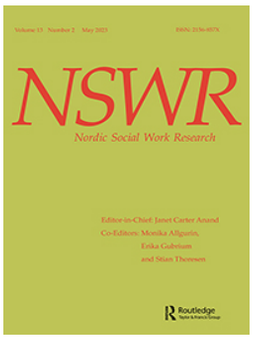
The flexible assertive community treatment fidelity scale: Description of the development in the Netherlands and adaptation in Denmark and Sweden



Nordic Social Work Research

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rnsw20

The flexible assertive community treatment fidelity scale: description of the development in the Netherlands and adaptation in Denmark and Sweden

K.H. Westen, M.D. van Vugt, A. Rosenquist, A. Lexén, Ph. Delespaul & H. Kroon

To cite this article: K.H. Westen, M.D. van Vugt, A. Rosenquist, A. Lexén, Ph. Delespaul & H. Kroon (2023) The flexible assertive community treatment fidelity scale: description of the development in the Netherlands and adaptation in Denmark and Sweden, Nordic Social Work Research, 13:2, 259-266, DOI: 10.1080/2156857X.2021.1952479

To link to this article: https://doi.org/10.1080/2156857X.2021.1952479

Published online: 28 Oct 2021.

NORDIC SOCIAL WORK RESEARCH
2023, VOL. 13, NO. 2, 259–266
https://doi.org/10.1080/2156857X.2021.1952479

Routledge
Taylor & Francis Group

The flexible assertive community treatment fidelity scale: description of the development in the Netherlands and adaptation in Denmark and Sweden

K.H. Westen [a], M.D. van Vugt[b], A. Rosenquist[c], A. Lexén [d], Ph. Delespaul[e] and H. Kroon[f]

[a]Academy of Healthcare, Avans University of Applied Sciences, Breda and Vice-president of the CCAF, Breda, The Netherlands; [b]Department of Mental HealthCare and Participation, Utrecht, HVO Querido, Amsterdam and Adviser of the board of the CCAF, Trimbos Institute, Utrecht, The Netherlands; [c]Region Hovedstadens Psykiatri, Copenhagen, Denmark; [d]Department of Health Sciences, Lund University, Lund, Sweden; [e]School of Mental Health and Neuro Sciences, Maastricht and Mondriaan Health Trust, Maastricht University, Maastricht, The Netherlands; [f]Department of Social and Behavioral Sciences, Tranzo Scientific Center for Care and Welfare, Tilburg and Trimbos University, Tilburg, Netherlands

ABSTRACT

Assertive Community Treatment (ACT) is the most common ambulatory service delivery model for people with severe mental illness worldwide. Flexible ACT, a Dutch modification of ACT, provides comprehensive care for the entire population of people with severe mental illness (SMI). FACT combines the principles of individual case management with ACT services. Researchers found an association between model fidelity and treatment outcome. Consequently, scholars formulated fidelity scales based on previous research and expert opinion (operationalizations of multiple criteria of team structure, organization and treatment processes). The first FACT model fidelity scale from 2008 facilitated the dissemination of FACT and prevented programme drift. Ten years later, an update was necessary to address relevant local variations in implementation, due to specific population profiles and available regional network services, and to improve recovery-oriented and evidence-based practices. Authors and stakeholders tested and updated a new FACT-model fidelity scale in the Netherlands, Denmark and Sweden. The resulting scale assesses 16 quantitative items and 8 qualitative, descriptive topics on 5-point Likert scales. The scale includes FACT-criteria that evidently work and still allow a team to diversify. The FACTs 2017 is a new standard to assess FACT-team model fidelity for the care of people with severe mental illness in The Netherlands and Scandinavia.

KEYWORDS

Assertive community treatment; community mental health; model fidelity; quality improvement

Introduction

In the early ’60 Marx, Stein and Test (Stein & Test 1980) noticed the positive impact of community living and the negative impact of hospitalization and created a programme, the Program of Assertive Community Treatment. They trained clients in community living and worked closely with community resources. Its core ingredient, Assertive Community Treatment (ACT), became the name most commonly used until today and spread around the world (Rochefort 2019).

CONTACT K.H. Westen kh.westen@avans.nl

All authors contributed to the study conception and design. The first draft of the manuscript was written by Koen Westen and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Since the introduction of the Flexible Assertive Community Treatment (FACT) model in the Netherlands in 2004 (Van Veldhuizen 2007) the number of FACT-teams increased rapidly. As an adapted model of Assertive Community Treatment (Stein & Test, 1980) FACT provides care for the entire population of people with severe mental illness (SMI), instead of a narrower target group in ACT (Cuddeback, Morrissey, and Meyer 2006) by combining the principles of individual case management with ACT services. When clients are experiencing difficult times, ACT services are provided by the entire team; their names are then posted on a digital register called FACT-board, which is inspected daily by all team members. In times of stability, clients receive individual treatment from a broad multidisciplinary team that includes case managers, a psychiatrist, and practitioners from other disciplines (Van Vugt et al. 2011; Bähler, van Veldhuizen, and van Vugt et al. 2008). As stability is no static trait, it's no reason for exclusion or discharge and thus enables larger caseloads per professional in FACT.

Along the way teams in the Netherlands started using FACT for subpopulations of SMI clients, including youth, people with intellectual disabilities and people with a forensic title. FACT-teams always deliver treatment for people with interrelated problems on multiple domains of life, for which integrated care and support is needed. FACT became a reference for the regional care for people with SMI in Holland and research on FACT showed that client satisfaction was rated high (Regional Expert Team, 2015), as well as professional satisfaction (Lexén & Svensson, 2016). High FACT-model fidelity is associated with less hospitalization (Nugter, Engelsbel, and Bähler et al. 2015; Sood, Owen, and Onyon et al. 2017; Nielsen et al. 2020).

With the introduction of the Dartmouth Assertive Community Treatment Scale in 1998 (DACTS; Teague, Bond, & Drake) and its successor in 2011, the Tool for Measurement of ACT (TMACT; Monroe-DeVita, Teague, and Moser, 2011) it was possible to assess the degree to which teams met essential criteria. Research found an association between (F)ACT model fidelity and treatment outcome (McGrew et al. 1994; McHugo et al. 1999; Latimer 1999; Van Vugt et al. 2011; Nugter, Engelsbel, and Bähler et al. 2015). Fidelity scales, like the DACTS, are operationalizations of multiple criteria of team structure, organization and treatment processes based on former research and expert opinion (Mowbray et al. 2003; Bond and Drake 2019). Reviewing model fidelity offers the possibility to compare results within and between teams. Besides research possibilities it helps teams to continuously improve quality of care. Transparency is important and allows clients, loved ones, professionals and stakeholders, like insurance companies, to check the availability of certified teams in a region.

The original FACT model fidelity scale from 2008 (Bähler et al.) has had a major contribution to the rapid implementation of FACT in The Netherlands (Westen et al. 2019). It helped new teams to implement the model and it supported existing teams to improve quality of care. But, after 18 years of the emergence of the first FACT-teams, this fidelity scale lost its relevance.

A review of different model fidelity scales in international mental health care by Mowbray et al. (2003) shows that items are defined very specifically and scored on Likert scales and/or dichotomous questions. Newly developed modalities to the model are added in time. Although necessary and preferred by professionals, this leads to an expanding item pool. Items often become too specific and this leads to just checking of items with limited validity: gradually the overly defined item becomes the guideline for implementation instead of its original meaning. For the same reason this makes specializing (in addiction care, childcare, personality disorders, and so on) more difficult, but likely to develop (Bond and Drake 2019; Rochefort 2019), and leads to the demand for specialized model fidelity scales with ultimately the same risks. Alternative and equivalent practices are unjustly excluded due to this gradual narrowing item definition which make unique and local adaptations harder to match. Perhaps one of the reasons Dutch teams drifted away from model fidelity and thereby possibly drifting away from fundamental principles and operations in (F)ACT, as seen in American ACT-teams by Monroe-DeVita, et al. (2012) and in Dutch FACT-teams by Van Vugt, Roosenschoon, and Kroon (2009).

Another reason for drifting away from the FACTs 2008 might be its lack of items relating to recovery-oriented practices and research (Van Vugt, Roosenschoon, and Kroon 2009). And, of the items that do, they show that the implementation of recovery-oriented care has shown to be insufficient, reflected in low-scoring recovery-oriented items of the fidelity scale. This seems valid for the implementation of evidence-based interventions, such as IPS, EMDR and IDDT, too.

Both these arguments resulted in the development of the TMACT too (Monroe-DeVita et al. 2012). A model fidelity scale for ACT-teams with more explicit instructions to score its 47 quantitative items. The idea of modelling a new FACT-scale based on the TMACT, as done before creating the FACTs 2008 using the DACTS was let go. Inevitably an enlarged quantitative scale would have let to the same circumstances. To fully implement FACT, more than fidelity measurement is needed (Monroe-DeVita, et al. 2012; Bond and Drake 2019; Rochefort 2019). A national transition in Dutch municipalities directed the development of the scale by showing the impact of giving freedom and responsibilities to its professionals (Oude Vrielink, Kolk, and Klok 2014). Professionals created innovative and local initiatives. This lead to the ambition to create a scale enhancing implementation by doing more than checking fidelity. The scale needed to improve the sense of professional responsibility and local unstructured innovation.

That large transition took place for Dutch municipalities in 2015 which changed community care considerably (Nederhand and Van Meerkerk 2018). A larger political focus on civil society transferred (financial) responsibilities from mental health organizations to local governments on sheltered housing, work, social activities and finances. A quantitative checklist of items didn't help FACT-teams to adhere to their core principles, whereas adapting to local situations and incorporating new practices have been one of its strengths in the early days of ACT (Liberman 1992). Nowadays, ensuring treatment for people with severe mental illness requires a joint network approach on all domains of life. FACTs 2008 offered too little flexibility for FACT-teams to adapt to different local realities as seen for ACT fidelity standards in American rural areas, which were impossible to meet (Weaver, Capobianco, and Ruffolo 2015). In addition, long existing and high functioning teams weren't challenged anymore.

A changing social context, dissatisfaction with the prescriptive nature of the FACTs 2008 and the limited implementation of recovery-oriented care and evidence-based resulted in the decision to develop a renewed FACT-scale in 2013. This article describes the path taken to develop a new FACT model fidelity scale, better suited for an ever changing context in a network of (mental health) teams and organizations, to enhance quality of care for people with severe mental illness in the Netherlands and its adaptation and implementation in Denmark and Sweden without compromising on its core principles (Bond and Drake 2019).

Development of the FACTs 2017

The Netherlands

FACT wants to contribute to the recovery of clients. There are no generally accepted sets of outcome indicators with corresponding reliable measuring instruments (yet). Apprehensiveness was taken into account regarding perverse incentives on selection and discharge of clients when specific outcome criteria would be selected. A scale based on outcome seemed impossible. It took a year before a decision was made to develop an instrument to measure the relationship between a team's casemix and its formal and informal resources and whether the resources used are relevant for the needs of treatment of its caseload.

Phase 1

At the beginning of 2014 the first phase started of developing the model fidelity scale: identifying and specifying reliability criteria (Mowbray et al. 2003). It relied on the earlier model fidelity scales,

a group discussion with the developers of the TMACT (Monroe-DeVita & Teague) and other relevant literature. The first version from July 2014 consisted of 10 themes, all individually outlined in a qualitative, descriptive manner. Opted were scores between 0 and 100 (0–30: ineffective implementation; 40–70: good elements but not consolidated; 71–89: implementation consolidated; 90–100: role model for reference teams). Outlining the themes was based on literature reviews and working visits. During focus groups with professionals, auditors and other stakeholders, it became clear that a full qualitative description of items gave too much undesired uncertainty. The original dissemination of ACT in the United States – by then still without fidelity scale- had shown that each next generation of ACT-teams had more diluted care (McGrew et al. 1994). Focus groups argued that specifying the desired disciplines, caseload and FACT-basics in the original FACT-scale had prevented such dilution in the Netherlands and Rochefort's article (2019) showed that multiple States in the US kept on using the structured DACTS as an audit instrument for a similar reason. Despite the former quantitative (F)ACT-scales and mentioned needs for structured items in focus groups, Spivak et al. (2019) showed that even this didn't help meeting all of clients' needs due to substantial differences between ACT-teams and missing out on core services (Spivak et al. 2019).

The Taskforce decided to upgrade the information requested prior to an audit. The scale was then split into two parts. Part A contains a short quantitative measurement scale on evidence based (F)ACT items (such as a shared case load) and the most distinctive FACT items scored on the usual 5-point scale. Part B is a qualitative and appreciative measurement tool based on topics that should allow a unique adaptation of the team to its casemix and its context. Describing these topics demands FACT-teams to steadily develop in the field of recovery oriented community, eHealth, and innovative care. Scores range from 1 to 8. This gave the FACTs-2017 its dualistic character: quantitative on the one hand and qualitative on the other hand.

Phase 2 and 3

The development of an auditing method for measuring model fidelity in the second phase went smoothly, as auditors had been trained in appreciative auditing since 2014. The most important changes originated from the feedback of clients, relatives and network partners.

The third stage in the development of the new scale consisted of the assessment of the validity and reliability of the instrument in two pilot rounds with trained auditors. After each round a focus group gathered consisting of the involved auditors, team members and external stakeholders. Throughout this period different drafts of the new FACTs were freely available online for feedback. Members from national mental health foundations, FACT-panels, consumer organizations and health insurers were explicitly invited to the focus group meetings and asked to provide feedback.

In 2015 and in the beginning of 2016 the first and second pilot round took place according to the same set up as the first round and ended with a focus group meeting. The new FACT-manual including the FACTs 2017 (Bähler et al. 2017) turned out to be workable for both teams and auditors.

Denmark

The FACT-model has been implemented in the Capital Region of Denmark in 2016, combining former ACT – and Community Treatment teams, and 26 new FACT-teams have been established in the region with nine more to come. FACTs 2008 was used for the first two years of re-organizing. Three days of FACT-training-on-the-job and multiple theme days with focus on Evidence-Based Treatment were used to enhance implementation. Teams were introduced to the FACTs 2017 (Bähler et al. 2017) during a one year period of implementation activities for managers, teams and staff in 2018. All professionals opted to use the new scale to better suit the Danish context and its mixture of rural and urban areas.

To understand the new Fidelity Scale, CCAF facilitated a four days action programme with a representative from CCAF (KW) for ten staff members from the first five FACT-teams in Denmark. Adjustment to Danish Mental Health Services, Community services and employment contracts were discussed and important adjustments, i.a. adding an occupational therapist, were made after consulting all authors of the scale. The FACT-manual including the scale (FACTs 2017) was then officially translated to Danish with help from the same ten staff members. The FACTs 2017 is currently being used by FACT-teams in the Capital Region of Denmark.

Sweden

Swedish government raised extensive criticism about disintegrated mental health services. As a result, an increased interest in integrated and community outreach models such as ACT and FACT emerged, to better meet the needs of persons with complex, and fluctuating mental health care issues. Goal is to integrate outpatient and inpatient care, as well as mental health and social services. As part of this strive towards a new organization in delivering care and support the FACTs 2008 and later the FACTs 2017 fidelity scale were translated to Swedish and adapted to the Swedish mental health care and social service context. A move to the FACTs 2017 made sense due to its focus on integrating mental health and social services. For the translation and adaptation of FACTs 2017 a working group was organized in 2018 with personel from the mental health care and social services, and expert researchers. Comments and suggested changes were summarized and discussed during a workshop with a representative from CCAF (KW). During this 3-day workshop differences in mental health and social services between the Netherlands and Sweden were discussed and the manual as well as the scale were adapted to a Swedish context. A newly written introduction to the Swedish context using Swedish research and adding two disciplines are examples of that. An occupational therapist was added as a core team member, and a physiotherapist was added as an expert on somatic health. The FACTs 2017 is currently being used by FACT-teams in the south part of Sweden and all comments and reflections are being collected for a final version that will be published in 2020.

FACTs 2008 versus FACTs 2017

The FACTs 2017 differs in form and lay-out from the FACTs 2008. The shape has shifted from a standardized fidelity scale using a quantitative questionnaire to a short list of closed questions and a large qualitative area in which different deliverables (topics, see Table 1) lead the way. On the one hand the characteristic and evidence based components of FACT are strictly maintained and, on the other hand, teams are able to optimally relate to its community and its casemix. The FACTs 2017 is generic. It's easier to apply on FACT-teams with different target groups.

In terms of content, some topics are added and enlarged. The topic 'recovery' and recovery oriented practices are way more evident than before. Topics 2 and 3 in part B, personal and social domain, originate from the ideas and research base on recovery. A greater emphasis in topics 5 and 7, planning and control at the individual customer level and cooperation with the network, on the use of formal and informal resources in the treatment of the client, and routine outcome monitoring are in line with the scale's recovery orientation.

The original FACTs 2008 gave little attention to the safety of the client, its family and the team and to risk assessment. The Forensic FACT-scale corrected this omission somewhat and that correction is included in the FACTs 2017.

The FACTs 2008 probably didn't contribute to the satisfactory implementation of evidence-based treatments for reducing symptoms in the field of somatic, psychiatric, addiction, mild cognitive impairment- and educational problems. These general characteristics of clients are widely spread in each caseload of FACT-teams and thereby attention to appropriate treatment services increased. Doubling the number of hours for a psychologist in the new FACT-scale and the explicit

Table 1. FACTs 2017: part A and part B.

Part A	16 items: small caseload, team, psychiatrist, psychologist, nurse, social/legal expert, employment expert, expertise in the area of experiential expertise, expertise in the field of somatic, expertise in the field of addiction, expertise in the field of LVB, self-management and autonomy, flexible care, team approach, daily ACT-Board consultation, outreach.
Part B	1) Flexible care: Flexible care is visible during daily team meetings, stages of treatment are visible in the treatment plan and is implemented, a team approach is visible, in which the expertise of multiple team members are deployed, the intensity of care is appropriate to the stage of recovery; upscaling of downscaling care is possible if needed or desired. 2) Personal domain: the team recognizes and acknowledges the identity of the client, empowers the client and its struggle with its cultural, sexual and spiritual identity and emotions like grief and sorrow and acts upon it jointly, there is attention to countering stigmatization by the team and self-stigma of the client, the team dares to take risks, the team has a hopeful attitude and uses hopeful language focused on an open and positive vision of the future. 3) Social domain: the roles of the client within the domain 'self-care' are visible, the roles of the client within the domain 'social network' are visible, the roles of the client within the domain 'work and free time' are visible. 4) Symptomatic domain: Psychiatric interventions, somatic interventions, psychological and pedagogical interventions, addiction interventions. 5) Planning and control at the individual client level: Planning and control cycle, integral responsibility. 6) Crisis and security: Assertive proactive crisis interventions, safety and risks. 7) Network cooperation: involvement and cooperation with the social network of the client, collaboration with professional internal and external resources. 8) Quality and innovation: education and training, expert knowledge, planning and control cycle on team level, innovation of care.

need for somatic, addiction and mild cognitive impairment expertise in the team hopefully contributes to better service delivery for the general population of clients in FACT-teams.

The previous FACT-scale increased the number of peer specialists in mental health care in the Netherlands. In this area, FACTs 2017 is future orientated again. A paid peer specialist is wanted and it's all about the competency of working with your own experiences instead of an individual discipline. Professionals are explicitly invited to out their own experiences with recovery in mental health and convert it into a professional competency. On the other hand, it offers peer specialists the opportunity for regular scholing without the loss of their competency by experience. A next step to fight stigma in mental health.

Discussion

The first FACT-scale helped spreading the model to all mental health organizations in the Netherlands, but didn't meet all needs for its clients by not focusing on recovery enough (Van Vugt et al. 2018) and not all needs for professionals too due to its quantitative lay-out. A new scale was needed to improve recovery-oriented practices and bring back the energy and flexibility of the early days of ACT and FACT (Liberman 1992; Rochefort 2019). Professionals in mental health care are satisfied with the new scale, which gives them the opportunity to adapt to their local context and continuously improve quality opposed to the former solely quantitative scale. The new scale has opened up to promote innovations, flexibility and ownerships and helps to improve successful implementation (Rochefort 2019), and not just fidelity measurement. A well-considered choice to abandon the recommended structure for EBP-fidelity scales (Bond and Drake 2019) and develop a scale combining qualitative and quantitative items. Continuous training of auditors is important to improve interrater reliability and discuss cases to understand new practices. The process of auditing has evolved and has shown to be more complex for teams and auditors. All share the idea that this is a necessary step to deliver integral care for people with SMI.

Recovery oriented practices are embedded in the new scale, opposed to the former FACTs from 2008. The TMACT has been developed with this same reason (Monroe-DeVita et al., 2011; Cuddeback et al. 2013), adding multiple recovery oriented items in a similar structured and

quantitative fashion. Early findings suggest high fidelity on the TMACT results in fewer days in hospital for other outcome criteria are not conclusive (Cuddeback et al. 2013). No research has been done with the FACTs 2017 in this matter. The new scale is based on research, as well as practical experiences and other sources, but it is not known whether there is a relationship between model fidelity and outcome for this scale. Nevertheless, building a scale fully based on outcome predictors wasn't an option due to possible perverse consequences.

Conclusions

The successor to the FACT-model fidelity scale of 2008 has been developed in recent years. Professionals in The Netherlands and members of the CCAF have set a new standard with the FACTs 2017. A standard for appreciative auditing in community care for people with severe mental illness. The FACTs 2017 offers opportunities for quality improvement and transparency in an ever-changing context and in a continuous developing domain of mental health. Swedish and Danish professionals have shown the FACTs 2017 to be easily adaptable to other (European) countries and enhance quality of care in other contexts too.

Find the FACTs 2017 on the website www.ccaf.nl.

Compliance with Ethical Standards

The authors did not receive support from any organization for the submitted work.

The authors have no financial conflicts of interest to declare that are relevant to the content of this article. All Dutch authors are involved in the CCAF Foundation; potential conflicts of interest cannot be excluded.

Declarations

Data reports generated during and/or analysed during the current study are available from the corresponding author on reasonable request.

Verbal informed consent was obtained prior to all (group)interviews during the development of the FACTS 2017.

Disclosure statement

No potential conflict of interest was reported by the author(s).

ORCID

K.H. Westen http://orcid.org/0000-0002-6609-5247
A. Lexén http://orcid.org/0000-0002-9776-9304

References

Bähler, M., J. R. van Veldhuizen, M. D. van Vugt, Ph. Delespaul, J. Lardinois, N. Mulder 2008. De FACT-schaal: FACTs. CCAF: Heiloo/Utrecht

Bähler, M., P. A. E. G. Delespaul, H. Kroon, M. van Vugt, K. Westen 2017. FACT-Schaal. Utrecht: CCAF

Bond, G. R., and R. E. Drake. 2019. "Assessing the Fidelity of Evidence-Based Practices: History and Current Status of a Standardized Measurement Methodology." *Administration and Policy in Mental Health*. doi:10.1007/s10488-019-00991-6.

Cuddeback, G., J. Morrissey, M. Domino, M. Monroe-DeVita, G. B. Teague, L. L. Moser 2013. "Fidelity to Recovery-Oriented ACT Practices and Consumer Outcomes." *Psychiatric Services* 4 (4): 318–323. DOI:10.1176/appi.ps.201200097.

Cuddeback, G., J. Morrissey, and P. Meyer. 2006. "How Many Assertive Community Treatment Teams Do We Need?" *Psychiatric Services* 12 (12): 1803–1806. doi:10.1176/ps.2006.57.12.1803.

Latimer, E. 1999. "Economic Impacts of Assertive Community Treatment: A Review of the Literature." *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie* 44 (5): 443–454. doi:10.1177/070674379904400504.

Lexén, A., and B. Svensson. 2016. "Mental health professional experiences of the flexible assertive community treatment model: a grounded theory study." Journal of Mental Health25 (4): 379–384

Liberman, R. P. 1992. *Handbook of Psychiatric Rehabilitation*. Boston: Allyn & Bacon.

McGrew, J. H., G. R. Bond, L. Dietzen, M. Salyers. 1994. "Measuring the Fidelity of Implementation of a Mental Health Program Model." *Journal of Consulting and Clinical Psychology* 62 (4): 670–678. DOI:10.1037/0022-006X.62.4.670.

McHugo, G. J., R. E. Drake, G. B. Teague, H. Xie. 1999. "Fidelity to Assertive Community Treatment and Client Outcomes in the New Hampshire Dual Disorders Study." *Psychiatric Services* 50 (6): 818–824. DOI:10.1176/ps.50.6.818.

Monroe-DeVita, M., G. Morse and G. Bond. 2012. "Program fidelity and beyond: multiple strategies and criteria for ensuring quality of assertive community treatment." Psychiatric Services63 (8): 743–750

Monroe-DeVita, M., Teague, G. B. and Moser, L. L. 2011. The TMACT: A new tool for measuring fidelity to assertive community treatment. Journal of the American Psychiatric Nurses Association, 17: 17–29. doi: 10.1177/1078390310394658

Mowbray, T., C. Holter, G. B. Teague, D. Bybee. 2003. "Fidelity Criteria: Development, Measurement, and Validation." *American Journal of Evaluation* 24 (3): 315–340. DOI:10.1177/109821400302400303.

Nederhand, J., and I. Van Meerkerk. 2018. "Activating Citizens in Dutch Care Reforms: Framing New Co-production Roles and Competences for Citizens and Professionals." *Policy and Politics* 4 (4): 533–550. doi:10.1332/030557317X15035697297906.

Nielsen, C. M., C. Hjorthøj, H. Killaspy, and M. Nordentoft. 2020. "The Effect of Flexible Assertive Community Treatment in Denmark: A Quasi-experimental Controlled Study." *Lancet*. doi:10.1016/S2215-0366(20)30424-7.

Nugter, A., F. Engelsbel, M. Bähler, R. Keet, R. van Veldhuizen. 2015. "Outcomes of Flexible Assertive Community Treatment (FACT) Implementation: A Prospective Real Life Study." Community Mental Health Journal 52 (8): 898–907

Oude Vrielink, M., H. Kolk, and P. J. Klok. 2014. *De Vormgeving Van Sociale (Wijk)teams*. Den Haag: Platform31.

Regional Expert Team. 2015. *FACTsheet over Optimale FACT-zorg Volgens Cliënten. Resultaten Van Een Onderzoek Door De Regionale Expert Teams in Amsterdam, Flevoland, Gelderland, Noord-Holland, Overijssel, Utrecht En Zuid-Holland*. Amsterdam: RET.

Rochefort, D. 2019. "Innovation and Its Discontents: Pathways and Barriers in the Diffusion of Assertive Community Treatment." *The Milbank Quarterly* 97 (4): 1151–1199. doi:10.1111/1468-0009.12429.

Sood, L., A. Owen, R. Onyon, A. Sharma, J. Nigriello, D. Markham, H. Seabrook. 2017. "Flexible Assertive Community Treatment (FACT) Model in Specialist Psychosis Teams: An Evaluation." BJPsych Bulletin 41: 192–196. doi: 10.1192/pb.bp.116.053967

Spivak, S., R. Mojtabai, C. Green, T. Firth, H. Sater, B. A. Cullen. 2019. "Distribution and Correlates of Assertive Community Treatment (ACT) and ACT-Like Programs: Results from the 2015 N-MHSS." *Psychiatric Services* 4 (4): 271–278. DOI:10.1176/appi.ps.201700561.

Stein, L. I., and M. A. Test. 1980. "Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation." *Archives of general psychiatry 37* (4): 392–397

Van Veldhuizen, J. R. 2007. "FACT: A Dutch Version of ACT." *Community Mental Health Journal* 43 (4): 421–433. doi:10.1007/s10597-007-9089-4.

Van Vugt, M. D., B. J. Roosenschoon, and H. Kroon. 2009. "Modelgetrouw Heeft Meer Effect." In Assertive Community Treatment. Bemoeizorg Voor Patiënten Met Complexe Problemen, edited by C. L. Mulder and H. Kroon, 41–56. Amsterdam: Boom

Van Vugt, M. D., H. Kroon, P. A. E. G. Delespaul, F. G. Dreef, A. Nugter, B.-J. Roosenschoon, J. van Weeghel. 2011. "Assertive Community Treatment in the Netherlands: Outcome and Model Fidelity." *Canadian Journal of Psychiatry* 56 (3): 154–160. DOI:10.1177/070674371105600305.

Weaver, A., J. Capobianco, and M. Ruffolo. 2015. "Systematic Review of EBPs for SMI in Rural America." *Journal of Evidence-Based Social Work* 12 (2): 155–165. doi:10.1080/15433714.2013.765815.

Westen, K. H., M. van Vugt, M. Bähler, Ph. Delespaul, and H. Kroon. 2019. "Development of the renewed Flexible ACT scale: F-ACT fidelity 2017." Tijdschrift voor Psychiatrie, 61 (2): 97–103.