

Does FACT have a future: A multi-perspective reflection on quality improvement in Flexible Assertive Community Treatment teams as part of networks of care for people with severe mental illness

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The image features three glowing, three-dimensional cubes suspended by thin black lines from the top. The cubes are white with black tops and gold-colored edges. They are arranged in a triangular pattern: one is tilted in the upper left, one is upright in the middle right, and one is upright in the lower left. The background is a solid grey color.

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Koen Hendrikus Westen

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Chapter 1.

Introduction

Introduction

The dismantling of psychiatric institutions all over the Western world, starting around 1950, has led to many variations of community mental health treatment for people with mental illness. People with severe mental illness (SMI; 1,2) have complex needs that require a range of support and services to help them manage their symptoms and improve their overall well-being. Originally this was done in an inpatient setting with the ability to deliver multiple services from different professionals 24 hours a day for seven days a week. Needs of people with severe mental illness didn't change over time, but circumstances did. A need to deliver the same kind of services outside of a psychiatric institution, in a community, became present. Good, community-oriented services for people with (a risk of) severe mental illness always require a cross-sectoral approach and thus the involvement of multiple service providers (1), as advised by the Dutch council of Healthcare as well (3). The future of mental health worldwide will encompass community-centric mental health services, integrating all community and inpatient components within the catchment area even more (4). To meet all needs requires a broad and diverse range of services from health care, public services and private agencies (5,6). In doing so, services should flow seamlessly, without waiting lists or unnecessary procedures (5).

These requirements for community mental health for people with severe mental illness calls for integrated care service networks, comprising "a group of three or more autonomous organisations working together across structural, temporal and geographic boundaries to implement a shared population health or health services strategy" (7). When professionals and organizations work together and align their efforts, it can lead to better communication, increased trust, and improved collaboration between care providers (8,9). This can ultimately benefit clients and their informal caregivers, as a more coordinated and holistic approach can better meet their diverse needs (10). In other words, by aligning their efforts, professionals and organizations can create a more integrated and effective system of care that benefits everyone involved. Much research has been done considering the implementation, development and effect of integrated community mental health teams for people with severe mental illness, but until recently the notion of what integrated care in a network of care requires (volunteers, professionals, teams and organizations) was lacking in research. This thesis will study the objectives that arise from omission in relation to the Flexible Assertive Community Treatment (FACT) model in the Netherlands. We studied the adaptation process of the FACT model in an integrated network of care for people with severe mental illness in the Netherlands and evaluated the impact of adaptation on quality of care, other models of care and collaboration between professionals and networks to make recommendations for future adaptations of the FACT model in a network of care.

History in the making

The Netherlands, some other European countries like Italy and Anglo-Saxon countries, share a past when it comes to helping people with severe mental illness (SMI). These countries have a long history of deinstitutionalization and associated reduction in beds in mental health care facilities. All rely heavily on the knowledge that people with SMI need integrated care (1). Transferring mental health treatment for the severely mentally ill from an institution to the community all started from 1950 onwards. Institutions were no longer believed to be the ideal surrounding to recover (11,12,13,14) and a substitution was needed outside of these institutions in the community. This movement of deinstitutionalization was a process, a fact and a philosophy (15). A still ongoing process of adapting community mental health to changing needs and circumstances is unfolding, without knowing the exact facts on the effects on quality of life, but holding on to the philosophy of deinstitutionalization as a humane alternative to institutions. The transition from hospital to community created a significant concern about how to help persons with severe mental illness live meaningful lives (16). The different trends in the deinstitutionalization movement, like trans-institutionalization of people with severe mental illness to inpatient units elsewhere (17), the underserving of people with severe mental illness due to financial or practical incentives and the rise of a profitable mental health sector (18) created confusion and suboptimal solutions. This resulted in insufficient development of proper outreach services for people with severe mental illness. People with severe mental illness living in the community lacked proper treatment (19) and in the early years after deinstitutionalization remained inadequate for people with SMI (20). Consequently, people with severe mental illness were victims of deinstitutionalization (21) e.g., homelessness, criminal involvement, social stigma, declining physical health.

This transition to community psychiatry in the Netherlands took place due to the work of Querido (22) and others. They brought psychiatry to the streets. But our reliance on beds remained high over the years up to now (23). So one can debate if deinstitutionalization in the Netherlands had a similar impact as it did in Italy, England or the US (24). In the US, Stein, Test and Marx, succeeding their predecessor Arnold Ludwig in the mid-1960s in Madison, Wisconsin, started experimenting with the substitution of inpatient treatment (25). Working together on the research ward of Mendota State Hospital they observed the 'revolving door' principle and became aware of the lack of good aftercare (26). This phenomenon of 'revolving door' clients emerged together with the rise of clients with mental health problems being treated in the community, without having the back-up of long-term institutionalization. So after discharge from a short-term inpatient unit, due to a crisis for example, clients were repeatedly readmitted because aftercare in the community was insufficient.

Those early adopters quickly noticed the effectiveness of community treatment (27) and learned from the work of Barb Lontz, a social worker, who showed how to train community living skills to mentally ill clients in the community (28). Step by step, from an intramural (local) training program, to a transmural (national) program on Training in Community Living to an extramural community model, the model gradually iterated into Assertive Community Treatment (ACT; 29), an integrated model delivering a broad range of services. This multidisciplinary service-delivery model was developed to establish proper services in the community for people with severe mental illness in the heydays of deinstitutionalization and counter 'revolving door' patient care (30).

Assertive Community Treatment

ACT teams deliver interdisciplinary services to people with severe mental illness in the community using outreach. Evidence based treatment, crisis interventions and recovery-oriented practices are all available for all clients of an ACT team, wherever they may be, to improve recovery. The overall aim of recovery is to support the client in gaining a meaningful and satisfactory life by promoting hope, attainment of personal goals, social inclusion, and supportive relationships and not merely focusing on symptom and problem reduction (31). An ACT team has all strategies available 24/7 utilizing all team members for a shared caseload to enhance continuity and coordination of care. Every morning all available team members discuss all clients using an (administrative and logistical) ACT board to plan and coordinate interventions. Client visits take place multiple times a week by different disciplines, like psychiatrists, psychologists, substance abuse specialists, nurses, social workers, vocational specialists and peer support workers, with as many visits as necessary to properly address the person's needs. These holistic and integrated services influenced the structure of Dutch mental health services in profound ways, as it did in many countries outside of the US (32,33).

Due to the initial time-unlimited nature of these holistic and integrated services, and the use of coercion in ACT teams, critics have suggested that ACT teams are paternalistic or oppressive and therefore anti-recovery (34,35,36). Whether this is inherent to the ACT model or the professionals working in a certain context seems debatable. Different ACT teams show different results on the use of coercion for example (37) and ACT teams in the US struggle to work according to model fidelity regarding client choice (38). But the idea of ACT not being recovery oriented enough, caught on in later, similar, articles too (39,40,41). Criticism surrounded ACT from the beginning after observing ambulatory hospitalization (42) or poor functioning of discharged patients in the community (43). It seems the recovery movement challenged the model and not the process of deinstitutionalization. And as Drake and Deegan (39) put it: 'Is ACT compatible with recovery? It had better be. The mental health system needs both science and values, and for the time being, ACT faces the challenge of combining both in the chaos that constitutes the U.S. public mental health system'. The recovery movement challenged the ACT model to adapt to a changing context once again.

Research was made possible due to the focus on quality improvement and model description from the start (29). When program models are not well-described, the interpretation of individual studies becomes ambiguous, as do comparisons between studies that ostensibly examine the same model (44). ACT professionals in the early years used training, consultation, and follow-up site visits by acknowledged experts to support new ACT teams (45). They quickly realised that more rigorous, standardized evaluation approaches to ensure adequate replication and model adherence were needed to live up to the need for growing number of ACT teams to be implemented with consistency (46). The development of a model fidelity scale for ACT supported the process of continuous improvement of the model and, at the same time, the dissemination of high-fidelity ACT teams (33). Due to the development of the Dartmouth Assertive Community Treatment scale in 1998 (DACTS; 47) a descriptive standard of care was made possible. Using a quantitative measurement tool linked to a 5-point likert-type scale helped dissemination of standard practices, but lacked the ability to evaluate in-depth practices of community mental health care. In 2014 this scale was replaced by the Tool for Measurement of ACT (TMACT; 45) which sets higher performance standards through enhanced assessment of recovery-orientation, evidence based practices and teamwork, and is more sensitive to change than the DACTS (47).

The ACT model has been consistently well researched (30), considered an evidence-based practice in 2001 (48), and has shown to be evidence based since (49,50). High ACT model fidelity using a model fidelity scale (47) is associated with a reduction in hospital days (44,51,52), fewer hospital admissions (53), better outcomes on the Health of the Nation Outcome Scales (HoNOS; 54) and less homelessness (55,54). A review from 2017 (56) confirmed the decrease of time spend in hospital when adopting ACT. However, findings outside of the US show little to no effect compared to standard care (57,58,59,60), probably due to a better standard of (mental health) care (60).

The ACT model fidelity scale ensures that ACT teams strive towards the outcome measures stated in the ACT model. An ACT team is supposed to prevent admission, readmission, and long-term hospitalization for people with severe mental illness, regardless of their level of functioning. Results from studies on the effect of ACT on admissions and hospital days are therefore inherent to the model, says Gomory (35), leading to discussions on circular reasoning to date. A review from 2001 showed improved outcome on housing stability, quality of life and client satisfaction (50), but not as clear as results found in research on hospital days and hospital admissions (44,51,53,56). Circularity may be in play. Despite this discussion on circular reasoning, the widespread consensus amongst professionals and policy makers about the clinical and social value of ACT kept the implementation and dissemination going in the US (33). A discussion that hindered the dissemination outside of the US arose when results on admissions and hospital days failed to be duplicated outside of the US (30). Gowda and

Isaac (61) suggest that patient satisfaction with ACT (also reported by Rapp and Goscha (62)), combined with the overall benefits, may be worth the perceived limitations. The ACT model was implemented in the Netherlands from 1999 onwards.

A Dutch perspective

In the Netherlands, an estimated 1.7% of the population suffers from a severe mental illness (1). The ACT model was introduced to deliver integrated services to this population in 1999. During the 90s Dutch mental health organizations used intensive clinical casemanagement as a service for people with severe mental illness (63). Clinical casemanagement from an individual case manager does not meet the needs of people with severe mental illness (1) and teams of individual casemanagers struggled delivering one standard of care (63). The ACT model lived up to the expectation of integrated care (64) and professionals wanted ACT to be available for all people with severe mental illness, even in rural and remote areas. The Flexible ACT model, still named Function ACT at that time, was introduced in 2003 to combine all ACT services with individual casemanagement in one and the same team. A FACT team was named so because it is able to effectively, flexibly, and systematically upscale and downscale the intensity of care within one team of different disciplines. FACT holds the promise to bring ACT services and less intensive casemanagement to all people with severe mental illness (65). This promise inspired many countries to develop FACT teams. FACT teams have been created in Austria, Belgium, Bonaire, Canada, Croatia, Denmark, Finland, France, Hong-Kong, Iceland, Ireland, Moldova, Norway, the UK, the USA and Sweden for instance. Being mentioned as one of Europe's Good Practices in Community Mental Health (66) must have helped FACT gain popularity. A historical overview of the origin of FACT in the Netherlands is given in chapter 2.

Research on FACT is not conclusive (67,68), mainly due to the current lack of well executed randomized controlled trials. Dissemination of FACT happened rapidly in the Netherlands and a randomized controlled trial has never been conducted in the Netherlands. Nonetheless, Nugter et al. (69) showed results on lowering admissions and hospital days in the Netherlands after following three new FACT teams for two years. Firn et al. (70) found similar results in the UK after four years of gathering observational data on the closing of assertive outreach teams followed by the transfer of patients to standard teams reinforced with the FACT approach. These results, undeniably leading to the same discussion of circular reasoning or discussing the natural improvement of clients over time, have been complemented with positive results on other outcome measures such as patient satisfaction (71,72), professional satisfaction (73), and cross-sectoral collaboration (74).

Generalist FACT teams have been set up in most Dutch regions. In some regions, in addition to generalist FACT teams, specialist FACT teams deliver services with a positive result for forensic clients (75), clients with mild cognitive disorders (76,77), and

young clients (78,79). Other specialist teams serve clients with personality disorders, the elderly, clients with a bipolar disorder and clients with an addiction as a primary diagnoses. Specialist Early Intervention Psychosis-teams using the FACT or ACT model with small adaptations were created as well (80). They play a role preventing severe mental illness surfacing and research suggests this is best done in a specialized team (81,82). Recent literature on integrated care on the other hand shows a preference for generalist FACT teams in small catchment areas (6,83) instead of these many specialized teams creating a fragmented landscape of care.

Implications of Dutch mental health policies

The number of FACT teams grew to 300 in the Netherlands (84), serving approximately 60.000 patients. This is insufficient considering the number of people with severe mental illness in need of community treatment estimated at 215.000 in 2013 (1,85). In 2015, Dutch municipalities received a much stronger position to reorganise the welfare sector and deliver housing, financial, social, educational and vocational services to all citizens of their municipality, of course including citizens with severe mental illness. The transformation of the welfare sector, a range of social services and programs provided by local governments to support individuals and families in need, in 2015 started with the adaptation of the Social Support Act. Since, professionals and local politicians from Dutch municipalities are responsible for finding appropriate housing, work and education for people with special needs and deliver services to support people with their finances and social life. Collaboration of the welfare sector and mental health care became indispensable (86) because integrated care from one team was no longer obvious due to fragmented (financial) responsibilities. FACT teams could no longer provide all necessary care and had to collaborate to support recovery. From 2012 on Dutch Mental Health care is being reformed too (87), trying to bring down the number of beds, to upscale the number of community outreach teams and trying to prevent (severe) mental illness. Administrative changes in the years before led, paradoxically, to an increase of specialized mental health services, larger mental health organizations and more people seeking help (23).

This reform combined content-driven changes and, mostly, economical changes, directed at containing or reducing costs. Mental health care has since been fragmented in mental health counselling at the general practice, basic mental healthcare in separate organizations and specialized mental health care, including FACT and inpatient care. Professionals in FACT teams needed to re-organize and adapt to these developments, undeniably challenging model description, service-delivery and model fidelity.

For a long time, FACT teams delivered integrated care and most services from disciplines within the team. Since 2015 services are scattered over many different agencies and professionals. A modern Dutch FACT team needs to re-adapt to new

situations and reconsider how to deliver integrated care within a network of care. A challenge, considering the struggles FACT teams already showed supporting recovery-oriented care (88). This thesis studies the process of adaptation of the FACT model in a network of care for people with severe mental illness and examines the quality impact for professionals and network collaboration.

Dutch mental health professionals already had adapted and adopted the ACT model in the late '90's and early 00's. This period in time has been described in **Chapter 2** to provide for an historical context. This happened long before the FACT model needed another adaptation to meet new challenges. Therefore we conducted an observational study comparing ACT and FACT, explaining both models using both cultural perspectives. This article is shown in **Chapter 3**. For a better understanding of the practical implications of the FACT model and its model fidelity scale we looked at the activities of professionals during a working day using an Experience Sampling Method study in **Chapter 4**. Thanks to the work of Maaïke van Vugt in 2018 (87) the struggle of FACT teams to support recovery became clear. One of recovery's key components, the concept of hope (89), was at the centre of our article exploring this concept for professionals in inpatient and outpatient (FACT) teams. A questionnaire was used to get a better understanding of the concept and results are presented in **Chapter 5**. The first chapters provided for a better understanding of the model. **Chapter 6**, a chapter from a book on network psychiatry, provides an outline on quality of care in a network of care and the chapters following will explore its impact on the FACT model. Implications of the challenges for model-fidelity and quality improvement using the FACTs 2008 are described in **Chapter 7**, developing a new FACT scale. Integrated care is a necessity for people with severe mental illness (1) and the impact of those on quality of care and FACT in a network of care has been described in **Chapter 8**. During the development of new perspectives on quality improvement for the FACT model in a network of care international inspiration was desired. Working visits have been made to Trieste, recognised by WHO as a world standard for community psychiatry (90), and literature on Trieste has been read. Less was known on another WHO collaborating centre; Lille. **Chapter 9** describes our findings and recommendations for clinical practice. Dutch challenges on integrated care within a team and within a network have been recognized by Scandinavian countries already working with FACT. Together with Swedish and Danish researchers and professionals we described the adaptations needed during the translation (and implementation) of the newly created FACTs 2017 in **Chapter 10**.

In the end this thesis aims for a better understanding of the development of FACT in the past and the present, followed by the question whether FACT has a future in networks of care.

Outline of the thesis

The outline of this dissertation is as follows. **Chapter 3** provides a comparative, observational description of the ACT and the FACT model. **Chapter 4** is also directed towards the first aim of the thesis to get a better understanding of FACT in daily practice by conducting an ESM-study in FACT teams. The study in **Chapter 5** aims to provide a better understanding of the concept of caregiver optimism among in- and outpatient mental health workers. **Chapters 6, 7, 8, 9** and **10** are directed towards the second aim of the thesis and include research done to address the process of quality development in community mental health. An introduction on quality improvement in a network is given in **Chapter 6**. **Chapter 7** describes the process of developing a renewed model fidelity scale for FACT in the Netherlands, **Chapters 8** focuses on the impact of quality improvement processes in integrated community mental health and **9** examines an international source of inspiration for community mental health; Lille. The study in **Chapter 10** provides a description of the process of translating the FACTs 2017 to a Swedish and Danish context. The thesis ends with a discussion of the findings, limitations, recommendation for future research and implications for clinical practice (**Chapter 11**).

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Chapter 2.

Historical Orientation

Whereas in the US the number of Assertive Community Treatment (ACT) teams increased from the 1980s onwards (1), Dutch mental health care continued to rely solely on inpatient treatment, sheltered living and individual case management until the late 1990s. These three services were delivered by separate organizations, and these merged into large mental health organizations with a regional focus during the 1990s. In 1997 the three separate sectoral associations merged into one Dutch Association of Mental Health and Addiction Care, adding addiction care as well. These merges led to large organisations having a (potential) regional monopoly on mental health care on the one hand and the hope for less fragmented care on the other (2). Wishful thinking, mental health organizations kept on organizing itself around large inpatient facilities and clusters organized by diagnosis or function. By doing so, holding on to fragmented care. The 90s seems the era when case managers started longing for better 'social psychiatry' (again) and looking for a better alternative (again). National substitution projects in the 80s led to some part-time outpatient treatment facilities and a formalization of short time hospitalizations when needed (bed-on-a-receipt), like the substituting of inpatient care with day treatment during the Substitution Project in Drenthe from 1986 onwards (3) and a similar project in Utrecht (4). During the 90s professionals started experimenting with (intensive) casemanagement (5,6) and early innovators experimented with teams consisting of multiple case managers (6).

As an early innovator, Henselmans wrote about four different case management projects in the Netherlands in his dissertation from 1993 (7). These teams were probably the first teams taking a next step towards intensive casemanagement teams for people with severe mental illness in the Netherlands by using assertive outreach. The title of his dissertation led to the frequent use and normalization of the term 'bemoeizorg' (assertive and proactive care or assertive outreach (8)) in Dutch mental health. Later on the first ACT teams in Amsterdam were a transformation of these teams and the term 'bemoeizorg' has been used to indicate assertive outreach in (F)ACT teams (8) or for 'Bemoeizorg'teams delivering 'bemoeizorg' all of the time (so called Critical Time Intervention (9) teams).

In West-Friesland the Team Integrale Zorg (10), with team leader Herman Peters at APZ Duin en Bosch in Castricum, used intensive casemanagement as well. Their working method was created during a research period by Kroon (6) with the help from international experts on casemanagement in the likes of L. Stein from Madison, Wisconsin and M. Muijen from London. Management noticed the necessity for a new working method to improve continuity of care in the community for people with long-term mental illness. These teams eventually combined intensive casemanagement with rehabilitation and kept close working relations with GP's and all other professionals in their catchment area (6). Already a close resemblance to ACT.

Weeda, Wunderink and colleagues were clearly inspired by ACT after a working visit to Washington and Wisconsin in the early nineties and created Kasperspad in Dordrecht (11,12). Their three mobile teams were visited and inspired by L. Stein as well. Clients were a member of Kasperspad and mobile teams were the responsible party in treatment, psychiatrists being part of the outreach service, not the inpatient units. A first article mentioning ACT in a Dutch peer-reviewed journal was published in 1989 by G. Pieters (13), but this didn't challenge daily practice of case management teams during the 90s yet. But almost simultaneously multiple community mental health initiatives seemed to add up to a breeding ground for ACT in the Netherlands. Clinical and intensive casemanagement in the Netherlands promoted long-term working relationships with people with severe mental illness and its importance for treatment. The Assertive Community Treatment model could, and would, add assertiveness and proactiveness to those relationships.

For a better understanding of the birth of FACT in the Netherlands ten interviews were conducted with experts playing an initiating role in the dissemination of ACT and FACT in the Netherlands. Many documents, books and articles describing those early years were collected and used to reflect the results from the interviews. Prof. Dr. Philippe Delespaul and Prof. Dr. Hans Kroon, experts of that period themselves, shared their knowledge during the writing process.

Many Sparks Make A Fire

The southern spark

In the southern city of Maastricht, the Netherlands, the likes of M. Bak, Ph. Delespaul, J. van Os and M. Hilwig received funding to find a solution for disintegrated and fragmented care for young clients with psychosis in 1999. Thanks to van Os his experience in an English ACT team this model was suggested as a possibility. On the 7th of April in 2002 the first three ACT teams started using an integrated multi-agency approach, integrating five different agencies. Teams enjoyed sharing the total caseload, sharing multidisciplinary and multi-agency knowledge and having full responsibility for admissions and discharge. The first Dutch translation of the Dartmouth Assertive Community Treatment Scale (DACTS; 14) arrived shortly after their start and, as M. Hilwig M.D. (January 2022) pointed out, it was said to hinder local innovations. Shortly after one agency took over and the financial systems changed. Early successes gradually faded out. Today M. Bak, inspired by Ph. Delespaul, is one of those psychiatrists trying to keep that energy alive in his community mental health team. His team focuses on integrated generalist mental health care, close collaborations with GP's and ambition. Having a waiting list is a choice, says M. Bak M.D. (February 2022), so don't allow a team to have one. Working in a well-defined and small catchment area helps (15,16).

The western spark

Inspired by an article on casemanagement and ACT by Kroon and Wolf in 2000, M. de Baan brought in N. Mulder and F. Bovenberg to enhance quality of care for people with psychosis in Rotterdam. Inspired by the work on 'Bemoeizorg' by Henselmans (7) and the philosophy of Social Psychiatry and casemanagement, and the lack of desired results, they quickly adapted ACT as the model to be. In the US they saw the ACT whiteboard meetings in action and took notice of the evidence behind the model. M. De Baan (January 2022) remembers meeting Stein and Test and seeing ACT as a format ready for adoption in the Netherlands and adapting it if necessary. ACT was, or is, part of a bigger program for people with severe mental illness, including Individual Placement and Support/Supported Employment, Housing First and early psychosis teams. According to M. De Baan (January 2022) this bigger picture was lost after implementation in the Netherlands. After starting the first ACT team at BAVO Europort Zuid-Hollandse Eilanden in 2001/2002, including a paid peer specialist, research was found to be needed. The organization hired a researcher and together with Bert-Jan Roosenschoon got in touch with Gary Bond. Bert-Jan Roosenschoon was already conducting research to 24/7 casemanagement and consulted Remmers van Veldhuizen, Niels Mulder and Hans Kroon regularly. Due to the work of Roosenschoon and van Dijk, the DACTS was translated into Dutch (14) and the national mental health research institute, Trimbos, became involved to conduct national research on ACT (17). Roosenschoon added that at first Illness Management and Recovery teams and ACT teams co-existed, before dissolving into one. As for B-J. Roosenschoon is concerned (February 2022), mixing these 'two different blood types' led to deterioration of both models and especially a lack of focus on recovery.

The first ACT teams that started in the capital of Amsterdam got their information from these early pioneers in Rotterdam. Before they were delivering casemanagement and, inconveniently, called it ACT in a randomized trial that was conducted in Amsterdam during the 90s (18). Their research (18) showed a reduction of hospital days for intensive casemanagement and no effects were found on other outcome measures, but strong reliability questions arose due to partial, or even no, implementation of ACT.

The Northern Spark

Lex Wunderink's experiences with the development of mobile teams working from Kasperspad (11,12) in Dordrecht laid a foundation for his dissertation (19) on early psychosis in the Northern city of Winschoten. Together with Sytema they started an ACT team called SoWiSo and conducted research from the start. In their team they tried to work in close collaboration with local municipalities and other stakeholders. And criticized the ACT model, and later the FACT model even more, due to its insufficiency to improve recovery (20,21). Time-unlimited care, as promoted in early descriptions of ACT (22) and contested in the US (23) and the Netherlands (21), was challenged, as well as the combination of stabilization and rehabilitation in one and the same team (21).

Later on a feasibility study on implementing EBPs separate from, but linked with their ACT team, actually seems to show the need for integrated care because the separately organized EBPs insufficiently reached the ACT team and population. Perhaps because of the distance or the criticism, this Northern ACT movement kept its distance towards national developments on ACT and, later, FACT.

In the meantime, most of Dutch mental health organizations started working with ACT (24) and ACT was included in a Dutch national guideline for schizophrenia (24). Nationwide implementation of ACT was on the verge of happening. The rise of ACT coincided with the rise of the recovery movement in the Netherlands and one movement may have strengthened the other, because recovery is ideally done in your own environment based on your own wishes (25).

Flexible Assertive Community Treatment

The fire

In 2001, Remmers van Veldhuizen, who initiated multiple interventions during the Substitution Project in Drenthe (4), arrived in Alkmaar to work for GGZ NHN. Until then GGZ NHN was substituting funding towards ambulatory care: clinical casemanagement. Together with Michiel Bähler and Hans Kroon they evaluated these casemanagement teams working monodisciplinary, without a psychiatrist and using exclusion criteria for addiction. But already having small caseloads, using outreach and working without clients dropping out. Their evaluation rapport spoke of an optimal mix ('de optimale mix') of services needed in a team. These so called 'learning outcomes' in their rapport already show a close resemblance to the later FACT model. But it wasn't until the continued casemanagement-meetings at the Trimbos institute sharpened their ideas and the support from the newly installed management-team and funding from VWS gave way to new innovations. Using the functionality of ACT in a community mental health team was first mentioned by van Veldhuizen in 2002. This happened during the first ACT platform meeting discussing the lack of step-down teams. Using ACT as an added functionality (function) became Function ACT (FACT) shortly after. His experience with the dissemination of day treatment, or lack of, in Drenthe led to the urge of writing a manual (26), creating a model fidelity scale (27) and organizing fidelity audits on a national level (CCAF in 2007). From that moment on, FACT took to the streets of the Netherlands and many other countries followed in the years after.

It's getting personal

It wasn't until 2011 I met Remmers van Veldhuizen for the first time. During a traditional masterclass in Tilburg, a day before the (F)ACT-conference in Goirle, he interrupted a presentation by stepping forward. After taking those huge steps, he corrected something that wasn't right in his eyes. It might have had something to do with the

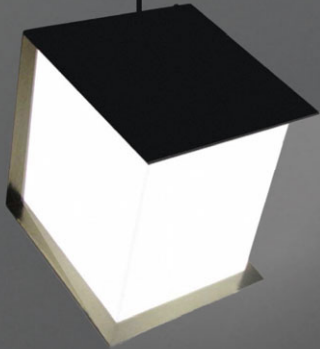
discussion on ACT and FACT, but it could easily be something else. I was working as a public mental health nurse and addiction specialist in an ACT-team and not a huge fan of FACT myself. It felt like 'slappe erwtensoepe en geen stevige snert', as L. Wunderink M.D. Ph. D. (January 2022) puts it. But those heated discussions caught my interest, got me involved and drove me to the eye of the storm. I have been involved ever since. First as an employee in an ACT team, later as a board member and vice-president of CCAF. CCAF helps professionals improving quality of care for people with severe mental illness by deploying audits and creating fidelity tools for ACT, FACT and High and Intensive Care. A master's in social work and Innovation helped create a broader perspective on community care and innovation. So teaching, training, consulting and researching community mental health care all became part of my daily job. Creating this thesis had an impact on me (retrospective reflexivity), but I had an impact on the content as well due to my years of experience with (F)ACT and everything around it (prospective reflexivity). My process of reflexivity went from personal to critical reflexivity. From just being part of the process of improving (F)ACT and all experiences around it to critically examine and question that process and all experiences. So, the next chapters wouldn't be written without these questions raised.

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Chapter 3.

An observational comparison of FACT
and ACT in the Netherlands and the US

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Abstract

Assertive Community Treatment (ACT) is a well-defined service delivery model for the care and treatment of the most severely mentally ill in the community with American origins. The Dutch have adapted the model in order to accommodate a broader range of needs and allow more flexible implementation. Functional Assertive Community Treatment (FACT) provides the intensity of care needed to help participants sustain life in the community as well as continuity of care over time for many vulnerable client populations.

Introduction

The process of deinstitutionalization led to an 80% decline of the inpatient population in American inpatient mental health institutions from 1965 onwards. Unfortunately, to achieve good quality of life and inclusion for people with severe mental illness, the closing down of institutions was not enough. Outpatient services in America were not systematically developed to deliver care to all people with severe mental illness (SMI) being released from inpatient institutions to help them integrate into society, as intended; services were not planned sufficiently to address the need (1). Marx, Stein and Test (2) envisioned the positive impact of community living and the negative impact of hospitalization and piloted a program, a precursor of Assertive Community Treatment, namely the Program of Assertive Community Treatment (PACT). They treated and trained clients in community living and worked closely with community resources. Its core ingredient, Assertive Community Treatment (ACT), became the name most commonly used throughout the country (3). Still ACT teams deliver mental health services in the community to people with the most severe of mental illnesses. ACT is an integrated, multidisciplinary service delivery model (staffed with expertise in case management, psychiatry, nursing, peer support, employment specialists and substance abuse specialists), and time-unlimited services. ACT is also characterized by a team approach, in vivo services, small, shared caseloads, flexible service delivery based on individualized consumer needs, a fixed point of responsibility for all services within the ACT team, and 24/7 crisis availability (4). Research has shown ACT to be effective in the U.S., reducing treatment costs, reducing psychiatric hospitalization and improving outcomes on several factors (5). The Patient Outcomes Research Team (PORT) found that people in America who might benefit from ACT often did not receive this intervention (6). Organizations see ACT as a fundamental element in a mental health service system. The Centers for Medicare and Medicaid Services (CMS) authorized ACT as a Medicaid-reimbursable treatment. ACT has been endorsed as an essential treatment for severe mental illness in the Surgeon General's Report on Mental Health (7). However, states have been slow to fully implement the model to meet consumer needs over the past 20 years due to inadequate staff and funding resources to cover and sustain the costs of ACT teams in America (3).

As stated, results inside the U.S. are not consistent (8), yet, ACT-teams have been developed throughout Western Europe, Scandinavia, Australia, Canada, and among other countries as mental health authorities have realized the need for assertive outreach services for this vulnerable population when closing inpatient psychiatric units. Currently, the program stands at a crossroads, strained by the principle of adherence to a long-standing operational framework, on the one hand, and calls to adjust to an environment of changing demands and opportunities on the other hand (3).

A few years after the introduction of ACT in The Netherlands during the National Evidence Based Practices Movement (9), Dutch mental health professionals stood on those same crossroads and called for adjustment to the ACT model. These adjustments needed to address two main concerns with the model. Firstly, it seemed difficult to develop ACT teams in rural areas and less densely populated areas. Secondly, professionals became aware of the narrow definition of the target group for ACT and wanted to provide the ACT ingredients to all people with severe mental illness. These two topics have been addressed in American literature on ACT as well. For instance, ACT was evaluated and found to be efficient in urban, densely populated areas (5) and less suited for rural settings (10). Rural areas do not need the intensity of care all the time and need to explore ways to deliver services to all people with SMI, not just the most severe as in ACT. As indicated in earlier writings about ACT in America, it has been difficult to develop such teams in rural areas (11,10).

This led the Dutch to introduce Functional, later Flexible Assertive Community Treatment (FACT) in 2004 (12), as an adapted and expanded model of Assertive Community Treatment (2). Just as ACT, FACT combines the principles of team case management with delivering services to a shared caseload as needed, together with all the other assertive and outreach services within one team. The main difference between ACT and FACT is that in FACT the upscaling and downscaling of care has been structured and systematically organized. Due to this process, clients receive team case management from one case manager coordinating treatment or assertive outreach services from the team as a whole, being part of a shared caseload (13,14). The number of FACT teams increased rapidly to 300 certified teams in 2018 (15). Along the way, teams in the Netherlands started using FACT for subpopulations of people with SMI, including youth, people with intellectual disabilities and people with a forensic title. Delivering treatment as a regular FACT team in times of crisis, treatment and recovery helps continuity of care and prevents drop-out (16). FACT has also shown to reduce (long-term) admissions for adult patients in the Netherlands (16), the UK (17) and Denmark (18). FACT always delivers integrated treatment for people with interrelated problems on multiple domains of life.

Raising doubt

At first a comparable model fidelity scale was created for FACT in 2008, adapting the Dartmouth Assertive Community Treatment Scale which was introduced in 1998 (DACTS; 19). Research found an association between (F)ACT model fidelity and client outcomes (20,21,22,13,16), so strict conformation to the model was promoted. Recently the FACT-scale 2017 replaced this initial version (23). Its shape has shifted from a standardized fidelity scale using a quantitative questionnaire to an appreciative audit with a short list of closed questions and a large qualitative area using different main topics (24) to keep up with myriad adaptations (10) of FACT and still be able to access

fidelity. Researchers in the US developed a successor to the DACTS as well and created the Tool for Measurement of ACT (TMACT; 25) adding quantitative, recovery-oriented items to the scale. ACT and, later on, FACT share a history together and have had similar struggles in developments during their existence. There would not be FACT without the years of experimentation and research evaluation done by ACT-specialists. Bond and Drake (26) compared ACT and FACT as being similar entities. Recent changes in both model fidelity scales and challenges for both models during implementation around the world has led us to think differently. Though FACT emerged from ACT, a new comparison applying this perspective will help the practical application in theoretical discussions going on in the field of community mental health. Especially now FACT seems to gain more and more popularity around the world (27). We conducted an observational comparison during a two-weekly observational study in Dutch FACT teams and multiple reflective conversations with experts from the US and the Netherlands. During the process literature on ACT and FACT and all fidelity scales were analyzed. Table 1 identifies several important qualitative differences between the scales. It will help the reader identify general, but not detailed, differences between the models made in a time of transition from one model fidelity scale (DACTs) to the other (TMACT) for the ACT model.

Comparison of ACT and FACT

As stated by Westen et al. (27), over time some criteria (of the initial FACT scale) lost validity. The care context has changed, and it is appropriate now to allow new qualitative initiatives and innovations. To adapt to the changing context, the Dutch have continued to evolve an essential community-based practice. American providers serve the most vulnerable people with fidelity to the DACT or TMACT. Three changes to the Dutch system has fostered its evolution: 1) nursing assignment - nurses specialized in mental health are now based in General Practitioner (GP) clinics, fostering increased integration of mental health and physical health practice. In the past, the Dutch mental health system could only downscale to GP's and consequently FACT often remained in charge for too long, impeding recovery. Now, more mental health expertise is available at the GP surgery, allowing shared responsibility for clients' physical health. GP care of recovering former FACT clients is a more fluid process; 2) High and Intensive Care (HIC) units – employ a multidisciplinary team (psychiatrists, nurses, psychologists, consumers) of sufficient size, and with specific training in crisis management, acute medication, and handling aggression and suicidal behavior. Even when considering hospital admission, the ambulatory recovery goals are the reference. The HIC-unit keeps admissions as short as possible and continually coordinates with clients, family and the FACT team (28); 3) Dutch policy change in 2015 – innovations in the service delivery system led to the development of District Social Service Teams and other municipal initiatives to foster more full civic participation and self-management. This policy change aimed for improved community integration, reduced stigma of having

Table 1. Comparisons of Elements of ACT and FACT between America and the Netherlands

Elements	American ACT team	Dutch FACT Team
Admission criteria	<p>Requires a combination of patterned psychiatric hospitalizations, emergency services, substance abuse and/or criminal justice system involvement, homelessness, medication non-adherence, and not benefitting from usual mental health services.</p> <p>Criteria is carefully applied to the team's client constellation to match insurance reimbursement qualifications. ACT criteria focuses only on the clients with the most severe and persistent problems (projected at 10-20%).</p>	<p>Includes 100% of people with severe mental illness (both the 20% for whom ACT was initially intended and the other 80% of that population, who need at times less intensive treatment and support). No one with SMI is excluded from services, thus enhancing proactive intervention rather than waiting for incidents that trigger authorization for ACT services to begin.</p> <p>Services are provided to a broader group of people outside of American ACT team criteria such as those having Borderline diagnosis, autism, developmental disability, and adolescents.</p>
Team Structure	<p>Small caseload (10:1) of about 100 clients/team on average; size of team may vary</p> <p>Team members: ideally 90% of clients have contact with more than 1 team member within 2 weeks, team meets at least 4x per week to discuss each client's care, supervisor provides at least 50% direct care, less than 20% staff turnover within 2 years, 95% full staffing within past year, including psychiatrist/psychiatric prescriber, nurse, substance abuse specialist, vocational/employment specialist; team size and diversity is sufficient for caseload coverage, explicit admission criteria (noted above), low intake rate, ideally 80% or more of contacts in community</p> <p>Full responsibility for services.</p>	<p>Small caseload (15:1) of about 200 clients/team on average; size of team may vary</p> <p>Team members: Flexible care (scaling of intensity up and down), team approach provides contact with at least 4 disciplines, daily FACT board meeting evaluates and directs interventions, over 70% community outreach; at least 50% of team members have at least .78 FTE with the team, including psychiatrist, psychologist, nurse, employment, social work, employment specialist, peer support, physical health, addiction, Mild Intellectual Disorder expertise, assigned coordinating and monitoring roles.</p> <p>Full responsibility for services presumed and not measured.</p>

Table 1. Comparisons of Elements of ACT and FACT between America and the Netherlands (continued)

Elements	American ACT team	Dutch FACT Team
Flexible Care	<p>Frequency of contact per week is determined by the team during ACT team meetings (optimally daily meetings), as needed, from daily contact to less frequently. Contact with the client support system in the community by the team is also expected and monitored. Clients appear to remain on the ACT teams for a long time (several years) and transferred off the team for ongoing care once determined to be more self-sufficient where care is rendered by other case managers not with the ACT team. Client support system in the community is not often successfully developed.</p>	<p>Care is scaled up or down during the daily FACT board meetings by the team and in collaboration with the network partners also providing care (includes General Practitioner, district social service team, inpatient care) in concert with stage of recovery as reflected in treatment plan. Flexibility allows the intensity of services to range from inpatient care to daily care and then transferred to community based district social service teams and other social supports over time. Intensive care appears to be needed for some (about 10%) on a temporary basis, for another 10%, longer term.</p>
Personal Domain	<p>Individualized treatment plans and individualized treatment are required that reflect the client's goals and is reflective of assessed issues. Consumer choice guides treatment in all ways, including the location of housing, the nature of general health care, assistance with financial management, daily living skills to be taught, medication support, and the nature of substance abuse treatment. Does not explicitly by designed expectation address client identity issues, staff stigma and hopeful attitude.</p>	<p>Central to this domain is the whole team acknowledging the client's individuality, the client's own strength as its starting point, perceiving the client's struggle with their cultural, sexual and spiritual identity and emotions such as grief and sorrow, combating stigmatization by the team and self-stigmatization by the client, taking risks and having a hopeful attitude while using hopeful language oriented towards an open and positive picture of the future.</p>



Table 1. Comparisons of Elements of ACT and FACT between America and the Netherlands (continued)

Elements	American ACT team	Dutch FACT Team
Welfare sector	<p>Consumer choice guides treatment in the location of housing, the nature of general health care, assistance with financial management, daily living skills, medication support, the nature of substance abuse treatment and other chosen issues identified by the treatment team and client. Expects connection with informal support system (family, friends, and proprietors) though by superficially counting number of contacts. Does not explicitly by designed expectation address loneliness, leisure, safe living, involvement of other professional network partners</p>	<p>Formulating and achieving goals of the client's roles within three domains are evident: 1) 'self-care and living' such as finding housing, preventing homelessness and sorting out financial issues; other team members may focus on loneliness, pathways to work or training, self-care or safe living; 2) 'social network'; and 3) 'work and leisure'. Interventions are prepared in conjunction with the client, their family and the team's professional network partners. Connection with a wider range of social contacts fosters community integration.</p>
Symptomatic Domain	<p>Consumers have standardized, high quality assessments that includes: history and treatment of medical, psychiatric, and substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors. The information is comprehensive across all assessment domains and updated at least annually. ACT model does not explicitly address physical health issues nor teaching strategies that address skill development.</p>	<p>The team seeks to achieve the highest possible level of mental and physical well-being for the client by implementing a system in which screening, diagnostics, treatment interventions and evaluation all take place in accordance with the most recent research findings from psychiatry, medication, physical health and follow up, psychology, addictions, and pedagogy in teaching/transferring skills. Client education in managing the understanding and care of symptoms (disease management) is vital to sustained recovery.</p>

Table 1. Comparisons of Elements of ACT and FACT between America and the Netherlands (continued)

Elements	American ACT team	Dutch FACT Team
Planning & Monitoring	<p>Process monitoring and outcome monitoring are expected of all teams. An example of a process indicator would be systematic measurement of how much time individual case managers spend in the community instead of in the office. Process indicators could include items related to training or supervision. The underlying principle is that whatever is measured is related to implementing ACT. Supervisors and ACT leaders monitor the outcomes of ACT consumers every 3 months and share the data with ACT team members in an effort to improve services. Systematic and regular collection of quarterly to annual outcomes for their monitoring involves a standardized approach to assessing results of client interventions. Individual client based outcomes continues to be a laborious process for most teams and has largely not been standardized to address psychological and social functioning, or quality of life and recovery issues.</p>	<p>The team has a clear treatment plan cycle, adheres to a logistical process according to good working procedures, and is responsible for the outcome of the treatment. It assumes a managing and coordinating role. Integration of the ROM (Routine Outcome Monitoring) data is part of this from a well-reasoned choice from the available standardized measuring instruments.</p> <p>The implementation and evaluation of the treatment and its progress take place collectively via a collaborative relationship between the team and the client, their family, the GP and the mental health worker at the GP surgery. Decision-making about treatment takes place collectively. Each party may contribute goals. At least yearly clinical Routine Outcome Monitoring (ROM) takes place for the benefit of individual strategies and treatment plans. Standardized instruments are used to measure (1) psychological and social function, (2) needs and (3) quality of life and recovery.</p>



Table 1. Comparisons of Elements of ACT and FACT between America and the Netherlands (continued)

Elements	American ACT team	Dutch FACT Team
Crisis and Safety	<p>The team cover responsibility for 24-hour crisis services and hospital admissions and discharges. Relationships with local hospitals is expected.</p> <p>Mechanisms for case finding or service drop outs are dependent on team member and team leader initiative not standardized.</p> <p>ACT team members' safety is often of concern.</p>	<p>The team works from 9 until 5 and has a working alliance with an out-of-office crisis resolution team. The team has implemented policy consisting of risk assessment and the provision of evidence-based interventions relating to crisis prevention and early detection. It can be expected for the team to have a structural relationship with regional services such as the police force and other health and safety services to ensure personal safety in and around homes.</p> <p>The use of assertive engaging interventions, acute up-scaling of care and collaboration with relevant partners are important in this regard. In its own catchment area the team can undertake targeted case finding when clients seem to drop out of care as well as untargeted cases.</p>
Network Collaboration	<p>Ideally, the Process Planning and Outcome Monitoring functions are the purview of a management team that includes participants from the larger organization and community stakeholders to provide objectivity and integration with the organization's philosophy and strategic plan.</p> <p>The team involved in such collaboration more often is restricted to mental health organization staff.</p>	<p>Committed collaboration with the client's network is of importance to ensure that control of the recovery process lies with the client and his resources of choice. The team involves the client's (social) network (including family, general practitioners, community police, and other community health providers) in the team evaluations, supports the network with the most appropriate forms of treatment for the target group and supports and facilitates the creation of forms of self-help by the client's personal network.</p>

Table 1. Comparisons of Elements of ACT and FACT between America and the Netherlands (continued)

Elements	American ACT team	Dutch FACT Team
Quality & Innovation	<p>A Quality Improvement Committee helps guide important decisions such as penetration goals, hiring/ staffing needs and sustaining the implementation by reviewing fidelity to the ACT model, making suggestions for improvement, advocating, promoting ACT within the agency and in the community, and deciding on and keeping track of key outcomes relevant to ACT. Ideally, this function is also the purview of a wider team of participants to provide objectivity and integration with the organization's philosophy and strategic plan. Team members are expected to participate in annual training activities to improve and sustain skills. Outside expertise is sometimes involved in this process.</p>	<p>The FACT team seeks to provide the highest quality of care and is open to new knowledge, initiatives and innovations. To achieve this the team has a specially designed training policy requiring at least four half-day training sessions per team member, which is set out in the Team Document. Team members continue to develop additional expertise in their field. The team regularly invites external experts or asks for their help. In addition, there is evidence the team works with a Plan-Do-Study-Act cycle to improve their quality.</p>



a mental health illness, speaking the same language, and increased ownership of the role of community members in all their citizens' welfare focused on normalizing life. These teams share responsibility for important recovery domains such as housing, work and social contacts. Implementation has local differences and plays a significant role in the social network around clients with severe mental illness that foster recovery in various domains. In a similar fragmented mental health context in Norway, FACT teams have shown to support closing of the gaps between organizations (29). Additionally, the Dutch have included clients with a variety of diagnoses (30) and ages (31) that indicate a need for intensive treatment and not just adult clients with severe mental disorders.

Implications for both models

People with severe mental illnesses have historically been underserved. While the ACT model embraces the most severely impaired clients, it does so to the exclusion of those somewhat less impaired, those still in need of attention and whose needs may intensify at any given time. The ACT model necessarily excludes some people with severe mental illness, largely based on state level qualifying functional and diagnostic criteria, e.g., people with Borderline Personality diagnosis. The American ACT model requires that once a designated level of functioning is attained, the client transitions from the ACT

team since they no longer qualify for ACT-services. Though care is taken during this transition time to ensure that sufficient engagement with the new case manager has taken place (possibly over several months), this new relationship is not necessarily team-based and is ordinarily with case managers under different supervision, with much higher caseloads, and detached from the original ACT team. Full recovery is less the focus than functionality. Given the high staff turnover in American mental health systems, it is common that clients are then reassigned to several different and new case managers within a short period of time and with less careful transition. This fragmented process creates an environment that could miss early signs of relapse due to lack of knowledge of client needs, tenuous engagement with the client, insufficient frequency in client contact due to larger caseloads, uneducated and less developed case managers, and less than adequate multidisciplinary team integration. Transition and reassignment may actually perturb conditions of relapse with the client. The Dutch FACT team structure and flexibility account for all of these conditions by allowing the client to stay within a (larger) team structure and receive an intensity of care from the same team over a much longer period. These differences are likely to ensure a longer and steadier recovery trajectory into more autonomous community living. Dutch FACT teams are more inclusive of people with several conditions benefitting from intensive care, thus expanding the strengths of the ACT model with new client populations. A goal of providing services to ALL vulnerable people is thus accomplished rather than the focus of ACT with the most severely impaired 10-20%.

Providing services for all vulnerable people in Dutch FACT teams has been a challenge since the policy changes in 2015. FACT teams provided integrated treatment until 2015; after 2015 a financial distinction was made between care and treatment. Professional mental health providers staff FACT teams and offer treatment. FACT team networks include GPs and local community social networks that engage consumers beyond the end of the care continuum, allowing more full integration of care within the local community (15). Currently this differentiation challenges the FACT team's ability to work in an integrated manner using a multi-agency approach and supported by the new FACT model fidelity scale of 2017. Unfortunately, these changes led back to a more treatment-oriented approach and thus a focus on those with more severe mental illness (32). More discharges to the GP and care-oriented teams from the municipality led to rapid deterioration of problems and a return to FACT or other specialized mental health treatment (33). A network-orientated approach is required, embedding seamless transitions of clients and professionals. Dutch FACT teams are experimenting using a multi-agency approach within a network of organizations or within one FACT team, combining professionals from up to three or four different organizations.

Differences

Several differences are apparent when comparing ACT in America with FACT in the Netherlands. These differences include who receives such services and for what duration. ACT focuses effort on those with the most severe mental illness; FACT is for all people that struggle with severe disorders that may limit their ability to live full lives in the community. FACT flexibility provides continuity of care throughout the service and into the community setting by more quickly upscaling and downscaling the care with the same team of providers. As stated earlier, the range of providers differs in important ways: ACT teams being largely professional mental health providers and FACT-team networks including GPs and local community social networks that engage consumers beyond the end of the care continuum, allowing more full integration within the local community (15).

Perhaps more importantly, the Dutch have intentions that reflect their national norms for wellness. Every resident of the Netherlands is insured for health care, unlike the American health insurance model Medicaid. However, the various health insurers in the Netherlands also demand delivery of certain services with minimal resources. In both countries, creativity and assertiveness are necessary to adopt the model and then adapt the model to the local community's needs. A full nationwide coverage of FACT teams as once intended has not yet been established in the Netherlands.

Many American states have implemented ACT in recent years thanks to professional effort and due to settlements resulting from Olmstead Act lawsuits against them since they were not providing adequate mental health services to enable people with severe mental illness to live in the least restrictive environments in the community. However, few American states have proactively identified the number of people needing ACT with a plan to add sufficient teams that provide the necessarily intensive care. A lack of funding for such community based mental health programs was often a primary argument provided by the states, yet America clearly struggles with a norm of providing basic medical treatment to its entire population. There are currently about 47 ACT teams in Ohio, an American state with nearly 12 million people; the Dutch have about 300 certified FACT teams for a population of about 17 million people, demonstrating the significant difference in allocating such resources for people in need.

Conclusion

Over the decades since its inception, more ACT teams developed in America, yet the ACT-model alone is not sufficient to serve all people with severe mental illness. Its structure and functions in American teams continues much as it did in ACT's infancy in the 1980's and 90's, while adding a recovery-oriented focus and evidence-based practices in recent years. In line with its national culture of pragmatism and care for all

people, the Dutch have demonstrated innovation and progressive thinking. They aim to ensure that a proactive community-based network strategizes to identify, engage, and treat a wider range and variety of people with mental challenges in such a manner that maximizes their ability to live full lives in the community. FACT is attributable to ACT in many ways and both models can exist side-by-side in (larger) cities. Being able to make an educated choice between the two models within a certain context is something that will improve quality of care for all people with severe mental illness.

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Chapter 4.

Daily practice of a FACT team: results of an experience sampling study

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Abstract

Background

Flexible Assertive Community Treatment (FACT) teams are widespread in the Netherlands. Despite the presence of a model description and model fidelity scale, it is unclear what FACT workers actually do daily.

Objective

Examination of the daily activities of FACT workers on weekdays in relation to the intended activities from the theoretical FACT framework.

Method

Repeated momentary activity assessments were made among all employed staff (n=54) of four FACT teams from three different organizations using the Experience Sampling Method (ESM) yielding multiple reports on each workday for one week. 936 reports were analysed with SPSS, providing a picture of the daily activities of FACT workers.

Results

Overall, employees spend 30% of their time with clients, 30% in consultation (4% with network partners), 20% on administration and 20% in travel time and personal activities (30-30-20-20).

Conclusions

The actual time spent by FACT workers with clients does not match the expected production standards. Contact with relatives and network partners lags far behind the desired figures required for modern network-oriented care. The ESM-based results are different from actual methodologies and require careful interpretation. Applying ESM in FACT teams promises to support a quality development dialogue.

Introduction

Flexible Assertive Community Treatment (FACT) is a model widespread in the Netherlands for community treatment for people with severe mental illness (1). The model builds on Assertive Community Treatment (ACT) as it was developed in the US from the late 1960s onwards. Shared characteristics of both models are: a multidisciplinary team that works and uses outreach collaboratively, facilitated by daily client meetings. The team can respond flexibly to urgent problems while taking a long-term perspective focused on supporting personal, clinical and social recovery.

The FACT model is described in a handbook (2) and a model fidelity scale (original version: FACTs 2008; 3).

The 2008 FACTs helped to make working with one's (client) experiences an important part of the Dutch ambulatory mental health care (4). However, audit data showed that supporting recovery and delivering recovery-supportive care lagged behind in practice (5). A new FACTs (version 2017, 6) aims to more sharply assess current practice while better reflecting the local context and policy choices. The assessment is done more on the basis of the desired effect (do people get the care that is indicated, such as Individual Placement and Support, trauma treatment, and recovery support) and less on the basis of compelling structural criteria (is there an Individual Placement and Support trained person, a Cognitive Behavioral Therapist, expert by experience... appointed within the core team) (4). We found that the structural criteria of accreditation as tested with the original 2008 FACTs did not sufficiently encourage the development of good practice.

What is the actual daily practice in a FACT team? For example, in negotiations between health insurers and care organizations, they expect production standards of 65-85% direct client contact and 35-15% non-client contact. The FACT model fidelity further requires that at least 40% of the time client contact takes place outside of the office and for a maximum score more than 70% of the time (6). Accreditation assesses how a team presents itself, not what the team actually does on a daily basis. This study describes the daily routine of FACT teams. With the central question of how the professionals in a FACT team shape their daily activities within a FACT team and to what extent this corresponds to the FACT model and the underlying theoretical concepts.

Method

Experience Sampling Method

The measurements in this study were made using the Experience Sampling Method (ESM; 7). In ESM, people receive a signal at random times during the day to complete a short questionnaire about how one feels and in what context (where, what, when and with whom) one is. ESM collects data prospectively and this provides more accurate data compared to retrospective questionnaires - the traditional method of data collection (8). ESM combines the ecological validity of naturalistic observational behavioral research, but provides more focus than a diary, through the use of questionnaires and systematic reporting at random moments (9). Research using the ESM methodology, allows for micro-longitudinal studies of particular phenomena (10). In ESM research, compared to traditional longitudinal research, the interval between measurement points is relatively small (minutes and hours, versus weeks and months). The ESM method reduces the likelihood of obfuscation of the measured items because the situation is questioned at the time it occurs and not after the fact. In addition, the chance of misjudging the measured data is reduced because the measurements are repeated over a set time period. Data collection at multiple time points increases the validity, reliability, and transparency of instantaneous data per individual and increases sensitivity to changes within that individual (8).

Digital questionnaire

To gain a picture of the daily activities of FACT teams and the time spent, the Pymate™ app was used. 54 staff from four certified FACT teams from three different organizations received a signal (beep) via this app for 5 consecutive work days 8 times a day at randomized times during the workday to complete a short questionnaire. The questionnaire (see Table 1) was developed in collaboration with the authors, professionals from the field, and an expert on ESM. The questionnaire consisted of questions about where the caregiver was at the time, with whom, and what they were doing. The answers to these questions (see Figure 1) are described in this article to provide a picture of daily practice in a FACT team. In the results section, the beeps were translated into time spent, under the assumption that the large number of beeps provides information about the time spent on activities. In addition, the questionnaire asked to what extent the contact was intensive and complex and how the caregiver experienced the contact in terms of competencies, safety and mood. In this article we will discuss the context questions. The analysis of the data was done in SPSS, version 27.

The digital questionnaire was administered to four FACT teams prior to the corona pandemic. Three FACT teams operate in an urban setting and one predominantly rural. All participants gave approval for participation in the study.

Table 1. Who, what and where

Question	Answer and percentage	
Where am I?	At a client's	20%
	Own office	53%
	Location of other institution	13%
	En route	10%
	Otherwise	3%
What am I doing?	Treatment	30%
	Consultation scheduled	21%
	Unscheduled consultation	9%
	Administration	21%
	Moving	8%
	Personal Activity	4%
	Otherwise	7%
Who am I in contact with?	No one	31%
	Client	30%
	Next-of-kin client	2%
	Colleagues	35%
	Otherwise	4%

Results

In total, data was collected from four certified FACT teams from three organizations. Of the 54 staff members surveyed, 23 were case managers, 5 were Public Mental Health Nurses, 3 were Employment Specialists, 1 was a Recreational Therapist, 4 Peer Support Workers, 5 were Psychologists, 5 were Psychiatrists, 1 was a Team Leader, and 7 had other disciplines.

Responses were possible within 15 minutes at 1312 possible measurement times. We obtained 936 (71.3%) completed lists, of which seventeen (2%) were so incomplete that they remained outside the analysis. Thus, 919 questionnaires were available for analysis, an average of 17 per person. The average completion time of the questionnaires was 1.28 minutes, with the shortest completion time being 31 seconds and the longest completion time being 12.26 minutes.

Where am I?

The FACT workers reported spending most of their working time in their own offices (52.6% of working time; range 48.1% for team A to 56.1% for team B). Travel time was spent 9.9% (range between 8.1% and 12.3%) of the time. FACT workers spent 19.9% (range 9.9% - 26%) of their time at a client's location and 1.3% at a client's informal network.

Who am I in contact with?

Employees were not in contact (actively) with anyone for about a third of their time (30.4%). Employees were in contact with a colleague 38.6% of the contact time, of which in 87% of the cases with a colleague from their own team. The total number of times that staff members were in contact with a client while completing the questionnaire was 275 times which represents 30% of the completion times. Per team this amounts to 32.1%, 19.8%, 32% and 35%, whereby the score of 19.8% concerned an urban team. In 87% of the 275 contact moments it was a client from the individual worker's caseload and in 13% of the cases it was a client who was not from their own caseload, but was part of the shared caseload in the FACT team. In 93.4% the contact was face-to-face. Table 1 and 2 provide a total overview of these data. During the study period, according to the measurements, there was a total of 18 contacts with a client's next of kin which amounts to 2%. Of the 275 client contacts, 65.6% took place in the client's home and 20.5% in the office. Case managers and public mental health nurses spent proportionally more time with clients in the home situation, 70.4% of their client contacts took place in the client's home.

Table 2. With whom and what activity by location

Location	%	Activity	%	Companion	%
At a client's	20%	Treatment	89%	Alone	0%
		Consultation scheduled	4%	Client	88%
		Unscheduled consultations	3%	Relative	6%
		Administration	0%	Colleague	6%
		En route	0%	Otherwise	1%
Office	53%	Treatment	15%	Alone	34%
		Consultation scheduled	27%	Client	11%
		Unscheduled consultations	13%	Relative	2%
		Administration	35%	Colleague	50%
		En route	1%	Otherwise	2%
Other organisation	13%	Treatment	15%	Alone	13%
		Consultation scheduled	43%	Client	18%
		Unscheduled consultations	10%	Relative	1%
		Administration	8%	Colleague	60%
		En route	2%	Otherwise	8%
En route	10%	Treatment	15%	Alone	77%
		Consultation scheduled	1%	Client	9%
		Unscheduled consultations	3%	Relative	0%
		Administration	1%	Colleague	13%
		En route	69%	Otherwise	1%
		Otherwise	9%		

What am I doing?

During the study period, staff in the four FACT teams spent about the same amount of time on treatment (30.5%) as on consultation (30.1%). 70.4% of consultations were scheduled. The percentage of staff time spent on administration was 21.1% (see Table 2).

If employees checked the answer options 'Consultation scheduled', 'Consultation unscheduled', 'Administration' or 'En route', they were asked a follow-up question about whether their current activity was care-related, organization-related, personal or related to continuing education. In 76.2% of cases, the activity was care-related, in 17.4% organization-related, 'Personal' in 2.8% and 'In-service training-related' in 3.6%.

Discussion

In the Netherlands, FACT teams provide outpatient treatment to people with severe mental illness (1). The participating FACT teams were certified; they were evaluated using the model fidelity scale FACTs 2017 (6) and worked in accordance with the FACT description from the handbook (2). To our knowledge, this is the first ESM study that has looked at the actual contacts and work of employees in FACT teams. Overall, staff spend 30% of their time with the client, 30% on consultation, 20% on administration and 20% on travel time and personal activities (30-30-20-20). In the negotiations between health insurers and the organization, production standards are determined: often between 65-85% direct client contact and 35-15% non-client contact. The difference between the measured reality in these four FACT teams and the desirability of the production norm is large. A possible explanation for this is the definition of certain consultation forms and administrative actions as directly client-related. For individual FACT teams as well as for the Dutch Mental Health Services, Dutch Healthcare Authority and health insurers, the '30-30-20-20' distribution is interesting steering information. Individual FACT teams can formulate goals in their planning and control cycle to work towards a different distribution in their working method. We assume that the found distribution 'fairly' reflects the work distribution of hard-working professionals. Dutch Mental Health Services and health insurers may consider replacing writing production with an annual ESM week to obtain more realistic data (and drastically reduce administration). A national dialogue with mental health professionals, relatives, (ex-)clients and health insurers is necessary to comment and/or adjust the found distribution.

Originally, ACT teams were developed to bring clinical 24/7 care to the client's home to prevent hospitalization, admissions and coercion (11). Similar to the ACT model, a FACT team works in the local community to support clients with severe mental illness to regain inclusion and participation in society (2,12,13). A high-scoring FACT team on the 2017 FACTs does this at the client's location more than 70% of the time (6). Case managers and Public Mental Health Nurses appear to achieve that percentage in this study, with other staff coming in just below.

Despite the consensus that seems to exist about the importance of community and network oriented working, as given attention through Network Psychiatry (14), resource groups (15) and de Nieuwe GGZ (16), among others, the results from this study indicate that working in a network with loved ones and other formal and informal sources of support is not yet commonplace. An individual conversation with the client is the rule, a conversation that includes loved ones and/or other professionals is an exception. In this respect, it seems that contextual work still has a long way to go before it can be implemented. The Netherlands is by no means unique in this (e.g. 17,18). In addition to time and methodical resources, this battle also requires a cultural shift in the institutions.

The ESM study shows clear differences between teams. For example, 1 team sees fewer clients on average and another team has more scheduled than unscheduled consultations on average. However, there is no clear difference between urban or rural teams with regard to the degree of client contact. The number of professionals in the teams correspond to those of a regular FACT team, so deviations are probably not related to this. More teams need to be examined to investigate patterns. In themselves, these are interesting and 'hard' planning data. By entering into a dialogue with a team about their results, it is possible to give a first interpretation of the data and set up their own goals and action points for their quality cycle.

Restrictions

The study took place (before COVID) at four FACT teams from three different organizations. Dutch FACT teams work relatively uniformly, in accordance with the described FACT methodology (2) and the FACTs 2017 (6). As such, it is not possible to generalize the data to other types of community mental health teams, such as community teams that have a less uniform method of working (19). Since this type of research has not been done before, it has not been possible to compare the results with similar studies.

Employees of FACT teams were asked to respond as quickly as possible (but within 15 minutes) to the beeps received on the cell phone. While traveling by bicycle or in the car, this will not always have been possible. It is suspected that the percentage of travel time is actually higher. In one team this was confirmed by adding up the number of kilometres driven and converting it into the number of minutes driven. This turned out to be higher.

The results found in the study appear to be useful for the quality cycle of individual FACT teams and a possible time-saving alternative to production scoring in mental health organizations. Using the current, descriptive results in this future dialogue requires caution and proper interpretation of the data. We assume that most professionals

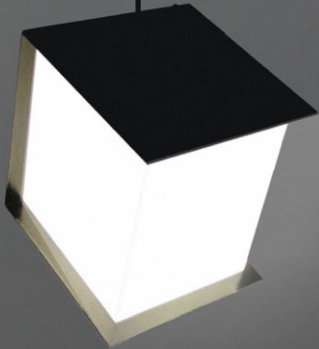
work very hard. There is no consensus on what “30-30-20-20” means; perhaps this division of time is the achievable norm for modern FACT teams. But the discrepancy with required production standards in the mental health system is striking and could lead to negative budget adjustments. Repeating this study in several FACT teams and comparing the results with the production of each FACT team based on other measurements is desirable to be able to say more about this. Furthermore, we intend to explore the data on mood, perceived appropriateness, and perceived safety in relation to time and activities not covered in this article in a subsequent analysis on perceived workload in FACT teams.

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Chapter 5.

Who is most optimistic about recovery?
Caregiver optimism among in- and
outpatient mental health workers.
*A cross-sectional, non-experimental
design based on questionnaires*

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Abstract

Insights into the factors influencing hope and optimism about recovery among care providers could help to increase it further. To replicate earlier findings on determinants of caregiver optimism and to further investigate the relation between caregiver optimism and working in an inpatient or outpatient setting. Questionnaires on caregiver optimism were distributed among in- and outpatient mental health workers in the US and the Netherlands. Linear regression using a backwards strategy was used to investigate the associations between caregiver optimism and the independent variables. No association was found between care setting and country. In accordance with earlier findings job tenure was found to be negatively associated with caregiver optimism. A negative association was also found for higher educational levels. Age was found to be positively associated with caregiver optimism such that older caregivers were more optimistic about consumer recovery.

Introduction

Over the past thirty years, researchers and scholars have developed a vision of recovery for consumers (1-3). These authors were, in part, responding to a powerful theme that emanated over the past two decades from consumer advocates: people with severe mental disorders want effective and accessible practices yet do not want to be clients forever in the public treatment system. They want to recover and enter the mainstream of life. Though there are subtle differences in the definition, the essence of the recovery movement is in the wish and expectation of people with mental and substance abuse problems to lead meaningful, productive lives – to contribute to people’s lives and the society around them.

Hope and optimism that recovery is possible play an important role in the recovery process (4,5). The concepts of hope and optimism are distinct; hope relates closer to self-efficacy and the possibility to attain goals while optimism relates more to general positive expectancies about the future (6), yet both serve as an important motivator for those suffering from a severe mental illness to invest effort into their recovery process. Optimism is an attitude, a belief that the consumers can overcome their history and present conditions and develop thinking and behavior to recover. Seligman (7) suggests that optimism may be an innate trait, though also one that can be learned. A spark of hope is often the starting point for recovery (4).

The role of hope in the recovery process makes fostering hope a goal for recovery oriented health care providers (8-10). In order to support recovery, it is the work of the professional treatment system and individual providers to acquire and apply the best possible information and skills on behalf of the consumer. Torrey and Wyzik (11) have outlined several important ingredients for the role of the individual provider whose practice is inspired by a recovery framework. First, providers should be skilled in communicating optimism to clients about the prospect of their recovery. However, this skill assumes that providers hold optimistic attitudes about recovery themselves, which is not always the case (12).

On an even more basic level than influencing provider skills, it has been shown convincingly that expectations from others influence an individual’s outcomes. This was first shown in the context of education, where high expectations regarding outcome by teachers leads to better student outcomes. Communicating high expectations is therefore viewed as evidence based practice in education (13). The effects of expectancy are less well researched in the field of health care. A study by Learman, Avorn, Everitt and Rosenthal (14) showed that nursing home residents randomized to a high-expectancy group had improved depression outcomes after several months. In mental health care even low levels of stigma at the individual provider level have been shown to affect clinical care (15). Hope inspiring therapeutic relationship is associated with more social inclusion and vocational activity status in people with schizophrenia (16).

Further insights into the factors influencing hope and optimism about recovery among care providers could help to increase it further. Knowledge on this topic is however scarce. In a study on leadership and the adoption of evidence based practice, Aarons (17,18) found that younger, newer clinicians, and those with more formal education, had more openness to learning about innovative practices that expect an optimistic attitude toward recovery. In a more direct study of caregiver expectancies, case managers with a shorter tenure in mental health were found to have higher expectations of consumer recovery (19). It appears that more experience working in mental health takes its toll on hope and optimism.

As much remains unclear about the factors influencing caregiver optimism, the present study has two aims. First, it aims to replicate the earlier findings on caregiver expectation in mental health care (17-19) with a different measure of caregiver expectations. Second, it aims to further investigate the relation between caregiver expectations and working in an inpatient or outpatient setting. Inpatient caregivers are more likely to (repeatedly) encounter consumers with less favorable prognoses compared to outpatient caregivers, who encounter these same consumers but also those that do not need inpatient care. This selection bias may lead to less positive recovery expectations. In this same vein, the type of care provided tends to be different between inpatient and outpatient settings, with the latter allowing for more recovery oriented practices in the personal environment of the consumer. We therefore hypothesized that outpatient caregivers would have more positive expectancies with regard to recovery outcomes for consumers than inpatient caregivers. As the data was collected in the USA and the Netherlands, the relation between nationality and caregiver expectations was also explored. While there are no direct indications that caregiver expectations differ between various western countries, health care systems vary vastly from nation to nation and may influence caregiver expectations. .

Methods

Design

We used a cross-sectional, non-experimental design based on questionnaires that were sent to caregivers in various settings in both the US and the Netherlands.

Participants

US-participants were employed in one of 42 agencies that agreed to participate in the study. These agencies are known to deliver services using Integrated Dual Disorder Treatment (IDDT) and/or Assertive Community Treatment (ACT) and use intensive multidisciplinary team-based case managements services. The agencies represent a range of urban, small town, and rural settings throughout Ohio, North Dakota, Colorado, Wisconsin, and Michigan. A total of 241 caregivers from 44 teams participated in the study.

Dutch participants were directly approached by the researchers through e-mails to their teams and an open call through LinkedIn. The outpatient caregivers were all members of ACT or Flexible Assertive Community Treatment (FACT) teams (20). Together the caregivers represented teams and inpatient wards from all the provinces of the Netherlands, coming from both urban, small town, and rural settings. Inpatient caregivers were all recruited from High Intensive Care (21) inpatient admission wards. A total of 84 inpatient caregivers from 37 wards and 513 outpatient caregivers from 179 outpatient teams participated in the study.

Measurement

The survey measured providers' demographic characteristics, including sex, age, educational level and tenure in mental health care. Furthermore, the survey included a questionnaire to assess optimism about consumer recovery developed by Grusky, Tierney, and Spanish et al. (22) and later expanded by Salyers, Stull, Rollins, and Hopper (25). The questionnaire contains 16 five point Likert items that assess a provider's optimism about a facet of the consumer's recovery (Example: I believe that the consumers I am working with will find work that enables them to be economically self-sufficient.). Totaled, these scores yield an overall optimism score with higher scores representing greater optimism about recovery. Cronbach's alpha for the 16 item scale is good (23,24).

Statistical analyses

Upon collecting the data from the digital surveying system, the last three items of the caregiver optimism scale were found to be consistently missing for the Dutch outpatient caregiver due to a technical error. In the consideration to either exclude all these data or analyse all data without the last three items of the scale, Cronbach's alpha was calculated for the US outpatient caregivers and Dutch inpatient caregivers with the 16 item scale (0,763 and 0,791 respectively) versus the 13 item scale (0,724 and 0,738 respectively). Weighing the slight decrease in scale reliability against the inclusion of a large set of data we deemed the scale reliability of the 13 item scale to be sufficient to justify including the data from the Dutch outpatient caregivers.

Descriptive statistics were obtained using the Explore function in SPSS (IBM SPSS Statistics version 27). The variables caregiver optimism, age, job tenure overall and job tenure in team were visually inspected for a normal distribution and skewness and kurtosis were examined. Caregiver optimism, age and job tenure overall were found to be sufficiently normal to include in the analyses without transformation. Job tenure in team was decidedly skewed towards shorter tenure (skewness = 3,02; kurtosis = 14,58). The analyses were conducted both with Job tenure in team without transformation and with job tenure in team successfully normalized using a logarithmic transformation. Both analyses yielded the same conclusions. The result for the non-transformed data are reported.

Analyses on caregiver optimism about recovery were conducted using linear regression analyses using a stepwise backwards strategy. The independent variables in the first model were age, sex, educational level, job tenure overall, job tenure in team, country, and care setting. Due to the ordinal nature of education level, dummy variables were constructed for this variable. The category 'other' was removed from the analyses as this category turned out to be too small and heterogenous. The dummy variables for education were entered into the stepwise analysis as a single block.

Results

Participants

Descriptive statistics stratified for country and care setting are given in table 1.

Table 1. Sex, Age and Job tenure

	USA	Dutch outpatient	Dutch inpatient
Sex (% female)	71%	62%	69%
Age (mean, SD)	40,1 (11,6)	42,9 (10,5)	38,7 (11,4)
Job tenure	9,5 (8,8)	15,4 (10,1)	13,3 (9,3)
Education level			
<i>High school</i>	4,1%	1%	0%
<i>Associate degree</i>	13,3%	8,4%	22,6%
<i>College degree</i>	37,8%	61,4%	60,7%
<i>Masters degree</i>	42,3%	27,1%	13,1%
<i>PhD</i>	1,2%	1,9%	3,6%
<i>Other</i>	1,2%	0,2%	0%

Caregiver optimism about recovery

No significant interaction effects on caregiver optimism were found between any of the independent variables. Country, care setting, job tenure in team and age were not significant predictors of caregiver optimism. Age was found to have a positive relation with caregiver optimism ($\beta = 0,101$, $t = 3,448$, $p = 0,001$). On the other hand, a negative relation was found between caregiver optimism and both job tenure ($\beta = -0,138$, $t = -2,781$, $p = 0,006$) and educational level (F Change = 14,2; $P < 0,001$).

Table 2. Analyses on caregiver optimism about recovery

	Standardized Beta	T-value	Probability
Nationality	-0,022	0,604	0,546
Care setting	0,044	1,130	0,259
Sex	0,053	1,526	0,127
Age	0,161	3,530	0,001*
Job tenure	-0,138	2,879	0,004*
Education level	$\beta = -0,201$	-5,893	0,000*

Discussion

The present study aimed to expand on the few existing studies to investigate factors that influence caregiver optimism about consumer recovery by replicating earlier findings and investigating care setting and country as additional variables. Both care setting and country were found to have no association with caregiver optimism. In accordance with the findings of Aarons (17,18) and O'Connell & Stein (24) job tenure was found to be negatively associated with caregiver optimism. However, seemingly contrary to findings of Aaron (17,18), higher educational levels in the form of a Master's degree or PhD were found to be negatively associated with caregiver optimism compared to associate or college degrees. In addition, age was found to be positively associated with caregiver optimism such that older caregivers were more optimistic about consumer recovery.

Given the sample size and small effect sizes of country and care setting the null findings on these variables are unlikely to be the result of a lack of statistical power. While we hypothesized that working in a different care setting within the same health care system was likely to influence caregiver optimism, such that outpatient caregivers were likely to be more optimistic than inpatient caregivers, this hypothesis has to be rejected. Perhaps the large improvements, in a relatively short time period, that can be made by some of the consumers in an inpatient setting provides a balance to clients in more complex situations.

Additionally, it appears that although the US and the Netherlands have vastly different health care systems and options available to consumers, this does not play a significant role in how optimistic caregivers are about the chances for consumers to recover from mental illness. Overall, these more systemic variables were shown to be of much lesser importance than the personal characteristics of the caregivers.

The negative association found between job tenure and caregiver optimism substantiates the findings by Aarons (17,18) and O'Connell & Stein (24). Something about working in mental health care appears to be wearing away on the optimism caregivers

have about the possibilities of recovery for their consumer. This relation may represent the simple reality of providing care to those with the most severe mental illnesses; that many do not achieve the recovery goals set out in the optimism questionnaire. While this would be known as a fact to most that work with people with SMI, being confronted with it for a longer period of time appears to additionally dampen optimism. Perhaps this decline in optimism is akin to a self-protection mechanism to prevent negative emotions resulting from disappointment.

Contrary to the studies by Aarons (17,18) a negative association was found between educational level and caregiver optimism. However, these apparent contradictory findings may also be the result of a differential focus on either hope or optimism. While Aarons (17,18) reports on participation in innovations that require optimism about recovery, this in itself may be more reflective of hope rather than optimism; a belief in consumer self-efficacy and the possibility to attain goals. The questionnaire used in the present study clearly focusses on optimism rather than hope; the expectation of positive outcomes for consumer recovery. This explanation would suggest that formal education would have differential effects on hope and optimism, such that hope, in the sense of knowing that there are options to effect positive changes, increases, while optimism about recovery outcomes decreases with better knowledge about generally poor prognoses.

To our knowledge the present study is the first to find a positive association between age and caregiver optimism. The positive association between age and caregiver optimism appears to be stronger than the negative association between job tenure and caregiver optimism, which suggests that as a caregiver 'ages on the job' the net effect should be a slight increase in optimism for recovery, even as the job itself wears on the caregiver.

While highly speculative, this positive association between age and optimism may be due to age-related increases in agreeableness. Even though the effects of aging on personality are still far from clear, increases in agreeableness with age is one of the more consistent findings (25) and agreeableness has some conceptual overlap with dispositional optimism (26).

It's evident that much is still unclear about the determinants of caregiver optimism. Future research should consider to more clearly distinguish between hope and optimism (6) in their inquiries and investigate differential effects of- and determinants for either, especially considering possible paradoxical effects of education. In the light of the negative association between educational level and caregiver optimism it would also be interesting to investigate the effects of recovery oriented training of caregivers on hope, as positive effects on caregiver optimism have already been shown in previous

studies (27). Positive results for recovery oriented training could further warrant the inclusion of recovery oriented training in the professional curriculum.

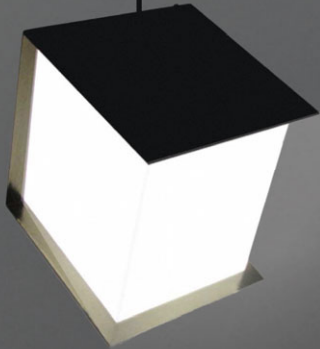
Finally, the replication of the negative association between job tenure and caregiver optimism (17,18,24) may be indicative of a worrisome effect of working in mental health care on caregivers. Qualitative research on the way working in mental healthcare affects optimism and hope for recovery would seem a logical next step to gain more insight in the dynamics behind this association. An insight that can hopefully be used to dampen this effect.

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Chapter 6.

Quality of care in a network

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In Network psychiatry (book), 2020

Introduction

The whole is more than the sum of its parts. Therefore, network psychiatry goes beyond the appreciation of individual models or interventions, such as FACT, High and Intensive Care (HIC), Resource Groups or Active Recovery Triade (ART). In each chapter [of this book (1), Red.], enthusiastic authors contribute to improvements in individual recovery processes to enhance the use of people's own wishes, self-direction and autonomy. For people with mental illness these improvements are paramount and using it, quality of life will grow. Authors are concerned with the fate of clients in mental health care, with the obstacles that citizens experience because of mental distress or the injustice that is done to people with a disability. This chapter seeks to promote the quality of network care provided to people with mental illness.

The development of quality in the mental health sector

Thinking about quality improvement in the care of people with severe mental illness emerged at the time of American deinstitutionalization. The goal of care shifted from the hospital to society and from care provided (treatment and counseling) to autonomy and social participation (including quality of life) of people. From the 1960s onwards, various ambulatory forms of support (case management) emerged as alternatives to clinical care. These included promising alternatives to clinical care. The follow-up of these alternatives was not done effectively and efficiently, resulting in diluted care with diluted outcomes. The need for quality standards arose from the sense of dissatisfaction felt by caregivers and researchers about the declining quality of outpatient care. Integrated care programs such as (Program) Assertive Community Treatment (ACT; 2) and Integrated Dual Disorder Treatment (IDDT; 3) emerged. Those were the first models of care that attempted to match, in the ambulatory field, clinical care intensity and multidisciplinary. The models were clearly described and extensively studied scientifically. (Inter)national research showed that model fidelity contributes to favorable outcomes (4,5,6; later in the Netherlands with (F)ACT; 7,8). Thus, ACT was labeled as an evidence-based practice in the US. This was picked up in America by NAMI (the family association) and received support from health insurers, which helped to spread these models in the US. The set standards helped, and still help, to monitor quality of care.

Model fidelity became an important factor in the dissemination of innovations in healthcare (9). The fact that widespread implementation in practice does not appear to be easy was identified too. The process of model fidelity does not stop with the testing of practice, but also requires continuous evaluation and follow-up. Table 1. describes the process of arriving at model-fidelity in seven steps.

Table 1a Stages in the development of model-fidelity

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1. (Bottom-up) care development gets picked up and becomes a social movement
 2. Draft description of critical ingredients
 3. Formal description of the model in a protocol or manual (manual)
 4. Operationalization of the critical elements from the manual to model fidelity scale
 5. Pilot test of the draft model fidelity scale for reliability
 6. Regular practice tests with the final model fidelity scale
 7. Practice evaluation and adjustment
-

Model fidelity can be operationalized in several ways. One can define model fidelity (a) on the basis of structural elements as was done in the original FACT scale: are the resources (formation and disciplines) available to provide good care? On a second level (b), one can also test whether the relevant expertise is present: experts by experience, addiction experts, knowledge of the social map, trauma therapist, and so on. Both levels have the advantage that they can be tested 'objectively' and assessed 'remotely' (you do not need to see people at work, you only need to request work records, diplomas and training). A more complex form of reliability assessment (c) answers the question of whether the resources are being used for what they are intended for: is recovery-oriented work being done, are people receiving evidence-based treatments, is the family or network involved, do professionals really use shared decision making. Finally, the 4^{de} level of quality assessment (d) is whether the care provided does achieve the intended goal (outcome) (10).

Table 1b Levels of quality policy development (10).

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1. Are the structural elements (FTE, consultations, records) in place?
 2. Is the necessary expertise present (experts by experience, somatics, diagnostics, trauma treatment,...)?
 3. Is the practice working to the standard (recovery oriented, network involved, is trauma treated, is there CBT for psychosis)?
 4. Is the expected outcome also achieved (ROM,...)?
-

Over the years, thinking about quality and how to improve it has changed. There is an increasing need to assess quality directly and not just rely on something that might indicate quality such as reports, staff composition and frequency of contact. And this even, when it means that criteria become less objective and "softer" values. After all, it's about validity over reliability. And that is why so much emphasis is placed on outcome measurements and Routine Outcome Monitoring (ROM) (level d). But this process of outcome quality is logistically complex (all patients have to be interviewed repeatedly) and the quality of the care provided cannot be deduced from these outcome data without difficulty. A poorer outcome may indicate inadequate care, but it may also indicate inadequately appropriate outcome indicators, a target population in which

substantial progress requires more time, or inadequate resources in the setting, which prevents care from reaching its full potential. More development work (and additional information) is needed to measure quality based on effect measures with standardized (ROM) instruments. This brings the measurement of model fidelity based on the practice of care (level c) back into focus. If care has a desired level of quality, it is more likely that desired outcomes will also be achieved, it is thought.

It is well known that model fidelity increases the likelihood of better outcomes. This is seen in Dutch mental health care and we see enthusiastic and pioneering teams achieving great results in bringing together an evidence based model and doing the 'right thing'. To continue doing this, collaboration with other domains, such as the welfare sector, is necessary. Model fidelity should be extended to network-centered psychiatry and thus evaluate the welfare sector as well.

Need for continued development

After systemic changes in Dutch health care and welfare from 2015 onwards following pressure on cost control, care for people with severe mental illness has changed significantly. In years before the transition and transformation of the specialist mental health care and the welfare sector, large mental health institutions provided integrated services on all areas of life. Care provided in institutions was, to be honest, very limited ('a chain of empty Sundays'; 11). A full integration of various services of care is even more difficult in an ambulatory care organization. FACT teams have tried to, but did not have the necessary expertise, manpower, or latitude. Activating the necessary resources to integrate needs across the different domains of recovery requires new forms of collaboration between institutions and services (the network). The welfare sector is taking responsibility for all citizens now, including those with severe mental illness, and this offers new opportunities. The Social Support Act (Wmo) offered municipalities and professionals to start a bottom-up movement and from that space to take up the responsibility to provide better care. This happens differently in every municipality: from generalist community teams to specialist community teams, from a separation of delivering services and indication of services to integration of both, and from actual outreach community teams to employees at a counter in the town hall.

Policies on quality improvement and evaluation are well established in health care and, as outlined above, constantly evolving. Only recently have we seen a demand from municipalities to describe best practices, measure and share results, and work together to improve care. In practice, this is limited to describing innovative care (Table 1a, step 2), possibly due to a somewhat wait-and-see attitude among social workers towards evidence-based thinking (12). One can choose to develop their own quality policy for this sector (as per Table 1b), but also advance to a network-oriented quality policy that includes both the mental health sector and municipal community

care. Standardized lists of resources (level a or b of table 1b) do not meet the needs of modern teams. After all, they want to demonstrate that they are doing more than following the rules, and that their care is having an impact (matters). This is true in both the care, and welfare domains. The teams want local conditions to be taken into account and for their investment and the care they put into practice to relate optimally to the neighborhood, with all its unique citizens, the living conditions, their specific questions and flexible and unique solutions, the institutions, volunteer organizations, possibilities and impossibilities present. The quality they want to be judged on must take these factors into account. After all, a care network that integrates different care models requires coordination, smooth transitions and optimal cooperation. This can be promoted by working with Coordination of Care Dialogues (13) and working out the cooperation model (14) in a process-oriented manner together with the network. In each case, solutions will prove to be locally relevant and only limited or not at all transferable to other regions. On the other hand, it could be the case that we are now at the beginning of a new movement to describe model-based working at the network level (Table 1a) and it will soon turn out that general statements about structures and outcome measures are possible after all.

Towards process control (model c) in the integrated mental health care - From the point of view of the mental health care system, FACT teams are important players in this process. The outlined national changes in the system have interfered with the working method of FACT. Integrated care can now only be offered in collaboration with the municipal (community) teams. The original fidelity criteria (FACT Scale; 15) sometimes stood in the way of good and desirable local developments. The FACT teams indicated that they needed the freedom to make local adjustments to the FACT model. Also, audit data from the CCAF showed that recovery supportive care and treatment lagged behind the desired standard in FACT teams (16).

Of course, similar contextual changes also occur in other ambulatory models, such as Intensive Home Treatment (IHT), IDDT or Critical Time Intervention (CTI; 17), and these models will also need to relate to the new reality. Since these care models are still in development and are not standardized as much as FACT, there does not yet seem to be an immediate need to adapt the fidelity scales.

Because ART as a model directs recovery-oriented care in the triad (input from outside the team), it is also difficult to capture in a classic model fidelity scale. In ART, individual-level variations are the starting point of care and no one solution is ever the right, best, desired, or most appropriate strategy. Again, the solution seems to be to focus on soft values to promote the quality of teams and their development.

Is outcome steering (model d) already feasible? - Ultimately, it is attractive to steer for outcome. But in practice this is not self-evident. The HIC model shows that steering

solely on outcomes is not what clients, relatives and professionals want. Because the HIC project had a clear goal - reducing the number of admission days and the number of compulsory admissions - it was obvious to use these criteria as the central outcome measure in the quality policy and in the model fidelity scale. But even with this clarity, steering for 'outcome' did not work. The proposed criteria for good care were judged by the field as too limited and sometimes undesirable. Satisfaction, hospitality, quality of treatment and a friendly environment were also important, so the scale now has several items.

Yet the question remains how quality can be weighed given the wide variation in care practices. Research (18) shows that departments differ greatly in the target group they provide care for and the collaborative network within which they operate. On average, on a HIC 48% of the admitted clients come from FACT teams and 30% from crisis service/IHT, but the referral channels differ greatly from practice to practice. There are HIC departments that only have FACT as referrer, but also departments where two thirds of the referrals come from crisis service/IHT.

All in all, reasons to strive for further development of the methodologies at the level of quality assurance of care models and to be cautious with normative comparisons. A further development towards a combination of quantitative structural items and qualitatively described result areas is obvious for each model. It is also important to share these (sometimes qualitative) data with each other and to dare to compare them for target groups, contexts and interventions.

The future begins now

To ensure good quality care for people with severe mental illness, we must preserve what works and provide room for necessary new developments. Modern network-centered care is complex. Citizens operate in networks of networks, sometimes outside of care in personal networks and families, sometimes in professional networks of care providers, sometimes in resources in the social field (e.g., a walking club or a community center). The quality of care and the impact it has on the lives of citizens depends on this context. As a result, quality of care must be tested in different networks: from the dual relationship between client and his/her stakeholders and caregiver, to the population level of the neighborhood or municipality. Quality institutes, such as CCAF, must develop or make available tools that are appropriate to these different circumstances: client outcomes and satisfaction in the triad, the team, the organization and the network.

Testing of quality in all these subnetworks is difficult, perhaps even impossible for the time being. Figure 1. shows the different subnetworks and the quality tools that fit them. For a quality tool to work properly, it must connect to the room for action

that actors have. A practitioner can improve the quality of his own therapeutic expertise, but is often unable to influence the organization's electronic patient dossier. A FACT team can be responsible for a recovery-oriented focus on care, and organize the necessary collaboration in networks, but cannot influence the funding of care. The interconnectedness between the different subnetworks is high, as is the interdependence. A dependency that needs to be understood and addressed by each actor with responsibility. Self-aware professionals who actually own their quality process will experience the power of this ownership and transfer this quality awareness into the network. This professionalization largely determines the quality (and job satisfaction?) of the entire network.

Individual in his/her living environment

From the perspective of the client or citizen, quality lies in the relationship with the immediate environment and own support group (sometimes through the mediation of a resource group, JIM, neighborhood circle, Family Group Conference or Coordination of Care Dialogue). At the level of the individual citizen, the degree of satisfaction and the experienced control over their own care process is reflected in quality indicators. These quality indicators should ideally be evaluated with the client (citizen) and his/her stakeholders. A mobile support group application can help with this, linked to the online ehealth platform or online client file that is under the client's own control. Tools ensure that data is made available the citizen and designated support group members who jointly direct the development of a better quality of life.

Individual and his/her context in the therapeutic relationship

Responsibility for the quality of the relationship between counsellor and client obviously lies with this duo. The professional is required to be continuously reflective in order to assess and adjust this relationship, both in the moment and afterwards. There are various instruments, to be filled in by (one of) both, to test the effect and satisfaction of the therapeutic relationship. Tools for instant feedback on effect and satisfaction are the Outcome Rating Scale (ORS) and Session Rating Scale (SRS), with the ORS administered at the beginning of the conversation and the SRS at the end (19,20). Of course, these standardized instruments are not useful or usable in every client situation. Evaluating the connection, proximity, and engagement collaboratively with the client and relatives remains a professional "soft" competency and cannot always be quantified.

Individual and his/her relationships in a (methodical) change-oriented context

One step above the therapeutic relationship, there are (methodical) care and treatment techniques aimed at change and treatment. These techniques could be contextual and need not be linked to one team or implementing organization. Examples are trauma treatment with EMDR or prolonged exposure, CBT for hearing voices, Individual Placement and Support, but also the use of Integrated Dual Disorder Treatment (IDDT),

the Coordination of Care Dialogue (CCD) or resource groups. These are (technical) actions that are initiated from the expertise of the social worker(s). Qualitative work can be assessed using evaluation tools (as a self-assessment tool, in intervision or supervision) based on didactic guidelines (step 4 in Table 1). The goal is reflection and process improvement, not to standardize. The reference material (e.g., the theoretical principles of the guideline) is applied in the unique context of healthcare practices. The CCD working method for care coordination dialogues is a good example of this. Individual caregivers and teams are asked to work with the network in an action-oriented way to achieve a locally specified CCD working method (13). Quality institutes can publish or provide model evaluation tools (from a community of developers) and/or be matchmakers for intervision circles or supervisor networks. For example, the IDDT model is a set of interventions that can be assessed with a self-assessment tool (see www.LEDD.nl).

Individual and his/her relationships in a multidisciplinary team

Team models are generally quite well-known in Dutch Mental Health Services. Since the turn of the century, ACT has been used, briefly IDDT teams too, in 2004 FACT was created and later the HIC, IHT, CTI and ART models were added. These are 'service delivery models' that have all been developed with a model description. When scientific validation is available, model fidelity can be tested by means of a list of criteria. From the network perspective, the CCAF has chosen to develop and update model fidelity scales for the (F)ACT, HIC and IHT models. Other team models may follow in the future. However, CTI as a model is not (yet) a widespread standard and ART has potential as a vision for recovery oriented care in long-term care.

The first FACT scale was a derivative of the DACTS and contains a set of structure items to be rated on 5-point scales. The other model fidelity scales followed this standard. However, changes within the mental health care sector and in the welfare sector require new ways of working, as optimal quality of care can differ per region or municipality. The new FACT fidelity scale has combined quantitative and qualitative items in one scale. Research made clear what is necessary in outpatient care for people with severe mental illness (5,7,21,22). The new FACTs 2017 (23) contains a limited number of structure items (resources for optimal care), combined with eight focus areas (the practice of optimal care). The focus areas provide teams the freedom with to implement optimal care in their own way in relation to the unique context of the local community, network and target group. The audit is done at the level of process, outcome and satisfaction in the triad (24).

New wishes and new questions from the ever-changing field of work require professionals, researchers, clients, relatives and other involved parties to shape step 7 of table 1: the process of periodic adjustment to improve quality of care. We hope the new FACTs will continuously serve as a standard to enable quality development in a network at the level of models of care.

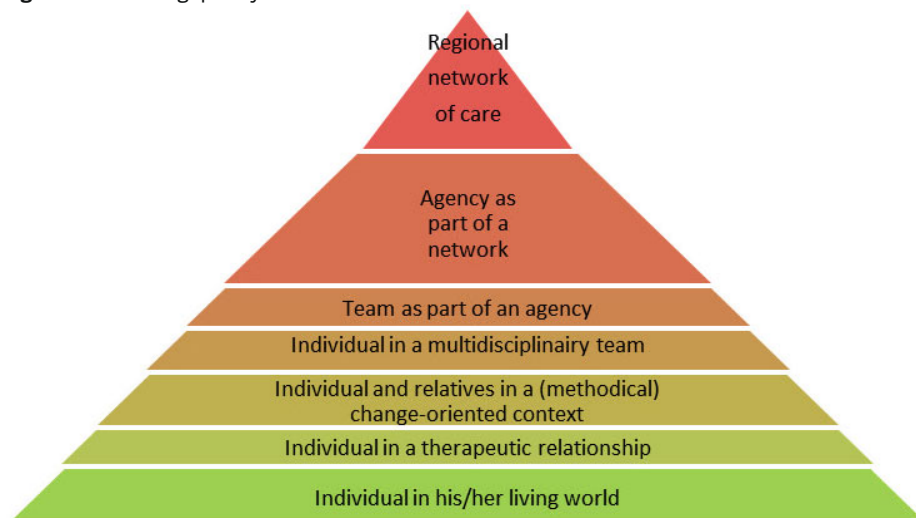
The team as part of an organization

Different models of care (FACT, HIC, IHT,...) are often housed within one organization. With the relatively newly introduced inter-agency approach, it is quite possible for staff from different organizations to come together in one team. The members of a multidisciplinary team must provide integrated care together and are entitled to clear direction from the team leadership, which is also their parent organization. This is quite a responsibility and can be challenging for team leadership. Audits by an external party provides feedback on the functioning of the team and the care achieved. In order to take the same flexible and appreciative stance as a quality-promoting organization as used in the team audits, a portfolio discussion with the management and board level, periodically, is necessary.

The organization as part of a regional network

At the highest network level (how, for example, to collaborate at the municipal level) there is insufficient consensus on how quality should be assured. The KRAS (25), dating from 2002, had the same goal for people with a diagnosis of schizophrenia in a certain region, but due to a very limited number of interviews with those involved, it provided too global a picture. Every community is obviously different, there are different resources, different challenges and opportunities for collaboration. It requires a thorough, collaborative analysis based on many observations and conversations. Two trial analyses in the south of the country using this method were positive. It proved possible to speak to many stakeholders (professionals from different organizations, client organizations, volunteer organizations and (former) clients) in a relatively short time and to make an assessment of gaps and strengths at a global level (26). By speaking to many different professionals in the network, it became clear how practical adjustments or alternative (non-descript) processes or actions lead to desired or undesired outcomes. Daily practices are studied rather than desired or described processes. The results were visualized and discussed in focus groups with all stakeholders. This final more action-oriented step allows for learning from the evaluation. FRAM (Functional Resonance Analysis Method) methodology (27,28) can be used to further improve this process, connect to appreciative auditing with model fidelity scales, and visualize the results in a more organized way and based on multiple themes.

Figure 1. Assessing quality of care at different levels



Responsibility

With new momentum and new tools, work can be done to improve the quality of relationships, care, teams, organizations and networks. The responsibility for achieving quality improvement lies largely with the service (care worker, team, organization or network) itself. Just as a care worker, is responsible for care in the relationship with a client, the same applies to teams, organizations and networks. The various approaches to model fidelity are given a place in this process. The end goal is a process towards quality improvement.

A stage-oriented implementation process, in which teams cyclically implement actions, interventions, or adjustments in care to adjust after review, has proven effective. Optimizing these procedures has characteristics of a *Doorbraakproject* (such as the *Doorbraakproject Schizophrenie*), in which professionals learn from each other about what works. The improvement process takes shape in interim short-term action-oriented cycles. From the evaluations flow improved practices based on input from all relevant stakeholders. This allows for smaller, interim goals and successes at the team or network level.

This modification and adaptation process is possible, without changing the content of, for example, FACT. The Region Hovedstadens Psykiatri in Copenhagen demonstrates this in their FACT implementation process. A tight and clear implementation process helps all involved to maintain focus for a long time. Precisely because mutual comparisons (based on measurements) are less relevant because the context is so different each time, it is good to enter into dialogue with each other and learn from

each other's new ideas, opportunities or experiences. This stimulates and inspires professionals to reanalyze the local community or target group or to integrate a new intervention into the team. Periodic adjustment based on information supports the quality process in teams, in institutions and in the network. This quality process is best driven by "hard" requirements if possible and otherwise by "soft", collectively defined performance areas. Applied to the new FACT scale: when it is possible to define and measure hard model fidelity criteria based on evidence, this should certainly be done. But these criteria exist alongside the outcome areas where teams, institutions or networks are given the space to develop their own practices, to experiment and evaluate and learn to deliver the best possible care each time in a unique context.

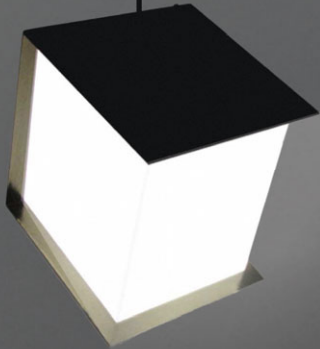
Quality institutes should develop into broadly oriented quality institutes with the aim of improving care within the network for people with severe mental illness. They should do this by entering into dialogue with the field and creating a learning and reflective network. New tools will be developed based on input from the triad of actors (citizens, stakeholders and care providers), researchers and interest groups. We want to arrive at a set of tools that cover all levels (the citizen and those involved, the therapeutic relationship, the techniques, the team, the organization and the network). Preferably, these tools are used to enter into learning processes with each other. Exceptionally, they will also be normative. The new reality requires a shift in thinking about quality (29), focusing on connecting with professionals, teams, organizations, and networks that understand what is needed to achieve excellence.

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Chapter 7.

Development of the renewed Flexible
ACT scale.

*From F-ACT-fidelity in 2008 to FACT-
fidelity in 2017*

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Abstract

Background

An important model for the organization of care for all people with severe mental illness is flexible assertive community treatment (FACT). FACT combines the principles of case management with ACT. The FACT fidelity scale from 2008 is no longer sufficient in the rapidly changing field. A new fidelity scale was needed to continue to improve the quality of care and to be able to continue measuring model fidelity.

Objective

Developing a new model fidelity scale for FACT teams.

Method

Using knowledge of experts, relevant articles and feedback from professionals, researchers, interest groups and family members, a model fidelity scale was developed: the 'FACTs 2017'. During two rounds of pilots with 21 teams using trained auditors, the scale was tested and adjusted.

Results

In 2017 the final version was established, which is now being used.

Conclusions

Due to the FACTs 2017, the (research) field has an instrument to measure the degree of model fidelity of teams that focus on patients with severe mental illness in a rapidly changing context.

Introduction

Since the emergence of Flexible Assertive Community Treatment (FACT; 1) in 2004, the number of FACT teams in the Netherlands has grown rapidly. Meanwhile, FACT is also applied in Belgium, England, Ireland, the Czech Republic, Denmark, Sweden, Norway and Canada. FACT is originally an outpatient care model for people with severe mental illness; there are also teams for more specific target groups, such as youth, people with mild intellectual disabilities (MID) and people with both psychiatric disorders and a forensic title. In each case, these are people who, in accordance with the EPA Consensus Document (2), have interrelated problems in multiple areas of life and require integrated care and support.

The model fidelity scale of FACT in 2008 (3) made it possible to assess the extent to which FACT teams meet the quality criteria considered essential by the field. Characteristics of FACT are the multidisciplinary team composition, the ability to scale up and down care, the joint sharing of care for the entire caseload, the provision of outreach, and a focus on preventing admission by providing intensive crisis interventions, evidence-based treatment and recovery support. These criteria are assessed using the FACT model fidelity scale.

The Dutch FACTs from 2008 was based in content and form on the American model fidelity scale for ACT teams (the DACTS; 4). The scale has 66 items, divided into 8 subscales (team structure, team process, diagnostics and treatment, recovery-oriented care, care organization, social care, monitoring and professionalization). Each item is scored on a 5-point scale, where 5 means optimal implementation.

The original FACT model fidelity scale made an important contribution to the rapid implementation of FACT in the Netherlands. It gave starting teams a framework and supported the further qualitative development of existing teams. It enabled clients, community members, and stakeholders such as purchasers of care to test whether the promised care was of sufficient quality. (Inter)national research has shown that model fidelity contributes to favorable outcomes for people with severe mental illness (5,6, 7,8,9). Evaluation research from the CCAF's audit certification database showed that teams could develop further. Items on recovery orientation and the use of evidence-based interventions showed persistently low scores.

Need for a new F-ACTs

The model fidelity scale and audit procedure had remained unchanged for a long time. The frameworks of the scale were beginning to fray. New developments in health care demanded attention. The transition to the welfare sector and the municipality's responsibility for participation have changed the way we work in the context of the

community considerably. Care for citizens with severe mental illness requires an integrated approach of the welfare sector and the specialized mental health care. It is not always possible or necessary to organize this centrally from a team to support recovery in all domains. The original FACT scale from 2008 offered too little room for variation in the organization of care based on FACT principles depending on the regional care network.

A model fidelity scale is an operationalization of an ideal-typical healthcare practice. A review of several model fidelity scales in international mental health by Mowbray et al. (10) shows that items are mostly specifically described. "Collaboration with family" is operationalized as the number of times caregivers speak to the family; "shared caseload" becomes the number of caregivers a client saw in the past few weeks. Specifically defined items lead in practice - as we saw with the FACTs - to checklist scoring. The scores reflected less and less the originally intended set of values with limited validity as a result. The item formulated as measurable becomes the goal of the implementation and the theme it originally stood for is lost from sight. Equivalent alternatives are excluded because they are not in the model fidelity scale. Providing optimal care for specific target groups is made difficult for the same reason. Necessary, thematic expansions desired by the field lead to an expansion of the item pool. This leads to a proliferation of specialized model fidelity scales with essentially similar principles.

Development of FACTs 2017

In this context, the CCAF decided in 2013 to develop a new FACT model fidelity scale. The authors of this article formed the development team. In the following, we describe the new FACTs and how it was created. What quantitative analyses and data this led to is described in a follow-up to this article.

Phase 1

In early 2014, the first phase of developing the model fidelity scale began: identifying and specifying reliability criteria (10). The development team relied on:

1. the 2008 F-ACTs,
2. the studies conducted on the effectiveness of and satisfaction with FACT (including 11,12) and the analysis of audit data from the CCAF;
3. relevant literature, including the Handbook of (F)ACT (1), the TMACT (a model fidelity scale for ACT; 13), the document "Over the Bridge" (14), the vision document FACT (15), the book "De Nieuwe GGZ" (16) and the various available guidelines;
4. multiple working visits to ambulatory, community-based teams with exemplary roles at home and abroad;

5. Expert information obtained from the various F-ACT platforms: F-ACT Youth, Forensic F-ACT, F-ACT MID and F-ACT in Addiction Care.

The first version from July 2014 consisted of about 10 themes that were then written out to allow for a qualitative, descriptive review.

During feedback rounds with professionals, senior auditors, and advisors to the CCAF board and interest groups, it became clear that the proposed full qualitative assessment provided too much uncertainty and was not desirable. Indeed, the ACT development in the United States - still without standards - had shown that the model was diluted over time (17). Specifying norms for team composition (desired disciplines), caseload and working method would have prevented dilution in the Dutch development of FACT.

The new scale was given two parts. Part A contains normative items based on proven effectiveness (such as a shared caseload) (11) and the most characteristic FACT items scored on the usual 5-point scale. Part B is an appreciative test based on themes that allow for the unique adaptation of the team to the case mix and the environment in which the team operates. Scores in this part range from 1 to 8.

Phase 2 and 3

The second and third phases involved developing a method for measuring model fidelity and evaluating the content validity and reliability of the instrument (10). This was done by administering both scales to 21 teams in successive pilot readings. The auditors determined their scores independently to test inter-rater reliability and to discuss variations in results in a focus group. There, the scores on both scales were also compared and the scores compared with the experiences of the auditors and teams to be able to discuss the consistency or negative correlation between the two. After each round, such a focus group was convened with the auditors involved, team members, external stakeholders, advocacy groups, the CCAF, and the development team to gain consensus on how to move the process forward based on the experiences and audit data. Throughout this period, draft versions of the new FACTs were available online for feedback.

The first pilot round took place in early 2015. The draft instrument was tested on two teams by trios consisting of two pre-trained auditors and one member of the development team. After this round, the design of the new FACTs proved unclear to auditors and teams. The inventory of training received by experts by experience and nurses needed clarification (items from part A) and users missed an extensive description of the themes in part B. Two themes, cooperation with the formal and cooperation with the informal network, showed overlap. Therefore, a preamble was

added to the manual, along with a thematic description and anchor points for scoring. This made the linkage between the information on the case mix, the core team set-up, the resources involved and the treatment offered much clearer. Thus, the first working version of the manual was created.

In late 2015 and early 2016, the second pilot round took place, again completed with a focus group meeting. The 21 teams were found to have scored on average the same on the old FACTs as the average of all FACT teams from 2008-2015 (3.8), and the team that scored lowest on the old FACTs was also found to have scored lowest on the new FACTs. The available audit data combined with the experiences provided sufficient reason to move the process toward completion. The new manual with more compact themes proved workable for the teams and auditors.

In 2016, auditors were trained to administer the new scale and auditing began in 2017 with the 2017 FACTs established. Initially, no certificates were issued. Anchor points will be established after more than 20 audits have been conducted in the established standard.

FACTs 2008 versus FACTs 2017

The new FACTs differs in concept, form and content from the original 2008 scale. The accreditation evolved from a prescriptive audit with checklist items to an appreciative audit with a limited number of checklist items and an open section (with greater weight). We test whether the team can access the necessary resources (Part A) and performs a healthcare practice that meets a modern field standard (themes from Part B, see Table 1). Structural features and proven effective components of FACT are checked. Teams are also given room to flexibly adapt to the characteristics of the caseload and the circumstances in their catchment or local community. FACTs 2017 is thus more universally applicable.

Table 1. FACTs 2017

Part A structure items (quantitative) score from 1-5	Part B themes (qualitative) score from 1-8
1) Small caseload	1) Flexibilization of care
2) Teamwork	2) Personal domain
3) Psychiatrist	3) Social domain
4) Psychologist	4) Symptomatic domain
5) Nurse	5) Planning and monitoring at the individual client level
6) Social/legal expert	6) Crisis and Safety
7) Employment expert	7) Network Collaboration
8) Expertise in the area of experiential knowledge	8) Quality and Innovation
9) Expertise in somatic care	
10) Expertise in the area of addiction	
12) Expertise in the field of MID	
13) Self-direction and autonomy	
14) Flexible care	
15) Team approach	
16) Daily FACT board meeting	
17) Outreach	

In terms of content, some themes are given more weight. Each time the choice is based on the previously mentioned sources in Phase 1. 'Recovery' is clearly more prominent than before (in themes 2 and 3 of Part B), because recovery and recovery-supportive care has become the visible core of the work more than before 2008. Furthermore, there is a greater emphasis on the use of formal and informal resources (themes 5 and 7) and on evaluation and adjustment. Teams are given the opportunity to choose from a broader set of interventions such as resource groups, Open Dialogue, or Your Inserted Mentor (JIM) (see 18 too). The original FACTs had little focus on the safety of client, environment and team. In the Forensic FACT scale, risk assessment was given an important place. This was built into the 2017 FACTs.

An analysis of the audit data showed that the original FACTs did not pay enough attention to implementing evidence-based treatments for symptom reduction. The focus on appropriate treatment delivery has increased in the new scale. A doubling of psychologist hours has been included. Further, we expect present expertise in somatic care, addiction and MID.

The original FACT scale has contributed to the presence of experiential experts in the mental health sector. The FACTs 2017 goes further and focuses on paid positions for experience experts and the further professionalization of this position in line with the Professional Competence Profile Experiential Expertise (19). Professionals are explicitly

invited to use any (latently) present knowledge of experience. A next step in countering stigma and developing professional proximity.

Application

The original FACTs made tradition and had explicit criteria. Letting go of old standards and practices proved an exciting exercise. But criticism, intensive dialogue and repeated rounds of improvement have contributed to a new quality instrument.

The 2017 FACTs calls for appreciative auditing. This poses challenges to a one-day audit. Good preparation is needed, timing during and after an audit is tight, and auditors need better training and coaching. The CCAF ensures the logistical process, the expertise of the auditors and the quality of the certificate.

Restrictions

Ideally, a model fidelity scale is based on scientific evidence, expert and practitioner knowledge. A limitation of the scientific evidence is that there has been limited international research into the effectiveness and critical elements of FACT. The development of the FACTs was therefore partly based on insights from research into the original ACT model from which FACT emerged. Expert and practitioner knowledge has been extensively utilized. More than 100 professionals from FACT teams, users and network partners were able to give their input, and there was open communication about concept versions. Based on experiences and analyzed audit data, consensus was reached and choices were made in focus groups to increase the validity and reliability of the instrument. The innovative nature of the FACTs 2017 meant that results of the analyzed audit data demanded expert analysis in the focus group. Extensive reporting of these data will follow jointly with a report on the cut-off points.

There has been (and still is) criticism that the scale differs from the FACT standard of 10 years ago. Classic FACT care may be appropriate in some scenarios, however, the current social context requires more adaptability to the local situation. The CCAF stands for optimal treatment of people with severe mental illness. The original scale sometimes offered a certificate to questionable practices, or meager ratings in the case of gems of care innovation. The new scale changes this and, at the same time, requires teams to be more rigorous in substantiating the choices made in relation to the target group and local context. This places greater demands on auditors and continuous attention to the reliability of the test.

Conclusions

In recent years, the successor to the 2008 FACT model fidelity scale has been developed in collaboration with the field. With the FACTs 2017, the CCAF has set a new standard and is hereby moving towards more appreciative auditing of care for people with severe mental illness. The FACTs 2017 aims to contribute to quality improvement and transparency in a dynamic care landscape where new insights into optimal care and a constantly changing context pose particular challenges.

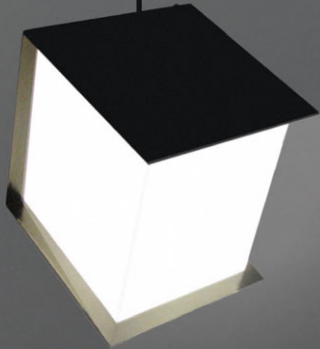
The FACTs 2017 can be viewed on the website www.ccaf.nl.

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Chapter 8.

FACT as part of a
community (health) network

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Abstract

Background

Community-based care for people with severe mental illness increasingly requires far-reaching cooperation between different domains. This cooperation must always be unique and local and at the same time provide an answer to generic, nationally set goals.

Objective

Offering new insights on collaboration within and between domains.

Method

Reflection on developments in the welfare sector and specialist mental healthcare using relevant literature and recent (inter)national experiences.

Results

It seems possible to provide better integrated care by allowing FACT teams to network together with community partners (e.g. by sharing financial and/or human resources). Networks of care for people with SMI develop in stages and realize new partnerships in the process. The model fidelity scale for FACT teams was adjusted to facilitate that process.

Conclusions

The new FACT model fidelity scale is ready to allow FACT teams to explore flexible local solutions for partnerships to realize the much-needed multi-domain integrated community care for people with SMI.

Introduction

Community based care for people with severe mental illness has been provided by Assertive Community Treatment (ACT) teams in the U.S. since the early 1970s. More than 40 years of experience and scientific research have provided the model with a solid foundation (1). However, it appears that only 2% of people with severe mental illness in America are offered this proven effective form of treatment (2). With the current, more restrictive definition of the target group in the Netherlands (3), one arrives at a range of 8%. In the Netherlands, Flexible ACT (FACT) teams have been in place since 2004 (4) and the model has also been implemented in the Netherlands Antilles, Belgium, Canada, England, Ireland and Scandinavia. The FACT teams are outpatient teams in which ACT characteristics such as outreach, disciplinary care and working with a joint caseload are combined with the flexible intensification and extensification of care. Dutch research shows that FACT teams prevent admissions and drop-outs, shorten admissions (5) and ensure good client satisfaction (6). However, with over 300 (certified) Flexible ACT teams (7), the model reaches only about 30% of people with severe mental illness in the Netherlands (8). And despite the positive results achieved by FACT, there are also signs that in terms of personal and social recovery FACT is not yet achieving what it aims to do (9).

In this article we reflect on the current situation and the developments within the welfare sector and specialist mental healthcare. New insights about collaboration between the domains are provided with feedback to enable quality development.

New developments in the field

Until 2015, FACT teams provided integrated care in all areas of life and collaborated on an indicative basis with social services, housing associations or other parties. As a result, clients could contact one FACT team and the underlying mental healthcare organization with all their requests for help, but there was no real (social) integration with the welfare sector. As a result, cooperation, continuity or sometimes the quality of care was not always optimal.

With the introduction of the Social Support Act (WMO), the municipality has the responsibility to guarantee support in several areas of life for all citizens. Whereas previously tasks in the areas of housing, work, finance and leisure were still the responsibility of the large mental health care institutions, this is now a joint responsibility of the FACT teams and the social community teams from the welfare sector for people with severe mental illness. This offers new opportunities and cooperation has become necessary. Municipalities deal with this (new) responsibility differently, so there are no standard solutions.

FACT teams are known not to be complete in their offerings, especially in the area of participation and recovery (9). A renewed model fidelity scale had to provide an answer to the new situation in the field and stimulate teams in the field of social participation and recovery of people with severe mental illness. The previous FACT scale (10), based on the American ACT scale (DACTS; 11), was characterized by a list of prescriptive items on team structure, procedures and team organization. The scale provided guidelines for mental health care institutions to build and organize their FACT teams and thus supported the (rapid) implementation of the model. The FACTs 2017 builds on this with a number of structured and standardized items on team structure, procedures, and team organization. The new FACT model fidelity scale (FACTs 2017; 12) also leaves room for reasoned connection to the care available in the local context and the mix of included clients. This is questioned on the basis of eight themes in the areas of treatment, recovery support, social care, crisis and safety, collaboration, flexibility and quality control (13).

There are examples in practice where the welfare sector and the mental health organization know where to find each other: Community teams in the Utrecht region and 'Optimaal Leven' teams in Drenthe: new network connections are emerging that support people with mental illness for help early, easily accessible and locally, and possibly offer treatment. The network, which focuses on needs of citizens, offers the opportunity to enter into dialogue with each other and develop integrated care together. This of course has the advantage of providing customization to large and diverse groups of clients. A great deal is already known about the needs of people with severe mental illness (14,15) and municipal teams do not always fit in well (16). Logically, the question arises as to whether cooperation is sufficient or whether teams need to integrate with each other.

Collaborate or integrate?

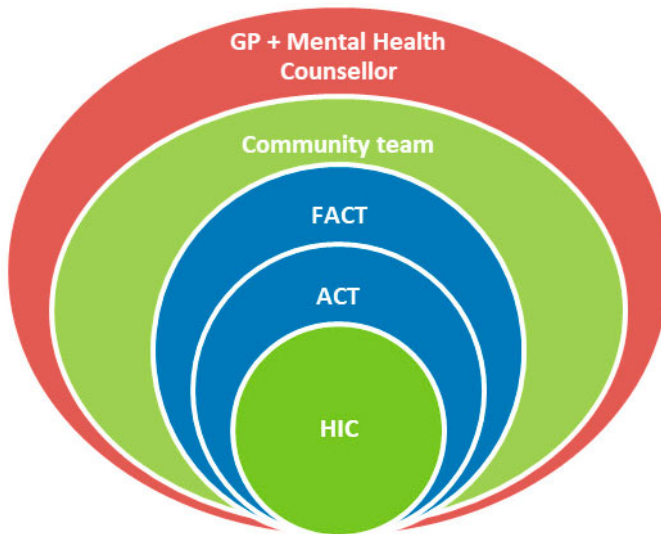
What we know from experience with FACT youth teams and foreign working visits is that a FACT team can be a composition of care providers from different domains (e.g. mental health and welfare sector) - the so-called 'multi-agency approach'. The resources and composition of the team match the characteristics and needs of the caseload and the available facilities in the area. The FACT model, which allows for this customization, seems to work in different contexts and health care systems, according to international developments. For example, during a working visit to Bonaire it became clear that integrated community care by a FACT team has greatly reduced the need for clinical beds (17). In Belgium, teams are active where a broader range of disciplines than the usual mental health disciplines are deployed (18). For more than five years, FACT youth teams have shown that integrated collaboration from different institutions is possible. FACT youth teams are combined teams consisting of employees from the Center for Youth and Family, the mental health organization and any other organizations (addiction

care, services for people with intellectual disabilities, residential counseling, etc.) (19). This shows that FACT teams can be complemented with financial and human resources from other funding sources, such as the Social Support ACT (WMO in Dutch). For example, partial WMO funding enables the deployment of prevention, family support, work coaching, first-line consultation and untargeted case finding.

International research on (F)ACT suggests that such integrated team solutions - for the patients thus treated - have better results than coordinated solutions (1,15). But this does not necessarily apply at the level of the broader healthcare system. A risk of the integrated approach is that the team becomes an island within the local care network, with its own indication criteria, demarcations, care doublers and people falling between the cracks.

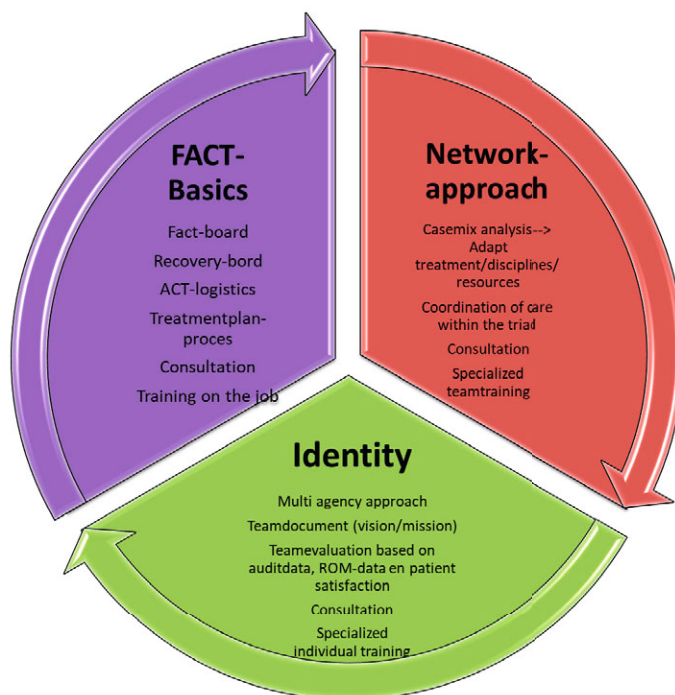
An alternative solution is a team that offers a basic structure of care and support, for example psychological treatment and occupational reintegration on indication from elsewhere in the care network. However, the implementation of this model regularly turns out differently from the intentions on paper. For example, the intended external expertise was hardly used in a study of such a coordinated structure in Friesland (20). At the same time, good experiences are reported in exemplary practices, such as in Lille (21). Such a solution therefore depends on the strength of local cooperation and there is no general crystallized evidence for integrated teams or care networks (22). The new FACT scale therefore does not prescribe a standard solution, but questions the way collaboration and integration take shape. In practice, with different financiers, this can entail the risk that money and manpower will end up in collaboration problems. Nevertheless, not opting for a fixed model is fully in line with the advice to integrate care for people with complex behavior (23). Ultimately, each region should have an integrated care network. This makes optimal flexible care possible. It unlocks the various resources in the neighborhood and makes it possible to scale up and down, from a closed admissions department (HIC) to a general practitioner (GP). The image below shows this.

Figure 1. Up- and downscaling in a chain of integrated care.



Discussion

Starting up new teams in a network context, as is currently happening in the Netherlands, creates an interesting mix of local collaborations between organizations. We see three development phases for network oriented care for people with SMI (see figure 2). Phase 1 is the classic FACT model, in which structural team characteristics (caseload and formation) make it logistically possible to offer crisis interventions, treatment, recovery, and consultation. The original criteria of the FACT model indicate what resources are needed for this. This clarity was seen by management as a guide for rolling out FACT teams. Think of organizing a daily structured FACT board meeting (24), adequately scaling up and down the intensity of care, introducing outreach and crisis resolution interventions, and planning agenda-free days for each employee. In phase 2 it is about network oriented working. Needs remain the same, but the composition and working method of the FACT team is partly determined by the supply of other facilities in the neighborhood. The composition of the caseload (the case mix) also determines the supply of care and therefore the necessary resources and the composition of the network. In Phase 3, the identity of a team, a vision, emerges, and one can work together in more complex ways and evaluate and improve results. Employees know their position in the network and can use the network to reflect on it self-confidently in order to continue to enable both individual growth and team development.

Figure 2. Developmental phases for network oriented care.

The original FACT model was based on (scientific) research and an extensive tradition of more than 40 years. In the Netherlands, we now see teams entering care practices on the basis of ad hoc collaborations (municipal teams) or on the basis of a strongly shared vision (e.g. De Goede GGZ; 25). When developing the new FACT fidelity scale (13), the analysis was that strict frameworks of accreditation did not always lead to optimal care. However, municipal and Mental Health staff now run the risk of losing themselves in complex modelled networks or in a too rigid (dogmatic) vision. The collaboration with municipal financiers brings FACT teams into the realm of political choices and a lower appreciation of scientific research (26). It is sometimes difficult to navigate. We described three phases. By offering care exclusively from one of these three phases, an impoverishment occurs that does not benefit people with mental illness. Fulfilling the parts of one phase is not enough. It is the combination of organizational, logistical and substantive factors that ultimately guarantee good quality of care (12).

Working in a network has many challenges that employees and organizations have to meet. Where at the start of treatment from the perspective of the citizen with (severe) mental illness an informal network may arise, after some time the need will arise to formally organize the network and clarify responsibilities (27). Questions about leadership, working from one location, one file and registration system, one complaints system, dealing with privacy and the mandate of the network are examples.

Understanding these preconditions and discussing them in the network supports composed teams from the different domains to get through the various phases of integration and maturation with each other.

Conclusion

In this article we have concluded that the collaboration between mental healthcare and the welfare sector is necessary to provide optimal care and should be done by well-functioning (FACT) teams in community-oriented care networks. The developmental phases of network oriented care make it clear how this process develops, so that teams can deliver appropriate care with the deployment of human or financial resources from different financiers. By making the process of upscaling and downscaling in the network transparent, as in figure 1, the teams have the opportunity to develop innovative initiatives for people with mental illness across the domains. It is a joint responsibility to make good care for people with severe mental illness, as described in figure 2, available to all people with severe mental illness. Reaching the entire target group of people with severe mental illness and providing support in the area of symptomatic, personal and social recovery requires, in our opinion, an expansion of the number of FACT teams and finding suitable partnerships in the local social network.

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Chapter 9.

Mental Health in Eastern Lille: a future of network-psychiatry?

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Abstract

Background

For some time now, East Lille has been working with a relatively modern mental health care system that remarkably resembles Dutch health care with the same values and norms that we want to implement in the Netherlands too.

Objective

Gaining inspiration to further investigate regional cooperation and 'network care' in Dutch psychiatry.

Method

A delegation from the board of F-ACT-Netherlands and CCAF paid a working visit to Lille.

Results

The basis of the East Lille working method is a charter of shared values developed with all parties, clients, relatives, employees and external professionals, which is signed by every professional. In case of doubt, a change of context or the introduction of new working methods, these values are used first.

Conclusions

High quality mental health care develops in dialogue, in which working methods, service delivery models and interventions are linked to each other by means of network care. Through reflection, moral deliberation and appreciative auditing, care is progressively improved. These procedures guarantee a modern process of quality improvement.

Introduction

Lille is less than two hours' drive from the Dutch border and is a WHO Collaborating Center in the field of mental health (as are, for example, Verona, Trieste and London). For years it has been pioneering a 'citizen-based' mental health care ('psychiatrie citoyenne') that, in contrast to the strongly ideologically driven Trieste, is remarkably close to a Dutch care organization with the same values and norms that we also wish to implement here. The Lille team repeatedly stated that it had drawn its inspiration from the Netherlands. A delegation from the board of F-ACT Netherlands and the CCAF went on a three-day working visit to learn about this model and to gain inspiration themselves.

Setting

With a region of 1.2 million inhabitants, Lille is the fourth largest city in France. It is the capital of French "Flanders" and part of the historic county of Flanders, which also included Belgian East and West Flanders and Dutch Zeeuws-Vlaanderen. Until 100 years ago, Flemish was the vernacular language and the city was called Rijsel. Lille has the shortest life expectancy in France and a high percentage of people living in poverty and without income from work (1). Lille is one of the few, successful projects of French 'sectorisation', the local variant of the first wave of deinstitutionalisation in Europe. France and also Lille had a classical institutional psychiatry in the 1970s, with 98% of mental health resources in hospital beds. The government decided to allocate psychiatric beds to "secteurs" (or regions of about 70,000 inhabitants - situation 1960). The budget (each an equivalent of 210 beds) could be freely spent on beds or outpatient care. The condition was that the funds were used to realize the integrated regional responsibility for mental health (2). In 1977, the East Lille sector (Sector 21), attached to the Psychiatric Hospital in Armentières, received new management. Inspired by Basaglia's Democratic Psychiatry in Trieste, it worked towards deinstitutionalization and social inclusion. In a first phase (1975-1995), a foundation was established to bring mental health care to the citizens of the six included "banlieues" or neighbourhoods of the sector of 85,000 inhabitants. Particular attention was paid to the process aimed at reducing stigma. At the same time, work was done on population-based funding for the entire sector. Only in the second phase (1995-2006) did the organization find its way into society, both socially, medically and culturally (3). Over 40 years, East Lille developed into a mental health organization where 80% of the available money is used in the (community) sector. The number of beds decreased from 209 to 10 (see Table 1) (4).

Table 1. Data sector 21, 1971-2012; source: Etablissement Public de Santé Mentale, Lille Métropole

	1971	2002	2005	2009	2010	2011	2012
Clients in care per year	589	1677	1898	2507	2572	2661	2798
Outpatient treatment contacts per year	-	23.478	25.808	34.700	48.315	44.704	61.058
Recordings (Total)	145	444	353	322	360	328	301
Forced Admissions	145 (100%)	96 (22%)	92 (21%)	66 (21%)	88 (24%)	81 (25%)	84 (28%)
Average duration of recording	±213	14.5	12.4	8	6.5	7.8	7.5
Occupancy	±314	17.5	11.6	7	6.4	7.4	6.6
Number of beds	209	26	26	12	12	12	10

The developments in Lille coincide with the ambitions of the Dutch mental health service and government to reduce the number of beds and to ambulate care (5,6). Over the past 15 years, the Netherlands invested in rolling out ambulatory FACT teams for people with severe mental illness. Recently, basic mental health care was established for people with psychiatric problems, a mental health counsellor was installed at the GP's practice for clear triage and prevention and the municipality has been given the responsibility for inclusion and participation of all citizens (with or without problems) in the various life domains. The intended shift from specialist to basic mental health care and mental health counselling is underway. Unintentionally, with the system changes, care for people with severe mental illnesses has become less intensive and more fragmented (7). The question is raised of how to better coordinate care (8) or, better yet, how to better work network oriented. The idea of network care in the mental health sector was born. A working visit to l'Établissement Public de Santé Mentale Lille Métropole (Sector 21) fitted in well with this new movement towards integrated care in a network.

'Psychiatry Citoyenne'

The goal of the organization in Lille was that psychiatry would eventually disappear as a separate organization and practice outside of society. When clinical infrastructure was needed, facilities from the general hospital were used. Originally, the initiators wanted a grass-root movement; change from an activist community (9). The movement was named 'Psychiatrie Citoyenne' (citizen psychiatry). The name reflects the pursuit of inclusion, not only of the client, but also of the mental health organization in society (10). Sector 21, where these ideas were elaborated, remains faithful to this aspiration even today. The team sees itself as part of society, with elected representatives from society as 'critical friends' and with clients, former clients and loved ones as an integrated part of the treatment team and management (1). Lille is the initiator of the

French interuniversity training for experience experts. Monitoring research around quality (ROM) is done by the client representation. The team feels responsible to realize their assigned task (contributing to the mental health of citizens) as well as possible. Fundamental human rights are leading. In conversations with staff members and client representatives, these underlying values are repeatedly confirmed and the implementation that follows seems to be completely logical. For example, there is a lot of cooperation with citizens, in particular local artists. One encourages and exhibits art by artists who are clients without distinction, alongside other artists. In Lille, they have nothing to do with outsider art or creative therapy that they dismiss as stigmatizing. Art is made with and by artists (whether they are clients or not...). The exhibitions in the local gallery are an important regional social event and an opportunity to meet politicians, business leaders, and social stakeholders in an informal way and to involve them in the agenda of the 'psychiatrie citoyenne'.

Organization

Total regional mental health care for a population of 67,200 residents (16+) is provided in East Lille by 120 staff; in 2018, a total of 3,500 clients were in care at any given time, of whom nearly 3,200 (or 4.7% of the population) were from the home region. There is an outpatient community team, a crisis team, an ACT team and a Recovery team (Frontières) and in these teams outreach is the norm. In addition, there is an inpatient unit with 10 beds. Four psychiatrists (there is a vacancy for a 5th) are employed by the organization and work for all teams. The 10 psychologists spread across the teams on indication. The nurses and social workers are however attached to specific teams. The integrated regional responsibility is coordinated in a daily telephone morning and evening consultation in which the psychiatrists, two psychologists and the team coordinators participate. The consultations are efficient, supported by a shared Excel spreadsheet (similar to our FACT board) that is maintained by the secretary. The morning consultation we were allowed to attend lasted 20 minutes and never exceeds the 30 minute limit. The consultation brings together information from the regional teams:

1. The outpatient team provides outreach treatment for people with single psychiatric problems. They work with a case management system, in which scaling up to a maximum of 2x per week is possible with shared case management. If more care intensity is needed, it is coordinated with the crisis team. They can intervene in the treatment or take over temporarily.
2. The crisis team provides treatment at the time of crisis for seven days a week, 12 hours a day. Staff start each day by calling all network partners (police, hospital emergency rooms) to ask if any of their residents have come into care. This is brought into the morning (and evening) consultation. This safeguards the regional responsibility and is made possible by the flexible deployment of the staff of the ambulatory and clinical teams. In addition to the clinical facility of 10 beds, the

region also has 4 host families (reception duration up to several weeks). The guest families, where clients in a (threatening) crisis can stay, receive support from the crisis team.

3. The ACT team offers intensive, outreach and multidisciplinary treatment to clients with long-term severe mental illness. Since there are no more transitions to residential support, basic mental health care or community teams - one works completely integrated - clients can be connected to this team for a long time through all phases of recovery.
4. The Recovery Team (Frontières) is multidisciplinary and works outside of psychiatry on social inclusion in the areas of work, leisure and culture. These staff members can temporarily serve as team members at the clinic or in the crisis team to increase the (treatment) offer and look for alternative options with the client, or work independently with clients on destigmatizing activities in the community. There is a sub-team for each of the 6 residential areas in the region.
5. The inpatient ward, on the grounds of the somatic hospital with short lines to the various specialties, has 10 beds that are rarely all occupied. Annual occupancy averages 70% and there were 4 patients admitted at the time we visited. On admission, an extensive psychiatric and medical screening is done. The regional psychiatrists take turns to be 'on duty' for 1 week and are then also responsible for the clinic. Intriguing anachronism: the psychiatrists are 'in plain clothes', but the nurses have white coats. The department is - also in case of compulsory admissions - completely open with single rooms (with space for family, also during the night) and has various possibilities to offer alternatives during increasing agitation. These include sports, art, manicure or make-up or even wellness activities. The large jacuzzi, sauna and wellness area is in Dutch eyes an almost wasteful rich environment. This was a deliberate choice. The department has a zero-separation policy (all team members sign a statement that is available for patients to see). In the Netherlands, when there is a threat of escalation and insecurity, one quickly runs out of options, and it is sometimes necessary to resort to isolation. In Lille, they opted for a rich environment with a constant invitation to distraction. During our visit, we felt that in such an environment, the pursuit of eliminating coercion becomes realistic. Admissions last an average of a week and begin with the question of what the client needs to be able to return home.
6. Another example of the focus on patient autonomy and self-responsibility in the inpatient unit is the art loan (with a collection by renowned regional artists). Each admitted patient is invited to choose a piece of art to hang in their assigned room. This is done upon admission. It is a symbolic act to make it clear that even with precious art, a patient is trusted.

In addition to clinical admission, approximately 100 clients make use of more or less individualized forms of protected living and there is a respite option: six families in the

region are available to house someone temporarily (two to three weeks on average). Clients thus accommodated are visited daily by the mental health team.

All employees work for the entire organization (within the work area) and have conformed to the basic values of the organization (everyone has signed the declaration). The whole of the organization is more than the sum of its parts and this is repeatedly confirmed in word and deed. Once every three weeks a policy or coordination meeting takes place with delegates from the teams and delegates from the elected client council.

Region responsibility

The East Lille healthcare system has population-based funding. With a total of nine million euros, both inpatient and outpatient care is funded with a 30/70 distribution, whereas in the Netherlands and the rest of France more than 60% is often spent on inpatient care (7,11). Freestanding psychotherapists and addiction care are outside the regional budget. We saw that the team is very aware of its responsibility, both for the region as a whole, for individuals with needs ('prise en charge' = taking responsibility).

Besides the aforementioned sector board meeting that takes place twice a day, the service orientation and flexibility at the front door also impressed. The local GPs have no mental health counselling structure, but refer directly to integrated mental health care. The norm is that clients are visited at home by a nurse within two days of GP referral. In 2018, this norm was met in 92.5% of clients, with an average response time of 1.2 days (11). The intakes are partly standardized, partly open interviews, during which the Mini Mental State Examination (MMSE) is taken and the suicide risk is estimated. Depending on the urgency, care is continued within 24 hours (crisis care) to two weeks (regular therapy by a psychologist). In addition, waiting list-free consultation is available at ten locations in the region with opening hours from 9 a.m. to 8 p.m. on weekdays and Saturday mornings.

Taking responsibility for the region means taking responsibility in the network and being a proactive part of the network itself. It is experienced as a fundamental value, so the subsequent actions are perceived as logical. The sector is continuously monitored with targets around, among others, response time, use of coercion, accessibility of care for people with psychotic disorder and bipolar disorder and numbers of suicides. We were able to request data that is not (or no longer) available in the Netherlands on an integrated regional level.

A seemingly odd point is that psychiatrists and psychologists do not work on a team basis, but are widely available to all teams. However, continuity of care remains important. A client can choose one of the four psychiatrists as primary caregiver,

psychologists and therapists are available to all teams, and case managers can shift with the client for shorter or longer periods during and after a transfer within the organization. During an inpatient stay, all treatments continue as usual. The psychiatrist on duty is on call but coordinates care with the patient and the referring team or professional. How this flexibility and collegiality works is seen in the crisis team. They have their own responsibility, but assist where necessary within the organization, both clinically and ambulatory.

Far-reaching logistical flexibility of employees is necessary to minimize coercion and pressure. At all levels, flexibility should lead to the creation of more and creative alternatives. In a Dutch chain, this is often not the case, and a FACT team is forced to switch to IHT or an inpatient unit when care needs to be scaled up. The scale of the team (8 FTE) is simply too small and no additional people can be freed up. The sector 21 teams in Lille leave all possible options open and support each other - after all, care is a joint regional responsibility. In this way, they are able to increase the care intensity to several times a day during all days of the week. The coordination lies with one of the multidisciplinary and outreach teams, possibly with the support of colleagues, and always attempts are made to ensure continuity of care and perhaps more importantly, continuity of relationship.

Care on what scale?

From a Dutch perspective, the developments in East Lille link up with the movement of De Nieuwe GGZ (12) and the resulting pilot projects in the country in which community teams work together with FACT teams at the district level. De Nieuwe GGZ assumes community-based care per 15,000 residents. Sector 21 with 100,000 inhabitants then looks large. The advantage of this scale is that the entire mental health infrastructure (including the clinic and regional permanence) can be secured at that level. Most of the facilities are located in the heart of the hourglass-shaped region, with limited travel distances by car of no more than half an hour. However, the ambulatory teams also have a sub-regional structure with teams per residential core (there were six, so approximately per 17,000 inhabitants). There is a daily, physical presence of staff in all six 'banlieues', which together form the sector. Because general practitioners continue to prescribe medication, there is frequent consultation between psychiatrists, general practitioners and pharmacists. Both for general consultation, and with regard to specific treatment and the method of administering medication (possibly at home). The community-oriented work offers a natural cooperation with general practitioners, pharmacists, community nurses and a municipal team. It is a framework for flexible work and offers intensive outreach, informal and formal contact and smooth, frequent care coordination (13,12,8). The absence of diagnostic silos and explicit regional responsibility contrasts with Dutch fragmentation.

Transferability

It is noteworthy that the Lille model is not representative of the rest of France. This raises questions of transferability. Even in directly adjacent sectors within the Lille metropolitan area, the model has not been adopted. Working with a lump sum budget for mental health care has thus been a facilitating, but not a sufficient measure to achieve this strong ambulatory, value driven care. As in Trieste, another factor is undoubtedly charismatic leadership, in this case by psychiatrist Jean-Luc Roelandt. Values must be driven literally and over an extended period of time if they are to guide daily practice. As in Trieste, it has been possible to maintain and further improve the practice, even after the retirement of the original “guru”, with new standard-bearers. Improvements are achieved through explicit and systematic reflection on one’s own working methods, through training and education of new staff, and by keeping an open eye on international developments.

The way the different models of care relate to each other in Sector 21 goes beyond the individual description of the models. No team stands alone. A network of (overlapping) care models has emerged and they relate to each other flexibly. The newly developed FACT scale (14) in the Netherlands by the CCAF offers FACT teams the possibility to organize themselves in networks, both inside and outside mental health care. However, our Dutch quality tools evaluate separate care models (e.g., FACT, IHT, HIC) and there is no (or too little) steering for interconnectedness. This sometimes leads to conflicting situations in the Netherlands. For example, the situation in which an IHT team is unable to provide intensive crisis care for non-registered clients, because a FACT team does not or cannot perform the intensive care scaling-up themselves and transfers this task. Or the funding of inpatient beds, which means that working on an outpatient basis is financially penalized and the focus is on high occupancy rates. If care were to be managed more on the basis of shared values and network cohesion, we could also stimulate this development in the Netherlands.

Quality assurance through accreditations as we try to do in the Netherlands leads to surprise among our French colleagues. Describing and certifying models has the risk of locking values into actions. But the rollout of FACT, partly through certification, appeals to them in France as well. They also wondered how to roll out their model further. Values-driven work demands a lot from the cognitive and reflective capacity of an organization, a team and an individual. Such practices prove difficult to disseminate. We see this in the isolated situation of the Italian Trieste too (15). The lack of a model description also hinders the possibilities for comparative research. Lille seems to meet the average requirements for mental health care by Thornicroft and Tansella (16), combined with clear alternatives to (long-term) hospitalization and inclusion-promoting interventions. Specialized treatment for specific target groups (e.g. addiction treatment) seems to be

outside the organization of Sector 21 and, given the ambivalent relationship with other types of practice, also (intentionally) outside their network.

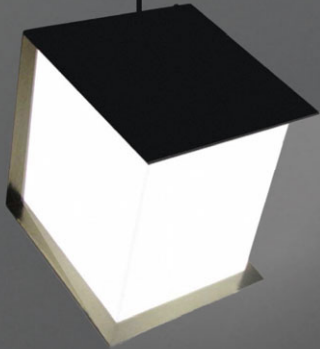
Decision

The way in which Sector 21 in Lille has developed from a clinically oriented psychiatry, through the democratic psychiatry of Basaglia, to a 'psychiatrie citoyenne' is to be praised. Employees are stimulated to mirror their actions to the universal rights of man and the values of the organization. Reflection on one's own actions on the basis of previously jointly established values frequently takes place. People are accustomed to addressing each other in a continuous dialogue. This gives rise to new, creative ways of working that increase the options for promoting social inclusion. As a result, a high-quality and relatively secular regional mental health network has emerged. The basis is a strong foundation of shared values that is shaped in consultation with other parties, such as clients, relatives, staff and external professionals. In case of doubt, change of context or the introduction of new ways of working, the basic values are used first. In the Netherlands we run the risk that, by exchanging treatment outcomes for recovery outcomes, we turn this philosophically fundamental shift into a semantic shift. The outcome would not fundamentally improve. In doing so, we would be evaluating a possibly disengaged network-centered psychiatry in the wrong way with incorrectly chosen outcome measures. The visit to Lille was inspiring. We saw a very unique, regional French development, which could serve as an example for a future Dutch mental health care, in the form of a regional, value-driven form of network care. Inspired, our search continues.

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Chapter 10.

The Flexible Assertive Community
Treatment fidelity scale: description of
the development in the Netherlands and
adaptation in Denmark and Sweden

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Abstract

Objective

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 program 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.

Method

Authors and stakeholders tested and updated a new FACT model fidelity scale in the Netherlands, Denmark and Sweden.

Results

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.

Conclusions

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.

Introduction

In the early '60s Marx, Stein and Test (1) noticed the positive impact of community living and the negative impact of hospitalization and created a program, 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 (2).

Since the introduction of the Flexible Assertive Community Treatment (FACT) model in the Netherlands in 2004 (3) the number of FACT teams increased rapidly. As an adapted model of Assertive Community Treatment (1) FACT provides care for the entire population of people with severe mental illness (SMI), instead of a narrower target group in ACT (4) 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 (5,8). 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 (7), as well as professional satisfaction (8). High FACT model fidelity is associated with less hospitalization (9,10,11).

With the introduction of the Dartmouth Assertive Community Treatment Scale in 1998 (DACTS; 12) and its successor in 2011, the Tool for Measurement of ACT (TMACT; 13) 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 (14,15, 16,5,9). Fidelity scales, like the DACTS, are operationalizations of multiple criteria of team structure, organization and treatment processes based on former research and expert opinion (17,18). 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 (19) has had a major contribution to the rapid implementation of FACT in The Netherlands (20). 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. (17) 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 (18,2), 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, Morse, and Bond (21) and in Dutch FACT teams by van Vugt et al. (22).

Another reason for drifting away from the FACTs 2008 might be its lack of items relating to recovery oriented practices and research (22). 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 (13). 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 led to the same circumstances. To fully implement FACT, more than fidelity measurement is needed (21,2). A national transition in Dutch municipalities directed the development of the scale by showing the impact of giving freedom and responsibilities to its professionals (23). Professionals created innovative and local initiatives. This led 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.

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That large transition took place for Dutch municipalities in 2015 which changed community care considerably (24). 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 (25). 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 (26). 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 (18).

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 (17). It relied on the earlier model fidelity scales, a group discussion with the developers of the TMACT (13) 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 (27). 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 (2) 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. (28) 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.

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.

Table 1: ACTs 2019

ACTs 2019: 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 MID, self-management and autonomy, flexible care, team approach, daily ACT Board consultation, outreach.
Part B	<ol style="list-style-type: none">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 stigmatisation 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, integrated responsibility.6) Crisis and safety: 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.

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 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 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 program 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 welfare 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 welfare services. For the translation and adaptation of FACTs 2017 a working group was organized in 2018 with personel from the mental health care and welfare 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 welfare 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

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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 welfare sector, 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 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 the 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 schooling 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 (2) 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 (25,2). 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 (2), and not just fidelity measurement. A well-considered choice to abandon the recommended structure for EBP-fidelity scales (18) 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 integrated 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 (13,29), 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 (29). 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.

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Chapter 11.

General Discussion

This thesis explored the rise of Flexible Assertive Community Treatment, a service-delivery model for people with severe mental illness, in an ever-changing context due to economic, political, cultural, societal and conceptual changes (often including new scientific insights) and the impact on the process of quality improvement. FACT holds the premiss to improve recovery of people with severe mental illness and teams are created to serve all people with severe mental illness in rural areas (1), but research results are not conclusive (2,3). FACT teams support clients during times of crisis and provide treatment and recovery-oriented continuity of care that prevents dropout (4). FACT has also shown to reduce (long-term) admissions for adult patients in the Netherlands (4), the UK (5) and Denmark (2), but it lacks results on recovery (6). Research shows that satisfaction is high amongst clients receiving FACT care (7) and professionals delivering it (8) what might be due to the expected effects found on citizenship (9). The teams can close gaps in a fragmented care system (10). FACT became the de-facto standard for regional care of people with severe mental illness in the Netherlands and is gaining increasing international recognition (11). These results suggest that moving forward with the FACT model is the right way to go. In practice, FACT teams appear to express the FACT model in many variations to meet local needs or for other reasons. Competing priorities challenge the current FACT practice. So, what is crucial for FACT, and how does the current fidelity scale and team structure fosters or hinders its recovery-oriented mission? How can enhancements be made to the scale to ensure FACT's resilience within a network of care and support for individuals with severe mental illness? In short, is the FACT model the most suitable approach to make a sustainable and future-proof contribution to community mental health care for people with severe mental illness?

The main research question explored in this thesis is related to better understand the development of FACT in the past and the present considering model fidelity and quality improvement. Also whether the FACT model has a future in networks of care for people with severe mental illness. This general discussion starts with a summary of the main findings. Next, three themes are discussed to integrate the qualitative and quantitative results into a vision of the future of FACT. The chapter ends with a summarizing answer to the main questions and recommendations for future research and clinical implications.

11.1 Summary of the main findings

Aim 1: To explore the development of FACT in the past and the present regarding model fidelity and quality improvement

Chapter 3 contains an observational study that compares ACT and FACT in the Netherlands and the United States. It shows FACT is attributable to ACT in many ways and 'dialects' of both models can exist side-by-side, especially in (larger) cities.

Managers and clinicians try to make educated choices between the two options within their specific context is to improve quality of care for all people with severe mental illness. Policymakers and other stakeholders can keep in mind that, compared to ACT, FACT aims to ensure a proactive community-based network strategy to identify, engage, and treat a wider range and variety of people with mental challenges to maximize their ability to live independent full lives in the community. The goal of both ACT and FACT has been clearly stated. What was unclear was what FACT (and ACT) professionals do throughout the day to achieve their goal.

To this end, we conducted an Experience Sampling Method (ESM) study to examine daily activities of FACT workers on weekdays in relation to the intended activities from the theoretical FACT framework. In **Chapter 4** we describe that overall, employees spend 30% of their time with clients (2% with relatives), 30% in care related meetings (4% with network partners), 20% on administration and 20% in travel time and personal activities (30-30-20-20). The actual time spent by FACT-workers with clients is lower than assumed or expected. And contact with relatives and network partners lags far behind the desired figures required for modern network-oriented care. Applying ESM in FACT teams promises to support a quality development dialogue and might be an interesting tool for quality improvement to support recovery for people with severe mental illness. An important next step is to increase understanding of ESM as part of quality improvement or as part of financial accountability. Meanwhile, considering these results, supporting recovery might be difficult to achieve.

To better understand the motivation of employees, **Chapter 5** addresses optimism about recovery among in- and outpatient professionals using a cross-sectional, non-experimental design based on questionnaires. No association was found between care setting (FACT and inpatient High and Intensive Care units) and the two countries involved (the US and the Netherlands). In accordance with earlier findings job tenure was found to be negatively associated with caregiver optimism. A negative association was also found for higher educational levels. Age was found to be positively associated with caregiver optimism such that older caregivers were more optimistic about consumer recovery. We need to follow-up on this research to understand the implications of hope and optimism on the implementation of FACT or its outcome. A revised questionnaire, based on this research, can be used to measure hope and optimism in FACT teams.

Aim 2: To investigate the question whether FACT, as a model, has a future in networks of care for people with severe mental illness

To address sustainable quality of care we developed a new model fidelity scale in 2017. The original FACT fidelity scale from 2008, using Likert-scale items only, lagged in a rapidly changing field. The original FACT model aimed for efficiency, reflecting the

broader trend in mental health care towards streamlined procedures and evaluation methods. Optimal care practices for people with severe mental illness evolved. A new fidelity scale was needed to further improve the quality of optimal care practices and to be able to measure changed model fidelity. We used expert knowledge, relevant articles and feedback from professionals, researchers, interest groups, peers and family members. The 'FACTs 2017' was piloted in two rounds. Trained auditors assessed 21 teams to test and adjust the scale. **Chapter 7** describes the process of developing the FACTs 2017. A total revision led to a fidelity scale combining quantitative items on team structure (using a Likert-scale) for 16 items in Part A and qualitative descriptions on eight key deliverables in Part B. The conclusion is that the (research) field now has an instrument to measure the degree of model fidelity of teams that focus on patients with severe mental illness in a rapidly changing context.

In this rapidly changing context optimal care for people with severe mental illness includes a broad range of services provided in different sectors. In the Netherlands, we have sectorized mental health care, primary care, addiction care and care for people with intellectual disabilities. This exceeds the scope of expertise available within the FACT team and requires far-reaching cooperation between different regional care partners. This cooperation needs to be customized locally while providing answers to generic, nationally formulated goals. **Chapter 8** reflects on developments in the welfare sector and specialist mental healthcare using relevant literature and recent (inter)national experiences to offer new insights on collaboration within and between domains. Results show that it is possible to provide better integrated care by allowing FACT teams to network together with community partners (e.g. by sharing financial and/or manpower resources). Networks of care for people with severe mental illness develop in stages and professionals create new partnerships in the process. The model fidelity scale for FACT teams was adjusted accordingly to facilitate that process. It is ready to allow FACT teams to explore flexible local solutions for partnerships to realize the much-needed multi-domain integrated community care for people with severe mental illness.

We got inspiration for an integrated care system for people with severe mental illness from the eastern part of Lille: sector 21. For some time now, East Lille has been working with a relatively modern mental health care system that remarkably resembles Dutch health care with the same values and norms that we also want to implement in the Netherlands. Therefore a delegation from the board of F-ACT-Netherlands and CCAF paid a working visit to Lille to gain inspiration to further investigate regional cooperation and 'network care' in Dutch psychiatry. Our observations are described in **Chapter 9**. The basis of the East Lille working method is a charter of shared values developed with all parties, clients, relatives, employees and external professionals, which is signed by every professional. In case of doubt, a change of context or the introduction of new working methods, these values are used first. High quality mental health care develops

in dialogue, in which working methods, service delivery models and interventions are linked to each other by means of network care. Through reflection, moral deliberation and appreciative auditing, care is progressively improved. These procedures guarantee a modern process of quality improvement.

The FACTs 2017 was developed to support a modern process of quality improvement. Scandinavian researchers and professionals, dealing with similar problems to improve recovery and integrated care, were interested in the newly developed FACT scale. Together with the authors and stakeholders we tested and updated the FACTs 2017 to meet Danish and Swedish requirements. **Chapter 10** describes this process for all three countries. It resulted in a new standard to assess model fidelity in FACT teams for these countries using the FACTs 2017 with subtle, cultural induced, changes. Adding an occupational therapist as a key discipline stands out and challenges the original mix of disciplines.

In this research project we chose to closely follow the development of quality improvement in FACT since major transitions happened in Dutch health care from 2015 onwards. Different research designs (i.e., quantitative and qualitative) and methods (i.e., observations, ESM) have been used to reflect on the past, present and future of FACT and subsequently quality improvement. Inherent to this empirical approach no causal relationships are described, as a Randomized Controlled Trail (RCT) was not part of the design. The design can be described as pragmatic, because we reflected on what happened and acted inductively on questions that came up during the process. The pragmatic and personal character of our research process demanded many moments of reflection with (ex-)clients, relatives, professionals, researchers, students, stakeholders and many others. It cannot be excluded that our perspective influenced the results. Results are helpful in the international field of quality improvement in FACT, but results will be difficult to duplicate due to its naturalistic and pragmatic nature.

11.2 Discussion

The first half of this thesis describes the (F)ACT model, what FACT professionals do and how they experience hope and optimism. The second half describes the process of enhancing quality of care in FACT teams for people with severe mental illness in a network of care. Together both halves represent a shift in thinking. The original FACTs 2008 reflected an aim for efficiency. Both in working procedures for FACT teams as in evaluating quality of care. A similar aim many insurance companies held, probably leading to a high percentage of administrative work in FACT (Chapter 4). Later on, affected by a lack of results on recovery (6) and the rise of integrated care, this thinking shifted towards an aim for wellbeing and positive (mental) health for clients and more autonomy and responsibility for professionals. A thinking that influenced

the development of the FACTs 2017. These three main topics following our research, i.e. recovery, integrated care and quality improvement, are discussed below.

11.2.1 Recovery

Recovery is seen as an ongoing journey rather than a final destination (12) and during this journey relatives and the community play an important role (13) to improve symptomatically, personally and socially (14). The first four chapters of this thesis demonstrate that only adding content-driven items (e.g. on evidence-based practices and recovery) to the organizational model of ACT, creating FACT, does not necessarily improve the outcome for people with severe mental illness. For FACT teams it seems difficult to improve recovery for their target population (6). Anthony (15) and Mueser et al. (16) already stated, that it is insufficient to keep on adding pragmatical interventions. Recovery is described as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals and/or roles” (17) and consequently we should strive for quality improvement and results on different life domains. This shows a need for a recovery approach in a network or care and working together to improve recovery on all domains of life.

Evidence-based practices, like Illness Management and Recovery, Housing First, Integrated Dual Disorder Treatment, Family Psycho Education and Individual Placement and Support, have become part of the FACT model or made available in a network that includes FACT and other agencies. Networks seem more suitable for people with severe mental illness (18,19, Chapter 6 and 7). M. de Baan (January 2022) remembers this umbrella-concept at the introduction of ACT in Rotterdam during the early 00’s, inspired by Drake et al. (20), and noticed it fade away during the years. Van Veldhuizen called FACT the tree in which different evidence-based balls (21) can hang. An example of this might be the introduction of resource groups, an intervention to ensure that relatives become and maintain collaborative partners in the recovery process (22), in the Netherlands. Adding resource groups to FACT shows great results (23), so hanging this ball in our tree seems to make sense. It would also support client-discharge from FACT teams; a client can step down to the resource group if FACT is no longer needed, or better stated; a FACT team professional can step out of the resource group. On the other hand, it would be evenly great if clients start a resource group at the General Practice, in a community team or with the help of relatives or volunteers. We still rely on FACT as a primary service-deliverer for people with severe mental illness. Our reliance on FACT solely might have proved too great. A return to an overarching multidomain program for people with severe mental illness, including multiple service-delivery models and integrated network interventions, seems needed to develop good integrated care for people with severe mental illness in the Netherlands.

Integrated care in a network of agencies requires a more legal-ethical view of what is offered or given to 'our' clients with severe mental illness. Entering the public domain and the world of local governmental community teams creates new relationships with external partners, which relate to their own (financial) rules and legislations. With a large, local government responsible for all areas of life of all citizens, advocacy becomes a true theme for FACT teams and their professionals (24) in the Netherlands (and Scandinavian countries). Advocacy can be seen as a competency of trained peer workers and social workers (19), both underrepresented in FACT teams. Advocacy is much more prominent in the international profession of social work than in the Dutch context (25). A new network of agencies demands a critical view on potential legal-ethical shortcomings, as well as potential gaps between agencies. Social workers need to be more involved to address these potential shortcomings from an advocacy perspective. This is an important task in which the social worker, also in the Dutch context, comes into its own. As recovery for clients is not well-implemented (6) and working in a network will remain necessary (chapter 6 and 7) FACT teams increasingly require social workers. These professionals promote and support recovery by being present in the community, utilizing resources and advocating for clients' needs and rights where needed (26). Critical reflections and raising ethical questions from peer support workers supports these actions. This requires a reflection on the professional and educational development of social work and on the position of social work and peer support in FACT.

As chapter 8 points out, the same can be stated for occupational therapists. In Scandinavian countries this discipline plays an important role in rehabilitating FACT clients. They enable occupational performance and engagement. Traditionally, generalist nurses in Dutch FACT teams have been given those tasks. From a recovery and de-stigmatization perspective it makes sense to include non-mental health professionals with a specialty on rehabilitation. New US legislation (27) will allow occupational therapists to act as a behavioral health professional and not be excluded anymore from interdisciplinary (ACT-)teams, as was custom in Canadian ACT teams (28). Allowing occupational therapists to be part of a FACT team is an option in Dutch mental health care too, but hasn't been put to use.

Anthony (15) describes a pragmatic reason to explain the lack of recovery outcome in ACT teams and believes a focus on structural items, as a low caseload, FACT board meetings and so on, diverts attention away from behavioural science research about normal functioning, how people change and grow (build relationships, skill teaching strategies, hope engendering techniques). Improving quality of care for the personal and societal domain doesn't seem to be the whole answer either, as people with severe mental illness are not given the proper evidence-based psychiatric treatment either (29,30,31,32,33) Like the multi-factorial explanation of the concept of recovery and recovery-oriented care, the solution on quality-improvement needs to be multi-

factorial. Clearly FACT teams struggle to deliver the right kind of services to improve recovery. A solution will require the integration of services within the model as well as a revalorization of integrated care between agencies (Chapter 5, 6, 7 and 8).

Australian Mobile Intensive Rehabilitation Teams (MIRT; 34) also felt the need to adapt the ACT model for its lack of a recovery orientation and added recovery-oriented practices and a time-limit. MIRT offered a time-limited programme that included illness self-management, as well as group and individual programmes for cognitive remediation, social cognition, CBT for psychosis (CBTp), sensory modulation, yoga, swimming, walking and cooking skills. The results of their evaluation were not conclusive and a need for integrated care was mentioned to improve recovery on multiple domains of life and support discharge. Adding resource groups to ACT in Stockholm, Sweden, creating RACT (Resourcegroup Assertive Community Treatment; 35), has similar ambitions to improve recovery-oriented practices. The original ACT model, after being criticized for its lack of a recovery orientation (36,37), evolved to add Illness Management and Recovery to the model in some teams (38,39). Despite the changes to the original ACT model, FACT teams still struggle to improve recovery for people with severe mental illness (40,6). We continue to risk of *ambulatory hospitalization* (41,42,43,18). The risk of clients getting into situations as deplorable as the clinic once was. Living in the community, but excluded due to sheltered living, sheltered work and social contacts solely amongst each other (44) without any expectations of change by clients, professionals or citizens. A catch22 situation. ACT was criticized to hold on to clients for too long and instead of enhancing, hindering recovery (43). Another risk might be our trust in a model without clear, evidence-based results on recovery, as Howick et al. (45) pointed out in their review on evidence-based practices in Healthcare. Both the ACT and the FACT model come from a similar medical background using medical disciplines and both are embedded in the mental health system (chapter 2). FACT has difficulties reaching out to the relatives and the community (chapter 3) and over time hope and optimism on recovery for people with severe mental illness declines for experienced FACT professionals (chapter 5). Maybe the risks mentioned and the troublesome results on recovery are inherent to the FACT model.

Results from Canadian research in ACT teams from 2003 (46) show similar findings. They found professionals spending more time on medical and psychiatric interventions, then on interventions supporting rehabilitation. Wunderink believes combining both the medical and rehabilitation model in one person or one team might be too difficult (47). Psychosocial interventions on the other hand were considered of secondary importance by ACT professionals (48). A substantial medical perspective seems present in FACT teams and, on the other hand, a preoccupation with crisis-interventions seems present as well. Daily FACT board meetings discussing potential crises, reinforce this preoccupation. This might be a viscous self-reinforcing circle. Maybe prioritizing the medical and crisis-oriented perspective in (F)ACT teams might have led to a decline in

the experience of care-giver optimism for recovery (chapter 5). FACT originates from the domain of psychiatry and relies heavily on old-school professions in Dutch mental health care. Nurses and psychiatrists are relatively well represented, in contrast to other professionals with a non-medical background. This shortage of perspectives can be resolved by working closely together with clients, relatives, volunteers and informal professionals. Almost like creating an ecosystem of (mental) health initiatives and interventions around a FACT team. A similar process seems needed within the FACT model and extrapolating integrated care for the FACT model might just be the right way to go for the future.

11.2.2 Integrated care

The future of mental health worldwide requires community-centric services, integrating all community and inpatient components within the catchment area (49). Good, community-oriented services for people with (a risk of) severe mental illness always require a cross-sectoral approach and thus the involvement of multiple service providers (18), as advised by the Dutch council of Healthcare (50). The introduction and Chapters 6 and 7 have made clear that FACT teams can't deliver all services and support alone. New Dutch initiatives like De Nieuwe GGZ (18) and Ecosystems for Mental Health (abbreviated to GEM; 51) are in line with the national goal to build "network psychiatry" (52) and the international aim for an ecosystem of mental health care (53). FACT teams, organized within the mental health sector, will need to participate and open up for new collaborations with all kinds of local partners. Professionals and leaders need to develop competencies accordingly (54,55).

Organizations deploying FACT teams need to make clear choices and to know that these choices have consequences for the teams and for a network of care. Organizing integrated care is a balancing act. Choices that narrow down the target population to more specialized teams will enlarge the catchment area and an enlargement of the catchment area will lead to a more difficult access and collaboration with local resources. Choices will affect the ability to deliver assertive outreach services and the close availability of FACT in a local community. Enlarging the scope to include people with common mental health disorders will lead to large teams and individual caseloads and difficulties to deliver assertive outreach and integrated care as a team. The need for support on all domains of life, as in people with severe mental illness, will always rely on multiple agencies. Also the inclusion of specialists and disciplines relates to the available expertise in the team and the network and the requirements of the specific casemix.

In the past FACT teams could make these choices autonomously from others, whilst now FACT teams are moving into an interdependent relationship with stakeholders. Choices made within this balancing act are often made by other parties within the network, or collaboratively, if organized well. These decision-making dilemmas within

integrated care service networks have been described by Michgelsen et al. (56) and transcend the practical choices and dilemmas of FACT teams in a network. FACT teams have been shifting from autonomous decision-making to interdependent relationships with stakeholders, from a coherent decision-making (FACT) group to a diverse one consisting of clients, relatives and external professionals and from a clear self-interest in outcome measures to common goals and related overarching outcome measures in a network. Choices made in a shared and inclusive decision-making process will inherently lead to local modifications of FACT teams and a continuous state of reflexivity. Parallel to this meso-level process, the Council of Public Health & Society (57) is recommending similar choices for a national program of transition for the same reasons. The main difference being the concrete actions that need to be addressed.

Alternatives for FACT have been created to improve integrated care and these initiatives inspired the FACT movement. Changes have been made to model fidelity to follow up on network psychiatry (Chapter 6 and 9) keeping the FACT model relevant and up-to-date in practice, but one can imagine changes are needed for the theoretical FACT model as well. For now, Dutch literature on FACT does not fulfil this need and this opens the possibility for many other community mental health teams to pop up and show an integrated approach (Chapter 6). Often named differently, they show a close resemblance to FACT (e.g. 58). For future development of community mental health care, it would be interesting to combine these efforts and let it influence the FACT model. But one might even argue if a FACT team is the best suited party to deliver services. Case management, for instance, is a service currently being delivered by FACT teams and this might be so for the near future. On the other hand one might argue other public health partners to be better suited for the job due to their non-medical-psychiatric background and the possible hindering of recovery by the FACT model in itself. Others would deliver case management for people with (severe) mental illness from a generalist team and FACT teams would be specialist teams delivering short term services. An evoking thought for now. In the end, FACT needs to be the best possible community mental health service for people with severe mental illness and if a local or model modification is needed, it needs to be supported.

From a prevention perspective, multi-sectoral programs like GEM and De Nieuwe GGZ will be necessary for people struggling with mental health in need of less intensive support. Most services in these programs will be delivered online, in Recovery Colleges, by local community teams, public servants, counsellors at the GP's, volunteers or relatives or other people outside of mental health. Professionals from FACT teams can support these professionals, teams or other structural collaborations by delivering consultation, quick access to the team and collaboration without boundaries. As Beekman (59) already pointed out in his commentary, this perspective puts new demands on public servants and community workers. They will need to develop new skills and adapt new (evidence-based) interventions, despite the reluctance of Dutch

social workers to engage in evidence-informed practice (60), from an overarching program to support people with mental health issues.

11.2.3 Quality improvement

One way to ensure that key components of an intervention are not “lost in translation” is the use of fidelity scales (61). Mowbray et al. (61) defines fidelity as “the extent to which delivery of an intervention adheres to the protocol or program model originally developed”. (F)ACT teams showing high fidelity are more likely to achieve the expected outcomes. *Fidelity scales can identify and measure optimal levels of implementation of program elements that contribute to its efficacy. The assessment process can also inform new staff and remind existing staff of these key elements. Assessments must be repeated on a regular basis to ensure continued fidelity despite changes in leadership, staffing, and resources* (62).

Drake et al. (63) identifies multiple factors to ensure successful implementation of evidence-based practices and this thesis only focusses on one of four. Improving quality of care using training, ongoing support within the team and on state-level (63) haven’t been addressed in this thesis, but regulatory strategies that align with model expectations and outcomes have. The process of quality improvement in a FACT team using the FACTs 2017-R and intermitted audits by CCAF can be enhanced using Drake’s (63) suggestions. Recommendations from audits, training and ongoing support will challenge educational, governmental, consultation and insurance agencies nationally to develop support fitted for network psychiatry.

As Drake and Deegan (64) point out, ACT fidelity scales focus on the structure of services, but fail to measure more valuable aspects of the therapeutic relationship between ACT participants and clinicians, such as the attitudes of staff and the quality of the relationship. The FACTs 2008 (65), based on the DACTs (66), had the same focus on structures, although it already added a recovery-oriented focus in services. The newly created FACTs 2017 (Chapter 5 and 8) resolves this omission by creating a focus area on personal recovery. This focus area wants professionals to tell and, in the revised version (67), show their recovery-oriented practices on the spot during interviews and regular FACT meetings. For now it is unclear whether a relation between creating this new topic (Chapter 5 and 8) and improved hope and optimism for recovery in FACT-professionals is there (chapter 4).

During this thesis we have overcome the idea of FACT being in the centre of care for people with severe mental illness, but we haven’t overcome the perception of fidelity scales being at the centre of quality improvement. Our results from the ESM study (i.e., high administrative load) in chapter 3 show the need to address quality improvement on a state and a national level with policy makers and insurance companies, as advised by Drake et al. (63). Chapter 5 and 8 describe the stages of Mowbray et al. (61) in developing

model fidelity scales as used, but to improve quality of care these stages need to be expended with the factors mentioned by Drake et al. (63).

Chapters 5 and 8 describe the development of the FACTs 2017 using qualitative and quantitative topics. In contrast of what literature says on fidelity scales (61) the choice was made to leave a Likert-scale behind. Multiple reasons have been mentioned in chapters 5 and 8, but the struggles found in daily practise performing audits confirm the need for ongoing training and support even more. Besides these practical struggles, Mowbray et al. (61) addresses the topic of too much or too few fidelity too. We lowered the rate of strict model fidelity by replacing most Likert questions for qualitative topics. This choice was made following researchers stating items that are found to be non-essential in research may be adapted, while elements that are critical may not be changed (68,69). This concept, implemented in the FACTs 2017, helps urban, rural and frontier teams adopt, without losing its main aim, and adapt by using fidelity-consistent modifications (70). The struggle using fidelity-consistent and fidelity-inconsistent modifications can be seen in Norwegian teams in frontier-like areas (71). They created smaller teams with very small caseloads and professionals working part-time for the team in very large catchment areas. These fidelity-inconsistent modifications are visible in the quantitative A part of the FACT scale and could be interpreted as inherent choices made for this specific context. Troubles arising from these modifications then need to be addressed in part B of the scale, which is linked directly to part A, to provide sufficient services to overcome lower fidelity in part A. Enriching the conversation on quality of care using ESM data (chapter 4) will help teams explain their rationale for modifications. The linkage between part A and part B has not been formally introduced and used as such. This linkage, which needs to be formalized by CCAF, might help future FACT teams in frontier areas or in areas with a shortage of staff or network.

Earlier research from van Vugt (72) helped deconstructing the first fidelity scale. Legitimacy was found in the need to tailor the FACT model to local circumstances, resources and its target group (73,74,75,70) and to the social and cultural needs of local communities (76). Interestingly the rationale of the development of the different FACT scales from 2008, to 2017 and 2022 (FACTs 2017-R; 67) show a close resemblance to the changing aims the Institute of Healthcare Improvement introduced in 2007 over the years. From the triple aim in 2008, focussing on improved patient experience, better outcomes and lower costs to adding clinician well-being in 2014 and health equity in 2021 (77) creating a quintuple aim. Model fidelity and research questions mentioning (F)ACT have developed accordingly. It's important to follow these societal changes when evaluating the FACTs 2017-R.

Relying on fidelity scales might not be enough anymore. In an integrated network of care FACT teams will need to monitor its place within the network of care more closely and continuously. Taking on responsibility for all people with a current severe mental

illness in a network of care goes beyond a FACT team's boundaries (and its model fidelity). Much is known on integrated care; topics need to be addressed (78,79), e.g. the process of collaboration (80,81) and its stages (82,83), but concrete practices will differ in every context and will change overtime. So choices will need to be made to adapt to local situations. Choices that need to be discussed during an assessment of a FACT team in an integrated network of care are 1) being a generalist vs specialist FACT team, 2) creating integrated care in a network vs integrated care within a FACT team and 3) the size of the catchment area for the FACT team. These three factors influence the work of a FACT team in a network of care, as well as it's score on the model fidelity scale (Chapter 6) and can only be discussed in an inclusive and shared decision-making process in a network (84). A FACT team in an integrated network of care will never reach an end-state, continuous improvement is needed, and the concept of *integrating care* (instead of integrated care) by Kee et al. (85) underlines this process nicely.

Looking at client and implementation outcomes from a team's perspective only will not suffice in a network. Monitoring the outcome of the integrated system as a whole (70) will be needed to improve quality on that level. As mentioned in the introduction of this thesis the movement of deinstitutionalization has been considered a process, a fact and a philosophy (86), the movement of network psychiatry shows the same characteristics. A model fidelity scale for network psychiatry will make it possible to start researching the concept, its outcome and its features creating a rationale underpinning the concept of network psychiatry without losing the philosophy behind it (aka the collaborative and shared values of a network).

Research Implications

For now the development of network psychiatry in Dutch mental health care hasn't been supported by randomized controlled trials. This new concept of working in ecosystems of mental health might need new research methods. The traditional randomized controlled trial will no longer lead to useful results if the effect of a team on a network or catchment area isn't monitored. We need to think of other research (and evaluation) methods to monitor the collaborative process (as described by Minkman et al.; 80,81) and its current stage (as described by Valentijn et al.; 82,83), the topics used to focus on and aim for (78,79), and the outcome of an integrated system as a whole (70) and its relation with FACT model fidelity and FACT model modification. More research is needed to understand the continued process of evaluating and developing integrated care in a certain catchment area and the role of models or care (like FACT) within. This might lead to the development, and research, of 'fidelity' scales evaluating collaborative and focussed processes of (integrated) care.

Similarly, one main topic hanging over FACT as a dark cloud is the absence of a well-executed Randomized Controlled Trail (RCT) on the effects and cost-effectiveness of

FACT, as mentioned by many authors (amongst many others; 2,3). From a traditional scientific point of view it would be interesting to investigate the effects on recovery and other social factors as inclusion, human rights and poverty as well in relation to model fidelity using the FACTs 2017. The rapid dissemination of FACT in the Netherlands made it impossible to conduct an RCT in the Netherlands. Afterwards the RCT design for generalist FACT teams will be transferable to youth FACT, FACT-MID, Forensic FACT and other specialist FACT teams (i.e., elderly, early psychosis, people with (borderline) personality disorders). Comparing regions deploying generalist teams with similar regions deploying some generalist and multiple specialist teams would help the field of community mental health.

On the other hand, our research shows that local adoption and adaptation is key to successful implementation of FACT teams and integrated care. Conducting an RCT will not overcome the issue of enormous diversity between teams, networks and regions. Closely follow these implementation processes, embracing complexity, bottom-up development of interventions and local adaptation using non-experimental approaches (87), and gathering rich data on recovery, satisfaction and quality of life locally might be a better way of pursuing research in the field of network care. Especially in combination with data on team operation (model fidelity or ESM for example).

Clinical Implications

Is the FACT model ready for further implementation?

Now the short answer is no, the FACT model is not ready for further implementation in a network of care.

Enhancing quality of care in FACT teams using model fidelity is moving faster than the intrinsic changes needed in the FACT model. Results from this thesis show that a FACT model fidelity scale should support a focus on integrated care in a team *and* in a network of care (Chapter 5 and 8) and strive for quality improvement and relevant recovery-oriented outcome measures on both levels of care. A FACTs 2017 has been created and its successor, the FACTs 2017-R, has seen the light in 2022. Again, combining empirical data with data from audits and articles provided in this thesis.

Important changes have been made to the FACTs 2017 using results from this thesis to promote the concept of taking responsibility in a certain catchment area and show, not only tell, about recovery-oriented activities enhancing recovery for people with severe mental illness. We suggest generalist FACT teams, consisting of specialists customized to the team's casemix, using a multi-agency approach in a small catchment area to take on the main responsibility for the coordination and continuation of service-delivery for all people with an actual severe mental illness in a network of care. A main goal of FACT teams needs to be to improve autonomy and empowerment of clients, relatives

and informal parties to become obsolete in a resource group. In a network of care all parties should deliver the right kind of services, when needed, following an overarching program of evidence based interventions for people with severe mental illness.

Taking on responsibility in a network of care means working collaboratively with multiple parties from different domains. *Quot homines, tot sententiae* (there are as many opinions as there are people), so values will be challenged and human rights (unintendedly) oppressed. We recommend the enriching of the cycle of quality improvement in a team and a network using the treaty created by Convention on the Rights of Persons with Disabilities (CRPD; 88). Something that wasn't done in Dutch Mental Health care so far and has now been added to the FACTs 2017-R. By introducing the topic of human rights a dialogue in a network is made possible and model fidelity is used to improve future healthcare again (like the introduction of peer workers in the FACTs 2008).

Changes in Dutch Mental Health care and the concept of integrated network care has challenged community mental health teams and a new FACT model fidelity scale has been created to fit these changes (chapter 5 and 8). FACT teams worked from an isolated position within a mental health agency in the past and are now developing into teams using a multi-agency approach in a network of integrated care. Newly created modifications to the FACT model challenge model fidelity. A clear linkage between quantitative items on team structure in Part A of the scale (using a Likert-scale) and qualitative topics in Part B (using descriptions on key deliverables) will need to support these local modifications instead of hindering it. This will support the continued calibration of the FACT model and its fidelity scale with new modifications and societal changes. FACT teams need to strive for optimal fidelity-consistency on both part A and B if possible and make clear, monitored and deliberate choices when modifying the model if needed. Only creating new model fidelity scales will not suffice, and education, training, consultation and support will need to be developed nationally to help implementation. These curricula need to be developed using a clear blueprint of the model. A recent FACT book or FACT manual has not been published for years. The chapters in this thesis may be particularly informative for further development of the model's new blueprint.

Macro-level policy guidelines show a gradual increase in awareness that the financing of care should be simplified. Local initiatives are supported to use a multi-agency approach and overcome fragmented care. However, mental health agencies and governmental teams are still mostly restricted to many rules and obligations. Hopefully successful local initiatives will lead to new national policies to enhance multi-domain collaboration, as mentioned by the Council of Public Health & Society (57).

A model fidelity scale combining a revised Part B of the FACTs 2017-R with related questions on integrated care is needed to introduce a new and incremental evaluation tool to support quality improvement for integrated care in a network. For a network of care a fidelity scale and a network monitor needs to be developed in order to be able to ask the right questions to all parties involved and monitor the right indicators. Questions addressing the topics mentioned in Chapter 5, 6, 7 and 8, namely the ability to stay flexible, to be adaptable, take responsibility for the target group and improve quality of care using outcome monitoring and patient, relatives and stakeholders' feedback. Hopefully stakeholders will be able to start asking the right questions to the right stakeholders in a certain region. It will help regular collaborative processes for a couple of topics in recovery-oriented integrated care, but not all and an integrated network of care will always (need to) be flexible, adaptive and subject to change. Taking it a step further, from an incremental change to an innovative one, development of a 'fidelity' scale evaluating a collaborative and focussed process of a FACT team in a network will be necessary to stay flexible and adaptive.

An interesting challenge for the future will be the ability to improve quality of care in a network of care. Evaluating single models of care will not suffice. How far will we be able to stretch a model fidelity scale for a single model to improve an integrated (*integrating*) network without being overly concrete or overly generalist? The FACTs 2017-R seems a good effort for now. It steps across former boundaries of the original FACT model and demands a responsible and responsive approach within a network of care. The model and its fidelity scale will need adaption when integrated care in a network will concretely unfold in the future. Current literature on integrated care provides relevant, but general, topics on overall capacity of a network and the implementation process that is needed to get there. The necessity for local adoption and adaptation of these topics in a network of care creates the need for fidelity scales evaluating the quality of continuous implementation processes and outcome on recovery, satisfaction and quality of life. Single model fidelity scales can support these processes and improve quality of care for individual teams and organizational entities.

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Chapter 12.

Summary

Nederlandse Samenvatting

Curriculum Vitea

List of Publications

Dankwoord

Summary

Background:

Flexible Assertive Community Treatment (FACT), a community mental health service-delivery model for people with severe mental illness (SMI), has become the de-facto standard for regional care in the Netherlands since it evolved from the American Assertive Community Treatment (ACT) model in 2003. The rise of Flexible Assertive Community Treatment (FACT) has been influenced by various factors including economic, political, cultural, societal, and conceptual changes. FACT aims to improve recovery, prevent drop-out and reduce admissions for individuals with severe mental illness by providing proactive community-based care to manage their complex care needs and the necessity for network-based care coordination. During the recovery process, clients may require the integrated FACT team at times, but to avoid hindering recovery and to facilitate participation and inclusion, support from both formal and informal networks remains essential. The delicate balance between care provided by the integrated team and access of network-based regional resources may put individuals with severe mental illness at risk of falling through the cracks. A FACT model fidelity scale was developed, based on the ACT model fidelity scale, to address the requirements of a comprehensive integrated team approach. Although satisfaction among clients and professionals receiving and delivering FACT care seems high, there's a lack of evidence on its impact on recovery.

Competing priorities challenge the current FACT practice. On one hand, a FACT team needs to support individual recovery by delivering optimal care while adhering to FACT fidelity that expects all care to be provided by the same team. On the other hand, FACT teams must continuously adapt to local and regional circumstances to deliver the best possible care within their catchment area, in network collaboration with other stakeholders. A catch 22 that seems to challenge the integrity of FACT. So, what is crucial for FACT, and how does the current fidelity scale and team structure fosters or hinders its recovery-oriented mission? How can enhancements be made to the scale to ensure FACT's resilience within a network of care and support for individuals with severe mental illness? Is the FACT model the most suitable approach to make a sustainable and future-proof contribution to community mental health care for people with severe mental illness?

Aims:

1. To explore the development of FACT in the past and present regarding model fidelity and quality improvement:
 - Investigating the similarities and differences between Assertive Community Treatment (ACT) and FACT in the Netherlands and the United States.
 - Examining the daily activities of FACT workers and their alignment with the intended activities outlined in the theoretical FACT framework.
 - Exploring the levels of optimism about recovery among inpatient and outpatient professionals involved in FACT.
2. To investigate whether FACT has a future in networks of care for people with severe mental illness:
 - Developing a new model fidelity scale (FACTs 2017) to measure the degree of model fidelity of FACT teams in a rapidly changing context.
 - Analyzing the potential for collaboration within and between different sectors of mental health care to provide integrated care for individuals with severe mental illness.
 - Drawing inspiration from successful mental health care systems, such as that in the eastern part of Lille, to explore possibilities for regional cooperation and network care in Dutch psychiatry.
 - Adapting the FACTs 2017 fidelity scale to meet the requirements of Scandinavian countries (Denmark and Sweden) and ensuring cultural relevance.

These aims collectively seek to provide insights into the past, present, and future of FACT implementation, model fidelity, and its potential role in future mental health care networks, while also contributing to the ongoing discourse on quality improvement in mental health care.

Study Design:

The thesis employs a mixed-methods approach to explore the development and current status of FACT, focusing on model fidelity and quality improvement. Various research strategies, including observational studies, Experience Sampling Method (ESM), cross-sectional surveys, and fidelity scale development are used to explore different aspects of FACT implementation and its sustainable future in mental health care networks. We chose to closely follow the development of quality improvement in FACT during the major transitions that happened in Dutch health care from 2015 onwards. Different research designs (i.e., quantitative and qualitative) and methods (i.e., observations, ESM) have been used to reflect on the past, present and future of FACT and subsequently improve quality. Inherent to this prospective approach to change no causal relationships are described. A Randomized Controlled Trial (RCT) was not considered feasible and therefore is not part of the design, because a RCT will not overcome the issue of enormous diversity between teams, networks and regions. Our

strategy was pragmatic, because we assessed what happened and acted inductively on questions that came up during the process. The pragmatic and personal character of our research process required many moments of reflection with (ex-)clients, relatives, professionals, researchers, students, stakeholders and many others. Results are helpful in the international field of quality improvement in FACT, but results will be difficult to duplicate due to its naturalistic and pragmatic nature.

Findings:

Aim 1: To explore the development of FACT in the past and the present regarding model fidelity and quality improvement

Chapter 3 contains an observational study that compares ACT and FACT in the Netherlands and the United States. It shows FACT is in debt to ACT and 'dialects' of both models exist side-by-side, especially in (larger) cities. Managers and clinicians try to optimize choices between the two options within their specific cultural and resource context. They aim to improve quality of care for all people with severe mental illness. Policymakers and other stakeholders can keep in mind that, compared to ACT, FACT aims to ensure a proactive community-based network strategy to identify, engage, and treat a wider range and variety of people with mental challenges to maximize their ability to live independent full lives in the community. The goal of both ACT and FACT has been clearly stated. What was unclear was what FACT (and ACT) professionals do throughout the day to achieve their goal.

To this end, we conducted an Experience Sampling Method (ESM) study to examine daily activities of FACT workers on weekdays in relation to the intended activities from the theoretical FACT framework. In **Chapter 4** we describe that overall, employees spend 30% of their time with clients (2% with relatives), 30% in care related meetings (4% with network partners), 20% on administration and 20% in travel time and personal activities (30-30-20-20). The actual time spent by FACT-workers with clients is lower than assumed or expected. And contact with relatives and network partners lags far behind the desired figures required for modern network-oriented care. While the ESM study did not focus on quality improvement and precise content of the work, this allocation of time raises questions about the extent to which FACT teams can adequately address challenges related to network based psychiatry and recovery care. Applying ESM in FACT teams promises to support a quality development dialogue and might be an interesting tool for required quality improvements to support recovery for people with severe mental illness. An important next step is to increase understanding of ESM as part of quality improvement control circle or as part of financial accountability with less bureaucratic burden.

To better understand the motivation of employees, **Chapter 5** addresses optimism about recovery among in- and outpatient professionals using a cross-sectional, non-

experimental design based on questionnaires. No differences in caregiver optimism were found between care setting (FACT and inpatient High and Intensive Care units) and the two countries involved (the US and the Netherlands). In accordance with earlier findings job tenure was found to be negatively associated with caregiver optimism. A negative association was also found for higher educational levels. Age was found to be positively associated with caregiver optimism such that older caregivers were more optimistic about consumer recovery. We need to follow-up on this research to understand the implications of hope and optimism on the implementation of FACT or its outcome. A revised questionnaire, based on this research, can be used to measure hope and optimism in FACT teams.

Aim 2: To investigate the question whether FACT, as a model, has a future in networks of care for people with severe mental illness.

To address sustainable quality of care we developed a new model fidelity scale in 2017. The original FACT fidelity scale from 2008, was insufficient for the rapidly changing field. The 2008 scale aimed for efficiency, reflecting the broader trend in mental health care towards streamlined procedures and evaluation methods. It allowed to implement more optimal care practices for people with severe mental illness in the Netherlands. A new fidelity scale was needed to continue the gradual quality improvement of care practices. We used expert knowledge, relevant articles and feedback from professionals, researchers, interest groups, peers and family members. The 'FACTs 2017' was piloted in two rounds. Trained auditors assessed 21 teams to test and adjust the scale. **Chapter 7** describes the process of developing the FACTs 2017. A total revision led to a fidelity scale combining quantitative items on team structure (using a 5-point Likert-scale) for 16 items in Part A and qualitative descriptions on eight key deliverables in Part B. The conclusion is that the (research) field now has an instrument to measure the degree of model fidelity of teams that focus on patients with severe mental illness in a rapidly changing context.

In this rapidly changing context optimal care for people with severe mental illness includes a broad range of services provided in different sectors. In the Netherlands, we have sectorized mental health care, community care, primary care, addiction care and care for people with intellectual disabilities. This exceeds the scope of expertise available within the FACT team and requires far-reaching cooperation between different regional resources. This cooperation needs to be customized locally while providing answers to generic, nationally formulated goals. **Chapter 8** reflects on developments in the welfare sector and specialist mental healthcare using relevant literature and recent (inter)national experiences to offer new insights on collaboration within and between domains. Results show that it is possible to provide better integrated care by allowing FACT teams to network together with community partners (e.g. by sharing financial and/or manpower resources). Networks of care for people with severe mental illness develop in stages and professionals create new partnerships in the process. The

model fidelity scale for FACT teams was adjusted accordingly to facilitate that process. It is ready to allow FACT teams to explore flexible local solutions for partnerships to realize the much-needed multi-domain integrated community care for people with severe mental illness.

We got inspiration for an integrated care system for people with severe mental illness from the eastern part of Lille: sector 21. For some time now, East Lille has been working with a relatively modern mental health care system that remarkably resembles Dutch health care with the same values and norms that we also want to implement in the Netherlands. Therefore a delegation from the board of F-ACT-Netherlands and CCAF visited Lille to gain inspiration for further regional cooperation and 'network care' in Dutch psychiatry. Our observations are described in **Chapter 9**. The basis of the East Lille working method is a charter of shared values, signed by every professional, and developed with all parties, clients, relatives, employees and external professionals. In case of doubt, a change of context or the introduction of new working methods, these values are used as a first reference. High quality mental health care develops in dialogue, in which working methods, service delivery models and interventions are linked to each other in care network. Through reflection, moral deliberation and appreciative auditing, care is progressively improved. These procedures guarantee a modern process of quality improvement.

The FACTs 2017 was developed to support a modern process of quality improvement. Scandinavian researchers and professionals, dealing with similar problems to improve recovery and integrated care, were interested in the newly developed FACT scale. Together with the authors and stakeholders we tested and updated the FACTs 2017 to meet Danish and Swedish requirements. **Chapter 10** describes this process for all three countries. It resulted in a new standard to assess model fidelity in FACT-teams for these countries using the FACTs 2017 with subtle, cultural induced, changes. Adding an occupational therapist as a key discipline is a typical Scandinavian improvement of the mix of disciplines.

Discussion:

The thesis presents a comprehensive exploration of the FACT model's evolution towards a more recovery-oriented, integrated, and quality-focused approach to care for individuals with severe mental illness. This thesis demonstrates the evolution of the FACT model over the past two decennia. Changes are influenced by historical trends and emerging needs in mental health care. The parallel development of a new fidelity scale and quality improvement initiatives signify improvements in recovery orientation and integrated care. Continued alignment of integrated care principles for FACT teams and those within the broader network of care is essential to ensure a sustainable future of FACT. Recovery, integrated care, and quality improvement are discussed as key components shaping the future of mental health care.

The thesis underscores a notable transition within FACT teams, moving away from a primary emphasis on efficiency towards prioritizing the well-being and positive mental health of individuals. This shift highlights a growing recognition of the significance of adopting a holistic **recovery** approach, which integrates evidence-based practices and actively engages both the community and relatives in the care process. However, challenges persist in enhancing recovery outcomes within FACT teams, indicating the necessity for a multidimensional approach and the implementation of integrated network interventions to address the complex needs of individuals with severe mental illness. In the evolving landscape of mental health care, future sustainability requires a shift towards community-centric services and **integrated care**, emphasizing collaboration among resources of diverse service providers. FACT teams need to adopt an interdependent approach with stakeholders, fostering informed decision-making and active participation in collaborative processes. Dutch initiatives as Ecosystems for Mental Health exemplify the necessary transition towards network psychiatry, underscoring the necessity for FACT teams to adapt and engage in collaboration with a myriad of local partners to effectively meet the needs of individuals with severe mental illness. Fidelity scales like the FACTs 2017 play a crucial role in maintaining adherence to program models and realizing desired outcomes within mental health care settings aka **quality improvement**. Nonetheless, the thesis underscores the limitations of solely relying on fidelity scales, emphasizing the necessity for continuous training, support, and adaptation to local contexts. Moreover, it advocates for the monitoring of FACT teams' position within the broader network of care and the adoption of shared decision-making processes to enhance quality at a systemic level. During this thesis we have overcome the idea of FACT being in the centre of care for people with severe mental illness, but we haven't overcome the perception of fidelity scales being at the centre of quality improvement. A new comprehensive approach ensures that fidelity scales are integrated into a broader framework of quality improvement, facilitating more effective and sustainable outcomes in mental health care delivery.

Overall, the thesis underscores the need for a comprehensive, multidimensional approach to mental health care of people with severe mental health problems, where FACT teams play a vital role within integrated networks, fostering recovery, collaboration, and continuous quality improvement.

The thesis pinpoints several crucial implications for both research and clinical practice regarding the implementation and evolution of the FACT model in Dutch mental health care. From a research perspective, the emergence of network psychiatry necessitates novel methodologies that extend beyond traditional randomized controlled trials (RCTs) to effectively monitor collaborative processes and outcomes at both team and network levels. Despite the acknowledged absence of well-executed RCTs on the effects and cost-effectiveness of FACT, the rapid dissemination of the model in the Netherlands poses ethical, comparability, and contamination challenges for conducting such

trials. The thesis emphasizes the importance of local adoption and adaptation as essential elements for successful implementation, suggesting that closely tracking implementation processes and collecting rich local data may yield more valuable insights than relying primarily on RCTs. Additionally, there is a call for research on fidelity scales that evaluate collaborative processes and focused care within integrated networks, along with investigations into the effectiveness of the FACT model across different contexts and its influence on recovery, human rights, and other social factors. Enhancing quality of care in FACT teams using model fidelity is moving faster than the intrinsic changes needed in the FACT model. These research endeavours are essential for advancing understanding and improving the delivery of mental health care within integrated networks.

The clinical implications outlined in the thesis shed light on crucial considerations for the implementation and advancement of the FACT model within mental health care networks. Firstly, it is acknowledged that the FACT model requires intrinsic changes to better align with the evolving landscape of mental health care. Thus, it is imperative to engage in practical adjustments and action-based research to facilitate these necessary intrinsic changes. Secondly, there is an emphasis on the need for enhanced quality of care within FACT teams, emphasizing the importance of model fidelity aligned with integrated care principles to promote improved recovery outcomes and endorse human rights. Additionally, the proposal of a revised FACTs 2017-R model fidelity scale intends to facilitate a multi-agency approach within networks of integrated care, prioritizing flexibility, adaptability, and responsibility among stakeholders. Lastly, the thesis underscores the necessity of national policies supporting collaboration across multiple domains and addressing fragmented care to foster the success of local initiatives and the broader implementation of integrated care practices. These clinical implications underscore the importance of aligning FACT with evolving care paradigms, promoting quality improvement, and fostering collaboration to enhance mental health care delivery within integrated networks.

In summary, the thesis underscores the need for ongoing research and adaptation to ensure that the FACT model effectively meets the evolving needs of individuals with severe mental illness within integrated networks of care.

Conclusion:

Taking the different chapters of this thesis together, it can be concluded that the evolution of the FACT model has been influenced by both historical trends in mental health care and the emerging needs of individuals with severe mental illness. The development of model fidelity scales and quality improvement efforts reflects a shift towards recovery-oriented practices and integrated care within a network context. However, challenges persist in aligning the FACT model with the principles of integrated care, resulting in changes to the model to better meet the needs of clients

and stakeholders. Recommendations include adopting a multi-agency approach, promoting professional and client autonomy and empowerment, and advocating for national policies supporting collaboration and overcoming fragmented care. Overall, the thesis underscores the importance of ongoing research, adaptation, and collaboration to enhance the effectiveness of the FACT model within evolving mental health care systems.

This comprehensive examination contributes valuable insights into the past, present, and future of FACT implementation, model fidelity, and its potential role in future mental health care networks.

Nederlandse Samenvatting

Achtergrond:

Flexible Assertive Community Treatment (FACT), een intensieve en multidisciplinaire teambenadering voor mensen met een ernstige psychische aandoening (EPA), is de de-facto standaard geworden voor regionale zorg in Nederland sinds het in 2003 voortkwam uit het Amerikaanse Assertive Community Treatment (ACT)-model. De opkomst van Flexible Assertive Community Treatment (FACT) is beïnvloed door verschillende factoren, waaronder economische, politieke, culturele, maatschappelijke en conceptuele veranderingen. FACT heeft tot doel het herstel te verbeteren, uitval te voorkomen en het aantal opnames voor personen met een ernstige psychische aandoening te verminderen door proactieve gemeenschapsgerichte zorg te bieden om complexe zorgbehoeften en de noodzaak van zorgcoördinatie in het netwerk te organiseren. Tijdens het herstelproces kunnen cliënten soms het geïntegreerde FACT-team nodig hebben, maar om het herstel niet te belemmeren en om participatie en inclusie te vergemakkelijken, blijft ondersteuning van zowel formele als informele steunbronnen essentieel. Het delicate evenwicht tussen zorg door het geïntegreerde team en toegang tot regionale netwerkzorg kan ervoor zorgen dat personen met een ernstige psychische aandoening het risico lopen door de mazen van het net te vallen. Er werd een FACT-modelgetrouwheidsschaal ontwikkeld, gebaseerd op de ACT-modelgetrouwheidsschaal, om tegemoet te komen aan de vereisten van een alomvattende geïntegreerde teamaanpak. Hoewel de tevredenheid onder cliënten en professionals die FACT-zorg ontvangen en leveren hoog lijkt, is er een gebrek aan bewijs over de impact ervan op herstel.

Concurrerende prioriteiten vormen een uitdaging voor de huidige FACT-praktijk. Aan de ene kant moet een FACT-team individueel herstel ondersteunen door optimale zorg te leveren en tegelijkertijd vast houden aan de FACT-modelgetrouwheid die verwacht dat alle zorg door hetzelfde team wordt verleend. Aan de andere kant moeten FACT-teams zich voortdurend aanpassen aan lokale en regionale omstandigheden om de best mogelijke zorg te leveren binnen hun verzorgingsgebied, in netwerksamenwerking met andere belanghebbenden. Een catch 22 die de integriteit van FACT in twijfel lijkt te trekken. Dus, wat is cruciaal voor FACT, en hoe bevordert of belemmert de huidige modelgetrouwheidsschaal en teamstructuur de herstelondersteunende missie? Hoe kunnen verbeteringen worden aangebracht aan de schaal om de veerkracht van FACT te waarborgen binnen een zorgnetwerk en ondersteuning voor personen met een ernstige psychische aandoening blijven leveren? Is het FACT-model de meest geschikte aanpak om een duurzame en toekomstbestendige bijdrage te leveren aan de zorg voor mensen met een ernstige psychische aandoening?

Doelstellingen:

1. Het onderzoeken van de ontwikkeling van FACT in het verleden en heden met betrekking tot modelgetrouwheid en kwaliteitsverbetering:
 - Onderzoek naar de overeenkomsten en verschillen tussen Assertive Community Treatment (ACT) en FACT in Nederland en de Verenigde Staten.
 - Het onderzoeken van de dagelijkse activiteiten van FACT-medewerkers en hun afstemming op de beoogde activiteiten die worden beschreven in het FACT-model.
 - Onderzoek naar de mate van optimisme over herstel onder klinische en ambulante professionals die betrokken zijn bij FACT.
2. Onderzoeken of FACT een toekomst heeft in zorgnetwerken voor mensen met een ernstige psychische aandoening:
 - Het ontwikkelen van een nieuwe model fidelity scale (FACTs 2017) om de mate van modelgetrouwheid van FACT-teams in een snel veranderende context te meten.
 - Analyse van het potentieel voor samenwerking binnen en tussen verschillende sectoren van de geestelijke gezondheidszorg om geïntegreerde zorg te bieden aan personen met een ernstige psychische aandoening.
 - Verkennen van mogelijkheden voor regionale samenwerking en netwerkzorg in de Nederlandse psychiatrie bij succesvolle ggz-systemen, zoals die in het oostelijk deel van Lille.
 - Aanpassen van de modelgetrouwheidsschaal FACTs 2017 om te voldoen aan de eisen van de Scandinavische landen (Denemarken en Zweden) en om culturele relevantie te waarborgen.

Deze doelstellingen proberen gezamenlijk inzicht te geven in het verleden, het heden en de toekomst van FACT-implementatie, modelgetrouwheid en de potentiële rol ervan in toekomstige netwerken voor mentale gezondheidszorg, terwijl ze ook bijdragen aan het lopende discours over kwaliteitsverbetering in de mentale gezondheidszorg.

Opzet van het onderzoek:

Het proefschrift maakt gebruik van een mixed-methods benadering om de ontwikkeling en huidige status van FACT te onderzoeken, met de nadruk op modelgetrouwheid en kwaliteitsverbetering. Verschillende onderzoeksstrategieën, waaronder observationele studies, Experience Sampling Method (ESM), cross-sectionele enquêtes en de ontwikkeling van modelgetrouwheidsschalen, worden gebruikt om verschillende aspecten van FACT-implementatie en de duurzame toekomst ervan in netwerken voor mentale gezondheidszorg te onderzoeken. We hebben ervoor gekozen om de ontwikkeling van kwaliteitsverbetering in FACT op de voet te volgen tijdens de grote transities die vanaf 2015 in de Nederlandse gezondheidszorg plaatsvonden. Verschillende onderzoeksontwerpen (d.w.z. kwantitatief en kwalitatief) en methoden (d.w.z. observaties, ESM) zijn gebruikt om te reflecteren op het verleden, het heden en

de toekomst van FACT om vervolgens de kwaliteit te verbeteren. Inherent aan deze prospectieve benadering van verandering worden geen causale verbanden beschreven. Een Randomized Controlled Trail (RCT) werd niet haalbaar geacht en maakt daarom geen deel uit van het ontwerp, omdat een RCT het probleem van de enorme diversiteit tussen teams, netwerken en regio's niet zal oplossen. Onze strategie was pragmatisch, omdat we inschatten wat er gebeurde en inductief handelden op vragen die tijdens het proces naar voren kwamen. Het pragmatische en persoonlijke karakter van ons onderzoeksproces vroeg om veel reflectiemomenten met (ex-)cliënten, naasten, professionals, onderzoekers, studenten, stakeholders en vele anderen. Resultaten zijn nuttig op het internationale gebied van kwaliteitsverbetering in FACT, maar resultaten zullen moeilijk te dupliceren zijn vanwege het naturalistische en pragmatische karakter ervan.

Bevindingen:

Doel 1: Het verkennen van de ontwikkeling van FACT in het verleden en het heden met betrekking tot modelgetrouwheid en kwaliteitsverbetering

Hoofdstuk 3 bevat een observationele studie die ACT en FACT in Nederland en de Verenigde Staten met elkaar vergelijkt. Het laat zien dat FACT schatplichtig is aan ACT en dat 'dialecten' van beide modellen naast elkaar bestaan, vooral in (grotere) steden. Managers en klinici proberen de keuzes tussen de twee opties te optimaliseren binnen hun specifieke culturele en netwerkcontext. Ze hebben tot doel de kwaliteit van zorg voor alle mensen met een ernstige psychische aandoening te verbeteren. Beleidsmakers en andere belanghebbenden kunnen in gedachten houden dat, in vergelijking met ACT, FACT streeft naar een proactieve, op de gemeenschap gebaseerde netwerkstrategie om een breder scala en een grotere verscheidenheid aan mensen met mentale uitdagingen te identificeren, te betrekken en te behandelen om hun vermogen om een onafhankelijk en volledig leven in de gemeenschap te leiden, te maximaliseren. Het doel van zowel ACT als FACT is duidelijk geformuleerd. Wat onduidelijk was, was wat FACT (en ACT) professionals gedurende de dag doen om hun doel te bereiken.

Daartoe hebben we een Experience Sampling Method (ESM)-studie uitgevoerd om de dagelijkse activiteiten van FACT-medewerkers op weekdays te onderzoeken in relatie tot de beoogde activiteiten vanuit het FACT-model. In **hoofdstuk 4** beschrijven we dat medewerkers in totaal 30% van hun tijd besteden aan cliënten (2% aan naasten), 30% aan zorggerelateerde gesprekken (4% aan netwerkpartners), 20% aan administratie en 20% aan reistijd en persoonlijke activiteiten (30-30-20-20). De werkelijke tijd die FACT-medewerkers met klanten doorbrengen is lager dan aangenomen of verwacht. En het contact met naasten en netwerkpartners blijft ver achter bij de gewenste cijfers die nodig zijn voor moderne netwerkgerichte zorg. Hoewel de ESM-studie zich niet richtte op kwaliteitsverbetering en precieze inhoud van het werk, roept deze toewijzing van tijd vragen op over de mate waarin FACT-teams adequaat kunnen omgaan met uitdagingen

met betrekking tot netwerkpsychiatrie en herstelondersteunende zorg. Het toepassen van ESM in FACT-teams belooft een dialoog over kwaliteitsontwikkeling te ondersteunen en kan een interessant hulpmiddel zijn voor de vereiste kwaliteitsverbeteringen om het herstel van mensen met een ernstige psychische aandoening te ondersteunen. Een belangrijke volgende stap is het vergroten van het begrip van ESM als onderdeel van de controle cyclus voor kwaliteitsverbetering of als onderdeel van financiële verantwoording met minder bureaucratische lasten.

Om de motivatie van medewerkers beter te begrijpen, gaat **hoofdstuk 5** in op het optimisme over herstel bij ambulante professionals met behulp van een cross-sectioneel, niet-experimenteel ontwerp op basis van vragenlijsten. Er werden geen verschillen in het optimisme van zorgverleners gevonden tussen de zorgomgeving (FACT en intramurale High en Intensive Care-afdelingen) en de twee betrokken landen (de VS en Nederland). In overeenstemming met eerdere bevindingen bleek de ambtstermijn van een baan (ervaring) negatief geassocieerd te zijn met het optimisme van de hulpverlener. Ook voor het hoger opleidingsniveau werd een negatief verband gevonden. Leeftijd bleek positief geassocieerd te zijn met het optimisme van de hulpverlener, waardoor oudere hulpverleners optimistischer bleken over het herstel van de consument. We moeten dit onderzoek opvolgen om de implicaties van hoop en optimisme op de implementatie van FACT of de uitkomst ervan te begrijpen. Een herziene vragenlijst, gebaseerd op dit onderzoek, kan worden gebruikt om hoop en optimisme in FACT-teams te meten.

Doel 2: Het onderzoeken van de vraag of FACT, als model, toekomst heeft in netwerken van zorg voor mensen met een ernstige psychische aandoening.

Om duurzame kwaliteit van zorg te garanderen, hebben we in 2017 een nieuwe modelgetrouwheidsschaal ontwikkeld. De oorspronkelijke FACT-modelgetrouwheidsschaal uit 2008 was onvoldoende voor het snel veranderende veld. De schaal van 2008 was gericht op efficiëntie, een weerspiegeling van de bredere trend in de geestelijke gezondheidszorg naar gestroomlijnde procedures en evaluatiemethoden. Het maakte het mogelijk om meer optimale zorgpraktijken te implementeren voor mensen met een ernstige psychische aandoening in Nederland. Een nieuwe getrouwheidsschaal was nodig om de geleidelijke kwaliteitsverbetering van zorgpraktijken voort te zetten. We maakten gebruik van vakkennis, relevante artikelen en feedback van professionals, onderzoekers, belangenorganisaties, vakgenoten en familieleden. De 'FACTs 2017' werd in twee rondes gepilot. Getrainde auditors beoordeelden 21 teams om de schaal te testen en aan te passen. **Hoofdstuk 7** beschrijft het proces van de ontwikkeling van de FACTs 2017. Een totale herziening leidde tot een modelgetrouwheidsschaal die kwantitatieve items op teamstructuur (met behulp van een 5-punts Likert-schaal) combineert voor 16 items in deel A met kwalitatieve beschrijvingen op acht belangrijke resultaatgebieden in deel B. De conclusie is dat het (onderzoeks)veld nu een instrument heeft om de mate van modelgetrouwheid te meten

van teams die zich richten op patiënten met een ernstige psychische aandoening in een snel veranderende context.

In deze snel veranderende context omvat optimale zorg voor mensen met een ernstige psychische aandoening een breed scala aan diensten in verschillende sectoren. In Nederland hebben we de mentale gezondheidszorg opgedeeld in vele sectoren, zoals eerstelijnszorg, wijkteams, verslavingszorg en zorg voor mensen met een verstandelijke beperking. Dit overstijgt de expertise die binnen het FACT-team aanwezig is en vereist een verregaande samenwerking tussen verschillende regionale bronnen. Deze samenwerking moet lokaal worden aangepast en tegelijkertijd antwoorden bieden op generieke, nationaal geformuleerde doelen. **Hoofdstuk 8** reflecteert op ontwikkelingen in het sociaal domein en de specialistische ggz aan de hand van relevante literatuur en recente (inter)nationale ervaringen om nieuwe inzichten te bieden over samenwerking binnen en tussen domeinen. De resultaten tonen aan dat het mogelijk is om beter geïntegreerde zorg te bieden door FACT-teams in staat te stellen samen te werken met netwerkpartners (bijvoorbeeld door financiële en/of personele middelen te delen). Zorgnetwerken voor mensen met een ernstige psychische aandoening ontwikkelen zich gefaseerd en professionals creëren daarbij nieuwe samenwerkingsverbanden. De modelgetrouwheidsschaal voor FACT-teams werd dienovereenkomstig aangepast om dat proces te vergemakkelijken. De schaal stelt FACT-teams in staat flexibele lokale oplossingen voor partnerschappen te verkennen om de broodnodige multi-domein geïntegreerde netwerkzorg voor mensen met een ernstige psychische aandoening te realiseren.

Inspiratie voor een geïntegreerd zorgsysteem voor mensen met een ernstige psychische aandoening haalden we uit het oostelijk deel van Lille: sector 21. Oost-Lille werkt al geruime tijd met een relatief modern ggz-systeem dat opvallend veel lijkt op de Nederlandse gezondheidszorg met dezelfde waarden en normen die we ook in Nederland willen implementeren. Daarom heeft een delegatie van het bestuur van F-ACT-Nederland en CCAF een bezoek gebracht aan Lille om inspiratie op te doen voor verdere regionale samenwerking en netwerkzorg in de Nederlandse psychiatrie. Onze waarnemingen zijn beschreven in **hoofdstuk 9**. De basis van de werkmethode Oost-Lille is een charter van gedeelde waarden, ondertekend door elke professional en ontwikkeld met alle partijen, cliënten, naasten, medewerkers en externe professionals. In geval van twijfel, een verandering van context of de invoering van nieuwe werkwijzen worden deze waarden als eerste referentie gebruikt. Hoogwaardige mentale gezondheidszorg ontwikkelt zich in dialoog, waarbij werkwijzen, teammodellen en interventies in zorgnetwerken aan elkaar worden gekoppeld. Door reflectie, moreel beraad en waarderend auditen wordt de zorg geleidelijk verbeterd. Deze procedures staan garant voor een modern proces van kwaliteitsverbetering.

De FACTs 2017 is ontwikkeld ter ondersteuning van een modern proces van kwaliteitsverbetering. Scandinavische onderzoekers en professionals, die zich bezighouden met vergelijkbare uitdagingen om herstel en geïntegreerde zorg te verbeteren, waren geïnteresseerd in de nieuw ontwikkelde FACT-schaal. Samen met de auteurs en belanghebbenden hebben we de FACTs 2017 getest en geactualiseerd om te voldoen aan de Deense en Zweedse vereisten. **Hoofdstuk 10** beschrijft dit proces voor alle drie de landen. Het resulteerde in een nieuwe standaard om modelgetrouwheid in FACT-teams voor deze landen te beoordelen met behulp van de FACTs 2017 met subtiele, cultureel geïnduceerde, veranderingen. Het toevoegen van een ergotherapeut als sleuteldiscipline is een typisch Scandinavische verbetering van de mix van disciplines.

Discussie:

Het proefschrift presenteert een uitgebreide verkenning van de evolutie van het FACT-model naar een meer herstelondersteunende, geïntegreerde en kwaliteitsgerichte benadering van de zorg voor personen met een ernstige psychische aandoening. Dit proefschrift toont de evolutie van het FACT-model in de afgelopen twee decennia. Veranderingen worden beïnvloed door historische trends en opkomende behoeften in de mentale gezondheidszorg. De parallelle ontwikkeling van een nieuwe modelgetrouwheidsschaal en initiatieven voor kwaliteitsverbetering duiden op verbeteringen in herstelondersteunende en geïntegreerde zorg. Voortdurende afstemming van de principes van geïntegreerde zorg voor FACT-teams en die binnen het bredere zorgnetwerk zijn essentieel om een duurzame toekomst van FACT te waarborgen. Herstel, geïntegreerde zorg en kwaliteitsverbetering worden besproken als belangrijke componenten die de toekomst van de mentale gezondheidszorg vormgeven.

Het proefschrift onderstreept een opmerkelijke overgang binnen FACT-teams, waarbij wordt afgestapt van een primaire nadruk op efficiëntie naar het prioriteren van het welzijn en de positieve psychische gezondheid van individuen. Deze verschuiving benadrukt een groeiende erkenning van het belang van een holistische herstelbenadering, die evidence-based praktijken integreert en zowel de gemeenschap als familieleden actief betreft bij het zorgproces. Er blijven echter uitdagingen bestaan bij het verbeteren van herstelresultaten binnen FACT-teams, wat wijst op de noodzaak van een multidimensionale aanpak en de implementatie van geïntegreerde netwerkinterventies om tegemoet te komen aan de complexe behoeften van personen met een ernstige psychische aandoening. In het evoluerende landschap van de mentale gezondheidszorg vereist de toekomst een verschuiving naar gemeenschapsgerichte diensten en geïntegreerde zorg, waarbij de nadruk ligt op samenwerking tussen diverse dienstverleners. FACT-teams moeten samen werken met belanghebbenden in het netwerk, waarbij gezamenlijke besluitvorming en actieve deelname aan samenwerkingsprocessen wordt bevorderd. Nederlandse initiatieven als GEM illustreren de noodzakelijke overgang naar netwerkpsychiatrie, en onderstrepen de noodzaak

voor FACT-teams om zich aan te passen en samen te werken met een groot aantal lokale partners om effectief te voldoen aan de behoeften van mensen met een ernstige psychische aandoening. Modelgetrouwheidsschalen zoals de FACT's 2017 spelen een cruciale rol bij het handhaven van de naleving van evidence-based interventies en het realiseren van gewenste resultaten binnen de mentale gezondheidszorg, ook wel kwaliteitsverbetering genoemd. Desalniettemin onderstreept het proefschrift de beperkingen van het uitsluitend vertrouwen op modelgetrouwheidsschalen, waarbij de nadruk wordt gelegd op de noodzaak van voortdurende training, ondersteuning en aanpassing aan lokale contexten. Bovendien pleit het voor het monitoren van de positie van FACT-teams binnen het bredere zorgnetwerk en het hanteren van gedeelde besluitvormingsprocessen om de kwaliteit op systemisch niveau te verbeteren. Tijdens dit proefschrift hebben we het idee overwonnen dat FACT centraal staat in de zorg voor mensen met een ernstige psychische aandoening, maar we hebben de perceptie niet overwonnen dat modelgetrouwheidsschalen centraal staan in kwaliteitsverbetering. Een nieuwe alomvattende aanpak zorgt ervoor dat modelgetrouwheidsschalen worden geïntegreerd in een breder kader van kwaliteitsverbetering, waardoor effectievere en duurzamere resultaten in de mentale gezondheidszorg mogelijk worden.

Over het algemeen onderstreept het proefschrift de noodzaak van een alomvattende, multidimensionale benadering van de mentale gezondheidszorg aan mensen met ernstige psychische problemen, waarbij FACT-teams een cruciale rol spelen binnen geïntegreerde netwerken en herstel, samenwerking en continue kwaliteitsverbetering bevorderen.

Het proefschrift belicht een aantal cruciale implicaties voor zowel onderzoek als klinische praktijk met betrekking tot de implementatie en evolutie van het FACT-model in de Nederlandse ggz. Vanuit een onderzoeksperspectief vereist de opkomst van netwerkzorg nieuwe methodologieën die verder gaan dan traditionele gerandomiseerde gecontroleerde onderzoeken (RCT's) om samenwerkingsprocessen en -resultaten op zowel team- als netwerkniveau effectief te monitoren. Ondanks de erkende afwezigheid van goed uitgevoerde RCT's over de effecten en kosteneffectiviteit van FACT, stelt de snelle verspreiding van het model in Nederland ethische, vergelijkbaarheids- en contaminatie-uitdagingen voor het uitvoeren van dergelijke onderzoeken. Het proefschrift benadrukt het belang van lokale adoptie en aanpassing als essentiële elementen voor een succesvolle implementatie, wat suggereert dat het nauwlettend volgen van implementatieprocessen en het verzamelen van rijke lokale gegevens waardevollere inzichten kan opleveren dan voornamelijk te vertrouwen op RCT's. Daarnaast is er een oproep voor onderzoek naar modelgetrouwheidsschalen die samenwerkingsprocessen en gerichte zorg binnen geïntegreerde netwerken evalueren, samen met onderzoeken naar de effectiviteit van het FACT-model in verschillende contexten en de invloed ervan op herstel, mensenrechten en andere sociale factoren. Het verbeteren van de kwaliteit van zorg in FACT-teams met behulp

van modelgetrouwheid gaat sneller dan de intrinsieke veranderingen die nodig zijn in het FACT-model. Deze onderzoeksinspanningen zijn essentieel voor het bevorderen van het begrip en het verbeteren van de zorg in geïntegreerde netwerken.

De klinische implicaties die in het proefschrift worden geschetst, werpen licht op cruciale overwegingen voor de implementatie en vooruitgang van het FACT-model in zorgnetwerken. Ten eerste wordt erkend dat het FACT-model intrinsieke veranderingen vereist om beter aan te sluiten bij het veranderende landschap van de mentale gezondheidszorg. Het is dus noodzakelijk om praktische aanpassingen en actiegericht onderzoek te doen om deze noodzakelijke intrinsieke veranderingen mogelijk te maken. Ten tweede wordt de nadruk gelegd op de noodzaak van verbeterde kwaliteit van zorg binnen FACT-teams, waarbij de nadruk wordt gelegd op het belang van modelgetrouwheid die is afgestemd op de principes van geïntegreerde zorg om herstel beter te ondersteunen en de mensenrechten te onderschrijven. Bovendien is het voorstel van een herziene FACTs 2017-R-modelgetrouwheidsschaal bedoeld om een multi-agency aanpak binnen netwerken van geïntegreerde zorg te vergemakkelijken, waarbij prioriteit wordt gegeven aan flexibiliteit, aanpassingsvermogen en verantwoordelijkheid bij belanghebbenden. Ten slotte onderstreept het proefschrift de noodzaak van nationaal beleid dat samenwerking tussen meerdere domeinen ondersteunt en gefragmenteerde zorg aanpakt om het succes van lokale initiatieven en de bredere implementatie van geïntegreerde zorgpraktijken te bevorderen. Deze klinische implicaties onderstrepen het belang van het afstemmen van FACT op evoluerende zorgparadigma's, het bevorderen van kwaliteitsverbetering en het bevorderen van samenwerking om de mentale gezondheidszorg binnen geïntegreerde netwerken te verbeteren.

Samenvattend onderstreept het proefschrift de noodzaak van doorlopend onderzoek en aanpassing om ervoor te zorgen dat het FACT-model effectief voldoet aan de veranderende behoeften van personen met een ernstige psychische aandoening binnen geïntegreerde zorgnetwerken.

Conclusie:

Als we de verschillende hoofdstukken van dit proefschrift samen nemen, kan worden geconcludeerd dat de evolutie van het FACT-model is beïnvloed door zowel historische trends in de geestelijke gezondheidszorg als de behoeften van mensen met een ernstige psychische aandoening. De ontwikkeling van modelgetrouwheidsschalen en inspanningen voor kwaliteitsverbetering weerspiegelen een verschuiving naar herstelondersteunende en geïntegreerde zorg in een netwerk. Er blijven echter uitdagingen bestaan bij het afstemmen van het FACT-model op de principes van geïntegreerde zorg, wat resulteert in wijzigingen in het model om beter te voldoen aan de behoeften van cliënten en belanghebbenden. Aanbevelingen zijn onder meer het aannemen van een multi-agency approach, het bevorderen van autonomie en

empowerment van professionals en cliënten, en het pleiten voor nationaal beleid ter ondersteuning van samenwerking en het overwinnen van gefragmenteerde zorg. Over het algemeen onderstreept het proefschrift het belang van doorlopend onderzoek, voortdurende aanpassingen en samenwerking om de effectiviteit van het FACT-model binnen evoluerende zorgsystemen te vergroten.

Dit uitgebreide onderzoek biedt waardevolle inzichten in het verleden, het heden en de toekomst van FACT-implementatie, modelgetrouwheid en de mogelijke rol ervan in toekomstige netwerken voor mentale gezondheidszorg.

Curriculum Vitae

Koen Hendrikus Westen was born on June 4th 1980 in Gilze-en-Rijen, the Netherlands. In 2001 he obtained his bachelor in nursing, after having spent 6 months in England as part of an apprenticeship in Lister Hospital. During his work in addiction care he obtained another bachelor in public health in 2004, having had extra apprenticeships in a crisis resolution team and a dual disorder clinic in Finland. In these years as a sociotherapist, nurse and public mental health nurse in addiction care and mental health he gained knowledge of IDDT, CRA, MI, CTI and community mental health work on and off the streets. Working for an ACT team gave many new opportunities and time was well spent visiting IDDT teams in the US and multiple conferences. A new life as a lecturer in Nursing started in 2010, working for the Academy of Healthcare at Avans University of Applied Sciences. He has been a guest lecturer for Social Work, Health Technology and Airlangga University in Surabaya and the Master of Nursing in Utrecht in present time. During these years he coordinated a special mental health program, visited Trieste and Lille for inspiration, and developed its successor, called Minor Positive Psychiatry. In 2017 he obtained a master degree in Social Work and Innovation at NCOI. With a master thesis about working together in a network of care, his interest in the subject was shown.

In the year 2011 he became a board member of CCAF. This is the moment his transition from mental health professional, lecturer and trainer to senior-lecturer, (senior-) researcher, author and consultant happened. Together with Pim Peeters he developed multiple research projects, of which working as a professional with lived experience and working as a professional in integrated care got the most attention. Without the idea of starting a PhD project, many innovative projects emerged from CCAF meetings, EuComs gatherings and discussions with Pim Peeters and many other (ex-) clients, relatives and professionals. With the help of Hans Kroon, Philippe Delespaul, Pim Peeters, Maaïke van Vugt, Niels Mulder, Michiel Bähler, Margreet Groen, Margret Overdijk and of course Remmers van Veldhuizen he went on a journey to improve quality of care for people with severe mental illness. Everything happened during ‘changing conversations’ in an international network of professionals, researchers, clients, critics, financiers, trainers and many other stakeholders. For instance the development of model fidelity scales for ACT, FACT, FACT-youth, Forensic FACT, Forensic ACT, FACT-MID, Network care, Resourcegroups and Work-focused Integrated Treatment bear his signature. A measurement tool for 3Cp was created during a 3-year granted project in Denmark. In 2022 he took the chance to finish this project at the Department of Tranzo at the Tilburg University. In 2023 he initiated the starting of a European Network on ACT and FACT research in Oslo and a FACT course at RINO ZUID. After finishing his PhD he will keep on working as a lecturer and researcher at Avans University of Applied Sciences, as well as senior-lecturer for his research program Recovery Support in a network of care in mental health at Reinier van Arkel Mental Health and vice-president at CCAF.

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'FACT as part of an ecosystem of mental health. How to adopt, adapt and improve the FACT-model in an ever-changing context?'

Nederlands-Vlaamse Wetenschapsdagen Palliatieve Zorg, Antwerpen, Belgium, 2023

'Implementation of palliative care for people with complex psychiatric problems'

5d European Congress on Assertive Outreach, Leuven, Belgium, 2023 2023

'FACT as part of an ecosystem of mental health. How to adopt, adapt and improve the FACT-model in an ever-changing context?'
Met Prof. Dr. Philippe Delespaul

Flexible Assertive Community Treatment (FACT): OECD, Lithuania, 2023

'FACT in the Netherlands: why and how?' and 'FACT practices: detailed insights'

FACT teams in Iceland - introductions and discussions, Webinar, Iceland, 2023

'FACT in the Netherlands and lessons learned'

Meeting on F-ACT in The Netherlands, Ministry of Health/OECD, Webinar, Lithuania, 2022

'FACT in the Netherlands and lessons learned'

ROP-Dagen, National competence service for simultaneous substance abuse and mental illness, Oslo, Norway, 2022

'FACT as one of the essential components of a mental health ecosystem'

Multidisciplinary work in recovery-oriented mental health care, Webinar, Moldova, 2022

'Implications of the new model of care for social work'

Ontario Association for ACT and FACT, virtual conference, Canada, 2021
'FACTs 2017 – Fidelity'

5d European Congress on Assertive Outreach, Verona, Italy, 2019
'Coordination of Care Dialogue'

4d European Congress on Assertive Outreach, Hamburg, Germany, 2017
'Optimism About Recovery on American and Dutch assertive outreach teams: a non-experimental, cross-sectional design'
With Patrick Boyle, PhD, LISW-S, LICDC-CS

EuComs, Belfast, Northern-Ireland, 2017
'How to work with people who are hard to engage in the presence of needs of care'
With Prof. Dr. Niels Mulder

3d European Congress on Assertive Outreach, Oslo, Norway, 2015

'FACT: What works? Some essential mechanisms reviewed'
With Margret Overdijk, MBA and Dr. Remmers van Veldhuizen

2d European Congress on Assertive Outreach, Avilés, Spain, 2013
'IDDT – Practical Implications'

3d International Nursing Conference (keynote speaker), Surabaya, Indonesia, 2012
'IDDT'

2d International Nursing Conference (keynote speaker), Surabaya, Indonesia, 2011
'Assertive Community Treatment'

Dankwoord

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Met een rugzak vol ervaringen kon ik starten in het onderwijs. Verschillende directeuren, Nicole en Tina, gaven mij telkens de ruimte om mooie dingen met studenten, alumni, (ex-)cliënten en andere professionals te doen. De komst van Pim leidde een heel nieuw hoofdstuk in, waarin ik heb geleerd anders naar de werkelijkheid te kijken en te vertrouwen op de vragen die ik daarbij had. Samen hebben we vele vragen omgezet in onderzoeken en projecten. Hoe vaak hebben we wel niet gezegd dat het voor dit schooljaar wel even genoeg is? Om er dan toch nog iets bij te gaan doen.

Met wat meer zelfvertrouwen durfde ik te solliciteren als auditor bij Margret en Remmers van het CCAF en werd wonderlijk genoeg aangenomen als aspirant-bestuurslid. Na drie

maanden waarin ik slecht uit de verf kwam in het bestuur (starstruck!), kreeg ik van Remmers te horen dat ik nu snel mezelf moest gaan worden, anders hield mijn tijd op. Vanaf dat moment lijkt het alsof alle gesprekken in het teken hebben gestaan van de inhoud van deze promotie. Margret, dank voor de vele reflecties; een zelfhulpgroep voor 'schalenbouwers' was er bijna geweest. Margreet, af en toe op tijd naar bed na één biertje is inderdaad niet zo'n gek idee. Niels Mulder, Philippe, Hans, Remmers, Michiel Bähler, Tom, Martijn Kole, Rob Jaspers, Maaïke... de discussies, de emoties, altijd op de inhoud, wat een leerschool. Ik heb die kleine aanmoedigingen van je gehoord, Philippe, en schrok er iedere keer weer van. Het heeft als een grote eer gevoeld om samen met jou en Hans, met ondersteuning van Niels, Pim en Maaïke te hebben mogen stoeien, klooiën, leren en fouten te hebben mogen maken. Helaas leer ik door veel mijn hoofd te stoten door dingen te zeggen of te doen. Gelukkig zijn er mensen als Frits Bovenberg die je een podium bieden, Hans-Jan Bonsma, Gerrit Valk, Frank Valkenburg, Bert Thijssen, Annamarië Suijkerbuijk en Bram Berkvens die hun organisaties open stellen, René Keet en Sonja van Rooijen die altijd bereid zijn tot sparren, Jelle Moerman die altijd mee denkt en enthousiast is (dank Astore), Jeroen Kloet die zegt waar het op staat, Savannah Landers die onwijs kan werken, Giton Slieker die het coördineren van en lesgeven in de Minor Positieve Psychiatrie tot een feestje maakt, Ronald van Gool, Jasper van Marle en Bert-Jan Roosenschoon die de nachten in Aviles, Oslo, Hamburg en Verona lieten oplichten, Cathelijn Tjaden met een onwijze vriendelijkheid en interesse, Esther van der Kruijssen die me terecht wijst, Willeke Bosse die haar B&B beschikbaar stelde voor Patrick, Anne Rosenquist, Nadja Lauesen en Dorte Mark die zich in Denemarken zo gastvrij opstellen, Annika Lexén die dat doet in Zweden, Trond Hatling en collega's met Hanne Clausen en Niels Zandstra die daarin voorzien in Noorwegen, Jaap van Weeghel die altijd een positieve noot weet te kraken, Gonne-Marieke en Charlotte die sneller reageren dan het geluid en nogmaals Tom van Mierlo die als een rode draad door mijn carrière loopt. Je hebt me naar het ACT-team gehaald, ons eerste boek uitgereikt en me als senior-onderzoeker aangesteld van een eigen onderzoekslijn. Daarnaast mag ik ook nog heerlijk met je botsen in en om het CCAF. Er zijn nog vele anderen; studenten, alumni, docenten, onderzoekers, professionals uit de ggz en het sociaal domein, deelnemers aan de platformen FACT-jeugd, FACT-LVB en Forensisch-FACT, het bestuur van FACT-NL, medewerkers van het Trimbos Instituut, de medewerkers van Phrenos en Fameus en (ex-)cliënten, die ik niet heb genoemd. Iedere les, iedere presentatie, iedere training, iedere vergadering, ieder consult, ieder onderzoek, ieder werkbezoek, ieder artikel en ieder boek was een moment van inspiratie.

Ik heb echt leuke dingen mogen doen met leuke mensen.

De leden van de promotiecommissie: prof. dr. J. van Weeghel, prof. dr. M.M.N. Minkman, prof. dr. J.J. van Os, prof. dr. S. Castelein en dr. R. Keet dank ik voor het beoordelen van dit proefschrift en voor de mogelijkheid om deze ten overstaan van hen te verdedigen.

