LECTURE

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Benefits and limitations of the certification of (F)ACT teams

Mr Chairman,
Ladies and Gentlemen, esteemed colleagues

I am pleased and honoured to be able to talk at the plenary preconference of the second international conference of the European Assertive Outreach Foundation in Aviles in Spain.

It is gratifying to see that there is so much international interest in assertive outreach.

Putting 'model fidelity' and 'certification' on the programme for this opening session was a bold step on the part of the conference committee. After all, ACT and FACT workers are first and foremost 'doers'. They are mainly involved in client care, and if you are talking to a homeless person or visiting a lonely psychotic man at home, model fidelity or certification is not the main thing on your mind. Nevertheless, these topics are of direct relevance to everyday practice.

This is why I would like to tell you about the path we have taken in the Netherlands; how we have come to appreciate the benefits and necessity of model fidelity and certification. Perhaps this can be of use in a wider European context.

Around 2000 there were many homeless psychiatric patients in the big cities in the Netherlands. This is why mental health services became interested in ACT. The first ACT teams were set up in metropolitan areas. The Dartmouth ACT fidelity scale (DACTS) proved to be a useful instrument. The DACTS was developed in 1998 by Teague, Bond, and Drake (1998). It contained 31 items that were rated on a five-point scale. In combination with another instrument with 12 items (the GOI) it provided a good benchmark for setting up the new teams.

At that point 'model fidelity' was a new concept for many practitioners. There had been guidelines for professional groups, but now the multidisciplinary composition and working procedures of a team were being set out in detailed guidelines.

At the same time, researchers were also interested in the DACTS as an instrument to measure the differences between ACT and 'care as usual'.

Between 2002 and 2005 there were three important developments:
1) ACT in metropolitan areas

2) the first multidisciplinary guideline for the SMI
3) introduction of the recovery vision.

From 2003 onwards these three streams inspired us to develop a Dutch version of ACT. At first we called this Function ACT (FACT), but it turned out that internationally this was not a clear title. We have now changed the name to Flexible ACT.

For those of you who are not yet familiar with FACT, I will give a very brief outline of the model. Over the next few days you can hear a lot more about it at various presentations and workshops.

The Assertive Community Treatment (ACT) model stands for an assertive outreach team with shared caseload. All team members work with every patient. The target group is the most vulnerable 20% of the SMI. ACT is internationally accepted and implemented and well known to all of you.

The Dutch version of ACT is FACT

<u>Flexible </u>Assertive Community Treatment, or FACT.

FACT can be summarized in the following principles or building blocks:
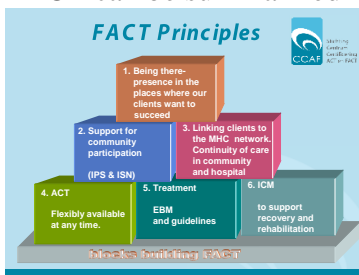
Firstly: '<u>We are present in the places where our patients want to succeed</u>'

Assertive outreach enables us to help patients in their own homes, in their own environments and with their families, assisting them in their struggle to survive and succeed.… providing training in community living.

Secondly: '<u>Support for Community Participation</u>'
FACT supports the Strengths Model and the vision that there are many ways in which the community can support the patients and work towards real community inclusion. Cooperation with social workers, volunteers, the police and others is vital to our patients' success.

Thirdly: '<u>We try to link the SMI to our MHC system</u>'
FACT teams work in an integrated MHC system of community and hospital facilities. The treatment approaches at the clinic and in the community are integrated.

Fourthly: '<u>ACT is flexibly available at any time</u>'
A crucial aspect of the FACT teams is that Assertive Community Treatment is available at any time for ALL SMI patients if it is needed in certain clearly defined situations. So…ACT is one of the building blocks of FACT.

Fifthly: 'Treatment in accordance with the professional guidelines and evidence-based practice'.
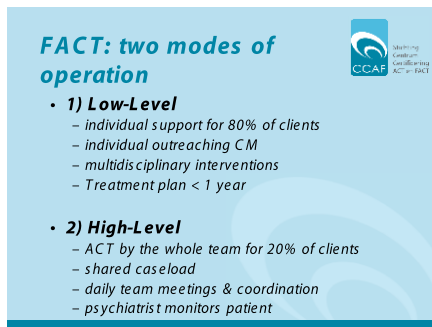
FACT teams are multidisciplinary. We can provide assessment, medication and metabolic screening, CBT, family interventions, IDDT and IPS.

Sixthly: 'Individual Case Management (ICM) to support recovery and rehabilitation'.

This is another cornerstone of FACT: each patient has an individual and personal relationship with one of the team case managers, who will support that patient in his or her recovery process.

Ladies and Gentlemen,

The most distinctive feature of FACT teams is the combination of two modes of operation within one team, which means that the team can provide both individual case management and – if necessary – full ACT with shared caseload.

FACT: two modes of operation
- **1) Low-Level**
  - individual support for 80% of clients
  - individual outreaching CM
  - multidisciplinary interventions
  - Treatment plan < 1 year
- **2) High-Level**
  - ACT by the whole team for 20% of clients
  - shared caseload
  - daily team meetings & coordination
  - psychiatrist monitors patient

A FACT team has two modes of monitoring patients and providing support for them:
1) 'low-level' individual support and
2) 'high-level' ACT involving the whole team.

With the team's 'low-level' mode of operation, the majority (80–90%) of patients are individually counselled by their case managers. They work on an outreach basis, visiting the clients at their homes.

The 'high-level' mode of operation provides the **intensive** outreach care. In this mode, the team operates as a fully-fledged ACT team, with a shared caseload. The patient can receive care every day, seven days a week. On average 10–20% of the patients (20–40 persons) need this type of intensive care at any particular point.

The second essential feature of a FACT team is that it **can switch** between these two modes of operation quickly and flexibly.

The FACT model has clear criteria for the transition from low-level to high-level care. The switching procedure is part of the daily FACT board meeting with a digital FACT board.
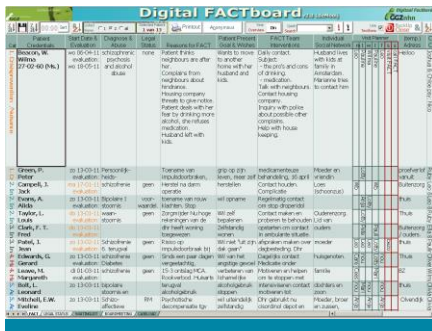
All patients who require intensive, 'high-level' care are listed on the FACT board, consisting of an Excel spreadsheet beamed onto the wall.

Shared caseload team care will end when the patient has stabilized again and there is no longer any danger. The patient's name is then removed from the board. The patient's personal case manager will continue to meet with the patient in the low-level care mode.

Because of this working procedure, Flexible ACT can provide long-term continuity of outreach care. If patients are getting better, they don't have to transfer to a different team – a 'step-down' team – as they do with ACT. This means more attention can be paid to rehabilitation and recovery support.

The natural course of severe mental illness with its relapses and recurring psychoses requires alternating forms of care – sometimes intensive, sometimes less intensive. In the past this led to a 'revolving door' between two systems (the hospital and the community) and later to a 'revolving door' between an ACT team and a step-down team. In FACT, the revolving door is inside the team itself, so that there is no loss of continuity of care.

There are now about 180 FACT teams (some of them still just starting) and we expect further growth. The National Board for Health Care has recommended that FACT be spread throughout the country, with 400–500 (certified) FACT teams for a Dutch population of 17 million inhabitants.

Ladies and gentlemen,

Model fidelity and certification have both contributed to the development of FACT. We used the DACTS to check on just which points the FACT model we wanted differed from the ACT model. The differences proved to be so big that we decided to develop a specific fidelity scale for FACT: the FACTs or FACT scale.

The FACTs differs from the DACTS on the following points:
- The target group definition (ACT the 20% most severe, FACT the 100% group)
- FACT's procedure for switching flexibly between low-level and high-level care
- Working with the digital FACT board
- The FACTs includes items about the multidisciplinary guideline
- The FACTs focuses specifically on the recovery vision under the heading 'recovery-oriented care'
- The integration of IPS
- Attention for Routine Outcome Monitoring (ROM)

Developing the FACT scale helped us to define the FACT model in detail. It forced us to substantiate each item and to be absolutely clear about what we wanted for our model.

The FACTs (version 2010) consists of 60 items in the following categories:
- The team structure, including team members and disciplines
- The team process
- Diagnostics, treatment, rehabilitation and recovery
- The mental health care organization (admission, organization of integrated service delivery and discharge)
- Social care
- Monitoring (including Routine Outcome Monitoring)
- Professionalism (vision, training courses, focus on recovery, quality assurance).

This scale has been used to rate more than 70 FACT teams in the Netherlands. The interrater reliability proved to be 0.83.

Now work is being done on a new version of the FACT scale. Items which turned out to be too difficult in the first 100 assessments will be adapted. It will be possible to make the disciplines in the team more suited to the specific target group served by a particular team, such as young people or mildly intellectually disabled people. There is a greater focus on recovery and outcomes.

Teague, Moser and Monroe-DeVita also developed a new version of the DACTS: the TMACT (Tool for Measuring fidelity to ACT). This new tool pays more attention to EBM interventions and recovery. In this sense there is a certain convergence between the TMACT and the FACTS.

The TMACT also focuses on the different *roles* played by the various practitioners. This adaptation is interesting in itself, but we did not take it over, because the TMACT cannot be administered in one day. In the Netherlands one day is the maximum, both for funding reasons and because of the burden it puts on the team.

Ladies and gentlemen,

There are two aspects of model fidelity:
1) designing, substantiating and defining a 'model'
2) then ensuring that teams maintain model fidelity.

A model fidelity scale is a practical, detailed instrument for asking the standard quality management questions:
1) Are we doing the right things?
2) Are we doing those right things right?

There is sufficient evidence that it pays to maintain model fidelity. Bond and Drake have published a lot about this. Randall (2012, *CMHJ*) from Canada recently summarized the findings: 'Despite complications [..in measuring fidelity and difficulties identifying the critical standards which must be complied with, a growing body of research] evidence has demonstrated a clear association between fidelity to program standards and a variety of positive outcomes'.

In the United States McHugo et al.[1] had shown previously that greater model fidelity had an effect on the implementation of EBP and on treatment outcomes at the client level, and in Canada Latimer (1999) also showed that 'higher-fidelity programs appear to reduce hospital days'.

In 2011 Van Vught et al. conducted a study in the Netherlands regarding the relationship between fidelity to the ACT model and patient outcomes and numbers of hospital days and homeless days. They concluded that high model fidelity was associated with better outcomes on HoNOS and fewer homeless days.

But if maintaining model fidelity pays off ... how can we monitor whether or not teams are maintaining and *continuing* to maintain model fidelity?

Large-scale ACT programmes (such as in the state of New York, which has over 70 ACT teams) have their own *internal* periodical audits of all teams, conducted by a separate support department. Randall (2012, *CMHJ*) reported a similar *internal* survey of the 66 ACT programmes in Ontario.

Internal audits have also been conducted in the Netherlands. However, in smaller organizations with a maximum of 10 FACT teams this was not ideal: the auditors know the team members and the teams and it is difficult for them to rate them objectively.

This is why we opted for *external* audits – with an objective report, an assessment and recommendations. In 2008 we set up the Certification Centre for ACT and FACT teams (CCAF). All of the main players committed to implementing ACT and FACT in the Netherlands were involved in this decision. It was very much a joint venture.

We recruit auditors among many organizations throughout the country. Most of them work in FACT teams or have experience with FACT teams (peer specialists, family members). This makes the CCAF different from other certification agencies that focus only on quality management. Practitioners often find these certifications, which are sometimes compulsory, too bureaucratic and not focused on professional aspects. CCAF auditors take their professional expertise with them and can examine the team's performance even at the client level (by inspecting anonymized files). This also gives the audit an element of interdisciplinary review.

The auditors are given several days off each year by the organizations for which they work to conduct the CCAF audits. The organizations receive a modest reimbursement for this. In this way the costs of certification are kept at a reasonable level. Most of the auditors regard the audit days as a time of reflection on their own work situation and inspiration for innovation.

I am still very satisfied with the decision to go with external, third-party certification by auditors who are fully involved in this work themselves. Some of the reasons why I think this is the best system are:

- An external audit means more impartiality with respect to the teams
- An external audit is taken more seriously by teams

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[1] McHugo GJ, Drake RE, Teague G, Xie H, (1999) 'Fidelity to assertive community treatment and client outcomes in the New Hampshire dual disorders study', *Psych Services* 50, 6.

- o They prepare better; they are more open to recommendations
- The certification organization can specialize
  - o Training for the auditors is organized centrally
  - o All auditing processes are carefully prepared and safeguarded.
- The certification organization can gain authority among government agencies and funding bodies.

This last point turned out to important in connection with protecting the name and brand of ACT and FACT. There were teams with absolutely inadequate staffing and teams which hardly worked at all with shared caseload or with the switching mechanism, but which still wanted to call themselves FACT teams because it led to success with funding bodies. This could have led to a bad reputation for FACT or ACT. The introduction of national certification prevented that happening.

This clarity was also important for the funding bodies. In the Netherlands funding is very fragmented and complicated, with three different sources of funding (insurers, the national government and municipalities) in the 20 to 30 regions. Because of this, a national standard and certification are very much appreciated.

The client organizations also supported certification. They wanted clearly defined quality standards for care and treatment. They value the recovery-oriented vision and the position of peer specialists in FACT. Family organizations also value the importance the FACT model attaches to the family and to EBP. All of these parties are represented on our advisory board. We are very happy that the CCAF has such wide support.

Ladies and gentlemen,
I will not go into detail about the CCAF and all the procedures we have developed. If you want to know about more about the CCAF you can visit our website www.ccaf.nl. I must say we have discovered that certification requires extremely meticulous organization and procedures.

An outline of the certification process:

For one day, two auditors join the team.
They have been given numerical information in advance.
On the day of the audit they talk to about ten team members and a few clients, attend the FACT board meeting and can access anonymized files.

After the audit, the auditors process their findings and rate the teams on the FACTs. This leads to a provisional rating. The team is given an opportunity to comment on the findings and the provisional ratings. Then the findings are monitored by an independent Certification Board, which establishes the final ratings and – based on these final ratings – makes one of four recommendations to the CCAF Board:

- No certificate to be awarded (team shows no model fidelity) (1x)
- Provisional certificate (with recommendations for changing working procedures and a repeated audit) (6x)
- Certificate (84 x)
- Optimal Certificate (34 x)

In a short time the CCAF has become widely known and accepted – and it seems set to grow. Funding bodies require mental health service organizations to have their teams certified. This is known to be a strong incentive to maintain model fidelity. But it also means that the funding bodies themselves are committed. They have shown their support for the requirements set by the FACT scale for teams of this kind. In times of austerity this is a line of defence against funding cuts.

In early 2013 the Inspectorate for Health Care asked for teams of this kind to be certified. The Dutch health minister supports this policy.

Ladies and gentlemen,

The CCAF is a success story.

Audit numbers are rising:
2009 – 16
2010 – 12
2011 – 35
2012 – 65
2013 – > 55

And in Sweden the FACT team Na Ut in Gothenburg has just passed the first English-language audit! Who wants to be the next? You are welcome!

The benefits are considerable:

- The model is well known, is regarded as standard, and is supported by clients and family organizations and by the Inspectorate
- Funding bodies have adopted this standard
- The ACT and FACT names or 'brands' are not legally 'patented', but they are increasingly linked to the requirement of a certificate
- The audits function as peer or inter-team evaluations
- For many teams the FACTs and DACTS are benchmarks for efforts to improve.

We have not really seen any 'limitations' to certification in the Netherlands. We have seen challenges, such as improving the business operations of the CCAF, in view of the growing demand for certificates, also in other fields such as forensic patients, young people and clients with mild intellectual disabilities.

The biggest threat is the austerity measures which are hitting the Netherlands harder and harder. Of course the situation is the same in all the other European countries. Up till now FACT teams that maintain model fidelity have received funding in the Netherlands. But what if the funding bodies have to cut their budgets? Are we going to have to cut down on outreach care? Will some disciplines have to disappear? Or will we have to cut back on EBP? I can imagine we will have to make some concessions, but they cannot be allowed to affect the model we want. There will be difficult discussions.

Ladies and gentlemen,

In the Netherlands external assessment and certification have proved to be of value not only in terms of improving everyday practice, but also in terms of developing, implementing and funding the model. Involving government authorities, funding bodies and client and family organizations turned out to be a very important factor in this. I hope that our experiences will contribute to maintaining model fidelity in other countries in Europe.

I do see limitations at the European level. There are big differences in the mental health care services – and funding for them – in the different European countries. Social support systems in different countries also vary widely.

Norway is looking for its own mix of ACT and FACT. In sparsely populated areas with long travel distances teams, have to rely more on local sources of social support. In Belgium we see that in this kind of care many services work together, and the GP plays a different role for people with SMI than in the Netherlands. There will be different models in each country. The different languages and the travel distances would also make it very difficult to arrange assessments between different countries. In other words – I don't think we are likely to see a European certificate any time soon.

But there is actually something that is much more important at this point: a broad European policy statement regarding ACT and FACT. The assertive outreach movement has to have its pitch ready for European policy makers and funding bodies. Health care, deinstitutionalization, phasing out institutions and public mental health are all high on the European agenda.
I hope that this conference and Professor Mulder's symposium next Friday will provide incentives to develop a joint policy statement regarding essential evidence-based components of care for people with SMI in Europe.

Ladies and gentlemen,

The exchange of ideas is crucial for European collaboration. Sometimes language barriers can be a problem. I am keen to be able to explain the FACT model without language barriers. This is why Michiel Bähler and I have developed a comprehensive – 70-page – account of the FACT model in English.
In the interests of optimal availability and exchange of ideas, this FACT Manual (70 pages) will be downloadable free of charge from several websites (including www.factfacts.nl and www.ccaf.nl, see slide).

On behalf of the Certification Centre for ACT and FACT teams I wish you a great conference!

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