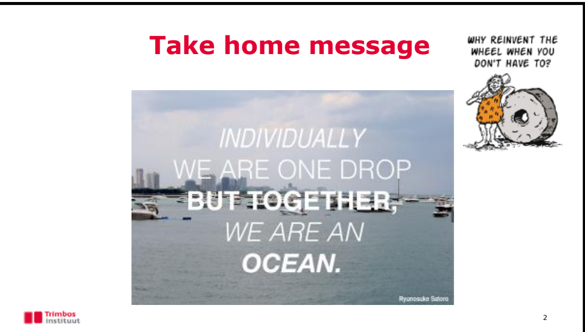


## Outline of today

- Flexible Assertive Community Treatment (FACT) in the Netherlands
  - Why FACT?
  - How FACT? *Flexible? FACT digi board?*
- Resourcegroups in FACT
  - Why RG in FACT? *What does it add? What are the similarities & differences?*
  - How RG in FACT? *First working experiences and national research*

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## Why Flexible Assertive Community Treatment (FACT)?

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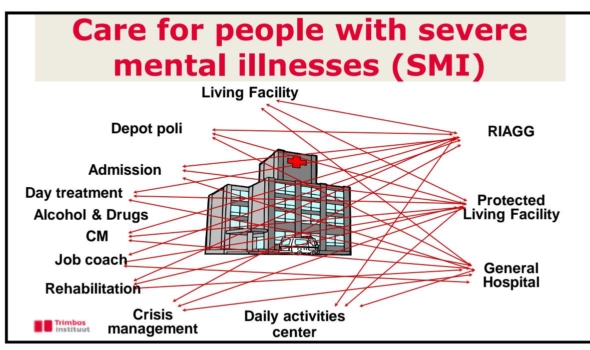


## Why FACT?

- Care for SMI fragmented: people moved around
- Lack of coördination
- Long admissions
- Drop out

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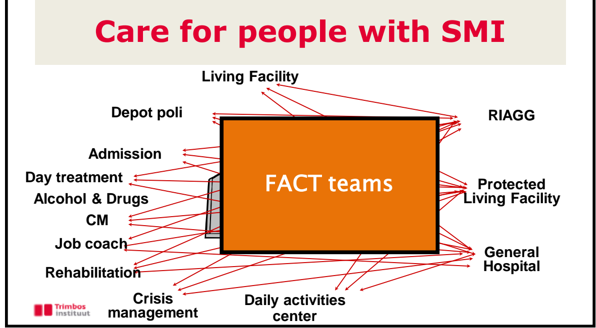


## Composition 'ideal' FACT team: 200 - 220 clients

- Team leader/manager 0,5 fte
- Psychiatrist 1 fte
- Case managers 7 fte
  - Psychiatric nurses 4-5 fte
  - Community psychiatric nurses 1-2 fte
  - Social worker 0,8 fte
- Peer support worker 0,6 fte
- Psychologist 0,8 fte
- Supported employment specialist (IPS) 0,5 fte

**Total** **10 -12 fte**

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## How FACT?

- Multidisciplinary team
- Catchment area = 50.000 inhabitants
- About 350 FACT teams in The Netherlands
- Collaboration with housing agencies, welfare, workplaces, primary care (GP/pharmacy)
- Two modes of operation within one team (flexible)



## FACT: two modes of operation

1. Low level
   - 80% of clients
   - Individual Case Management (ICM) by one team member (CM) and a shadow CM
   - Once every two/four weeks
   - Use of multidisciplinary interventions (peer-expert, IPS, psychologist)
   - Share knowledge/bottlenecks with team
2. High level

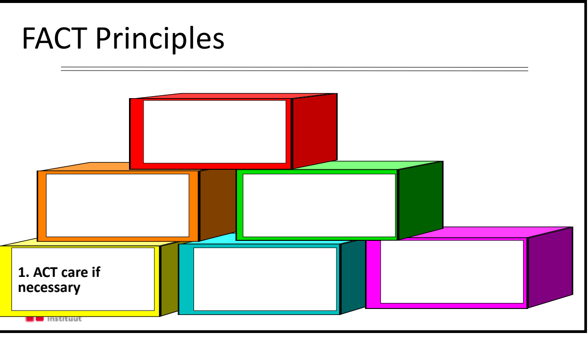


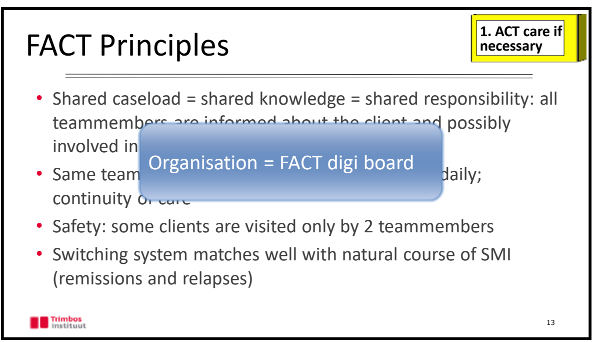
## FACT: two modes of operation

1. Low level
2. High level
   - 15 – 20% of users
   - Intensive ACT team care
   - Shared caseload
   - Daily team meetings & coordination



## FACT Principles




FACT Principles
1. ACT care if necessary
Shared caseload = shared knowledge = shared responsibility: all teammembers are informed about the client and possibly involved in
Same team daily; continuity of care
Organisation = FACT digi board
Safety: some clients are visited only by 2 teammembers
Switching system matches well with natural course of SMI (remissions and relapses)
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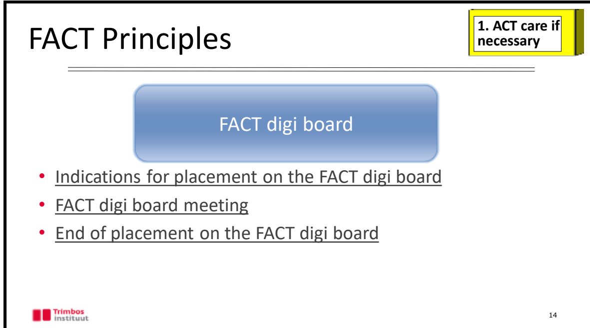
FACT Principles
1. ACT care if necessary
FACT digi board
Indications for placement on the FACT digi board
FACT digi board meeting
End of placement on the FACT digi board
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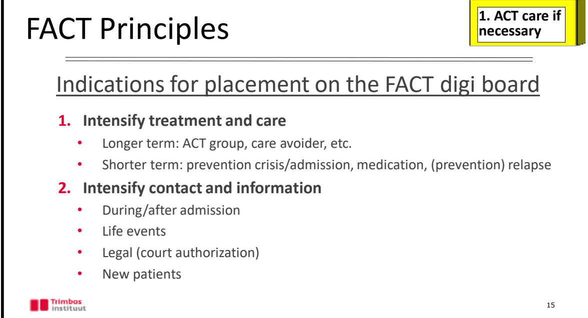
FACT Principles
1. ACT care if necessary
Indications for placement on the FACT digi board
1. Intensify treatment and care
Longer term: ACT group, care avoider, etc.
Shorter term: prevention crisis/admission, medication, (prevention) relapse
2. Intensify contact and information
During/after admission
Life events
Legal (court authorization)
New patients
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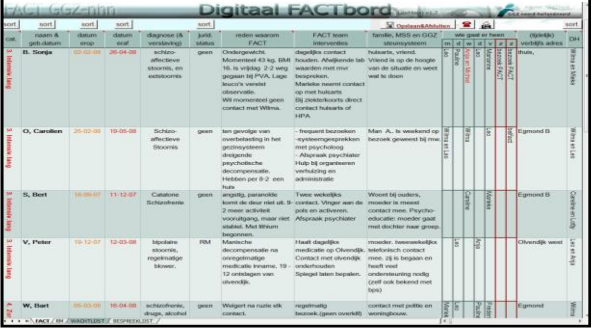
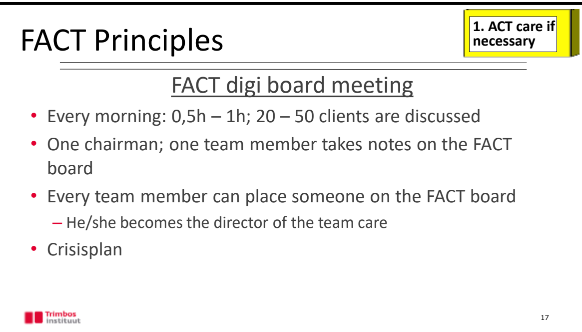

Digitaal FACTbord


FACT Principles
1. ACT care if necessary
FACT digi board meeting
Every morning: 0,5h – 1h; 20 – 50 clients are discussed
One chairman; one team member takes notes on the FACT board
Every team member can place someone on the FACT board
He/she becomes the director of the team care
Crisisplan
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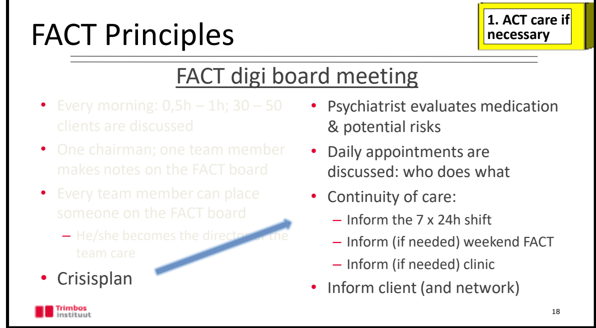
FACT Principles
1. ACT care if necessary
FACT digi board meeting
Every morning: 0,5h – 1h; 30 – 50 clients are discussed
One chairman; one team member makes notes on the FACT board
Every team member can place someone on the FACT board
He/she becomes the director of the team care
Crisisplan
Psychiatrist evaluates medication & potential risks
Daily appointments are discussed: who does what
Continuity of care:
Inform the 7 x 24h shift
Inform (if needed) weekend FACT
Inform (if needed) clinic
Inform client (and network)
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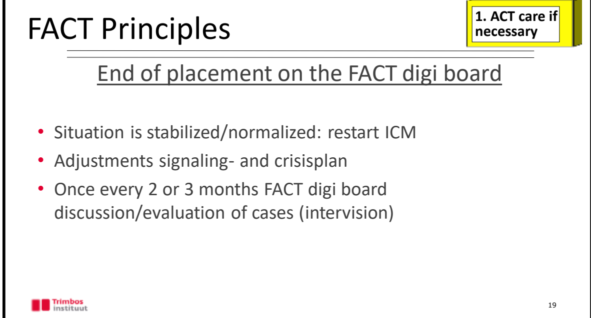
FACT Principles
1. ACT care if necessary
End of placement on the FACT digi board
Situation is stabilized/normalized: restart ICM
Adjustments signaling- and crisisplan
Once every 2 or 3 months FACT digi board discussion/evaluation of cases (intervision)
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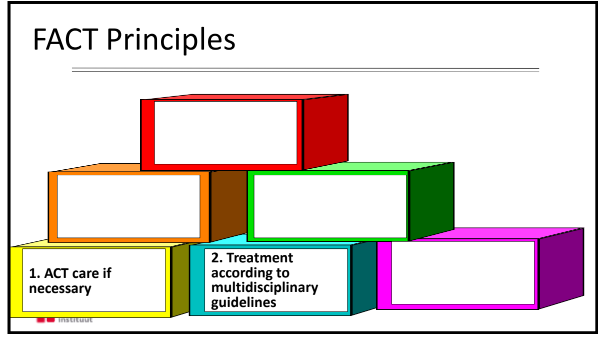
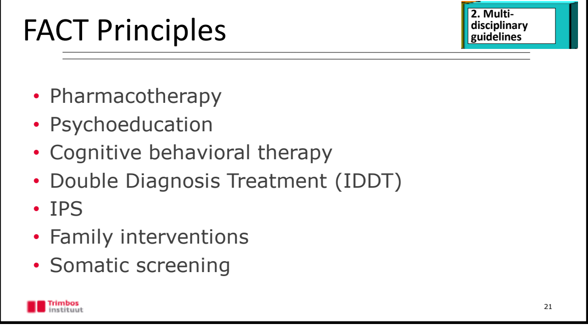

FACT Principles
1. ACT care if necessary
2. Treatment according to multidisciplinary guidelines


FACT Principles
2. Multi-disciplinary guidelines
Pharmacotherapy
Psychoeducation
Cognitive behavioral therapy
Double Diagnosis Treatment (IDDT)
IPS
Family interventions
Somatic screening
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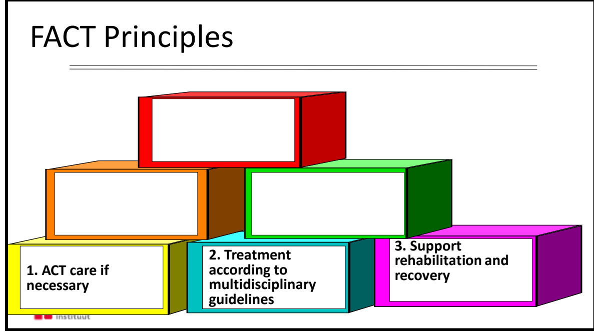
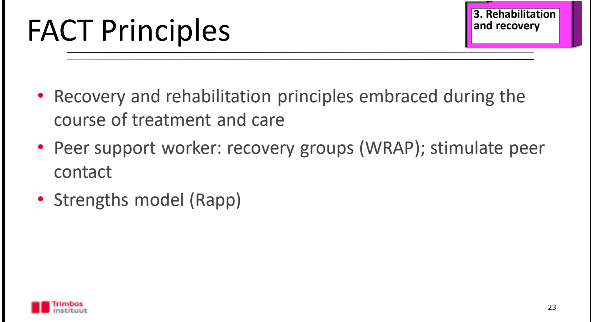

FACT Principles
1. ACT care if necessary
2. Treatment according to multidisciplinary guidelines
3. Support rehabilitation and recovery


FACT Principles
3. Rehabilitation and recovery
Recovery and rehabilitation principles embraced during the course of treatment and care
Peer support worker: recovery groups (WRAP); stimulate peer contact
Strengths model (Rapp)
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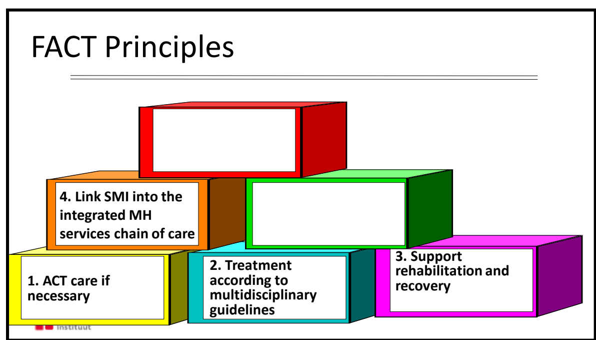
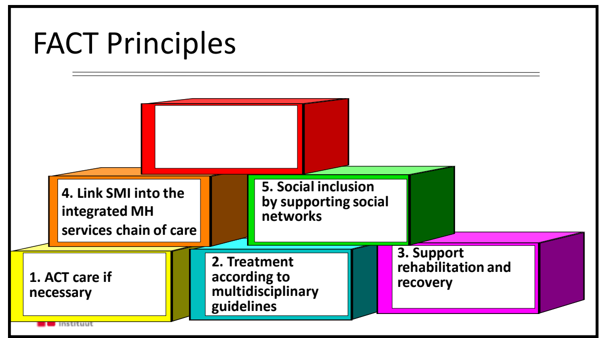
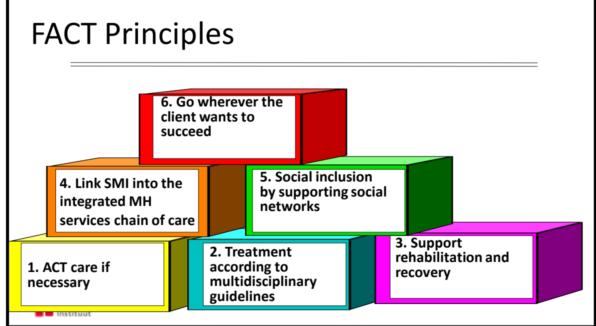

FACT Principles
4. Link SMI into the integrated MH services chain of care
1. ACT care if necessary
2. Treatment according to multidisciplinary guidelines
3. Support rehabilitation and recovery




## But….

- FACT more temporary ("first line" mental health, social domain)
- Wish: more personal and social recovery
- Wish: small-scaled, more in community, collaboration social domain
- Wish: equality in relation, agency of the client, strength, peer expert knowledge
- Wish: more social inclusion, together with significant others

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## Outline of today

- Flexible Assertive Community Treatment (FACT) in the Netherlands
  - ✓ Why FACT?
  - ✓ How FACT? *Flexible model; six building blocks*
- Resourcegroups in FACT
  - RG method in the Netherlands
  - Why RG in FACT? *What does it add? What are the differences?*
  - How RG in FACT? *Research and first working experiences*

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## Resourcegroups in the Netherlands

**What are the essential components?**

**1.** Client is the director

- » Nomination RG members? Goals in the RG plan? Chair? Place? Frequency of the meetings?
- » Development sense of agency and empowerment



## Resourcegroups in the Netherlands

**What are the essential components?**

**2.** Structurally involvement and activation of the social environment (but client decides who)



## Resourcegroups in the Netherlands

**What are the essential components?**

**3.** Continuity of care

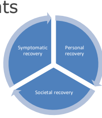
*A person or group standing next to you, not leaving you alone with your illness, at all times*

Quote Nisse, 2017



## RG and FACT: similarities

- Developed from the same principles
  - Multidisciplinary teams
  - Recovery and rehabilitation central components
  - Symptomatic, social and personal recovery
  - Personalize care
  - Social environment



## RG and FACT: differences

1. Treatment plan
2. Social network
3. Continuity of care



## Treatment plan

| FACT | FACT + RG |
|---|---|
| • A new patient is discussed during the FACT board meetings; within three weeks there is a multidisciplinary meeting to develop the treatment plan | • A new patient is discussed during the FACT board meetings and the first action is to encourage a client to think about and write down his goals + who to involve (RG-plan) |
| • The team decide actions based on the treatment plan and their expertise | • The developed RG plan is discussed with the FACT team, expertise is used to develop actions that fit the RG-plan |
| • Treatment plan is discussed at least a year by the multidisciplinary team (treatment plan meeting) | • Treatment plan is discussed every three months with client, RG and CM; psychiatrist is present at least once a year |



## Treatment plan

| FACT | FACT + RG |
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| • The team decide actions based on the treatment plan and expertise of the team members | • The developed RG plan is discussed with the RG, expertise is used to develop actions that fit the RG-plan |
| • Treatment plan is discussed at least a year by the multidisciplinary team (treatment plan meeting) | • Treatment plan is discussed every three months with client, RG and CM; psychiatrist is present at least once a year |



## Treatment plan

| FACT | FACT + RG |
|---|---|
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| • The team decide actions based on the treatment plan and their expertise | • The developed RG plan is discussed with the RG, expertise is used to develop actions that fit the RG-plan |
| • Treatment plan is discussed at least a year by the multidisciplinary team (treatment plan meeting) | • Treatment plan is discussed every three months with client, RG and CM; psychiatrist is present at least once a year |

## Treatment plan

**FACT**

- A new patient is discussed during the FACT board meetings; within three weeks there is a multidisciplinary meeting to develop the treatment plan
- The team decide actions based on the treatment plan and their expertise
- Treatment plan contains SMART formulated goals

**FACT + RG**

- A new patient is discussed during the FACT board meetings and the first action is to encourage a client to think about and write down his goals + who to involve (RG-plan)
- The developed RG plan is discussed with the FACT team, expertise is used to develop actions that fit the RG-plan
- RG-plan contains two long term and two short term goals (SMART)

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## Treatment plan

**FACT**

- A new patient is discussed during the FACT board meetings; within three weeks ther… mee… trea…
- The … ased on t… d their expertise
- Treatment plan contains SMART formulated goals

Client's own agency, strengths and dreams are embraced **during** care and treatment

**FACT + RG**

- A new patient is discussed during the FACT board meetings and the first action is to en… ink abou… goals + wh… )
- The … discu… am, expertise is used to develop actions that fit the RG-plan
- RG-plan contains two long term and two short term goals

Client's own agency, strengths and dreams are the starting points for **setting up** care and treatment

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## Family and social network

**FACT**

- Family and social network is involved on indication
- Family and social network are (on indication) informed about treatment and treatment goals
- Caregiver and family roles
- Contact can be developed during course of treatment

**FACT + RG**

- Family and social network is always involved (client decides who)
  - Emotional climate around a client
- Family and social network form collaboration partners in treatment and treatment goals
  - Recovery happens within society
- Working as a team, every member is an expert (equal ≠ same)
- Within three months there is an interview to get to know each other

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## Family and social network

**FACT**

- Family and social network is involved on indication
- Family and social network are (sometimes) informed about treatment and treatment goals
- Caregiver and family roles
- Contact can be developed during course of treatment

**FACT + RG**

- Family and social network is always involved (client decides who)
  - Emotional climate around a client
- Family and social network form collaboration partners in treatment and treatment goals
  - Recovery happens within society
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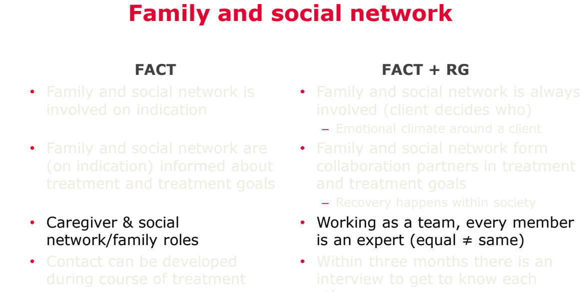
Family and social network
FACT
Family and social network is involved on indication
Family and social network are (on indication) informed about treatment and treatment goals
Caregiver & social network/family roles
Contact can be developed during course of treatment
FACT + RG
Family and social network is always involved (client decides who)
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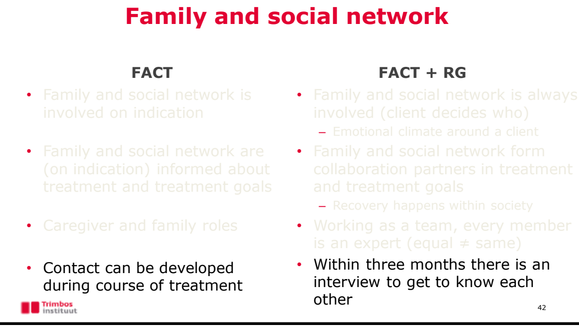
Family and social network
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Recovery happens within society
Working as a team, every member is an expert (equal ≠ same)
Within three months there is an interview to get to know each other
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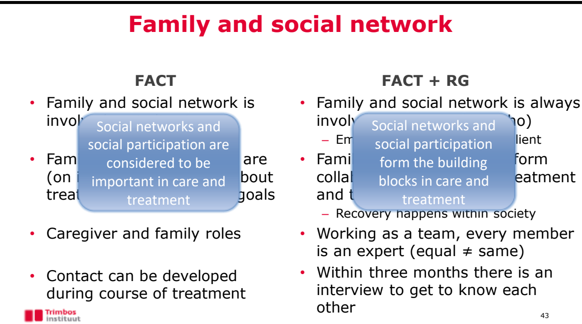
Family and social network
FACT
Social networks and social participation are considered to be important in care and treatment
Caregiver and family roles
Contact can be developed during course of treatment
FACT + RG
Family and social network is always
Social networks and social participation form the building blocks in care and treatment
Recovery happens within society
Working as a team, every member is an expert (equal ≠ same)
Within three months there is an interview to get to know each other
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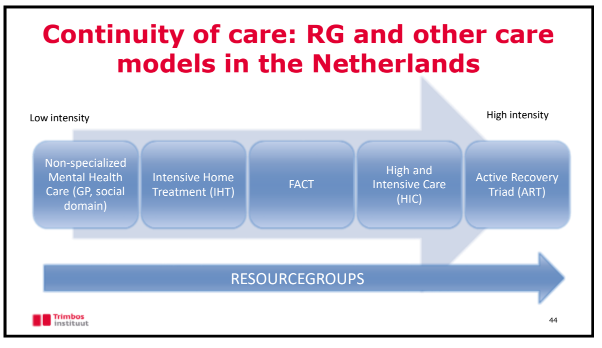
Continuity of care: RG and other care models in the Netherlands
Low intensity
High intensity
Non-specialized Mental Health Care (GP, social domain)
Intensive Home Treatment (IHT)
FACT
High and Intensive Care (HIC)
Active Recovery Triad (ART)
RESOURCEGROUPS
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## Main Research Questions

- Do Resource Groups have an **added value** to FACT-care as usual?
- What are **essential elements** of the method in Dutch mental health care?
- What is the **meaning** of participating in a Resource Group for a client, casemanager and his/her RG?

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## Implementation

- Board with managers, family/peer experts, researchers and practitioners
- National training (± 65 caregivers)
- Yearly booster sessions
- 6-8 weekly peer to peer coaching sessions (intervision)
- Regular visits of research teams
- Resourcegroups Model Evaluation Tool (R-MET)

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## R-MET: two parts

1. **Questionnaire after every RG meeting**
   - CM + client fill in together during evaluation
   - Questions on the size, composition, frequency, ownership, interviews (with or without client), etc.

2. **Yearly questionnaire**
   - RG, client and CM fill in at the start of a RG meeting + discuss it with each other
   - Questions on the emotional climate of the group, responsibility, feeling of belonging, ownership (client)

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## R-MET: goals

- To see how the described aspects of the RG method are evolving in practice
- To disentangle essential components of the RG method
- To monitor individual cases
- To promote uniformity in implementation

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## Effectiveness study

**Quantitative: randomised controlled trial (RCT)**
- Efficacy of the RG :
  - Clienteffects (empowerment, quality of life, social support)
  - Satisfaction client
  - Well-being network
  - Costeffectiveness

**Qualitative: case study**
- In-depth information on the functioning and meaning of the RG method for clients and group members: cooperation processes, personal perspectives, procedure for successes / setbacks, personal recovery process, etc.

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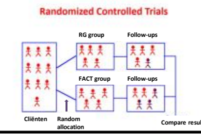
# Design: randomisation (individual level) in 2 conditions

- **Condition 1 = FACT + RG.** In addition to usual FACT care, the client is guided to start his/her RG, to formulate his own treatment goals and to invite significant others, service and care providers for the RG meetings;
- **Condition 2 = FACT.** Collaboration with family and other services, setting up treatment goals as usual in FACT
- Three measurement moments: baseline, 9 and 18 months

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# Effectiveness study

**Quantitative: randomised controlled trial (RCT)**
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**Qualitative: case study**
- In-depth information on the functioning and meaning of the RG method for clients and group members: cooperation processes, personal perspectives, procedure for successes / setbacks, personal recovery process, etc.

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# Qualitative case study

- Selection 6 to 8 clients + their resourcegroups
- Interviews: client, 2 significant others, CM, main practicioner, management
- Observation: participation RG-meetings

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# Qualitative case study: focus points

- **Dynamics**
  - How do decision making processes take place?
  - How are recovery goals and needs defined?
  - How do collaboration processes unfold within the RG?
  - How do mutual relationships and expressed emotions unravel during the RG-meetings?

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## Qualitative case study: focus points

- **Dynamics**
- **Meaning**
  - How can the RG method influence client's personal processes of recovery?
  - How can the RG method influence the resilience of the social network?
  - Wat are helpful and non-helpful aspects of the used protocol?

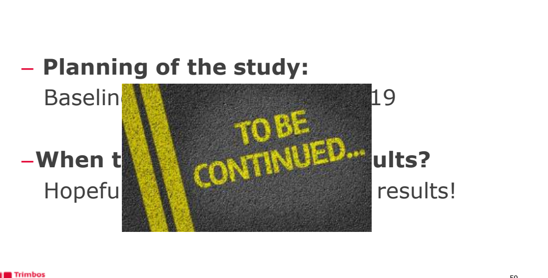


## Qualitative case study: focus points

- **Dynamics**
- **Meaning**
- **Implementation**
  - Which factors (facilitators/barriers) influence successful implementation and sustainable continuation of the RG method?
  - Are there conditional aspects that determine successful implementation of the RG method?



- **Planning of the study:**
  Baselin … 19
- **When t … ults?**
  Hopefu … results!






## What do you think?

What are the main similarities and differences between the RG- method and FACT?

## Outcomes: interviews/self-report

- **Primary outcome :**
  - Empowerment: NEL
- **Secondary outcome:**
  - Quality of life: MANSA
  - Personal recovery/needs: I.ROC
  - Global functioning: WHODAS 2.0, GAF, SOFAS
  - Clinical symptoms: BSI-18
  - Social contacts: frequency and quality
  - Attachment: RAAS
  - Use of care and costs: TiC-P, EQ-5D-5L
  - Consumer satisfaction
- **Questionnaire for significant others**
  - Wellbeing significant others: BES
  - Evaluation aspects of the RG
  - Satisfaction of care

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