Home Treatment in Europe
FACT: Flexible Assertive Community Treatment

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Psychiatric Beds in Europe

Eurostat, 2017
Psychiatric Beds 2009 – 2014
(per 100,000 inhabitants)

Eurostat, 2017
Balance between community and institutional resources

Countries where the number of people with mental health problems receiving long-term support in the community is greater than the number of people in long-stay hospitals or institutions.

Countries where the number of people with mental health problems receiving long-term support in the community is lower than the number of people in long-stay hospitals or institutions.

Unknown
Deinstitutionalisation

To get better you need to be at home
Health and social policy...

“Medicin is a social science, and politics is nothing else as medicin for society....“
Rudolf Virchow (1848)

Thus: to improve mental health services we also need to influence politics!
We need a shift

From disability-medical model

To person centered - recovery model

(Jan Pfeiffer MHS EEG)
What is good quality (outpatient) care?
Patients with severe and enduring mental illness

“A failure of social policy and health promotion, illness prevention and care provision.”
Common Aim

• To find the best outpatient care model that supports recovery:
  – While fitting quality standards
  – In line with human rights
  – High degree of cost effectiveness
  – Fitting the country / region of interest
Recovery is the ability to live well in the presence or absence of psychiatric illness.
Recovery

“Recovery isn’t waiting for the storm to pass.

It’s learning to dance in the rain.”

(Jan Pfeiffer MHS, EEG)
How should we proceed to reach these goals?

Reaching out together.....
Different sources of knowledge

• Science

• Professional knowledge, clinical experience

• Knowledge by experience – service users – consumers

• Grounded on the basics of human rights
Scientific evidence for the best ways to reach recovery?

• No consensus about best service delivery models and their ingredients for optimally working towards recovery

• Evidence for ACT (20% SMI) or FACT (100% SMI) in Europe is mixed:
  – Depending on treatment as usual: some good results in Denmark and Hamburg (Nordentoft et al. OPUS Studies; Lambert et al. ACCESS studies)
  – Depending on target group (early psychosis), specific model, ingredients (IPS), and model fidelity
  – Trends for more recovery through FACT in the Netherlands (Drukker et al. 2007; Nugter et al. 2015)
Professional knowledge

- Depends on discipline, context, history
- Depends on opinions and values of individuals
Knowledge of experts by experience

- Focus on personal recovery
- Provide interventions to gain meaningful activities and work
- Provide home-based care whenever possible
- Respect autonomy and use as less coercion as possible
Need for integrated care

- Psychiatrist
- Psychologist
- Nurse
- Social worker
- Peer expert / consumer

-> providing interventions in an integrated way!
Integrated care versus fragmented care
Actors in recovery-oriented care and treatment for severely mentally patients
Parallel, not sequential interventions
Case History Peter: First Episode Psychosis

- Peter, 23 years, living with his parents in a large city.
- Friends noticed strange behaviour, but no aggression
- Stopped classes since one year
- Withdrawal from social contacts
- Does not take drugs
- Parents noticed strange behaviour: room a mess, strange answers, talking to himself
- Not aware of his strange behaviour and does not want any help
Typical case history?

• 22 countries (100%): yes
GP examines Peter, who does not want help; GP would send patient to:
Case History George, 45 years

- George, 45 years, living on the streets in a large city
- Actively hearing voices and has paranoid delusions
- Eats left-overs
- Not dangerous to others or himself
- Dirty cloths, smells badly, long hair and beard
- Somatic situation unknown
- Unknown income and health insurance
- Drug use unknown
- Psychiatric history unknown
- Citizens notice “strange behaviour”
- George does not want help
Typical case history?

• Yes : 16 (73%) countries
• No : 6 (27%) countries

» Bulgaria, Finland, Italy, Norway, Slovakia, Switzerland (few homeless)
In your country, would George receive any help?

Yes; 17
No; 5
GP has examined George, he would refer to:

Number of countries (max n=21)
ACT en FACT
History of Assertive Community Treatment (ACT)

- Started in Mendota Mental Health Institute, Madison, 1970’s
- Founders: Leonard Stein en Mary Ann Test
- Reaction to closing state hospitals / revolving door patients
- Evidence base for ACT in US:
  - Reduction of hospitalisation and costs
  - More patient satisfaction
Assertive Community Treatment

- Target group:
  - 20% most severely ill patients
  - Who do not seek treatment

- Teamwork
- Multidisciplinary
- Implementing other EBP’s: IDDT, CBT, IPS
- No brokerage
- Small caseload (1:15)
- Shared caseload

- Outreach
  - No limits in duration of care
Assertive Outreach

• Effective ingredients (Burns et al. 2006) for association with reduction of hospitalisation
  – Smaller caseloads
  – Regular home visits
  – Responsibility for health and social care
  – Multidisciplinary team
  – Psychiatrist in the team
Flexible ACT (FACT): a Dutch version of ACT (Veldhuizen 2007)

- For all patients with severe mental illness
- Integrated care (medical, psychol and social)
- Multidisciplinary team
- Increasing continuity of care
- Flexible response (2 levels of intensity: ACT and individual case management)
- Regional teams » social inclusion
- ‘Transmural’: linking hospital & community care
FACT (continued)

• Can provide almost all necessary interventions (biopsychosocial)
• Home- as well as office-based treatment
• 200 -250 patients
• 10 fte
• FACT Board
FACT = integrated care

- Psycho-education
- Motivational interviewing
- Medication + Medication Management
- Psychotherapy: CBT and EMDR
- Support of family and network
- Work: Individual Placement and Support (IPS)
- Addiction: Integrated Dual Diagnosis Treatment (IDDT)
FACT-board

• All patients
  – Regular patients (individual case management, discussed weekly within FACT team)
  – FACT patients (shared caseload; multiple care needs, discussed on a daily basis)

• On FACT board also information per patient about:
  – Medication (depot)
  – Judicial status
  – Other
<table>
<thead>
<tr>
<th>Cat.</th>
<th>Personal identification data</th>
<th>Start &amp; evaluation date</th>
<th>Diagnosis &amp; abuse</th>
<th>Judicial state</th>
<th>Reason for FACT</th>
<th>Patient current goals &amp; wishes</th>
<th>FACT team interventions</th>
<th>Individual social network</th>
<th>Visit planner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adriaanse, L. Lia</td>
<td>fr 19-02-10 evaluation: fr 02-04-10</td>
<td>Schizophreni psychosis and alcohol abuse</td>
<td>none</td>
<td>Patient thinks neighbours are after her. Complains from 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.</td>
<td>Wants to move to another home with her husband and kids.</td>
<td>Daily contact. Subject: - the pros and cons of drinking. - medication. Talk with neighbours. Contact housing company. Inquiry with police about possible other complaints. Help with housekeeping.</td>
<td>Husband lives with kids at family in Amsterdam. Marianne tries to contact him</td>
<td>Cal FACT</td>
</tr>
<tr>
<td>2</td>
<td>Benthuizen, B. Ben</td>
<td>dl 13-10-09 evaluation:</td>
<td>Schizophrenie</td>
<td>geen</td>
<td>Risico op impulsdoorbraak bij terugval alcoholgebruik</td>
<td>Wil niet &quot;uit zijn dak gaan&quot; alcoholgebruik stoppen</td>
<td>afspraken maken over dagbesteding. Dhr intensiveren contact motiveren tot huisgenoten.</td>
<td>Thuis</td>
<td>Lotty</td>
</tr>
<tr>
<td>3</td>
<td>Blaazer, G. Gerard</td>
<td>vr 28-08-09 evaluation:</td>
<td>Bipolaire stoornis</td>
<td>geen</td>
<td>Herstel na darm operatie</td>
<td>Dagelijks contact Mediacatie onder hulp</td>
<td>Loes (schoonzus)</td>
<td>Buitenzorg</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Bosman, M. Michael</td>
<td>do 01-10-09 evaluation:</td>
<td>Schizofrenie Diabetes</td>
<td>geen</td>
<td>Sinds een paar dagen vergeetachtig, 15 okt ontslag MCA. Rooikweld. Huisarts</td>
<td>Wil van het angstige gevoel herstellen</td>
<td>Dagelijks contact hulp</td>
<td>Thuis</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Briefies, A. Alida</td>
<td>ma 12-10-09 evaluation:</td>
<td>Schizofrenie</td>
<td>geen</td>
<td>Herstel na darm operatie</td>
<td>Dagelijks contact Mediacatie onder hulp</td>
<td>Loes (schoonzus)</td>
<td>Thuis</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Been, S. Silvia</td>
<td>do 01-10-09 evaluation:</td>
<td>Schizofrenie</td>
<td>geen</td>
<td>15 okt ontslag MCA. Rooikweld. Huisarts</td>
<td>Verbeteren van lichamelijke toestand Wil opname</td>
<td>Regelmatig contact om stop droperidol goed omgaan</td>
<td>Thuis</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Broersen, P. Pieter</td>
<td>vr 24-07-09 evaluation:</td>
<td>Bipolaire I stoornis</td>
<td>voorwaardelijk</td>
<td>Toename van rouw klachten. Stop dhr heeft woning te overgeven gekregen. Zelfstandig wonen</td>
<td>Regelmatig contact om stop droperidol goed omgaan</td>
<td>Thuis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Prinsen, A. Alex</td>
<td>dl 06-10-09 evaluation:</td>
<td>Persoonlijkheidsstoornis</td>
<td>voortgezet</td>
<td>Toename van alcoholgebruik. Zelfstandige wonen</td>
<td>Regelmatig contact om stop droperidol goed omgaan</td>
<td>Buitenzorg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Stadhouders, E. Els</td>
<td>15-09-09 evaluation:</td>
<td>Persoonlijkheidsstoornis</td>
<td>voortgezet</td>
<td>Toename van 15 okt alcoholgebruik. Zelfstandige wonen</td>
<td>Regelmatig contact om stop droperidol goed omgaan</td>
<td>Thuis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Wijnkoper, T. Thea</td>
<td>do 05-05-09 evaluation:</td>
<td>diagnosis bijgesteld nu</td>
<td>geen</td>
<td>Na overlijden moeder, weggelopen van werk en levensertoezeggingen. Zelfstandig wonen</td>
<td>Regelmatig contact om stop droperidol goed omgaan</td>
<td>Thuis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Kwakman, F. Fred</td>
<td>vr 28-08-09 evaluation:</td>
<td>Persoonlijkheidsstoornis</td>
<td></td>
<td>Toename van impulsdoorbraken, leven, meer zelf</td>
<td>Intensieve begeleiding, 16 okt medicamentenbehandeling</td>
<td>Moeder en vrienden</td>
<td>Proefvertrek vanuit</td>
<td></td>
</tr>
</tbody>
</table>
ACT as well as FACT provide:

1. Integrated care
2. Assertive outreach
3. According to a well defined model
4. Stabilisation, treatment, rehabilitation and recovery
5. Choice for ACT or FACT depends on target group and region (urban – rural)
Flexible aufsuchend-nachgehende gemeindenahe Behandlung

Flexible Assertive Community Treatment (FACT)-Manual

Vision, Modell, Praxis und Organisation | J.R. van Veldhuizen und M. Bähler
Erstellung der deutschen Version durch V. Niehaus, A. Wüstner, M. Lambert
### Interventions by FACT: the Seven C’s

| 1. Cure (Heilung) | • Evidenzbasierte Behandlung mit dem Fokus auf Heilung, Stabilisierung oder die Situation erträglich zu gestalten, konform mit den multidisziplinären Leitlinien, die in verschiedenen Ländern erschienen sind |
|                  | • Behandlung durch Ärzte oder Pflegepersonal |
|                  | • Psychologische Behandlung (kognitive Verhaltenstherapie, metakognitive Therapie, EMDR*, etc.) |
|                  | • Suchtbehandlung: IDDT** |
|                  | • Somatisches Screening/Behandlung (metabolisches Screening) |
| 2. Care (Versorgung) | • Tägliche Unterstützung, Beratung |
|                  | • Pflege-Beratung, Hilfe im Alltag, Verwahrlosung vorbeugen, Augenmerk auf Hygiene |
|                  | • Rehabilitation |
|                  | • Genesungsorientierte Versorgung |
|                  | • Versorgungskontinuität; drop-out verhindern |
| 3. Crisis intervention (Krisenintervention) | • Intensive Betreuung und Versorgung beim Klienten zuhause mit „shared caseload“ |
|                  | • jederzeit erreichbar (24/7) |
|                  | • Krisenintervention, Risikoabschätzung |
|                  | • Notfallaufnahme, kurzfristig, „Bett auf Anfrage“ |
|                  | • Familien- und Unterstützersystem einbeziehen |
| 4. Client expertise (Klientenexpertise) | • Den Erfahrungsschatz des Klienten nutzen |
|                  | • „shared decision-making‘ (SDM) |
|                  | • Genesungsorientierte Versorgung |
|                  | • Empowerment (Stärken-Modell) |
|                  | • Interventionen der Peer-Berater |
| 5. Community support (Gemeindeauf Unterstutzung) | • Familienkontakte |
|                  | • Gemeindenahes Unterstützungssystem |
|                  | • Unterstützung bezüglich Wohnen, Arbeiten und Wohlbefinden |
|                  | • IPS: individuelle Unterstützung einen Job zu finden und zu behalten |
|                  | • Inclusion von Klienten fördern |
|                  | • Belästigung vorbeugen |
| 6. Control (Kontrolle) | • Risikoabschätzung und Sicherheitsmanagement für Klienten und Umgebung |
|                  | • Verschreiben und Umsetzen von Zwangsmaßnahmen der psychischen Gesundheitsversorgung auf gerichtliche Anordnung bei Gefahr im Verzug |
|                  | • Manchmal forensische Versorgung (auf gerichtliche Anfrage) |
| 7. Check (Überprüfung) | • Evaluation der Behandlungseffekte |
|                  | • Routinemäßige Ergebniskontrollen |
|                  | • Evaluation der Versorgungs- und Behandlungsstrategie |
|                  | • Zertifizierung |

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* Eye Movement Desensitization and Reprocessing  
** Integrated Dual Diagnosis Treatment
How: by the six building blocks for FACT

1. Folge dem Klienten dahin, wo er etwas erreichen möchte
2. Unterstütze Inklusion durch soziales Netzwerken
3. Finde Menschen mit SMI und verschaffe ihnen Zugang zum Gesundheitssystem
4. Biete intensive ACT-Versorgung an, wenn nötig
5. Biete eine leitliniengerechte Behandlung an
6. Unterstütze Rehabilitation und Genesung
Process of care
Fundamental problem in mental health

- 50-75% of people with severe mental illness do not seek treatment

- Reasons for not seeking treatment:
  - Lack of insight
  - Negative experiences with (involuntary) treatment
  - Stigma
Motivation Paradox

Classic Assumption

Motivation Paradox in SMI

Problems

Distress ↔ Motivation

Lack of insight

Cognitive problems ↔ Motivation
Thus: assertive outreach is needed for severely mentally ill patients, especially for the difficult to engage subgroup
Untreated severely mentally ill patients...
Neglect
Severe Neglect
Social Breakdown
Danger to others
Assertive Outreach in Europe?
How satisfied are you with the quality of outpatient care for **difficult to engage SMI** patients in large cities in your country?

Highest scores: Denmark, Netherlands (7)
Lowest scores: Czech, Lithuania, Portugal (0)
Effectivity of (F)ACT: the evidence

• American studies: ACT reduces hospitalisation days

• European studies do not confirm these findings, except for less drop-out of care (Burns ea 2007)

• European studies: more positive results in early psychosis patients (ACT+; Nordentoft et al. 2007)
Scientific evidence FACT

- Low level evidence
- Pre-post studies

- FACT
  - Best Practice
  - Face validity
Conclusion (F)ACT

• Best described outpatient model for patients with severe mental illness
• Lack of RCT’s for the FACT model
• Successful implementation in Netherlands both bottom-up and top-down
• Many people want FACT:
  – Professionals
  – Managers
  – Insurance companies
  – Municipalities / government
Financing FACT

- FACT = medical care -> (private) insurance companies / NHS
- FACT = social care -> public / municipalities
- FACT = biopsychosocial care -> multi-modal financing

- Money from inpatient to outpatient, by closing beds
Flexible Assertive Community Treatment

FACT-Qualitätssicherungsskala
Center for Certification of ACT and FACT (CCAF)

• Non profit organisation
• FACT professionals visit other FACT teams, using a model fidelity scale
• Content and quality of care are central
  – Necessary professionals in place
  – Provision of best-practices and evidence-based practices
  – Working towards recovery
  – Involvement of significant others
  – Methods for systematic improvement

• See: www.ccaf.nl
Netherlands: high FACT fidelity

- Medication
- Presence of required medical staff
- (shared) Caseload
- Outreach
Netherlands: low FACT fidelity

- Psychological treatments (CBT/Trauma)
- Treatment of somatic comorbidity
- Peer support in the team
- Rehabilitation activities
- IPS

- Working with families?
Conclusions

- Higher chances for recovery outside the hospital -> home based treatment
- FACT is a model for providing integrated, home based treatment and care
- Model fidelity helps implementation
- Professionals as well as clients like the FACT model
- Financing FACT/home based care:
  - By insurance companies / state / social domain
  - By closing beds
de ‘wijk/buurt’
het ‘persoonlijke’ netwerk

FACT

PATIËNT
hulpverlener
omgeving
resource ACT
Meldingen overlast verwarde personen bij politie:

2011: 40.000
2013: 52.000 (+30%!)

"Het kan dan gaan om overlast en opstootjes, maar ook om grote incidenten zoals afgelopen maandag toen een verwarde man zijn 9 weken oude zoontje gijzelde."

Oorzaak: "bezuinigingen in de zorg en doordat mensen met psychische klachten vaker thuis worden behandeld. 'De zorg in de wijk is er alleen nog niet altijd,' zegt de Amsterdamse hoofdcommissaris Pieter-Jaap Aalbersberg."
Reduction of beds parallel to increase of involuntary admissions in UK

Keown et al. BMJ 2011
Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial

Tom Burns, Jorun Rugkåsa, Andrew Molodynski, John Dawson, Ksenija Yeeles, Maria Vazquez-Montes, Merryn Voysey, Julia Sinclair, Stefan Priebe

Summary
Background Compulsory supervision outside hospital has been developed internationally for the treatment of mentally ill people following widespread deinstitutionalisation but its efficacy has not yet been proven. Community treatment orders (CTOs) for psychiatric patients became available in England and Wales in 2008. We tested whether CTOs reduce admissions compared with use of Section 17 leave when patients in both groups receive equivalent levels of clinical contact but different lengths of compulsory supervision.

Interpretation In well coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients’ personal liberty.

Burns et al. Lancet 2013
KEEP CALM AND BEDANKT VOOR JULLIE AANDACHT
Reduction of beds parallel to increase of involuntary admissions in UK

Keown et al. BMJ 2011
Number of psychiatrists

Note: Slovakia: not available.
(*) Break in series.
(“) 2014: estimate.
(”) 2013.
(*) 2014: not available.
(†) Definition differs.
(‡) 2008: not available.

Eurostat 2017
Figure 3  The six dimensions on a subjective scale, visualised for practical use, indicating a fictional estimation of a person’s state of ‘positive health’.
Redefining health (BMJ 2011): The disability paradox

despite limitations. This is shown in evaluations of the Stanford chronic disease self management programme: extensively monitored patients with chronic illnesses, who learnt to manage their life better and to cope with their disease, reported improved self rated health, less distress, less fatigue, more energy, and fewer perceived disabilities and limitations in social activities after the training. Healthcare costs also fell.\textsuperscript{15} \textsuperscript{16} If people are able to develop successful strategies for coping, (age related) impaired functioning does not strongly change the perceived quality of life, a phenomenon known as the disability paradox.\textsuperscript{17}
Process
Recovery takes time...
Road to Recovery...

(Richard Lamb, 1979)
Recovery

• Symptomatic recovery
• Functional/Societal Recovery
• Personal Recovery

• Now, only 15% of patients with SMI reach symptomatic and functional recovery!

• Prognosis of personal recovery unknown?
Recovery– conceptual model

Personal Recovery

A = Therapy compliance
B = Illness insight
C = Empowerment
D = Personal development

Social Environment

Physical challenges

Initiation  Propagation  Consolidation  Integration
Recovery – conceptual model

**SOC**

**PSY**

**BIO**

Personal Recovery

- **A** = Therapy compliance
- **B** = Illness insight
- **C** = Empowerment
- **D** = Personal development

Initiation  Propagation  Consolidation  Integration

Social environment

Physical challenges

Symptoms

Skills

Social roles
National aim

- 30% of patients with SMI are in recovery
- 30% less SMI patients
- Less somatic morbidity (longer survival)

Interventions
- Better psychiatric treatments
- More attention for somatic health and lifestyle
- More social inclusion (RACT?)
- Better prevention
Situation in the Netherlands

- (certified) F-ACT teams almost in every region
- Usually general F-ACT teams
- Some specialty (F)ACT-teams
  - Addiction
  - Personality disorders
  - Forensic
  - Intellectual disability
  - Early Psychosis
  - Youth
Dilemma’s

• We don’t know the effectiveness of F-ACT

• We could assess who benefits and who doesn’t (addiction, ID)

• Caseloads within F-ACT seem to rise

• National discussion on bewildered persons: role of F-ACT?
Dilemma’s

• Collaboration with social domain
  – Social teams differ per municipality

• We want to offer specialized treatment and care versus 1 F-ACT team per 20,000 inhabitants?

• Should we have diagnostic group F-ACT teams or general F-ACT teams?
Dilemma’s

• Geographic responsibility for care of patients with SMI or not?

• Active case-finding?
Dilemma’s

• Collaboration with the social domain: how?
Dilemma’s

- We are now in a stage of trying to add resource groups to F-ACT
  - Improving chances of recovery
  - Continuity of care

- Implementation challenges

- Study the effects of RG in an RCT
RG Phase I

FACT

Caregivers

Social team

Others
RG: the evidence

• Trial on RACT in Gotheborg: effects on symptoms and functioning (Malm et.al).

• Similar interventions have been shown to be effective in reducing symptoms and improving functioning (Norden et al.)

• RCT on effects of RG starts in 2017 in the Netherlands
RCT: RG vs CAU (=FACT)
Challange for mental health care

- National plan Netherlands in 2020:
  - 30% less beds
  - 30% more recovery / health
EPA: ‘Steeds onderweg... Naar nergens...’
(Richard Lamb, 1979)
Vanaf eeuwisseling onvermijdelijk: paradigm shift in de psychiatrie

- Detectie van psychiatrische aandoeningen in voorstadia
- Stadiëring van psychische aandoeningen
- Interventies die effectief zijn in een bepaald stadium

Interventie doelen EPA
(in een triadische omgeving)
Interventie doelen EPA
(parallele zorg)

- Psychiatrische symptomen verminderen
- Persoonlijk herstel nastreven
- Maatschappelijke participatie bevorderen
I Over de brug

Plan van aanpak voor de behandeling en ondersteuning bij ernstige psychische aandoeningen.
Principles of Mental Illness Management Based on the Stress-Vulnerability Model

Managing Your Recovery
- Pursuit of goals
- Knowledge of mental illness and treatment
- Relapse prevention plan

Taking Medication
Avoiding Alcohol and Other Drugs

Biological Vulnerability
Stress

Coping Strategies for Stress and Symptoms
Getting Social Support

Symptoms and Relapses
Where does recovery take place?

• **Symptomatic recovery**
  – > hospital, society and home

• **Societal / functional recovery**
  – > society

• **Personal recovery**
  – > home
Challange for mental health care

• Provide the best possible treatment and care
• Use resources optimally
• Situation of patients with SMI
  – 13% recovery (symptomatic and functional remission), life time
  – 15% have work (NL)
  – 20 years shorter life expectancy

→ Value based health care
What is deinstitutionalization?

<table>
<thead>
<tr>
<th>From institutional culture</th>
<th>To a client oriented culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolation from the community</td>
<td>Inclusion in the community</td>
</tr>
<tr>
<td>Clients are compelled to live together</td>
<td>Clients decide where and with whom to live</td>
</tr>
<tr>
<td>Lack of control over their lives</td>
<td>Maximum support for clients to gain control over their lives</td>
</tr>
<tr>
<td>Rigidity of routine</td>
<td>Normalization principle</td>
</tr>
<tr>
<td>Block treatment</td>
<td>Needs-based support</td>
</tr>
<tr>
<td>Paternalistic relationship</td>
<td>Partnership between staff and clients</td>
</tr>
<tr>
<td>Social distance</td>
<td>Team cooperation</td>
</tr>
<tr>
<td>Rules of the institution are more important than the needs of</td>
<td>Flexibility in care provision</td>
</tr>
<tr>
<td>the clients</td>
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</tbody>
</table>
Mental Health Care for SMI patients

[Bar chart showing percentage of countries and citizens in hospital-based, community-based, and mixed settings]
Rethinking Mental Illness


- Prognosis in cardiology is much improved
- Cancer mortality is decreasing recently for the first time ever

*But what are the gains of research in mental illness?*

- Prevalence nor mortality decreased for any mental illness up to now
- Diagnosis is by observation, detection is late, prediction is poor
- Etiology is unknown, prevention is not well developed
- Treatment is by trial and error, there are no cures
Dr. Philippe Pinel at the Salpêtrière, 1795 by Robert Fleury. Pinel removing the chains from patients at the Paris Asylum for insane women.
Promote Mental Well-being and Recovery

Risk factors
- Mental and physical vulnerability
- Unemployment
- Poverty
- Stigma
- Poor living conditions

Protective Factors
- Subjective symptom control
- Building internal resilience
- Physical health
- Social support
- Participation and Inclusion

Recovered Individual in the Community
Care needs of patients with severe mental illness

- Psychiatric, including addiction and learning disabilities
- Somatic
- Social

<table>
<thead>
<tr>
<th>Care needs</th>
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</thead>
<tbody>
<tr>
<td>Psychosis, trauma,</td>
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<tr>
<td>anxiety, depression,</td>
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<tr>
<td>substance abuse,</td>
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<tr>
<td>intellectual</td>
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<tr>
<td>disability</td>
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<tr>
<td>Cardiovascular,</td>
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<tr>
<td>diabetes</td>
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<tr>
<td>Social contacts,</td>
</tr>
<tr>
<td>work, housing,</td>
</tr>
<tr>
<td>finance, self care,</td>
</tr>
<tr>
<td>judicial</td>
</tr>
</tbody>
</table>
**CAPS**

**Post-treatment**
- PE vs WL: $d = 0.78$
- EMDR vs WL: $d = 0.65$

**6-month FU**
- PE vs WL: $d = 0.63$
- EMDR vs WL: $d = 0.53$

---

T0-T2  T0-T6
-31.8  -32.9
-31.8  -33.3
-11.6  -16.2

*Estimated means (LMM)
Main outcome competitive work (Weeghel ea 2012)

TVS = Traditional vocational services
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.