A brief history of the development of our community mental health service 2003-2019

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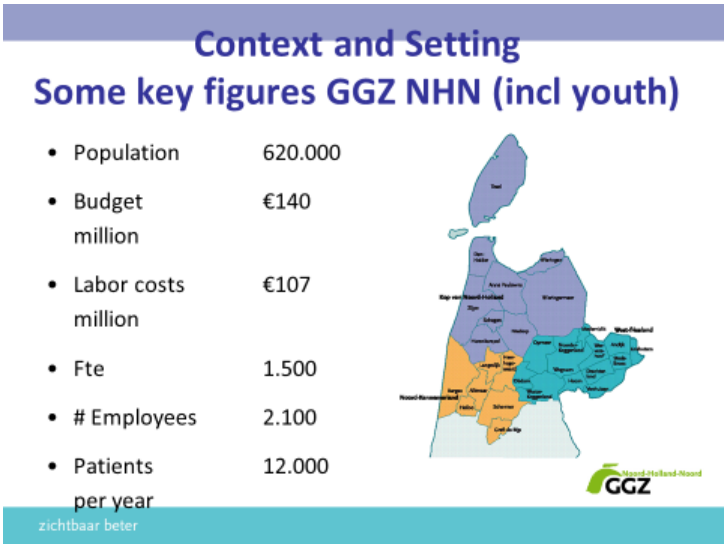
Content

1 Key figures

The Netherlands is a country in West Europe, and borders with Germany in the east and Belgium in the South:

GGZ Noord-Holland-Noord is the main provider of mental health care in an area in the North Western part of the country.

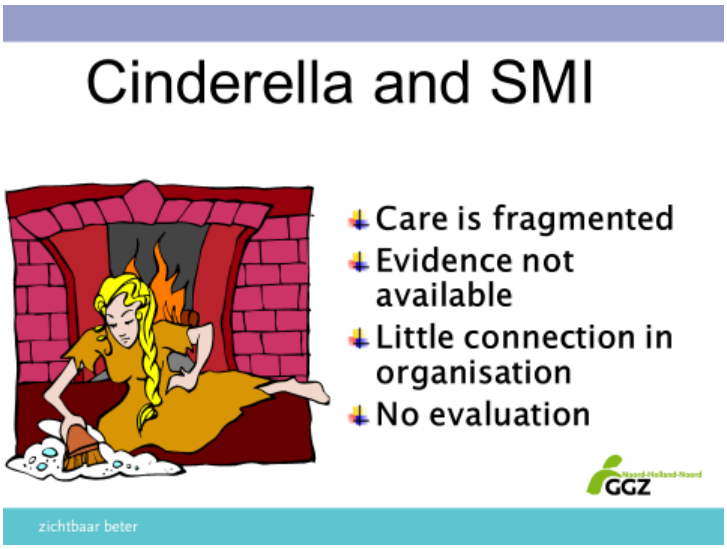


The catchment area is both rural and urban:

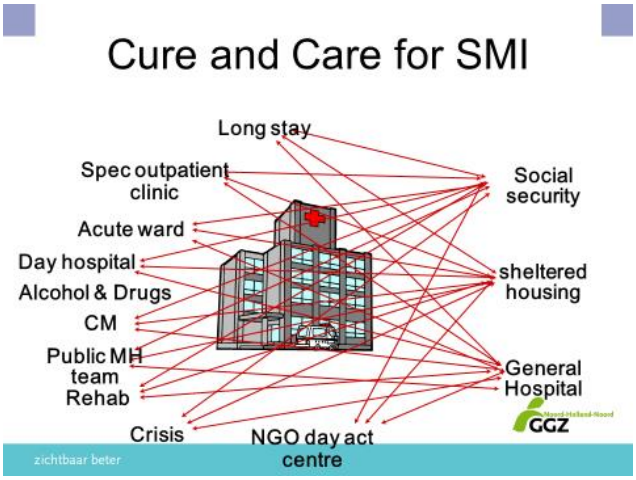
2 From Cinderella care to Flexible Assertive Community Model

In 2003 the Flexible Assertive Community model was designed and developed here. It combines the principles of Assertive Community Treatment and the casemanagement model. Inspiration for the model came from the USA, The UK, Italy and Australia. It was described by Remmers van Veldhuizen and developed by Michiel Bahler and Diana Polhuis. When we introduced it to a new area in our region we did implementation research (Nugter). Research on the model has also been done in an area in the south of The Netherlands and in London.

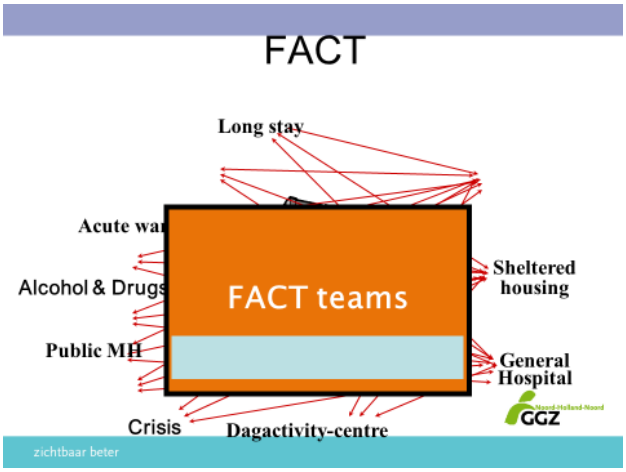
The model was a flexible ambulatory response to the needs of persons with severe mental illness. In the past this group was either institutionalized, neglected, or both. This situation we described as Cinderella care:



Cinderella care in a high income country is often highly fragmented, with many stakeholders involved, little coordination and a central place for the hospital. This is described in this Figure:



Flexible ACT was a first step to a more integrated care system:



3.The F-ACT model as a basis for community mental health care

1. F-ACT in The Netherlands

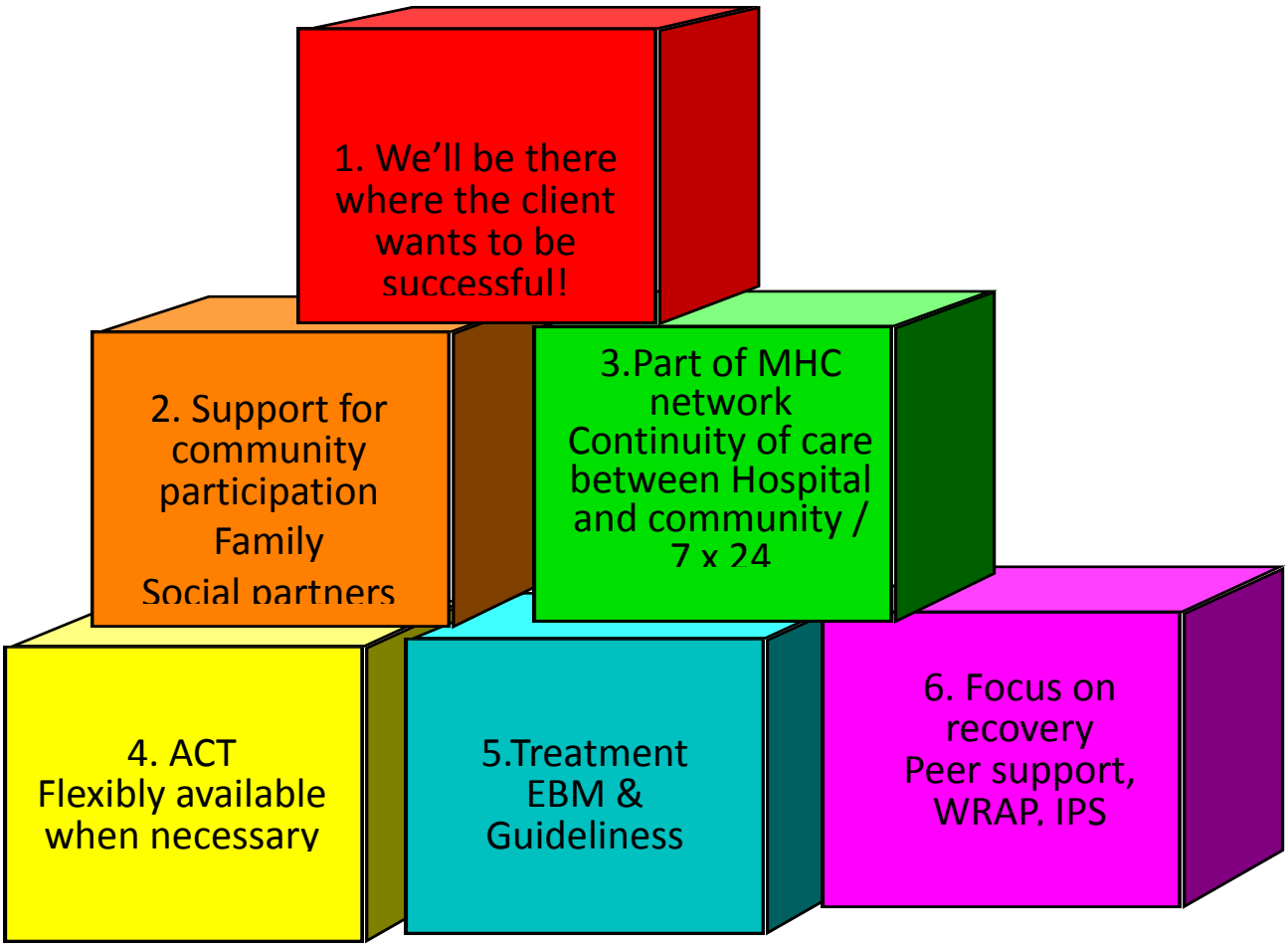
Flexible Assertive Community Treatment (F-ACT) is a service structure model that integrates medical and social interventions within one team. F-ACT was developed in the Netherlands to provide community mental health care for persons with a severe mental illness (SMI). Persons with SMI have in addition to psychiatric problems many limitations in their social functioning, for instance in relation to housing, self-care, employment and finances. Strengths in persons with severe mental illness are often overlooked and treatment is frequently limited to the symptoms of the psychiatric disorder. Care is usually organized for and not with the patients.

F-ACT is based upon a broad biopsychosocial model, providing (a) management of illness and symptoms (treatment), (b) guidance and practical assistance with daily living, (c) rehabilitation and (d) recovery support. One integrated team provides all of this. F-ACT also aims to ensure continuity of care, to prevent admissions to psychiatric hospitals and to stimulate inclusion, so that clients can participate in society.

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

The most salient feature of the F-ACT model is the flexible switching system. The group requiring the most intensive care is discussed daily and for this group the team adopts a shared caseload approach. The names of these clients are listed on the digital FACT board. For the clients requiring less intensive care, the same team provides individual case management with multidisciplinary treatment and support. When clients become more stable, they do not have to be transferred (as in ACT, through 'graduation') to a different team; they stay with the same FACT team. This flexibility to switch between the two modes of service delivery in the same team enhances continuity of care and reduces drop-out.

Another important feature of the F-ACT model is that it integrates community and hospital care. Admission to a hospital is introduced by a care coordination meeting and admission to the ward is always accompanied by an admission to the digital FACT board, to ensure continuity of care. This Figure depicts the principles of F-ACT:



2. F-ACT in other contexts

The flexible nature of the F-ACT model has shown to be an inspiration for services that go from a risk-focused practice to recovery-oriented personalized care. The F-ACT model has supported the development of community mental health in other contexts, including West European High Income Countries (HIC) like the UK (Firn) , Sweden and Denmark, but also in Hong Kong (Chui).

The strength of the FACT model is that it is flexible by nature and therefore can be adapted to different contexts. The different contexts and availability of resources necessarily result in quantitative deviations from the Dutch F-ACT model, not from the key concepts, which are: two levels of care, daily meetings, recovery-oriented care, working in a well defined region, integrated community and hospital care, evidence-based medicine and best practices and making a comprehensive care plan.

-two levels of care
The two levels of care help in responding to the fluctuating needs of patients with severe mental illnesses that run a chronic and relapsing course.

-daily meeting
A daily handover meeting with the use of a digital board through which every staff member can access the clinical information and track the progress enable ambulatory treatment of patients with high needs of care. It strengthens the cohesion within a team, a whole team approach, a shared vision and interdisciplinary collaboration.

-recovery-oriented care
In recovery oriented care, care is organized in cocreation with the patients. In F-ACT teams, rehabilitation is integrated into treatment and peer workers are one of the key disciplines. Interventions are focused on the empowerment of clients In addition care workers mobilize support from the environment . It is better to put clients in the desired environment as quickly as possible rather than preparing them for a long time, step by step. This is the principle of both Housing First and Individual Placement support (IPS) .

-working in a well defined region
The key feature of recovery oriented care is the presence in the client's 'real' environment and this is strengthened by working in a well defined district, that enables collaboration with the social stakeholders and general practitioners. The caseload in FACT is not as extreme low as in the conventional Assertve community Treatment model (ACT) and therefore more feasible for countries with les resources. The exact caseload and size of the region will depend on the available resources The ratio in the Netherlands is 1: 25 , yet 1:50 in Hong Kong. (ask William size of catchment area in Hong Kong)

-evidence-based medicine and best practices
In addition to the core skills of delivering intensive case management to patients with SMI in the community,case managers in F-ACT teams are also be equipped with expertise in a number of evidence-based interventions that meet the recovery needs of patients. This would include interventions such as medication management, motivational interviewing, cognitive behavior therapy for psychotic symptoms, and family intervention. Expertise in dual diagnosis and vocational rehabilitation service is particularly important in a multidisciplinary community team for patients with SMI. Specified substance abuse workers should be available in the team, providing both direct patient care and coaching to other case managers.

-comprehensive care plan
Care provided by an interdisciplinary community mental health team in collaboration with social stakeholders and general practitioners enable the presence of a shared integrated and comprehensive treatment plan.

4 Model fidelity and Certification

The F-ACT models spread all over the Netherlands. A fidelity model was created as well as a centre for the certification of ACT and FACT teams. This was a bottom up movement. By now there are over 300 certified teams (https://ccaf.nl/):

5. Developments 2010-2016 in ambulatory and hospital care

In the years 2010-2016, 3 other developments took place in our mental health service.

1 Teams were developed with the focus on specific diagnosis-classification groups: Teams on depression, anxiety, bipolar disorder, early psychosis, autism and others. The rationale was that this development was helpful to organize the practice as described in the guidelines, that were organized in the same way. This development was successful for the practice of evidence based psychiatry

2. The reform of the mental hospitals and long stay wards. In the early years of the development of the FACT model , the hospitals remained more or less the same. This reform took place later, following two models that we helped to develop and also became a national standard: High Intensive Care (HIC) for the psychiatric hospital and Assertive Recovery Triad (ART) for long stay care wards.

The model of HIC includes a close collaboration with the community mental health teams as well as replacing the seclusion rooms by comfortable safe rooms in which the nurses stays with the patient.

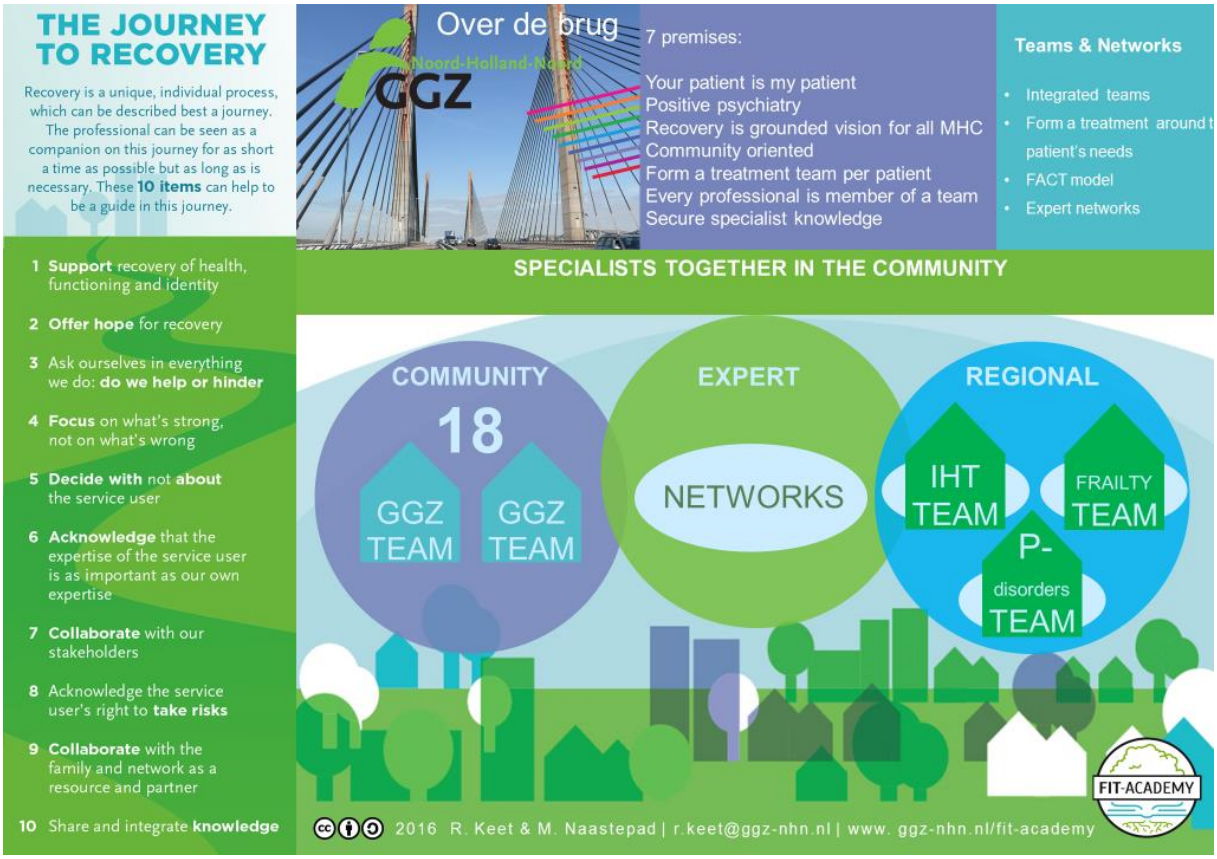
3 Strengthening of mental health care in primary care

In a nationwide reorganization budgets of mental health were reallocated to strengthen the role of primary care: first by training assistants (nurses, social workers or psychologists) to support general practioners in their practice. Secondly by organizing a basis mental health care for treatment according to the guidelines in non-complicated cases

6 Integration of FACT and diagnosis specific teams

In 2015 we made an analysis of the two models of ambulatory care that were created: FACT and diagnosis specific teams. The conclusion was that these approaches were markedly different, but that there was a great overlap in the patient population. Both had specific complementary strengths and weaknesses. We then decided to integrate the 2 models. Thus we could create integrated community mental health teams with catchment areas of 30.000 to 35000 inhabitants. These teams are organized according to the FACT model. The recovery model is the grounded vison of all care in our service. We described 10 principles of recovery supporting care. The focus on recovery was also visible in the creation of 4 consumer run recovery colleges. These colleges are run by our 30 peer experts.

Expertise organized in expert networks. Therefore, each professional is now member of a team and member of an expert network. This is a pictogram of our new model of care:



We created a model fidelity scale for this new model and all teams will be audited yearly to create a plan do study act (PDSA) cycle in the implementation of our new model of care. The baseline has already been measured.

7 International contacts

The FACT model was developed with inspiration from various countries. We continue our tradition with learning from each other in an international context. This is visible in our active participation in the European Community mental health Service providers network (www.EUCOMS.net). It is a network of practice, based upon a shared vision on community mental health. This vision is described in the consensus document that you can download from our website. https://assets-sites.trimbos.nl/docs/3297941c-f835-4f16-9b45-c4f1e02cf154.pdf

The 6 principles are described in 15 minutes in https://vimeo.com/256413380

PERSPECTIVES		ACHIEVED? HOPE? RISK?
ETHICS		Little: limited life expectancy/ competitive jobs/ participation community life
PUBLIC HEALTH		Little, Insufficient focus, underestimation of importance
RECOVERY		Hope: Paradigm shift. Risk: recovery as window dressing
EFFECTIVENESS		Hope: Paradigm shift. Risk: divide camps between effectiveness and recovery.
NETWORK		Hope: Many models for integrated organisation mental health care. Risk: little connection beyond mental health care
PEER EXPERTISE		Hope: Third domain of expertise. Risk: few peer experts, few other open professionals

EUCOMS has participating services in 17 European countries and in addition services in Hong Kong and Japan: