European Union
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WELKOM

Project Support of FACT model in the Czech republic,
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zichtbaar beter

Noord-Holland-Noord GGZ

Clinical outcomes FACT

Improvement in unfulfilled care needs

Improvement in quality of life

Improved treatment compliance

Improvement in remission (better use guideliness)

yet

Insignificant improvement in social recovery

Netherlands

- medio 2016 about 300 certification FACT-teams, with about 70.000 clients in care. Since than no growth.
- Total number not-certificated FACT-teams about 100 teams.

- FACT youth, EIT, FACT personality, FACT MID,
- Forensic (F-) ACT, FACT addiction

- FACT teams in Denmark, Sweden, Norway, Canada, England, …

New FACTs (2017)

- Ccaf website

3 questions to a FACT-team:

1) For who do you do it? (pre information list)
2) With who do you do it? (pre informationlist, Part A)
3) How do you do it? (pre information list + part A+B)

…. and is there a match between “for who”, “with who” and “how”? (JUDGEMENT!)

- An adequate quality assurance cycle and a vivid Team Document
- (including a mission statement, a vision, all the background information, their strategy, feedback from the survey and the PDSA cycle relating to the focus areas)

New Facts part A

1. Small caseload	12. Self-determination and autonomy
2. Team employment	13. Flexible care
3. Psychiatrist	14. Team approach
4. Psychologist	15. Daily Factboard meeting
5. Nurse	16. Outreach services
6. Social worker	
7. Employment specialist	
8. Peer support expertise	(17. OT, other disciplines??)
9. Physical health expertise	
10. Addiction expertise	Score 1 - 5
11. Expertise related to MID	

New facts, part B

1. Making care flexible
2. Personal domain
3. Social domain
4. Symptomatic domain
5. Planning and Monitoring at the Individual Client Level
6. Crisis and safety
7. (social) network collaboration
8. Quality and innovation

Section B of the FACTs is assessed on a scale from 1 to 8

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1-2	3-4	5-6	7-8
Not evident	In development	Correctly implemented	Exemplary

Making care flexible

1) Flexible care is evident during the FACT board meeting.

2) Staging of care is reflected in the treatment plans and is implemented.

3) There is a team approach, with several team members actively contributing expertise.

4) The level of care provided is appropriate to the stage in the client's recovery process; care is up scaled or down when necessäry or desirable.

Personal domain

1) The team recognizes and acknowledges the client's individuality.

2) The team takes the client's own strength as its starting point.

3) The team perceives the client's struggle with their cultural, sexual and spiritual identity and emotions such as grief and sorrow.

4) The team pays attention to combating stigmatization and self-stigmastization

5) The team is not afraid to take risks.

6) The team has a hopeful attitude and uses hopeful länguäge

Social domain

3.1 The client’s roles within the 'self-care and living' domain

3.2 The client’s roles within the 'social network' domain are evident

3.3 The client’s roles within the 'work and leisure’ domain are evident

Symptomatic domain

4.1 Psychiatric interventions

4.2 Physical health interventions

4.3 Psychological and pedagogical interventions

4.4 Addiction interventions

Planning and Monitoring at the Individual Client Level

5.1 Planning and Monitoring cycle

5.2 Integrated responsibility

6. Crisis and safety

6.1 Assertive Proactive Crisis Interventions

6.2 Safety and risks

7.(social) network collaboration

7.1 Engagement and Collaboration with the Client's Social Network

7.2 Collaboration with Internal and External Professional Networks

8. Quality and innovation

8.1 Training

8.2 Expert knowledge

8.3 Planning and Control Cycle at the Team Level

8.4 Care Innovation

Ghosh and Killasy :
Staffing of ACT teams in England in 2007

- 36% had no consultant psychiatrist (rest 0.5 FTE)
- 22% had no Dr
- 52% had psychologist (0.4 FTE)
- 65% had OT (0.9 FTE)
- 92% had social worker (1.7 FTE)
- 99% had support workers (2.7 FTE)
- 100% had nurses (4.6 FTE)
- 16% employed service users
- 29% had substance misuse specialist
- 49% had vocational rehabilitation specialist.

Good treatment and support
in the coming years

Six major changes:

1. From stabilisation to personal and social recovery
2. From only professional care to empowerment and self-management
3. From support only for client to always involve others
4. From only MH to collaboration with other institutions
5. From separate pathways to integration of treatment and rehabilitatio
6. From separate domains to integration of MH and somatic care.

AMBITION!

Less needs of care,
more recovery

Through better prevention and state-of-the-art care in 2025:

- 1/3 gains in mental somatic health (recovery of health)
- 1/3 more participation in work or study (recovery of social roles)
- 1/3 more achieving individueal goals (personal recovery)

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Desired outcome of an appreciated inquiry

- the most promising improvements ot the team
- Inspiration really to improve
- Set the scores and have commitment about it

Ask the questions so to that
the desired out will be achieved !

Not a list to set the score,
but on goals and results

Your promissing improvements

- Focus on monitoring and improving the services
- Strong Focus on recovery
- Outreach!
- More psychiatrist and psychologist