Flexible Assertive Community Treatment (FACT)

Dutch model for recovery oriented cure & care for people with severe mental illness

Dan Cohen

Consensus Development Conference
Edmonton 2014

Statement of Potential Conflicts of Interest

Flexible Assertive Community Treatment (FACT)

Dutch model for recovery oriented cure & care
for people with severe mental illness

Relating to this presentation, there are no relationships that could be perceived as potential conflict of interests:

Dan Cohen

Noord-Holland-Noord GGZ

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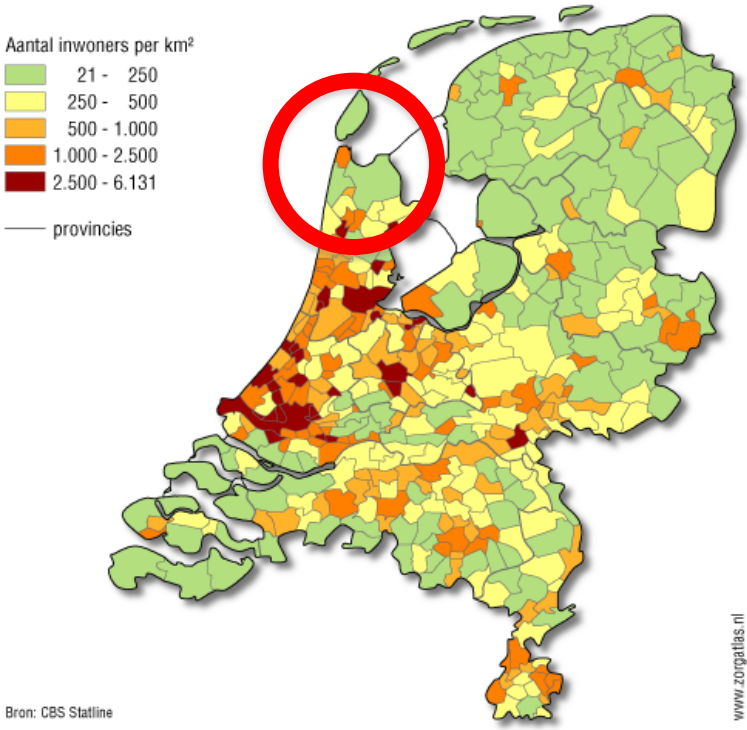
FACT: A Dutch Version of ACT

J. Remmers van Veldhuizen, Psychiatrist

Noord-Holland-Noord GGZ



Community Mental Health Journal, Vol. 43, No. 4, August 2007 (© 2007)
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Should We Adopt the Dutch Version of ACT? Commentary on "FACT: A Dutch Version of ACT"

Gary R. Bond, Ph.D.
Robert E. Drake, M.D., Ph.D.

(FACT). Controversy is healthy in science, and serious alternative viewpoints to referred wisdom should be welcomed. FACT provides a well-articulated model, bolstered by preliminary experiences suggesting that it is not only feasible but also well received by clinicians.

What is ACT?

For the 20 % most severe SMI

10 FTE per 100 patients

Essentials:

1. assertive outreach
2. shared caseload
3. multidisciplinary approach

FACT: a Dutch version of ACT

- For all patients with severe mental illness
- Instead of ACT and step down teams, different levels of care are provided by 1 FACT team
- Increasing continuity of care
- Flexible response: up- and downscaling
- Regional teams » social inclusion
- ‘Transmural’: linking hospital & community care

FACT: a Dutch version of ACT

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- Instead of ACT and step down teams, different levels of care are provided by 1 FACT team
- *Increasing continuity of care*
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Continuity of care

Treatment by the FACT-treatment is life-long, unless the patient:

- ➢ has been cured. For instance:
- addiction has come under control and drug-induced psychosis has disappeared
- first-episode schizophrenia with favourable outcome
- ➢ moves from out of the catchment area of one team (into the area of another (FACT-)team)
- ➢ dies. Unfortunately no rare event with 20 years reduced life expectancy in this population

Continuity of care

- is referred back to the GP. Criteria:
- psychiatric stability for 2 years.
- no changes in psychiatric medication
- Does not use lithium or clozapine (currently under discussion)

Continuity of care and drop-out

Continuity of care suggests low drop-out rates.

Indeed, drop-out rates are below 5%, with all reasons mentioned above included.

Continuity of care: obligations

Well-functioning contacts with

- the patient
- family, friends, relations and/or other important persons
- neighbours

Example: mr. T.

Relevant Institutions:

- Police
- GP
- Housing companies
- Social service
- Local government

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Flexible response: up- and downscaling

Example:

- a patient with a first episode psychosis had been stable and well-functioning for over 5 months: she rarely needed our service.
- On an afternoon she phoned for a recipee she needed the same afternoon.
- Arguments pro- and contra.

Flexible response: up- and downscaling

Actions on the same afternoon:

- a home visit by a case manager
- prescription of the asked for recipee

Flexible response: up- and downscaling

Results:

Short term:

- prevention of a probable escalation
- a possible hospitalisation

Longer term

- reassurance of the patient that we are there when needed
- boosting of confidence to explore on their unused potentials.

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Regional teams » social inclusion

- A regional team with a certain catchment area goes with a *responsibility*, to know of all and to look after SMI-patients in your region
- Good contacts are required with GP and non-medical institutions that might detect/suspect SMI:

- police
- housing companies
- social services

Rich Multidisciplinary team

+/- 10 FTE for +/- 180 clients:

- 0,8 -1 FTE psychiatrist
- 0,5 FTE Team coordinator
- 7 FTE Community nurse

  of whom 2 have addiction expertise
- 0,8 FTE psychologist
- 0,6 FTE peer specialist
- 0,5 FTE IPS

Sailing the 7 C's

Combining:

- Cure (EBM, medication, CBT)
- Care (nursing, rehab)
- Crisis (Admission prevention /shorter)
- Client know how (Peersupport)
- Community (Family, Work, Housing)
- Control (legal / forensic/ safety)
- Check (Outcome Monitoring)

Effectivity of (F)ACT: the evidence

- American studies: ACT reduces hospitalisation days
- European studies do not confirm these findings (Burns et al., 2007)
- European studies: in early psychosis patients positive effects on clinical symptoms and functioning until five years follow-up (ACT+; Nordentoft et al., 2007; OPUS Studies)

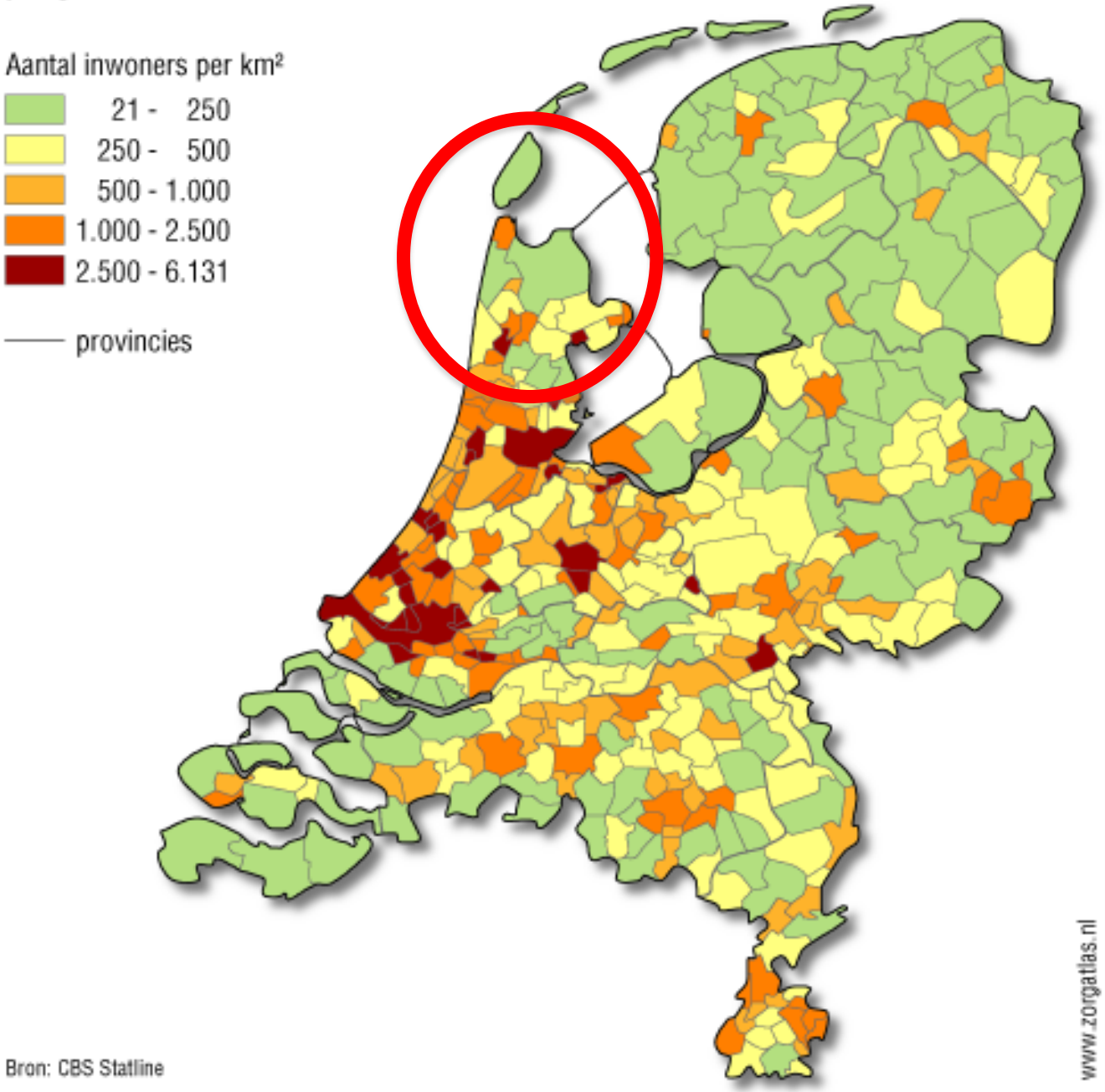
Dutch Studies on FACT

- Higher % remission after start of FACT
- FACT region (mental health organisation NHN): less use of beds and shorter admissions over time
- Regions with FACT not more mental health care costs compared to regions without FACT

- Bak et al., 2008
- Report Ernst & Young
- Report Insurance Companies

Bevolkingsdichtheid 2012

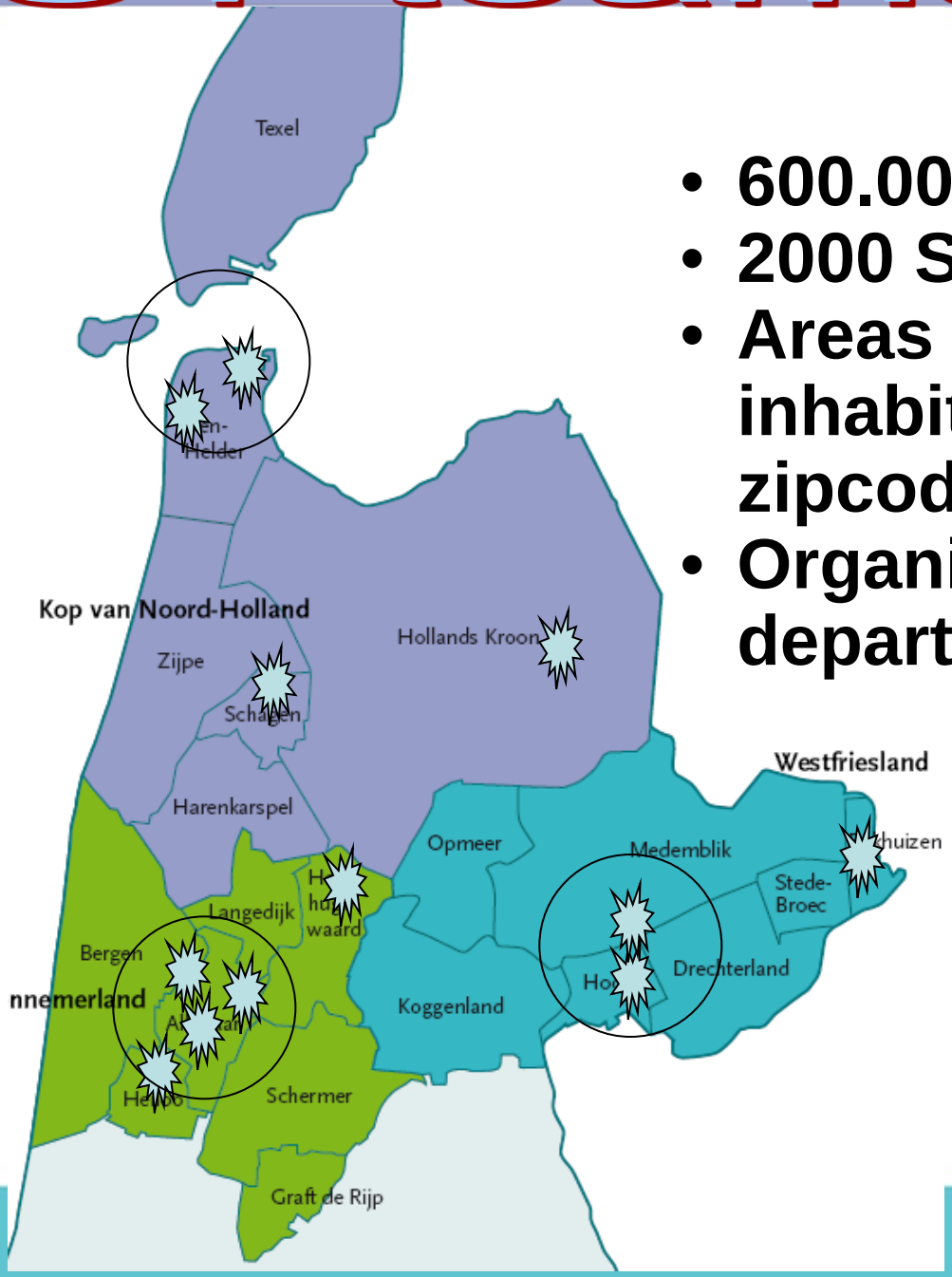
per gemeente



Bron: CBS Statline

www.zorgatlas.nl

FACT teams



- **600.000 inhabitants**
- **2000 SMI in FACT**
- **Areas of 50.000 inhabitants: district, zipcode, area**
- **Organized within 1 department: CMHS**

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Service delivery model : EBP

- Diagnosis and medication
- Somatic screening
- Psycho-education
- Psychotherapeutic interventions (a.o. CBT)
- Support of family and network
- Individual Placement and Support (IPS)
- Peer support
- Addiction: Integrated Dual Diagnosis Treatment (IDDT) and motivational interviewing

Digital FACTbord v2.0 LdeMooij

26:04 Set | aantal regels 1 2 alles | huidige rij bovenaan | huidige cliënt 1 van 15 | namen anoniem | jaar overzicht aan | snel naar: | BackUp & Afsluiten

cat	personal identification data	start & evalution date	diagnose & abuse	juridical state	reason for FACT	patient current goals & wishes	FACT team interventions	individual social network	visit planner m	t	w	t	f	s	s	(temporary) adres	DK
1. Crisisvoork. /Toename	**Adriaanse, L. Lia 19-04-75 (Mrs.)**	fr 19-02-10 evaluation: fr 02-04-10	schizophrenic psychosis and alcohol abuse	none	Patient thinks neighbours are after her. Complains frorn neighbours about hindrance. Housing company threaten to give notice. Patient deals with her fear by drinking more alcohol, she refuses medication. Husband left with kids.	Wants to move to another home with her husband and kids.	Daily contact. Subject: - the pro's and cons of drinking. - medication. Talk with neighbours. Contact housing company. Inquiry with police about possible other complains. Help with house keeping.	Husband lives with kids at family in Amsterdam. Marianne tries to contact him	Leo	Pauline	Wilma	Pauline	Leo	visit FACT	call FACT	Heiloo	Wilma & leo
1. Cr	**Benthuizen, B. Ben**	di 13-10-09 evaluatie:	Schizofrenie		Risico op impulsdoorbraak bij	Wil niet "uit zijn dak gaan"	afspraken maken over dagbesteding. Dhr	moeder		Pauli		Lotty				thuis	Paulir
2. Ini	**Blaazer, G. Gerard**	vr 28-08-09 evaluatie:	bipolaire stoornis en		terugval alcoholgebruik	alcoholgebruik stoppen	intensiviseren contact motiveren tot	dochters en zoon	noud	Mari	noud		noud	noud		thuis	Mariar
2. Ini	**Bosman, M. Michael**	do 01-10-09 evaluatie:	schizofrenie Diabetes	geen	Sinds een paar dagen vergeetachtig,	Wil van het angstige gevoel	Dagelijks contact Medicatie onder	huisgenoten.	Carel	noud		Lotty	noud			Thuis	noud
2. Ini	**Brieffies, A. Alida**	ma 12-10-09 evaluatie:	schizofrenie	geen	Herstel na darm operatie	herstellen	Contact houden. Complicatie	Loes (schoonzus)	Wb			Wb				Buitenzorg	rose
3. Ini	**Been, S. Silvia**	do 01-10-09 evaluatie:	schizofrenie	geen	15 okt ontslag MCA. Rookverbod. Huisarts	verbeteren van lichamelijke	Motiveren en helpen om te stoppen met	familie	Cees			Mari				BZ	Mariar
3. Ini	**Broersen, P. Pieter**	vr 24-07-09 evaluatie:	Bipolaire I stoornis	voor-waardel.	toename van rouw klachten. Stop	wil opname	Regelmatig contact om stop droperidol goed			Anja	Lotty					thuis	anja e
3. Ini	**Prinsen, A. Alex**	di 06-10-09 evaluatie:			dhr heeft woning toegewezen gekregen.	Zelfstandig wonen	opstarten cm contact in ambulante situatie.	ouders		Peter		Pauli				Buitenzorg / ouders. Per	Peter
3. Ini	**Stadhouder, E. Els**	di 15-09-09 evaluatie:	Persoonlijk-heids-	voort-gezette	Toename van alcoholgebruik.	Zelfstandige woonvorm	regelmatig contact en goed monitoren op						Mari			Egelen-borgh	Mariar
3. Ini	**Wijnkoper, T. Thea**	di 05-05-09 evaluatie:	diagnose bijgesteld nu		Na overlijden moeder, wegvallen van werk en	wil zich gelukkiger	intensieve begeleiding ivm depressiviteit en	geen	lotti		Leo			bel	bezo	thuis	Frédéi
5. Op	**Kwakman, F. Fred**	vr 28-08-09	Persoonlijk-heids-		Toename van impulsdoorbraken, life	grip op zijn leven, meer zelf	medicamenteuze behandeling, 16 okt	Moeder en vriendin		Lotty						proefverlof vanuit	Mariar

FACT | RM | WACHTLIJST | BESPREEKLIJST

Indications for ‘admission’ on the FACT board

- Temporary
  - Crisis, Life events
  - Nuisance, threat of readmission
  - Need for intensification of treatment
- Long term & Revolving door
- Difficult to engage
- Admission (Psychiatry / Hospital / Jail)
- Legal (outpatient commitment)

On and Off the FACT board

- Every team member can put a person on the FACT board
- Decision to take a person from the board has to be taken by team
- Evaluation with team/client /family
- Flexible process of intensifying/ step down

On and Off the FACT board

- When looked at the data, in 3 years nearly 60 %of the whole FACT-population was on on the FACT board, for one reason or another.
- This vindicates the policy of including all patients with SMI and non-dismission of SMI-patients with less acute needs.

FACT board meeting

- Shared caseload
- Shared knowledge / ideas
- Discussed during daily meetings

Every day
½ – 1 hour
everybody present
Chairman!

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FACT | RM | WACHTLIJST | BESPREEKLIJST

Vision, shared by the outpatients and inpatients teams

- Recovery takes place at home, not in a clinical crisis unit
- The aim of outpatient care is treatment at home and therefore to prevent admission
- Clinical admission is an intermezzo in a longterm outpatient treatment
- Recovery-oriented attitude, also - as far as possible at least - during admission

Beds


weg te schuiven panelen
lage ramen voor optimaal uitzicht
patiëntenkast
werkplek
technische aansluitingen weggewerkt
eenvoudig bed om te bouwen

Care coordination meeting by the out- and inpatient teams

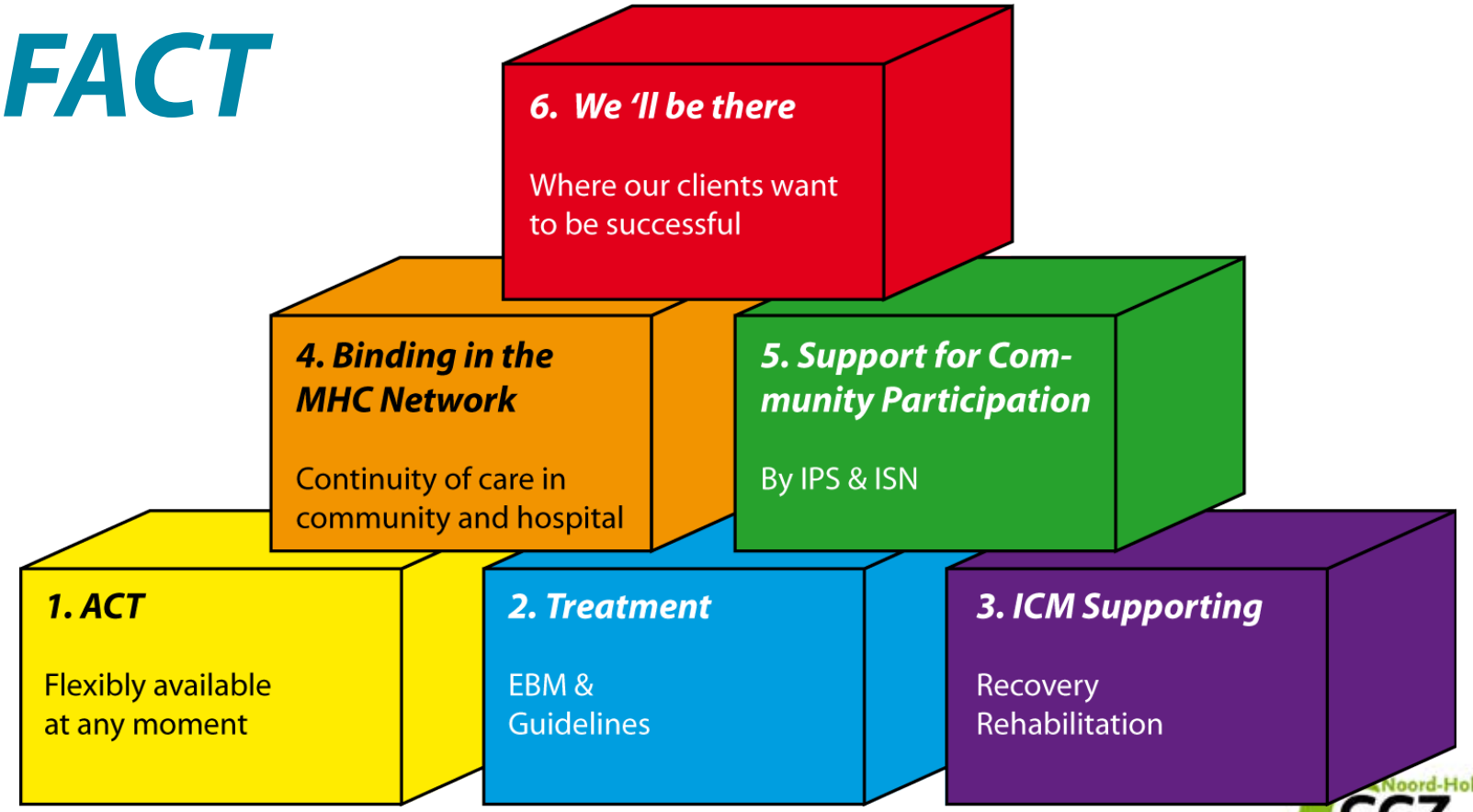
- Three timepoints
  - Beginning: within one day after admission
  - Mid term
  - End
- All parties involved
  - User
  - Family
  - FACT team
  - Ward

‘Transmural’

- Weekly meeting psychiatrists FACT teams and crisis unit
- Crisis unit offers (outreaching) FACT care in evening and weekend
- 24 x 7 possibility to call crisis unit

Six building blocks

FACT



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Does FACT influence acute forced admission rates?

FACT and hospital admissions

- IBS=acute forced admission.

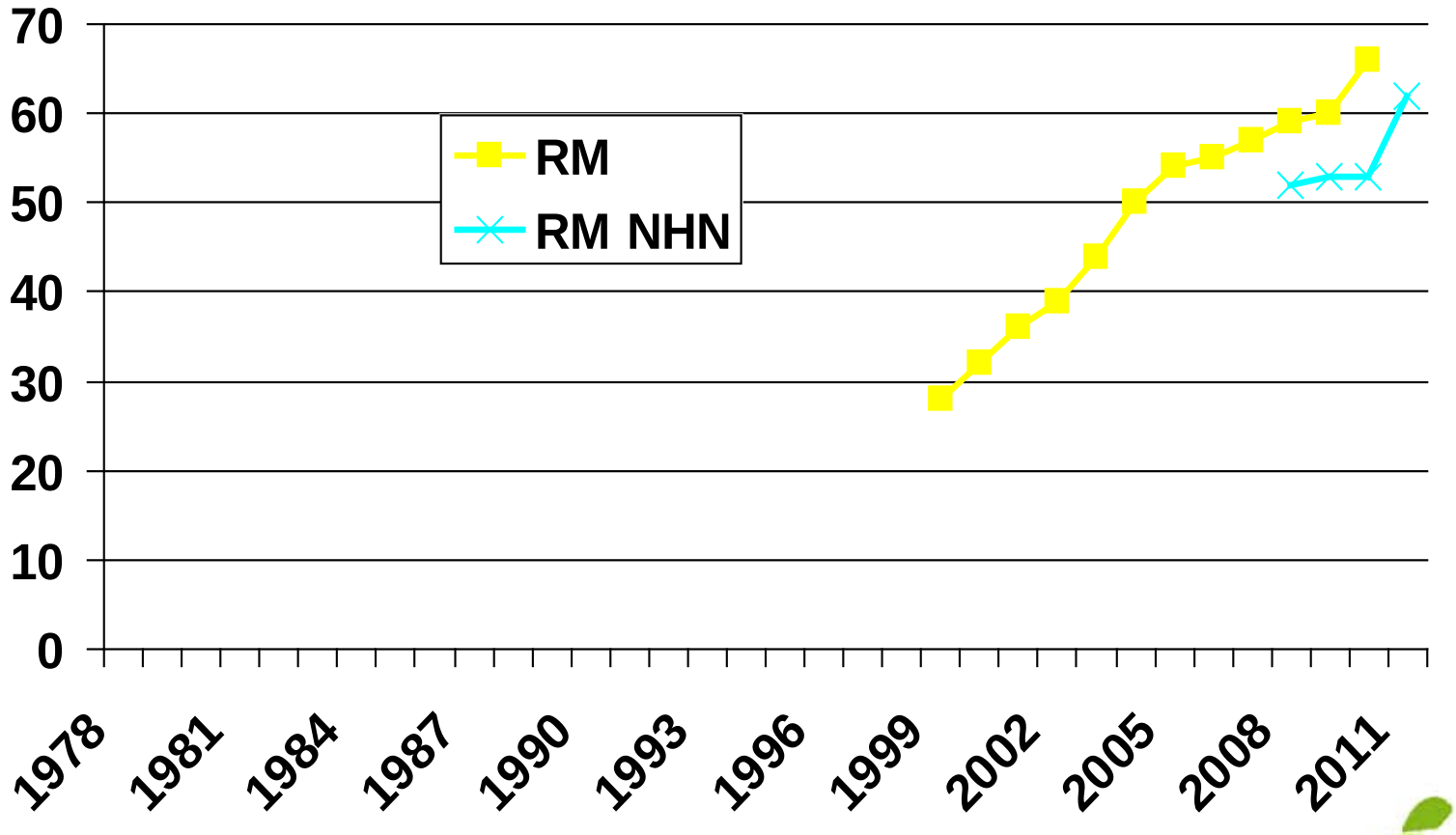
Criterion: presence of a psychiatric emergency that requires acute psychiatric hospitalisation.

- RM=chronic forced admission.

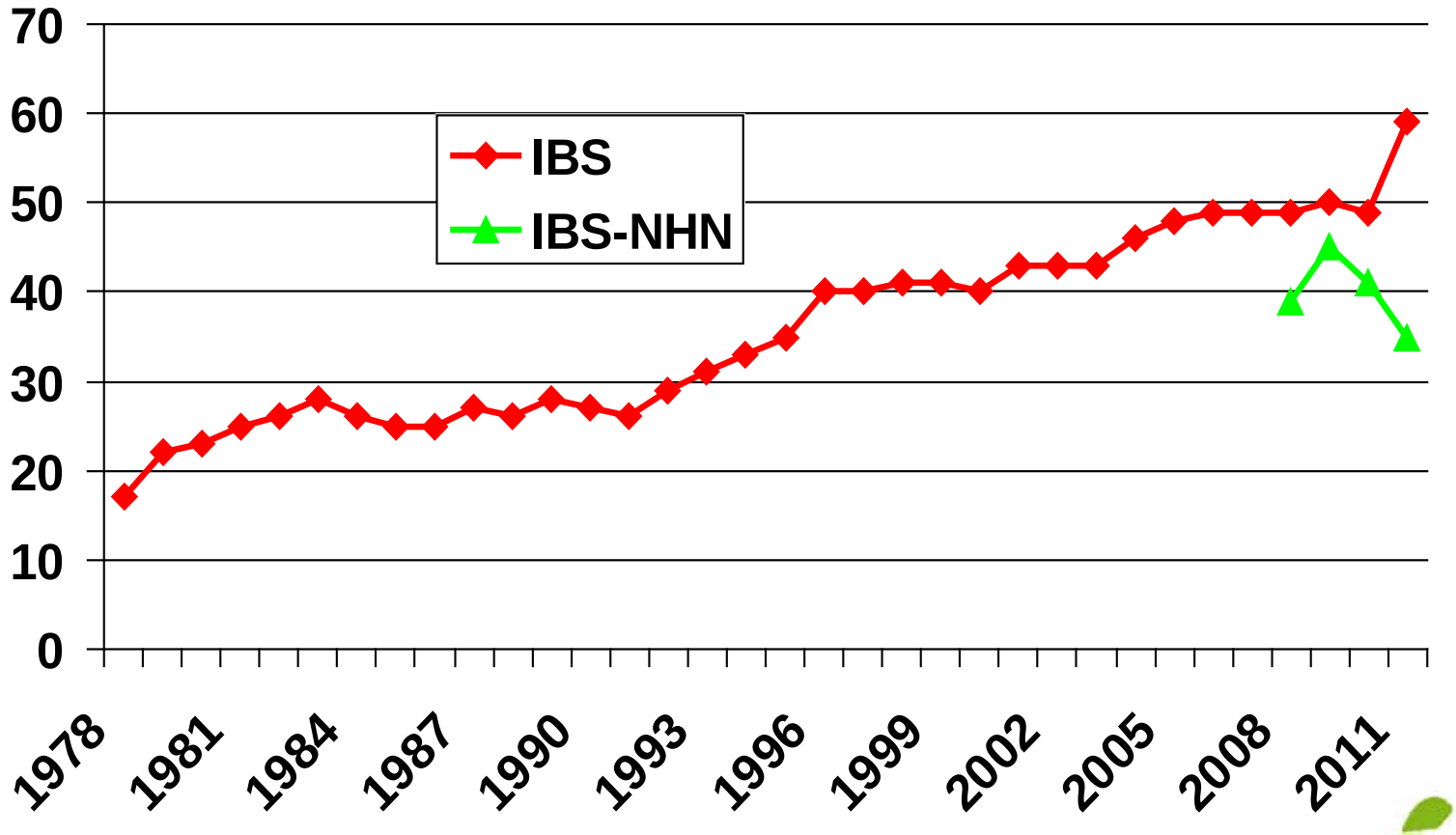
Criterion:

a. presence of a psychiatric illness.
b. severe decline in functioning that poses a threat to public order, safety of inhabitants or own somatic health.
c. out-patient care has proven to be insufficient

Forced long-term admission (RM) per 100.000 Dutch inhabitants.
North-Holland North vs The Netherlands



Acute forced admission (IBS) per 100.000 Dutch inhabitants: North-Holland North (NHN) and the Netherlands.

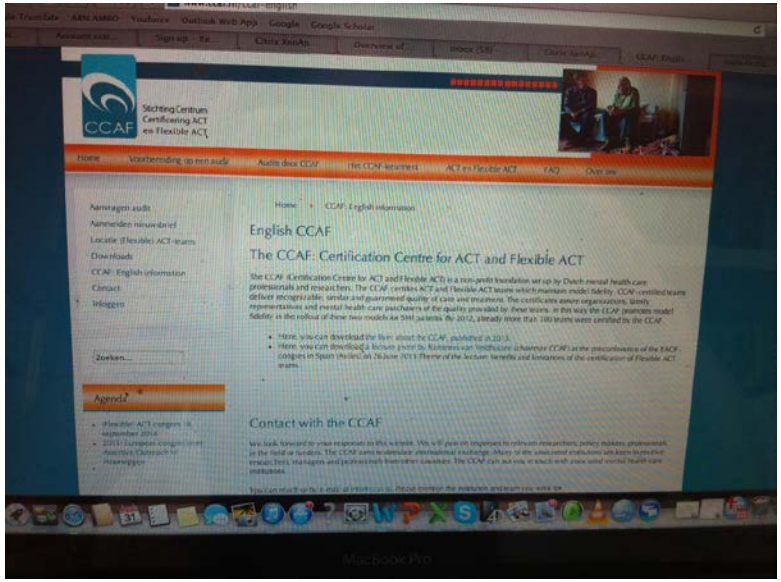


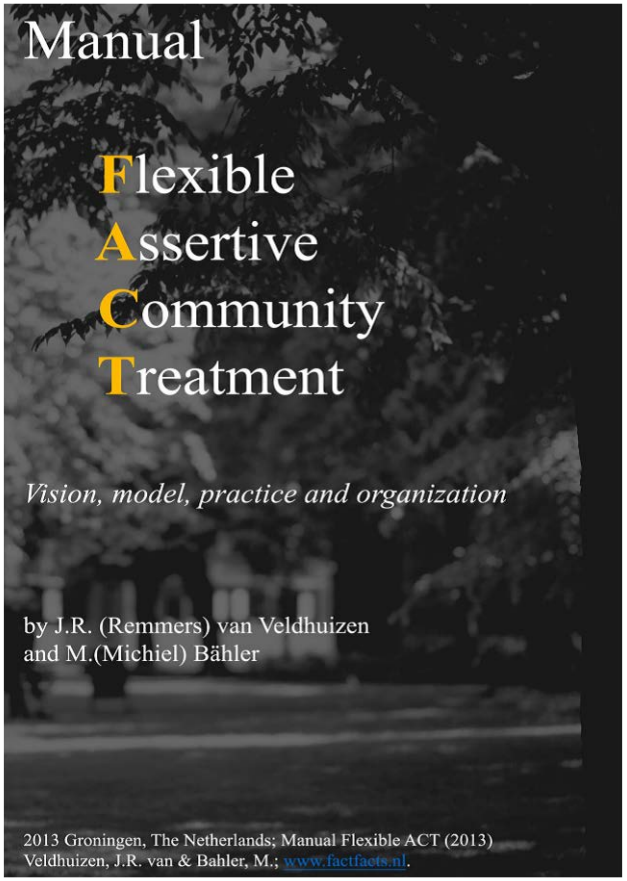
Conclusions

- Integrated multidisciplinary recovery-oriented FACT-care is needed for patients with SMI
- Variability of the psychiatric disorder – 60%/3 years on FACT-board- justifies inclusion of 100% of SMI-patients in FACT-care
- Flexibility of FACT positively contributes to patient and family satisfaction and to furthern explore their possibilities
- FACT-care is feasible, cost-neutral and patient friendly, with reduction of acute forced admision
- FACT requires intensive collaboration with many different parties and partners

Centre for Certification of ACT and FACT

- Non profit foundation
- Fidelity scales
- See: www.ccaf.nl





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Thank you for your attention!

d.cohen@ggz-nhn.nl

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