attitudes from which the recovery movement wants to distance itself. Steps towards recovery can just as well be taken in a crisis.

Another problem is that during treatment or when averting destabilization, care practitioners are sometimes unaware of or forget what the client's recovery goals are – and sometimes even overlook recent results of a recovery process. In that case they may well disrupt the recovery process with well-intended interventions.

This is why in the hourglass model the green bar on the right goes from 'recovery' all the way up to the 'treatment' and 'destabilization' processes. This green bar symbolizes that even during treatment and destabilization the focus must remain on the client's recovery goals; it bar means that recovery is present in all the phases.

Example

After many psychoses and frequent drug abuse, John had lost contact with his father. John's father had withdrawn because in psychotic episodes John would arrive at his home with threats and demands. The father was very disappointed, partly because of John's drug abuse and theft, including at the father's home.

John came into contact with the FACT team in a calmer phase and then realized that he wanted to restore contact with his father. This took a lot of time and required a cautious approach. The father did not want to be bitterly disappointed yet again. However, John managed to reconnect; with the help of his case manager, he built new bridges with his father. They were able to talk things out. Eventually John was visiting his father every Wednesday.

Unfortunately John had a relapse and for a while he became just as demanding as in the past. He was probably also not entirely clean. At the FACT board meeting on Tuesday it was observed that extra measures were now needed to prevent the father being confronted with the old problems again.

In consultation with John, the father was notified and the Wednesday afternoon visits were first suspended for a while and then resumed under supervision. For John this was acceptable: the purpose was to temporarily protect one of his own recovery achievements, which he did not want to endanger.

One of the case manager's key roles is to draw the attention of the team and the treating practitioners to the client's recovery process and to matters that are particularly important to the client.

Chapter 5 : FACT in practice

5.1. Strengths, recovery and rehabilitation

For a FACT team it is very important to formulate its vision of clients' own capabilities and strengths clearly. We realize that this aspect may have different implications in the different countries where FACT is implemented. We will therefore include only a few short passages from Chapter 4 of the Dutch FACT manual, in which Van Weeghel discusses at length the interaction between recovery support and rehabilitation.

In the Netherlands the Strengths Model of case management (Rapp, 1998) has been a good source of inspiration for giving recovery and rehabilitation a key place in the practical implementation of FACT. The principles of the Strengths Model are:

- * emphasis on clients' strengths rather than on their pathology
- * the working relationship between the case manager and the client is essential
- * the interventions are oriented towards self-determination
- * the community is an oasis of resources rather than an obstacle
- * contacts with clients take place in the community, not at the mental health centre
- * people with mental disorders can learn, grow and change.

The Strengths method is not set out in as much detail as some other rehabilitation approaches. It is more pragmatic, which is why it seems to fit in better with the dynamics of an ACT or FACT team.

Apart from the Strengths model, recovery-oriented care in general is becoming increasingly common in the Netherlands. Recently Dröes (2008) formulated the following specific characteristics:

With recovery-oriented care, care practitioners

- are attentively present
- use their professional frame of reference in a restrained and modest way
- respond personally to feelings and emotions
- make space for the client's own narrative, support it and comply with it
- acknowledge and stimulate the client's own strengths, both individually and collectively (empowerment)
- acknowledge, utilize and stimulate the client's experiential expertise
- acknowledge, utilize and stimulate support given to the client by significant others
- Focus on alleviating suffering and enhancing the client's own autonomy and control of his or her life.

According to Dröes, care practitioners often fail to see clients' own strengths. He advises them to seek those strengths. Clients are empowered by creating their own narrative, using experiential expertise and gaining more control over their own lives. Support from others plays an important role in this; treatment also plays a role, provided that role is modest and not dominant. Recovery is inhibited if there is too much suffering. Care practitioners' actions must always be focused on reducing that suffering.

As well as finding strengths and supporting recovery, it is also FACT's task to promote clients' rehabilitation. Rehabilitation is a broad set of ideals and practices aimed at facilitating the functional recovery and social integration and inclusion of people with mental disorders.

Major rehabilitation areas are housing, work, training and social contacts. Providing rehabilitation interventions as well as other forms of care can contribute a great deal to the client's recovery.

Several approaches are known internationally. Most can be put to good use within FACT. This is shown by a summary by Drake et al. (2003) of the main trends in rehabilitation thinking:

- interventions must be focused on the empowerment of clients
- clients should be taught skills for ordinary life in a community setting
- specific skills must be taught for each social role or environment, because very few skills can be generalized for several areas
- as well as teaching skills, care workers must mobilize support from the environment
- it is better to put clients in the desired environment as quickly as possible rather than preparing them for a long time, step by step
- it is best to integrate rehabilitation into treatment and other care
- rehabilitation also implies combating stigma and amending laws and regulations

Clearly everything revolves around presence in the client's 'real' environment. This fits in well with FACT. Rehabilitation methods can be applied effectively within FACT and a FACT team should include several rehabilitation specialists.

5.2 Working towards inclusion: helping to build community support systems

Another key task for FACT is to help build community support systems. The concept of a community support system was introduced from the United States. In the Netherlands it means that various individuals and services agree to work with each other and with their clients to provide the social support that is needed. In the Netherlands, in practically every area of life there are agencies, groups and individuals who can contribute to the support and social inclusion of people with mental disorders. However, this potential is often not utilized, because it is disorganized, inconsistent and inaccessible. It is important for a team to identify the possibilities and mobilize them for the client. This is why the FACT team maintains contact with the various community and welfare services; each case manager has a number of services for which they are the contact person. This means that the team can make suggestions about building a community support system for each client. In teams which are actively working towards inclusion, the team can indicate for each client which people and which services are part of that client's individual community support system.

Recently there has been discussion in the Netherlands about how FACT teams should relate to various general social teams set up by municipalities. Some people argue in favour of very close collaboration or even 'merging' with these teams. The present author is not in favour of this. In my opinion a FACT team should be service-oriented and should be very open to collaboration with other teams, but should also explain that they have a very specific target group and that they provide specialist *treatment* for patients with SMI. The fact that we work in the community and in people's homes does not mean that we are a home care or welfare service. If FACT teams were to merge with other teams, the danger would arise that expertise about SMI would leak away and that the all-important link with the rest of the mental health services (and the psychiatric hospitals) would be put under pressure.

5.3 Guideline-compliant interventions

In previous chapters references have been made to the Dutch multidisciplinary guideline for schizophrenia. In the Netherlands this guideline (which was updated in 2012) is very important. Some of the interventions it includes are:

- * Psycho-education (for clients, family members and other people directly involved)
- * Medication management
- * Psychological interventions (CBT)
- * Family interventions
- * Integrated Dual Disorder Treatment (IDDT)
- * Individual Placement and Support

It would go beyond the scope of this manual to describe all of these interventions. The important point is that because the team is multidisciplinary, in principle attention is paid to each of these interventions.

In this connection FACT teams are sometimes compared with Christmas trees: the tree is the multidisciplinary team, which can switch flexibly between intensive and less intensive care. The decorations are the evidence-based practices and other interventions.

It is imaginable that the relative importance of various interventions is different in different countries. However, when setting up FACT teams, practitioners should look at what is regarded as state-of-the-art treatment in their own countries and then implement those interventions in the FACT teams.

5.4 Integrated treatment for clients with a dual diagnosis

Chronic abuse of alcohol and drugs is the most common comorbidity in people with severe mental illnesses. On average, 50 to 70% of the clients of FACT teams have this problem. Clients with a dual diagnosis benefit very little from addiction treatment, while psychiatric treatment often fails because of the addiction. It is important for the treatment to be integrated, by a team that treats both disorders at once. FACT works on the principles of Integrated Dual Diagnosis Treatment (IDDT) (Drake et al., 2001). At least two team members must have extensive training in this; they can then also help the other team members in dealing with such situations. The central vision of the model is that practitioners must understand at which phase a patient is as regards substance use, abuse or addiction. All interventions are geared to this and practitioners are constantly looking for steps which appeal to the patient. This treatment is integrated into the rest of the psychiatric treatment. A commonly used technique is motivational interviewing.

It is very important for the FACT team to reach agreements with the psychiatric hospital about continuity of vision and approach to addiction problems in accordance with IDDT; within this approach it can be very helpful for a client to take some time out in a clinic and after leaving it to receive further guidance as an outpatient. The clinic and FACT must have the same vision and attitude to such admissions.

An interesting finding emerged from research in Limburg (Drukker 2011). This was a study of FACT teams which had not yet appointed addiction specialists. It turned out that the trend for FACT to lead more often to remission did *not* apply to clients with a dual diagnosis. In

short, without addiction treatment integrated into the FACT team, these people probably have less chance.

5.5 Work: Individual Placement and Support

It used to be assumed that the clients of ACT and FACT teams were not up to doing paid work or had no chance on the employment market. However, research in both the United States and the Netherlands has shown that the direct availability of employment counselling leads to favourable results, even for clients who initially have no interest in work. Individual Placement and Support (IPS) (Bond et al., 1997) is the most successful model of employment rehabilitation for people with severe mental illnesses. The most distinguishing features of IPS are: paid work as the goal; looking for the desired jobs quickly; long-term support; integration of employment counselling into mental health services. Integrating employment assistance and other forms of assistance in the FACT team means that clients are reached sooner, that coordination is improved, that team members see the advantages of work for clients sooner and that the expertise of treating practitioners is utilized to help clients to find work.

The development of IPS in the Netherlands has been supported by the fact that employment counselling and preferably IPS are included in the requirements for FACT model fidelity. This is one of the reasons why in the Netherlands more and more frequently the team has an IPS worker as a permanent member. In teams where IPS works, there is marked satisfaction with the effects. An interesting study in West Friesland shows how much more satisfied clients are with their situation if they have paid work (compared with volunteer work or no work).

5.6 Physical health

It is internationally known that the physical condition of people with SMI needs a lot of attention. Because of their illness and their living conditions, but also because of psychiatric medication, the life expectancy of this group is considerably lower than that of the rest of the population (Tiihonen et al. 2009). According to the Dutch multidisciplinary guideline (Multidisciplinaire Richtlijn Schizofrenie Nederland 2007/2012) and guidelines which have appeared in various other countries, adequate physical treatment and interventions such as stimulating exercise are part of adequate care and treatment for people with mental illnesses. Inpatient psychiatric units also always pay attention to these aspects. This applies equally to a FACT team, but we do need to think carefully about which interventions are part of the service delivered by the FACT team and which should be delivered by the GP. In the Netherlands everyone has access to GP services. In many cases the FACT team will leave most of the clients' physical care to the GP. However, in many cases the FACT team also arranges the physical examinations needed in connection with medication needs assessments or with metabolic syndrome; this is coordinated with the GP.

This area also entails an important monitoring task for the team, particularly the nurse case managers and the psychiatrist. People with SMI sometimes tend to underestimate physical problems or to neglect them. If team members observe this, they will discuss it with the client and sometimes also with the family, and try to motivate the client to go to the GP. The GP usually appreciates it if someone from the FACT team accompanies the client, for instance to bring along an up-to-date medication chart. If clients are admitted to a regular hospital, it is

also important for team members to visit regularly so that hospital practitioners can consult with them and ask their advice.

Another aspect is a healthy diet – helping clients to lose weight through various interventions and referrals. Sometimes a dietician is involved. All such interventions are directly related to visions and the level of service delivery desired and achieved in a country which wants to implement FACT.

One rule of thumb is that while a FACT team cannot be responsible for providing all the physical care that is needed, it is the team's task to determine whether the clients are receiving care and treatment from the GP or other services in accordance with the standards of health care for the normal population. If there are gaps, the team will take over the client's care if necessary and look for systematic solutions within the health care sector.

5.7. Compulsion and pressure

In several countries compulsion and pressure is regulated in legislation. In Australia community treatment orders (CTOs) are often made; a CTO requires a person to obtain treatment for their mental illness while not detained in a psychiatric unit. Many countries do not have any such form of outpatient commitment. The Netherlands is in a transitional phase, moving towards a system like this.

It would go beyond the scope of this manual to compare these systems. However, we must point out that FACT teams cannot ignore or avoid this issue and that – depending on the legislation of the particular country – will have to develop procedures relating to pressure and compulsion. The fact that the teams want to help their clients to survive in their communities also means that the FACT team is partly responsible for the clients' safety and that of the other people in their community. Moreover - a community cannot be expected to be open and welcoming to a person who is very clearly causing nuisance or posing a threat.

We have observed that all the teams are inclined to use a stepped-care approach; first they use persuasion and 'enticement' to get a client's behaviour on the right track, then pressure, and finally (after a court order has been made) compulsion. It is important for FACT teams to have a vision of what kind of compulsion should be used in certain cases. Pressure may seem less intrusive than compulsion, but it can profoundly affect relations between team members and the client and sometimes permanently disrupt them. Pressure is applied by still giving the client a 'choice', but making it clear that there will be very serious consequences if the client continues to display the unwanted behaviour, for instance by pointing out the threat of eviction or losing benefits if they do not take their medication and as a result make a lot of noise every night and frighten the neighbourhood. By using the threat of eviction as a means of pressure, the team is potentially creating the extremely undesirable situation of homelessness, which would make treatment even more difficult. This is why it is often a good idea to go to the authorities – the police or the court – if situations like this arise.

For some time now there have been forensic FACT teams in the Netherlands: teams that are specialized in the treatment of clients – often with SMI – who are in the criminal justice system or who have been given suspended sentences. These teams, which have expertise in risk assessment and risk management, are sometimes consulted by FACT community teams if they suspect serious risks, for instance with a patient they think might be a 'lone wolf'.

The members of a FACT team who usually perform tasks associated with restriction, such as checking that clients comply with conditions imposed by the court and liaising with the police, are the psychiatrist, the community psychiatric nurse, the case manager and sometimes the social worker. However, it is important for the team that other members, such as the psychologist and the peer support worker, also participate, contributing their point of view. There should be a shared perspective on pressure and compulsion. It can sometimes be very helpful for several members of the same team to assume different roles in their approach to the client; usually the psychiatrist and the nurse will be the ‘bad guys’, because they notify the court and administer the compulsory medication. Others in the team (such as the peer support worker or the psychologist) can then try to maintain more positive contact with the client, so that not all contacts are defined by pressure and compulsion. A recent and promising development is ‘family group conferencing’ to avert pressure and compulsion. This is a new approach in which clients are helped by the people in their own environment to change their behaviour.

5.8. Termination of FACT care

The limitations of people with SMI are often long-term and sometimes chronic. The natural course of a severe mental illness is characterized by fluctuating improvement, remission, relapse or recurring psychosis and then improvement again and resumption of the journey towards recovery. Good times and bad alternate. However, some people with SMI achieve recovery and remission for good. Symptomatic remission means the disappearance of symptoms; functional remission means that the client’s social functioning has improved. The convention is that if a client has been symptom-free for three months, they are in symptomatic remission. Then the question arises whether FACT care delivery can be terminated.

The main criterion for signing a client off is the client’s own wish – the wish to live a more ‘ordinary’ life, without specialist treatment or guidance. In principle care practitioners will consent to this wish for a more normal life, but they will consider several criteria and discuss them with the client and in the team.

Within FACT, often a rule of thumb is applied that a person must have functioned according to criteria a. to f. for at least two years:

- a. Low-frequency contact, < 1–2 x per 1–2 months (no more than 10 to 12 contacts per year), not focused on change
- b. No complex medication use; client must be capable of dealing adequately with the requirements associated with the prescribed medication (taking it, having blood tests etc.), the GP must have sufficient motivation and expertise to take responsibility for providing adequate guidance; both of these factors will be assessed by the responsible treating practitioner
- c. Adequate support system, to be assessed by the multidisciplinary team
- d. Some form of work or daytime activities, to be assessed by the multidisciplinary team
- e. Independent accommodation¹⁵
- f. Financial situation is reasonably well organized (possibly through an administrator).

¹⁵ This implies that people who are living in a unit of a psychiatric facility or in sheltered accommodation or some similar setting are not eligible to be signed off by the community team. If the disabilities are so great that the patient cannot live independently, then ongoing treatment and recovery support will always be needed.

In addition to the criteria listed above, before a client is transferred to primary care, it is important to be sure that:

- This is what the client wants; the client has confidence in his or her own recovery process
- The client is capable of accepting guidance
- The client is able to call for help if it is necessary
- A practitioner in primary care is willing to monitor the client (GP, primary care psychologist, nurse practitioner).

The consensus document referred to previously recommends that people in remission should continue to be regarded as patients with SMI and remain in treatment for even longer (3 to 5 years).

The above criteria are fairly strict. There are three reasons for this:

- Firstly, we opted for these criteria on the basis of experiences in the United States, where in our opinion patients were sent from ACT to step-down teams too soon. Our impression is that this increases the risk of relapse and drop-out.
- Secondly, we are aware of the limitations of GPs in the Netherlands. These practitioners are certainly willing to take over monitoring a patient's medication and physical condition after FACT, possibly with the assistance of nurses who work individually. However, they do not have the capacity or expertise for a broad biopsychosocial approach. General practice would not be able to pay attention to the recovery process or enhance the patient's inclusion in the community.
- Thirdly, we see the positive aspects of monitoring patients within FACT, with low-frequency contacts, provided the team makes sure this does not turn into 'outpatient hospitalization' and with all the benefits referred to above.

GPs appreciate it if the FACT team can provide a 'return warranty' when FACT care ends. If the patient shows any signs of relapse or has greater care needs for some other reason, he or she can immediately return to the FACT team and receive intensive team care from the very first day.

The last reason why we have set such strict criteria is to prevent teams from using transfer to primary care as a 'back door' for clients with whom they have reached an impasse. In the past we have observed this response in newly-formed FACT teams, who behaved like many other teams in mental health services: if you don't fit in with us, we will terminate the treatment. In our opinion this cannot be the right response for patients with SMI.

Sometimes a client wants to terminate FACT care even though the above criteria have not been met. If the team thinks this is not a good idea and is concerned about possible relapse or self-neglect, they must talk to the client and their family. If the client and the team fail to resolve their differing views, there are two possibilities. If termination of care would not result in actual danger or the risk of serious disadvantage, we will respect the client's wish. We can suggest a step-by-step plan to taper off treatment, or agree to a 'trial discharge'. To prepare this, we must consult with the GP or other supervisors or people in the client's network. The FACT team can provide a safety net arrangement, committing itself to take the client back at the client's request. Sometimes the client is willing to make evaluation appointments after three, six and twelve months to see if they are happy with the way things are going. In this way the team respects the client's wish and avoids conflicts which might make it harder for the client to return.

If it is impossible to reach agreements with the client and the team are seriously concerned about ending care, a form of assertive care is set up. In the first instance this focuses on staying in contact (at a distance), being available (presence), and assessing risks. If there is a threat of relapse, self-neglect, nuisance or danger, active outreach care will be deployed; if there is danger, pressure and compulsion will be used.

Chapter 6: The disciplines in FACT

The Dutch FACT manual contains extensive sections about the roles of the various disciplines. This would go too far for this manual. We will provide a general outline for each discipline.

6.1 The peer support worker

We will discuss the role of the peer support worker first because FACT and experiential expertise are closely interwoven. The first jobs for peer support workers in the Netherlands were created in FACT teams in 2005.

Peer support workers were introduced into FACT following the example of the ACT model (and also earlier models for addiction treatment in the United States). In the Netherlands there is now a growing body of literature about the peer support worker approach and several training programmes have been set up. An essential element is the implicit hope peer support workers represent: they are living proof that recovery is possible. In addition to this, they use their experience of illness and care services to support the recovery process of other clients.

Peer support workers actively approach clients and maintain contact with them. They provide information about recovery and rehabilitation, about client rights and about collective experiential knowledge regarding recovery processes and forms of treatment and supervision. Peer support workers work in a wide range of ways, both individually or with groups such as WRAP groups (Cook et al., 2012) to support and empower recovery. They can play a role in shared decision-making and in motivation issues. They address the client from a different set of life experiences. They can talk to clients in their own homes or wherever else they may be staying. In the case of homeless people, it works better if the initial approach is made by a peer support worker rather than a health care practitioner. A peer support worker can first do things with the client such as helping them to do paperwork or clean up their house.

In addition to client-oriented tasks, peer support workers have a specific role in the team. At meetings they always introduce the client's perspective, try to judge whether the treatment will appeal to the client, question why team members are so insistent on certain matters which the client may not find necessary at all. This puts the peer support worker in a special and sometimes solitary position in the team, which is why there is currently discussion about the possibility of raising the standard FACT requirement (as formulated in the FACT scale) of a 0.6 FTE position for a peer support worker to 1.2 FTE per team. Then there would be two peer support workers in each team, who could also support each other.

6.2 Nurses

Nursing is the biggest discipline in FACT. In the Netherlands, nurses have traditionally always played a very major role in psychiatric care for people with SMI, in the first place because much of this care was provided in inpatient units, but also because many psychiatric nurses have also had training in rehabilitation techniques and providing support for patients living in the community. This is why in the Netherlands psychiatric nurses occupy the position in FACT that social workers occupy in the American ACT teams. These ACT teams often include only one nurse, whose main tasks relate to medication, depot injections and physical care.

In addition to psychiatric nurses, in the Netherlands we have the more specialized community psychiatric nurses and since a few years ago we have had the even more highly-trained psychiatric nurse practitioners. A nurse practitioner's profile includes not only independent patient care (and in the future also carrying out physical examinations and prescribing medication), but also expertise in leading and coaching teams, innovating the service and implementing new techniques, conducting research, and teaching. The number of teams with a psychiatric nurse practitioner (sometimes part-time) is growing and experiences have been very positive.

Too many specialists in a team also entails a risk. If a full-time nurse practitioner is appointed in addition to the psychiatrist, the psychologist and the IPS worker, there may not be enough FTEs over for the 'ordinary' case managers – and ultimately, in FACT everything revolves around the quick and flexible deployment of the case managers. It is the case managers who have to divide their attention between long-term processes and rapid intensive care with a shared caseload (see the hourglass model). They have to be able to play their role flexibly in recovery support processes, in treatment and motivating treatment and also when patients are destabilized; they have to help support them, provide them with structure, find ways to de-escalate the situation, motivate them to accept help and possibly medication, etc. Nurses also play an additional role in providing information about medication, dealing with side effects and stimulating healthier living patterns.

As case managers, the nurses are also responsible for coordinating social care – finding solutions relating to work, living, finances and well-being for the client. They also evaluate the treatment plan with the client and their family, on the basis of the ROM results, at least once a year. The draft treatment plan the case manager develops with the client is discussed by the multidisciplinary team and then adjusted and adopted.

Clearly the nurses have a very wide range of tasks. In connection with the creation of many FACT teams, a course consisting of ten half-day sessions has been developed which provides clinical nurses who have transferred to FACT with the special training they need to be FACT nurses.

6.3. The psychiatrist

In the Dutch FACT model the psychiatrist occupies a central place in the team. This is not the case in other countries, where the psychiatrist's role in outpatient care is sometimes limited almost exclusively to prescribing medication. In some Australian teams the psychiatrist can only be called in on a consultation basis. Within FACT this is unthinkable. In the Netherlands the treatment plan is signed by the psychiatrist on the team's behalf. The psychiatrist is responsible for the content of that treatment plan and can be held to account by external supervisory bodies for its implementation. The psychiatrist is not concerned only with his or her own interventions (medication, psycho-education), but also with the composition of the team interventions, in conjunction with the psychologist, the community psychiatric nurse or psychiatric nurse practitioner, and the case managers. The psychiatrist's role is both strategic (what is the long-term treatment strategy?) and operational (what will the team do today?).

The psychiatrist, in conjunction with the community psychiatric nurse, will often take the leading role in combating destabilization (see the hourglass model) and managing crises. This is partly because in the Netherlands emergency medication, risk assessments and requests for

emergency admissions are usually handled via the psychiatrist. In a crisis this will mean that the psychiatrist will accompany the client's case manager on a home visit. The psychiatrist's role is also accentuated by the fact that all compulsory treatment and monitoring (under court orders) can only be delivered under the responsibility of a psychiatrist.

Dutch psychiatrists are trained to work in accordance with the biopsychosocial model. A team psychiatrist will feel involved in all three dimensions and make contributions to them in the team. Another point is that many Dutch psychiatrists have been trained with the idea that they would assume the role of 'playing captain' in the team. On the basis of this view, they work with the team leader to improve teamwork and coordination between the disciplines.

All these aspects are topics of discussion, and one psychiatrist may focus more on individual patient care, while another contributes very actively to shaping the team; however, the psychiatrist is very much present in FACT, especially in comparison with systems in other countries.

This has not always been the case in the treatment of patients with SMI. It seems that FACT has brought the psychiatrist back into this treatment, whereas in the late twentieth century the psychiatrist remained at a greater distance from patients with SMI. Within the Dutch Psychiatric Association there is an SMI department and further models of working with FACT are being developed. The Dutch FACT manual is now compulsory literature in the training programme for psychiatrists. The manual sets out the tasks and competencies of a FACT psychiatrist in terms of the hourglass model:

- the psychiatrist's contribution in dealing with destabilization relates to emergency medication, risk assessment (suicide), consultation with the family, possible decisions regarding admission or coercion and diagnostic assessment
- in treatment, the psychiatrist's role relates to psychopharmacology (for example outpatient prescription of clozapine medication, alertness to metabolic syndrome) and dealing with substance use, working towards compliance, and also sometimes talking to the client's family or considering whether compulsory treatment is needed
- with regard to recovery, the psychiatrist's role is mainly to optimize the patient's mental state and to deal respectfully with the client's recovery process and goals.

Dutch psychiatrists can draw inspiration from a rich tradition of social psychiatry in the Netherlands. According to this tradition, a psychiatrist is first and foremost a doctor and a diagnostician. Both in stable phases and in phases of destabilization the psychiatrist always asks the question what the underlying pathology is and whether or not this is being treated optimally. As a diagnostician, the psychiatrist also keeps an eye on the patient's physical condition. An additional task for a FACT psychiatrist is to be constantly on the lookout for synergy between treatment, rehabilitation, empowerment and recovery. The challenge is to find the balance between giving advice, taking over, letting go, respecting the client's choices, working on compliance and if necessary using coercion. Psychiatrists must also always be aware that they are working within systems and that their interventions for the client will also have an impact on the family and the community.

6.4. The psychologist

In the Netherlands there are two levels of expertise: Mental Health Psychologist (with a university degree) and Clinical Psychologist (who has done post-graduate programmes

focusing on specific psychotherapies, psychodiagnostics, research, coaching and team supervision). Both levels work in FACT teams, but mostly Mental Health Psychologists.

There have also been very significant changes in the position and role of psychologists, partly due to the introduction of FACT. Essentially, in the past ten years a new branch of practical psychology has appeared. Until 10 to 20 years ago, the work psychologists did with people with SMI took place almost exclusively in the clinic, where they contributed to diagnostic assessment and often to the quality of life in the clinic. After that cognitive behavioural therapy was developed, then specific applications of this therapy such as ‘unravelling thoughts’ and later meta-cognitive behavioural therapy. The psychologist in FACT had more contact with the client’s family and began to focus more on specific on-the-spot training. Others set up various groups, such as Hearing Voices Groups, psycho-education, metacognitive training, skills training (Lieberman modules, emotional regulation disorder skills and various treatment groups oriented towards IDDT and IMR (Illness Management and Recovery)).

Wider familiarity with EMDR has also shown FACT teams that a very large number of our clients – more than we were previously aware of – are grappling with traumatic events. This is a growing area of concern.

Apart from these client-oriented activities in connection with treatment, the psychologist is also very important in relation to team culture. The psychologist has a different view of humanity and different perspectives on processes of change and recovery from the medical practitioners and nurses. The psychologist usually also coaches the case managers. Another contribution is information derived from research and the very rapidly developing discipline of psychology.

6.5. The employment rehabilitation specialist

Over the past ten years the employment rehabilitation specialist has gained a new profile and new competencies as a result of IPS (Individual Placement and Support). This model has brought employment specialists into the heart of society, looking for jobs for their clients, and also into the workplace itself, where they train their clients for their jobs and assist employers.

In other countries employment specialists sometimes make a contribution from a different position – in the context of employment reintegration projects or social employment projects. Within FACT, IPS workers focus exclusively on paid employment for people with SMI. In a more generalized social approach to employment reintegration, these people are nearly always eliminated first, losing out to people with less severe disabilities. The intensive IPS approach also helps to keep the FACT team focused on employment.

In the Netherlands (perhaps more than elsewhere) there was a long-standing tradition of occupational therapy, with supervisors assisting the patients in psychiatric hospitals with all kinds of activities and pursuits, partly to alleviate boredom, but also partly as employment-oriented training to help the patient prepare for a return to society. In the first stage of deinstitutionalization in the Netherlands these activities were transferred to day activities centres (similar to day centres or social clubs in other countries). In recent years these centres have come under pressure in the Netherlands. The view is that people with SMI in the community should increasingly make use of less stigmatizing general facilities.

The IPS worker can gain a great deal of support from other disciplines in the FACT team. A new paid job may mean challenges, such as getting up on time and travelling to work, or self-care. We have also observed that old problems tend to resurface at the workplace. The case manager, the psychologist and the peer support worker can all help with these potential problems to ensure the success of the IPS process.

IPS workers do not make a direct contribution to shared-caseload care; their focus is on paid employment. Working in compliance with the IPS model means that the IPS worker may not be involved with any other aspects of care; crisis work is not part of the IPS worker's job. Nevertheless, since IPS workers attend the morning FACT board meetings they are familiar with the clients' stories and if there is a threat of relapse they can put clients on the board themselves.

Chapter 7: Implementing FACT

7.1 Region-oriented work; rules of thumb for region size

The first thing that needs to be done when a FACT team is to be set up is to define a region for the team in question. The size of the region is important in relation to the number of clients that can be expected; this should not exceed 250 for one team.

The size of the region is also important in connection with assessing the feasibility of travel times for the outreach care workers. For the sake of efficiency and affordability they need to be able to visit a certain number of people a day. Regions are often defined in terms of postcodes.

For the partners of FACT teams it is also important for a FACT team to have a clearly-defined working area. For GPs, community services, housing agencies, welfare services and police stations it is important to be able to contact their 'own' FACT team, which covers the neighbourhood or region.

Ideal district sizes are based on practical experience. The experiences of the first hundred FACT teams seem to show that a rural district with 50,000 residents will have about 180 to 220 FACT clients. More people with SMI live in metropolitan areas. In a metropolitan area with 35,000–40,000 residents, 180–200 people with SMI will be eligible for FACT.

If we were to follow the consensus document referred to previously, the regions would have to be smaller, since this document estimates that in the Netherlands, which has a population of nearly 17 million, there are 162,000 people aged between 18 and 65 with SMI. This means that around 1% of the population belongs to the group regarded by the mental health services as being severely mentally ill, so that in a region with 50,000 residents 500 people with SMI could be expected. However, the situation in real life is different. Why a FACT team possibly cares for only the half the number of clients that might be expected is not yet clear. Some factors that may play a role are: some of the SMI patients avoid treatment, but do not attract attention; others are treated only by their GP; others are catered for by community care services or addiction treatment services or are in the forensic system (prisons and psychiatric units).

It is quite possible that the Dutch figures are not very relevant for other countries where the mental health services are organized in a different way. Social care and family support systems may also be different. However, we have observed that the basic principle of one team for 50,000 residents applies in other countries as well. For instance, the mental health services in Trieste in Italy, which have a strong emphasis on social psychiatry, have a structure of regional units with 50,000 residents. We see the same figure again in the size of the 'sectors' in the French '*psychiatrie du secteur*'. In Australia many teams for long-term treatment and care also have a catchment area of 40,000 – 50,000 residents. When defining a FACT team's working area, a good rule of thumb for rural or small urban regions is probably to choose an area with approximately 50,000 residents. For metropolitan areas it is best to choose a community or cluster of communities with around 40,000 residents.

For remote communities that are hard to reach and have fewer than 50,000 residents, the FACT model will have to be adapted. We often see that for this kind of area a smaller FACT

team is developed which covers a wider group than the SMI group; for instance, such a team might also treat child and adolescent psychiatric patients and addiction patients.

7.2 Integrated mental health services

The Dutch mental health services have a strongly developed clinical sector. In the last decades of the twentieth century, the former ‘psychiatric institutions’ were converted into psychiatric hospitals, in which a great deal of attention is paid to the rights of patients while in hospital and their privacy (many single rooms). In comparison with other countries, the duration of admissions is still long (sometimes very long). Internationally, along with Belgium (and to some extent with Germany) the Netherlands has the highest number of psychiatric beds per capita in the world. Per 100,000 inhabitants, the Netherlands has more than twice as many beds as the United Kingdom and four times as many as Australia. This has been starting to change in recent years. In 2011 it was agreed that within ten years 30% of the capacity would be phased out.

In the Netherlands a great deal of attention has also been paid to collaboration between inpatient and outpatient mental health services – perhaps more than in other countries. In the Netherlands this collaboration, which is referred to by the term ‘transmural’ psychiatric care, entails:

- * ensuring that *inpatient* (‘*intramural*’) psychiatric care is ‘time out’, as short as possible, from treatment which is in principle *outpatient* (‘*extramural*’)
- * ensuring that *inpatient* psychiatric care focuses on the patient’s social treatment goals and that the control of treatment remains an outpatient matter
- * working on a range of aspects such as continuity of care between inpatient and outpatient care (a shared vision, an integrated treatment plan, ongoing outpatient contacts during an admission, etc.).

This is reflected in admissions which can be very short, including admissions for just one night, at the direct request of the patient (‘bed on request’), so that the outpatient team can take over the treatment again the next morning. Members of FACT teams visit their clients at the clinic every week. They are involved in discussions of treatment plans. There is continuity of vision. We have found that when a FACT team is set up, it is very important for the team to make clear and detailed arrangements regarding these matters with a psychiatric unit in the area. Many mental health service organizations arrange for the FACT psychiatrists and the hospital psychiatrists to meet once a week to discuss and coordinate treatment. Together they decide on treatment strategies in the hospital.

7.3 Starting out and forming a vision

Now that the first 150 FACT teams are operating in the Netherlands, there is growing acceptance of FACT’s working procedures. More and more family members have heard about it and are much less critical than they were around 2005, when FACT was sometimes seen as a potential disruption of a patient’s safe existence in an institution.

At first family members were surprised about the regular home visits. Sometimes clients did not like the fact that different team members came to see them. It proved helpful to explain why this was done – that only a team can provide intensive care, that if the client’s own case manager is ill or on holidays treatment can continue as usual, and that in the long run it can be more pleasant if you have contact with several people. Now patient and family organizations

strongly support the FACT model and FACT's rapid expansion and implementation is partly due to them.

However, when a team is just starting it will be necessary to provide not only the clients and their families, but also policy makers, politicians and funding bodies with thorough information. It is not easy to establish confidence in the cohesiveness and intensity that FACT's outreach care can offer – at least, in the Netherlands there was a great deal of dissatisfaction with the mental health services and initially FACT was not seen as a change in the right direction. Moreover, representatives of regular and psychiatric hospitals and hospital psychiatrists did not support these developments from the outset.

Looking back on the implementation process in the Netherlands, it is clear that it was extremely helpful that FACT was introduced by a number of substantively motivated prominent practitioners, some of whom were also researchers, who together managed to set up a 'movement' and soon gained the support of patient and family organizations.

7.4 Setting up and training teams

At the local level it is important to prepare a sound plan. In a bigger region it can be very stimulating to start with one or two pilot teams which can implement the procedures; then it becomes clear how FACT compares with the existing system, how arrangements with the psychiatric unit work and how collaboration in the community operates (social teams, police, housing services). Pilot teams can also implement the working procedure with the FACT board, set up a digital FACT board and arrange various administrative processes in coordination with the existing parent organization.

Once all these things have been put in place, it is much easier to set up full-scale teams. When the pilot team phase comes to an end, a seminar can be held for family, municipal authorities, services etc., so that everyone can feel involved in the transition to the new model of care delivery.

At the same time it is also important to provide training courses for members of the pilot teams (and later the other teams), including:

- A FACT introduction course (with a whole team)
- An on-the-spot team training session, aimed at introducing and improving everyday working procedures with the FACT board
- Training for FACT board chairs (if possible 3 per team) regarding working procedures with the board and appropriate meeting techniques for the FACT board meetings
- Training for each discipline (for instance with 8 psychologists from 8 FACT teams) regarding the role of their discipline within FACT.

Most training courses focus on the change in attitude between working in an inpatient or outpatient clinic and outreach care. For some practitioners this is a huge step; it is as though they are losing their protective environment. Outreach care also confronts them with new situations and risks. Sometimes this requires targeted on-the-spot training and actively banning continued provision of care in a clinical setting.

Another step that is sometimes difficult for practitioners to take is working with a shared caseload. Many Dutch care practitioners had been trained to work very individually and were

not used to sharing their patients with other practitioners. The idea of team care sometimes meets with resistance, which must be dealt with actively. This includes working via the team; case managers have to learn to convey to the team what team care their client needs at a particular point.

Talking about all these issues is often very enlightening. If practitioners can overcome these hurdles, they are richly rewarded:

- Again and again we have found that after being introduced to outreach care, practitioners like it very much and soon see its advantages
- We have very frequently heard after induction periods that practitioners are more relaxed in their work and feel much less isolated and weighed down; there is a meeting with other team members every morning and they no longer have the sole responsibility for the most difficult clients.

7.5 FACT offices

The way a FACT team's office is set up can now be seen in many places in the Netherlands and has been described in detail. The most important feature is the meeting room with the FACT board, where the FACT board meeting is held every morning. Preferably this meeting room should contain a large meeting table with a computer from which someone can project the Excel sheet. The team members (about 15 people) have to be able to sit around the table comfortably, possibly with an extra circle (students on work placement, trainee team members). The rest of the day the big meeting room can serve as a general administrative area, where work stations with computers are set up along the walls and on the table.

Other features of the office will depend on the views of the service organization in question. In the Netherlands offices of this kind increasingly tend to be flexible spaces where practitioners rarely have rooms of their own. There are consultation rooms for the psychiatrist and the psychologist and sometimes a case manager or psychiatric nurse practitioner. Apart from that there are many workstations with computer and telephone, where the case managers can write their reports at the end of the day.

Relatively few clients and family members will have appointments at the office. This happens mainly with the psychiatrist and the psychologist. As a result, the 'public area' of the office can be limited to 3–5 consulting rooms.

The *location* of the FACT should be in the neighbourhood or region where the team works. Unfortunately many services in the Netherlands do not comply with this rule. Sometimes they house the FACT teams a long way away from their neighbourhood or region in the empty buildings of a former psychiatric hospital. Often this is a case of 'penny-wise, pound foolish', partly because the travel distances are too long. The best locations are in the neighbourhood or region where the FACT team works, and preferably in buildings where other services are also housed, for instance a youth care centre, a social support centre, a social housing office or a health centre. If the FACT office is located in the centre of the region and close to other community services, the team can itself take steps towards inclusion.

Offices in large rural areas also require parking space for team members' cars. Offices in big cities often need bicycle parks.

7.6 What happened to ACT in the Netherlands

The FACT model is an adaptation of Assertive Community Treatment (ACT); however, in the Netherlands FACT has outstripped ACT. ACT was introduced in the Netherlands in around 2000, when increasing numbers of psychotic, often addicted, often homeless patients were causing nuisance, particularly in the big cities. They had dropped out of the health care system and were avoiding treatment. ACT teams were launched in the four biggest cities.

In the big cities ACT was a huge success. Several years later the problems in the big cities had been considerably reduced, more people were entering and remaining in the care system and accepting treatment and housing. There was less nuisance. The situation stabilized and the very intensive ACT methods were no longer always necessary. Moreover, it was felt that services were also needed for the rest of the patients with SMI.

Since 2010 more and more ACT teams have been converted to FACT teams in big cities such as Amsterdam, Rotterdam and Utrecht. Amsterdam, for example, now has almost 20 FACT teams and just 2 ACT teams. The ACT teams actually guided the patients into care and treatment and reduced homelessness. They also managed to keep these people in treatment. However, when patients became more stable and had fewer social problems, it became less necessary to discuss them every morning. ACT had become an approach that was too intensive.

Another factor was that ACT teams provided care throughout the whole city, whereas FACT provides care in a smaller community or region. This smaller scale results in more opportunities for collaboration with the GPs and various services in the community. Travel times are also shorter.

In the big cities in the Netherlands a model gradually developed whereby FACT teams are available in all districts. They constitute the basis of specialized care and treatment for people with SMI in the community. In Amsterdam and Utrecht there are also still two ACT teams working with people with SMI who have very severe problems and are still often at risk of becoming homeless and roaming through the city, from district to district.

A new development is that forensic FACT and ACT teams are being set up; these are teams that specialize in providing treatment and care for patients with SMI who have come into contact with the law. There are now ten of these teams in the Netherlands and further growth is predicted. These forensic ACT teams have a slightly higher staffing level. This is partly because some clients always have to be visited by two case managers. These teams also need more psychologists in connection with risk assessment, psychological reports and reports for the court. Collaboration between the forensic teams and the ACT and FACT is good; one way in which the forensic teams can help the general teams is with risk assessment.

Chapter 8 ACT and FACT, model fidelity, the FACTs and certification

8.1 Differences between ACT and FACT

Flexible ACT is an extension of ACT and uses several important components of ACT.

ACT does not target all patients with SMI, but focuses on the most severe cases – mostly unstable, psychotic patients who need frequent readmissions. Many of them have personality disorders, substance use problems, poor medication compliance and a tendency to avoid treatment. This target group of severe cases is assumed to constitute about 20% of the whole group of long-term psychiatric patients (Bond et al., 2001). With ACT, all patients receive care and treatment from the whole team (shared caseload) and the team coordinates its activities every day at a meeting with a board on which all 60–100 patients are listed. The team provides assertive outreach care.

FACT targets the entire group of people with SMI, that is, both the 20% group of severe cases and the other 80%. This means that team supervision is not always necessary and not all clients need to be discussed every day. Of the 180-220 clients, about 15% are listed on the FACT board.

Table 2. Differences between ACT and FACT

	ACT	FACT
Target group	20% most severe cases, mostly revolving door patients, treatment avoiders	All patients with SMI in a particular district or region
Number of clients per team	60–100	220–250
Size of region	Often targets large areas, for example with 250,000 residents	Rural: 50,000 residents Urban: 40-45,000
Team composition	Broadly multidisciplinary: case managers, social workers, nurses, psychiatrist, peer support worker (almost identical to FACT)	= ACT With extra emphasis on psychologist and IPS worker and sometimes independent living support, and with more rehabilitation specialists. FACT teams in the Netherlands include many nurses.
Caseload (number of clients per team member)	1:10	1:20
Psychiatrist	1: 100	0.8:200
Psychologist	Not compulsory	0.6:200
Team leader provides direct client care	Compulsory	Sometimes, but can be replaced by 2–3 FACT board chairs
On ACT/FACT board for daily discussion	All 100 clients	Only 20–30 clients who need daily care and attention at that particular point; also ‘cases to

Contact frequency	> 3–4 times a week	discuss' If necessary, 4–5 a week is possible, but in many cases the frequency is much lower
Focus on EBM interventions	Often difficult because many clients are not stable and not yet open to psychological interventions	More feasible due to 'hourglass' approach
Focus on recovery and empowerment	In the past to a lesser extent in ACT, but this is now changing rapidly	One of FACT's basic principles
Discharge	When no more contact than once a week is needed, 'graduation' to stepdown teams.	Only clients who have been functioning stably for a long time (2–3 years) in all areas of life and who no longer want care. Then clients are transferred to GP
Relapse	Can return to ACT, but sometimes there are waiting lists	Can go straight back to being listed on FACT board.

8.2. ACT versus FACT

The ACT model is an evidence-based treatment approach for the 20% group of the most severely mentally ill long-term patients. The FACT model cannot yet claim this; further research is still required. However, in practice the FACT approach has proved effective, and a comparative study in the United Kingdom (Firn et al., 2012) and the first results of research in the Netherlands (van Os 2006 and Bak, Van Os, Delespaul et al. 2007) show that there are good reasons to assume its effectiveness. In 2012 FACT was classified as 'best practice' in an update of the Dutch multidisciplinary guideline for schizophrenia.

ACT seems to be particularly helpful for target groups requiring very intensive care, specifically for patients who roam from district to district. In section 7.5 we discussed how in the Netherlands FACT has now been chosen as the basic care model in the big cities.

Internationally there is an ongoing discussion about the 80–20% rule. This rule was formulated by Bond et al. (2001): ACT was intended for the 20% group of people with the most severe cases of SMI. However, apparently this rule has never been substantiated with figures. Bond and Drake (2007) stated that FACT may well provide a more reliable percentage, since clients are placed on the board when they need to be.

In practice, usually not 20% of a FACT team's clients are on the board, but only 10–15% of them. Evidently crisis, threat of admission and treatment avoidance are slightly less common. This may also be an effect of the FACT teams' work, because FACT teams also pay attention to the 80% group; possibly this helps to prevent relapses.

Because of the two working procedures within the same team, in the FACT model continuity between stable and unstable phases is guaranteed. This has advantages as regards rehabilitation and recovery and also provides continuity in contact with the client's family and support systems.

We have also observed that over about three years more than 60% of a FACT team's 200 clients need an episode of intensive care or treatment and are therefore placed on the FACT board. Recently listings during 2011 on the FACT board of a team called Team Centrum in North Holland were examined. In 2011, 132 of the 165 clients were placed on the board. Seventy-one of these were in crisis. Others on the board were treatment avoiders, new clients, and clients with life events, admissions and physical problems.

We think this finding is extremely important and possibly the most compelling argument in favour of FACT: it shows that FACT is geared to the natural course of severe mental illness. In the past, patients with SMI were stuck in the revolving door between the psychiatric unit and outpatient care and later between an ACT team and a 'stepdown' team. With FACT, the revolving door has moved to the FACT board – but the patient is cared for by one and the same team.

8.3 Model fidelity: the FACTs

Inspired by the Dartmouth Assertive Community Treatment fidelity scale (DACTS, Teague et al. 1998), in the Netherlands we developed a FACT fidelity scale – FACTs. This scale was first published by Bähler et al. in 2007. In 2010 the FACTs was revised by the Centre for Certification of ACT and FACT teams (CCAF). In 2013 a third version will appear. Dutch and English versions of the FACTs can be downloaded from www.ccaf.nl.

While the first FACT scale was largely based on the DACTS and the General Organizational Index for Evidence Based Practices (GOI, Lynne et al. 2005), supplemented by specific FACT items relating to switching from individual case management to shared-caseload care, the second version of the FACT scale (2010) developed along its own lines.

The FACTs 2010 consists of 60 items which can be rated on a five-point scale and which touch on all aspects of FACT:

- The team structure, including the number of team members per discipline
- The team process (and working with the FACT board)
- Diagnostics and treatment (with guideline-compliant interventions, rehabilitation and recovery)
- The mental health care organization (including admission, organization of integrated service delivery and discharge)
- Social care
- Monitoring (including Routine Outcome Monitoring)
- Professionalism (vision, training courses, focus on recovery, quality assurance).

Over the past few years this scale has been used to rate more than 70 FACT teams in the Netherlands. The interrater reliability was 0.83. In response to these outcomes, experiences and new developments, in 2013 several items in the FACTs will be adapted. The biggest change will be to the structure of the scale. Now that there are FACT teams for different target groups, the FACTs will consist of a general section and a special section depending on the target group of the FACT team in question. This concerns mainly the items relating to the disciplines and the multidisciplinary interventions.

In connection with the revision of the FACTs, the TMACT – successor of the DACTs – was also examined. Like the TMACT, the new FACTs has a greater focus on recovery. The structure of the TMACT was not followed exactly, partly because it remained a requirement that the FACTs could be administered properly in one day, whereas the TMACT may take more than one day.

Research (van Vugt et al. 2011) has now shown that greater model fidelity does in fact have an effect on the implementation of EBP and on treatment outcomes at the patient level.

8.4. Certification

In 2008 the Centre for Certification of ACT and FACT teams (CCAF) was set up. It had become obvious that FACT was really going to take off in the Netherlands. However, the risks of such rapid expansion were also clear – wide distribution could easily result in the development of many different versions of FACT. That did not seem desirable. We wanted to provide patients with SMI (and their families) with consistent standards of care and treatment. It had to be clear that a FACT team could deliver strong outreach care and guideline-compliant treatment.

In the Netherlands, funding for this kind of care comes partly from private insurers and partly from the government (partly the national government and partly the municipalities). These funding bodies have to make arrangements with local mental health care providers in about 20 to 30 different regions of the country. It was clear that these arrangements between so many different parties would be facilitated by a consistent model (FACT) that was well defined and that could also be tested for model fidelity in practice.

The CCAF has now assessed over a hundred ACT and FACT teams. For one day, two assessors join the team. They have been given numerical information in advance and on the day of the assessment they talk to about ten team members and a few clients, attend the FACT board meeting and can access anonymized files. The assessors are practitioners, experiential experts and family members of patients with SMI; they have been trained as assessors by the CCAF. After the assessment, the assessors process their findings and rate the teams on the FACTs. This leads to a provisional rating. The team is given an opportunity to comment on the findings and the provisional ratings. Then the findings are monitored by an independent Certification Board, which establishes the final ratings and – based on these final ratings – makes one of four recommendations to the CCAF Board:

- No certificate to be awarded (team shows no model fidelity)
- Provisional certificate (with recommendations for changing working procedures and a repeated assessment)
- Certificate
- Optimal Certificate

The CCAF is now widely known and recognized. Insurers and funding bodies require mental health organizations to have their teams certified and in this way highlight their endorsement of the requirements formulated for this service delivery model.

Interest in this kind of certification has now also been expressed in Belgium, Bonaire (Netherlands Antilles) and in Sweden the first international assessment of a team in Gothenburg has started.

For more information and English version of FACTs (free download): www.ccaf.nl

References

- Bachrach LL (1993), 'The Biopsychosocial Legacy of Deinstitutionalization', *Hospital and Community Psychiatry* vol 44(6) 523-524.
- Bak M, van Os J, Delespaul P, de Bie A, à Campo J, Poddighe G, Drukker M (2007), 'An observational "real life" trial of the introduction of assertive Community Treatment in a geographically defined area using clinical rather than service use outcome criteria', *Soc. Psychiatry Psychiatric Epidemiology* vol 42(2) 125-130.
- Bak M, Drukker M, de Bie A, à Campo J, Poddighe G, van Os J, Delespaul P (2008), 'Een observationele trial naar "assertive outreach" met remissie als uitkomstmaat 1', *Tijdschrift voor Psychiatrie* vol 50(5) 253-262.
- Bond GR, Becker DR, Drake RE, Vogler KM (1997), 'A fidelity scale for the Individual Placement and Support model of supported employment', *Rehabilitation Counseling Bulletin* vol 40(4) 265-284.
- Bond GR, Drake RE, Mueser KT, Latimer E (2001), 'Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients', *Disease Management and Health Outcomes* vol 9(3) 142-157.
- Bond GR, Drake RE (2007), 'Should We Adopt the Dutch Version of ACT? Commentary on "FACT: A Dutch Version of ACT"', *Community Mental Health Journal* vol 43(4) 435-437.
- Cook JA, Copeland ME, Floyd CB, Jonikas JA, Hamilton MM, Razzano L, Carter TM, Hudson WB, Grey DD, Boyd S (2012), 'A randomized controlled trial of effects of Wellness Recovery Action Planning on depression, anxiety, and recovery', *Psychiatr Serv.* vol 63(6) 541-547.
- Delespaul, PAEG & Consensusgroep EPA (Cahn WDG, Drukker M, Van der Gaag M, Van Heugten T, Van Hoof F, Keet R, Kroon H, Mulder N, Van Os J, Slooff CJ, Sytema S, van Veldhuizen R, van Weeghel J, Wiersma D, Willemsen E, Wunderink L), 'Consensus over de aard en omvang van de EPA populatie', (2012 (submitted) *Tijdschrift voor Psychiatrie*, The Netherlands.
- Drake RE, Essock SM, Shaner A, Carey KB, Minkoff K, Kola L, Lynde D, Osher FC, Clark RE, Rickards L (2001), 'Implementing Dual Diagnosis Services for Clients with Severe Mental Illness', *Psychiatric Services* vol 52 (April) 469-476.
- Drukker M, van Os J, Sytema S, Driessen G, Visser E, Delespaul P (2011), 'Function assertive community treatment (FACT) and psychiatric service use in patients diagnosed with severe mental illness', *Epidemiology and Psychiatric Sciences* vol 20(3) 273-8.
- Firm M, Hindhaugh K, Hubbeling D, Davies G, Jones B, White SJ (2012), 'A dismantling study of assertive outreach services: comparing activity and outcomes following replacement with the FACT model', *Soc. Psychiatry Psychiatric Epidemiology*, Springer.

- Intagliata J (1982), 'Improving the quality of community care for the chronically disabled: The role of case management', *Schizophrenia Bulletin* vol 8(40) 655-674.
- Lynne D, Finnerty M, Boyle P (2005), General Organizational Index for Evidence-Based Practices, SAMHSA website.
- Multidisciplinaire Richtlijn Schizofrenie (MDR)* (2005), Trimbos Instituut, Utrecht.
- van Os J, (2006), 'Een onderzoek naar het verschil in remissie bij assertieve outreach en het standaardmodel', *Patient Care*, December 2006 4-6.
- Phelan M, Slade M, Thornicroft G. et al. (1995), 'The Camberwell Assessment of Need (CAN): the validity and reliability of an instrument to assess the needs of people with severe mental illness', *British Journal of Psychiatry* vol 167, 589-595.
- Priebe S, Huxley P, Knight S, Evenas S (1999), 'Application and results of the Manchester short quality of life (MANSA)', *International Journal of Social Psychiatry* vol 45(1) 7-12.
- Rapp CA (1998b), *The Strengths Model: Case Management with People suffering from Severe and Persistent Mental Illness*, New York: Oxford University Press.
- Rapp CA, Goscha RJ (2006), *The Strengths Model: Case Management with People with Psychiatric Disabilities*, New York: Oxford University Press.
- Ridgway P (1999), 'Recovery paradigm project: deepening the mental health recovery paradigm, defining implications for practice. A report of the recovery paradigm project', Lawrence, KS: University of Kansas School of Social Welfare.
- Salyers MP, Tsemberis S (2007), 'ACT and recovery: integrating evidence-based practice and recovery orientation on ACT teams', *Community Mental Health Journal* vol 43(6) 619-641.
- Teague GB, Bond GR, Drake RE (1998), 'Program fidelity in assertive community treatment: development and use of a measure', *Am J Orthopsychiatry* vol 68(2) 216-32.
- Test MA, Stein LI (eds.) (1978), *Alternatives To Mental Hospital Treatment*, Plenum Press USA.
- Tiihonen J, Lönnqvist J, Wahlbeck K, Klaukka T, Niskanen L, Tanskanen A, Haukka J (2009), '11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study)', *Lancet* vol 374(9690) 620-7.
- van Veldhuizen JR, 'FACT: A Dutch Version of ACT' (2007), *Community Mental Health Journal* vol 43(4) 421-433.
- van Veldhuizen JR, Bähler M, Polhuis D, van Os J (eds.) (2008), *Handboek FACT*, De Tijdstroom Utrecht.

van Vugt MD, Kroon H, Delespaul PAEG, Dreef FG, Nugter A, Roosenschoon BJ, van Weeghel J, Zoeteman JB, Mulder CL (2011), *Canadian Journal of Psychiatry* vol 56(3) 154–160.

Wing JK, Beevor AS, Curtis RH, et al. (1998), 'Health of the Nation Outcome Scales (HoNOS): research and development', *British Journal of Psychiatry*, vol 172, 11-18.