FINAL REPORT
European Assertive Outreach Federation (EAOF) Conference Hamburg 2017

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DECLARATION OF INTERESTS

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Nursing & Midwifery Practice and Development Unit
Flexible Assertive Community Treatment is a flexible approach to providing care towards individual's experiencing severe and enduring mental health challenges by providing both assertive outreach and standard community care by the one multi disciplinary team (Van Veldhuizen 2007)
Introduction

On the 12th of September 2017 a number of staff were afforded the opportunity to attend the European Assertive Outreach Federation conference in Hamburg. This group were selected as each participant was involved in the development of the Carraig Mór Assertive Outreach team. We agreed to submit a report of the conference to HSE management upon our return. The following provides this report and is outlined in four sections. Part 1 will outline the context and reasons for attending the conference in Hamburg. Part 2 will outline how the conference was received. Part 3 will offer a discussion of the FACT model and Part 4 will consider how we should proceed. First we will consider the context.

Context

Carraig Mór Centre is located in Cork City and is an 18 bedded Psychiatric Intensive Care Unit (PICU). The hospital primarily receives admissions from acute psychiatric hospitals within the Cork/ Kerry CH04 area. Admission to Carraig Mór occurs when a person is extremely unwell and their associated behaviour results with them exceeding the capacity of sector teams to provide care. The hospital also has developed links with the Irish Prison Service and has received admissions from Cork prison on a number of occasions.

Carraig Mór also operates a hybrid Flexible Assertive Community Treatment (FACT) programme and this service provides care to 63 people (as of 10/10/2017). This programme was originally developed in 2006 within an environment created by Mr John Kelleher, Mr Ned Kelly and Dr Martin Lawlor. This was necessary as a small number of service users required extra support due to the seriousness of events that led to their admission. These service users were asked to continue and attend Carraig Mór following their discharge from hospital. This was to ensure concordance with treatment. This also allowed hospital staff the ability to assess discharged service users who required long term input. Over the following decade this number has increased to 63 service users who attend Carraig Mór on varying frequencies and require varying levels of input. An audit into the effectiveness of the FACT programme was completed in 2016. This audit looked at the rates and durations of admissions to the mental health services prior to commencement in the FACT programme and post acceptance onto the programme. The audit used the data of 20 anonymized service users and showed that the mean duration of admission lengths to Carraig Mór while receiving assertive outreach reduced the requirement on beds by 715 days per year. It showed a reduction in both admission lengths and admission rates to mental health inpatient wards. In 2016 focus was directed to the further development of the assertive outreach service with consideration to international best practice. Focus was brought towards various models including the Assertive Outreach model developed in the USA and the Flexible Assertive Community Treatment model developed in Europe. The FACT model was deemed, and chosen, to be more suitable in Ireland for a number of reasons, namely it was developed to provide care with populations spread over large geographical areas with an ability to shift between providing high support and standard support depending on service user needs. (Van Veldhuizen, 2007). It also is a model that does not require intensive service reorganisation, is flexible, person centred and based on recovery principles.
One aspect of the Carraig Mór service initiative was to develop professional links with our Dutch colleagues. Our hope was this approach would help to further develop the service we are providing, increase our fidelity to the Dutch model and place us in a position to receive international recognition for this. This was felt important and beneficial to ensure best international practice. In addition, to these reasons, another potential benefit is that it would allow us to engage in quality international research to further contribute towards evidence based practice of the FACT approach.

Initial contact with our Dutch colleagues was established in September 2016. This cumulated in an invitation to attend the CRSI conference in Cork in June 2017. This provided an opportunity to discuss the FACT model and how we could develop our programme. This collaboration resulted with the Dutch agreeing we could use the FACT terminology and we would also continue to develop professional links with them. As part of the development of professional relationships we were invited to attend the 3rd European Assertive Outreach Federation conference in Hamburg.

Goal/ Objectives

The goal of the Carraig Mór programme is to develop a fully resourced and functioning Assertive Outreach team based on the FACT model. To achieve this it is essential to develop fidelity with the Dutch model. It was expected that attendance to this conference would assist with achieving this goal. Our intention was to focus on a number of objectives. These included:

1. Developing and building upon established professional relationships.
2. Clarifying the process required to obtain FACT accreditation.
3. Understanding the steps involved in the development of FACT teams.

Developing Professional Relationships.

The conference provided a platform to develop close links and professional relationships with European healthcare leaders. This objective was met. During the conference we enhanced the professional relationships we have with Michiel Bähler and Jeanette DeGrand. Both are core and essential members of the Dutch implementation team. We were further introduced to Shuna Vanner who currently implements the international educational aspects of the FACT programme. We had the pleasure to meet with Remmers van Veldhuizen. Remmers was one of the original founders of the FACT model with Michiel Bähler. This model has currently developed in 300 of the Dutch teams. We were also introduced to Anne Rosenquist. Anne is programme leader within the Danish services who have implemented FACT teams in 9 sectors this year. Denmark would have had both community teams and ACT teams. These were combined to form the one functioning FACT team in localities. They are currently awaiting accreditation from the Certification Centre for ACT and Flexible ACT (CCAF). Anne has also offered to discuss with us any aspects of their implementation of the FACT programme.
We also met with Casper Buchardt of the Danish team, a Consultant Psychiatrist involved in the Danish service change with Anne. We also met with Camilla Munch Nielsen. She is a PhD student in Denmark. She is currently undertaking RCT research into the effectiveness of FACT teams within sectors and comparing this data with traditional community care teams. Further contacts were made with Pavel Rican, Director of Mental Health Care Development. Pavel is involved in developing suitable health initiatives to be considered for the future policies within the Czech Republic. His current focus is in the development of early intervention/ home based crisis teams. With regard to the objective of developing professional links, this objective was met and we were extremely satisfied with our progress during this trip. The content of these meetings will be developed further in this report.

Clarification of steps required for accreditation

Clarification was provided with the steps required for certification in a number of workshops. These discussions focused on fidelity/ similarity to the FACT model, how this is measured and included clarification on utilising the fidelity audit tool. This audit tool can be used by healthcare teams, themselves, to identify where development is required. It can also be used on a bi annual basis and would allow for on-going re-assessment leading to the development of services that would ensure high standards of care. Carraig Mór Centre completed a self-audit in 2016 and received moderate scoring. Feedback suggests this score is similar to what most teams would initially achieve in the Netherlands. This tool also allows flexibility when applied to different countries and their healthcare systems. Following guidance from our Dutch colleagues, healthcare teams would be able to self-monitor. In areas’ where a number of FACT teams develop, it would be the aim for the native country to develop their own auditing team and would work closely with the FIT Academy. This is the international accreditation body for FACT fidelity. In circumstances where the FACT model is implemented in a small number of places within a country the FIT academy, located in the Netherlands, require an external audit every three years for the country to receive international accreditation.

More recently a new fidelity scale has been developed which takes into consideration the uniqueness of member states and recognition that different European countries provide care unique to their territory. The Danish team shared their experiences with developing this new service model and outlined in detail a step by step guide in developing FACT teams (Appendix A). With regard to whether the Irish delegation achieved success on this intended objective; we have gained clarity on fidelity, auditing and accreditation. Therefore we believe this objective was also met.

The steps involved in the development of FACT teams in Ireland.

- Commence the discussion.

Carraig Mór is taking the lead and is attempting to develop its service based on a FACT model with regards to providing community care. This initiative should continue with the support of management. The main focus
The main focus within Carraig Mór should be to continue and develop fidelity and complete self-audits biannually and provide progress reports post audit.

Consideration should also be given to a wider FACT service re-organisation and a discussion will need to take place by senior management of the potential benefits of FACT. It is hoped this report may help initiate this conversation by outlining current developments within Europe. Consideration could be given to the development of a pilot project with a ‘forward looking’ sector team to implement FACT principles. For this to be realised support from the mental health services would be required from the top – down.

- Maintaining momentum

Maintaining momentum will be essential for this project to have any chance of success. We held three meetings with our Dutch colleagues and discussed potential ideas to develop the professional ties between countries. Consideration was given to inviting three of our Dutch colleagues to Ireland. This group would provide workshops to a small number of motivated healthcare staff. The purpose of these workshops would be to give these initial teams the necessary knowledge of the FACT model to enable them to share the knowledge received with their colleagues. This would further allow for the discussion on service change to develop. This forum would also provide an opportunity for senior management to meet with our European colleagues of whom I have no doubt would impress. We had conversations of whether it would be possible to develop a pilot project outside Carraig Mór whereby high quality research would commence to allow for comparison studies. We would also hope to be in a position to invite our Danish colleagues to Ireland at this stage. They have recently adopted this model and have rolled out, within the last year, 9 FACT teams within particular sectors. As mentioned they are awaiting accreditation shortly and are willing to work with us by sharing their knowledge of implementation. Their motivation and energy show them as true leaders within a european healthcare service context. Developing local workshops in Cork/Kerry (CH04) could also potentially help maintain momentum during 2018 towards a larger event in 2019.

- Developing Key Strands

In the immediate future Carraig Mór Centre will continue to develop its service and increase its fidelity to the European models. This will also allow for Carraig Mór MDT members to advocate for the FACT model. Consideration should also be given to developing a pilot study within certain community sectors. As mentioned above this would provide an opportunity whereby high quality research could commence and allow for comparison studies to be completed. This would show the level of effectiveness this model of care offers. This would also add to the growing level of research within Europe into the effectiveness of FACT teams.

- Advocate for FACT during Conference in Ireland

The development of the Carraig Mór FACT team, the teaching (local teams could receive), senior management support, international presentations, consideration for a pilot study would all add to ‘having the conversation’ which could be further developed by a suggestion from Dr Martin Lawlor of that the 2019 CRSI conference be
held in Cork, launching under the theme of Assertive Outreach. This could provide a natural launch pad for the FACT model within Carraig Mór and possibly beyond. Our Dutch and Danish colleagues could also be invited to the CRSI conference in 2019 and may facilitate a presentation at the conference and make the case for the FACT model.

Discussion

- Carraig Mór and FACT

Carraig Mór is a tertiary service and receives admissions from secondary care psychiatric hospitals and provides a hybrid version of FACT utilising similar principles. We will continue our efforts to continue and develop the service we provide with fidelity to the Dutch model. The Carraig Mór team would be defined as a specialist FACT team required to provide care to the small percentage of service users with severe and enduring mental ill health (SMI) and who present with complex high risk behaviours. This specialist team would support sector teams where necessary and fits into current Dutch thinking re specialist teams. This service change has slowly been developed within current service resources, it is a service that is shown to be effective and should be developed further to continue and increase the level of care it can provide to service users who traditionally ‘fall between the gaps’.

- Wider Service Change.

The American version of ACT is recognised as an evidenced based health intervention and despite this, according to literature, has not shown the expected results within Europe (Burns et al, 2001). This has been attributed to a number of reasons; including the size of geographical areas where teams operate, in Europe, being much larger than that of the United States. Another reason forwarded to explain this lacking in positive results has to do with questions relating to fidelity of the model being implemented compared to international standards. Ireland also has an effective community based and integrated healthcare system that allows for the seamless care pathway from the community to hospital care and back into the community. It would be important to consider international and national practices and consider evolving the model of community care to incorporate FACT principles into all sector teams. This could be implemented within CH04 initially following validation studies or perhaps a smaller area. Ultimately the FACT model works on the premise; if a service user becomes unwell the level of care/ contact time and support is increased and shared among the team. If a person is doing well, care is reduced to a standard level and provided by a key worker. This model incorporates a flexible method of implementing care. Based on the composition of the Irish community teams it is quite possible that the teams would already have sufficient resources available to them to adopt this new model. The structures of community teams could be adapted to provide care using the FACT model with little drain on resources. With this vision Ireland could also join and become a leader with similarly minded countries in the development of community services. It is recognized that this would require further study into the similarity/ differences of the Irish healthcare structure and that of European countries. In particular with the Danish team who potentially have a similar public based healthcare system.
- Pilot Study

Denmark has taken up this challenge with enthusiasm. In adopting the FACT model they combined the ACT and community teams to form FACT teams. This has occurred within 9 teams with plans to extend this to another 15 teams. They are also leading on research with a PHD student currently undertaking a research study into the effectiveness of FACT compared to the treatment of usual community teams. In Ireland a smaller pilot study could be developed initially that may form part of a comparison study to measure its effectiveness against a standard community team. This would complement the Danish and international studies.

- Leading Change

There have been strident moves within Europe to develop a new model of community service. A number of countries are taking the lead, developing international links and working together to provide the best quality care to service users within communities. Ireland has the opportunity to join these forward looking countries and become a European leader in collaborating and implementing European initiatives within our own services.

Naturally there will be a number of areas and factors to consider. These include whether the Dutch/ Danish model and the Irish model are comparable and how a service change would affect us if we were to consider the implementation of FACT. Naturally, different countries will require the FACT model to adapt to their host countries’ health care system. How this model is developed in Ireland would need to be examined carefully. What is essential is the core components remain the same. These components are very achievable and are publically available in the FACT manual (https://www.eaof.org/FACTmanual.pdf).

Next steps

- To formalise a date and confirm arrangements for the Dutch and Danish team leaders to attend Ireland.
- To arrange for a presentation to be given to senior management re the FACT programme in 2018.
- Core staff to receive training from our Dutch colleagues.
- To continue to build the Carraig Mór FACT team.
- To seek support of a pilot study and discuss the implementation of this initiative.
- Advocate for a service change from community care, as is the usual, to the flexible community and assertive care model approach.
- Completion of the Carraig Mór FACT standard operating procedure.
- Undertaking of bi-annually FACT audits and respective reporting of results.
- To build upon established international relationships.
- To develop an understanding to how the mental healthcare systems are provided in Denmark in detail.
Conclusion

This conference was the conclusion of a conversation that began with our Dutch colleagues in 2016 when we realised that the care we were providing had similarities with the Dutch FACT model. We travelled to Hamburg with a number of objectives and were not disappointed with the results. The event of the conference can only be described as successful as we met all our objectives, if not exceeded them. Now, it is our hope that this does not mark the conclusion but opens a new chapter on developing FACT within Ireland. One of the essential requirements of this project will be for senior management approval and support. It is essential that the conversation is maintained, with this leading to a discussion of how Ireland sees its role within the European context. The FACT approach is spreading within Europe and may provide a model that enables teams to provide care to people in a flexible manner which can also be developed to target service users with severe and enduring mental illness who would traditionally disengage from the services. Furthermore it is the FACT model that is attracting most attention in Europe as providing a method of providing quality care to service users within the community. Adopting this model would allow Ireland to join this European group and also become a leader within the field in community care.

References:


Implementing Flexible ACT: two Danish psychiatric outpatient services learning from a Dutch model

Step-by-step implementation

1. Study of the F-ACT model, study tour, the hospital management expectations and goals with besting the model in a Danish context
2. Having a kick-off day about F-ACT
3. Establishing a coordination group
4. Detailed timeplan for implementation
5. Restructuring from outpatient clinics/ACT to F-ACT teams
6. Establishing the new management structure
7. Organising in new teams
8. Procurement of F-ACT tools
9. Competence (and cultural) development
10. Implementation of new forms of activity
11. Recruitment of peer support workers
12. Audit of team done by colleagues
13. Certification by CCAF

Appendix A  (Danish Presentation, EOAF conference 2017)
FACT is a dynamic recovery based approach which provides long term care, specifically to people with severe mental health challenges that require intensive support with regard to employment, education, accommodation, medication management and self care (Veldhuizen & Bähler 2013). It is an approach that brings focus and attention to people who have, in the past, found it difficult to maintain lasting engagement with mental health services and who are at increased risk of disengagement.
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