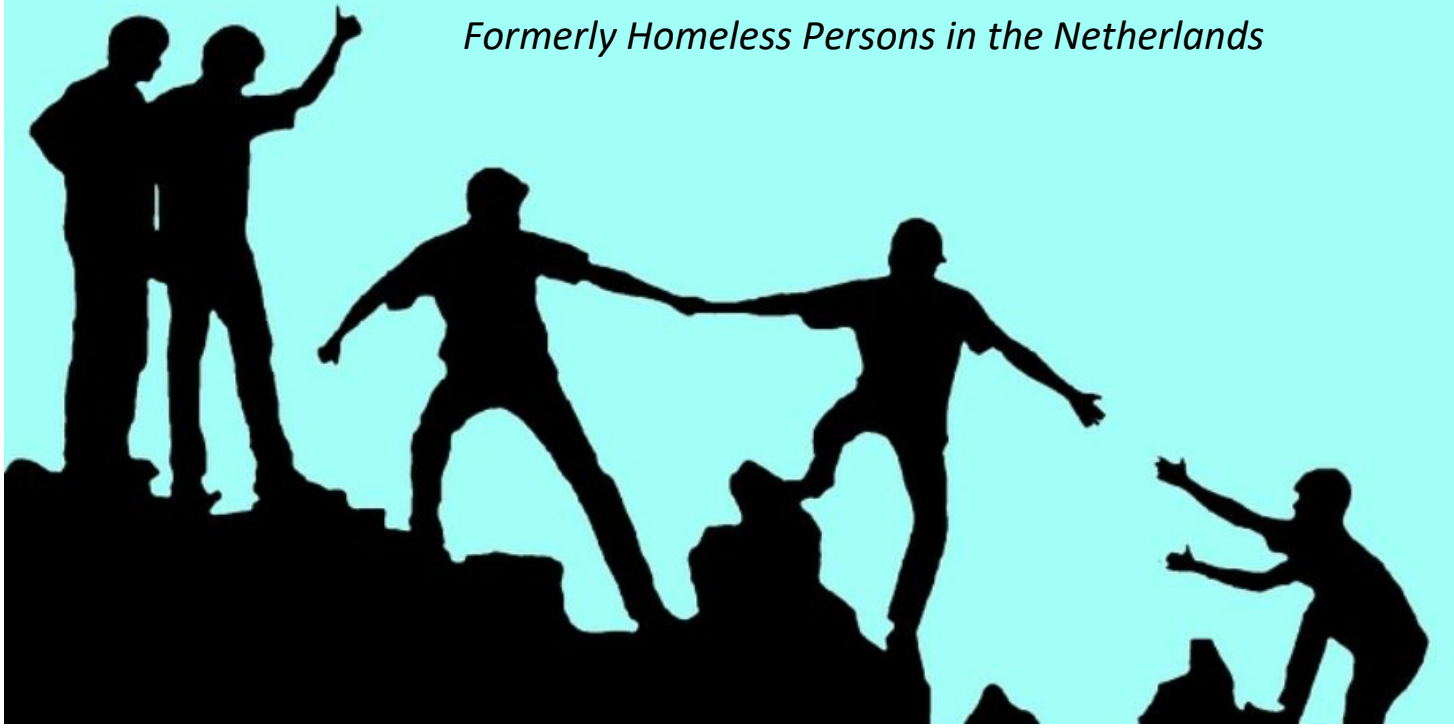
Refuge for the Homeless

Accessibility and Effectiveness of Ambulant Psychiatric Support for Formerly Homeless Persons in the Netherlands



Universiteit Utrecht

Master Thesis

Social Policy and Public Health

Utrecht University

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Words: 9631

Date: 24-06-2019

Abstract

The right ambulant psychiatric support is necessary for formerly homeless persons to succeed in their independent living. In this research is explored how an ambulant support network around a client is organised by care professionals. Thereafter is examined how effective and accessible this support is from the viewpoint of the care professional. The cooperation and accessibility between care organisations are assessed to understand if the basis for ambulant support is yet available. In this explorative research 22 semi-structured interviews are conducted with care professionals in the Dutch regions: Gooi en Vechtstreek and Waterland. During the interviews it became clear that on the policy level a concrete and substantial vision was developed, but the care organisations did not have a mutual understanding. Social district Teams are not structured according to the vision of the regions. Besides that, the communication between different stakeholders is still not developed enough to have a conclusive approach of psychiatric ambulant support. It is recommended to incorporate the social district teams better and expand the responsibilities of the crisis response teams. Another possibility is to install an additional team, like the 24/7 supervision in the neighbourhood pilot that has started in Gooi en Vechtstreek. The insights given by care professionals are helpful to understand, on an organisational and policy level, how clients are served in their reception of care.

1. Introduction

In recent years policy around mental healthcare has been subjected to multiple changes. This resulted in health care provision with as starting point, care on the right place (Ministry of Health, Welfare and Sports, 2018). The aim of ambulant psychiatric support is to let clients recover in their own home. As a consequence of this new starting point the reduction of intermural care within mental healthcare started. However the reconstruction of the required ambulant psychiatric support remained behind (Louwes, 2018). Besides, the Dutch government has failed to prevent homelessness and to reduce homelessness after the economic crisis. Homeless persons are faced with environmental, social and medical challenges to their physical and mental health (Tsai, O'toole, & Kearney, 2017). Fazel, Khosla, Doll and Geddes (2008) show in their meta-analysis that the prevalence of mental health issues is two to twenty times higher among homeless people as compared with the general population. Another study from Folsom et al. (2005) revealed that 15% of the population in the United States that lives on the street struggles with one or more mental illnesses. Fabian (2013) did comparable research in a European context and found that more than half of the homeless persons have to deal with a mental issue. So homelessness is a serious problem among patients with severe mental illnesses, unfortunately solutions to house and support this group are still scarce.

Since 2015 the focus of the Dutch government is on decentralisation and deinstitutionalisation of the social support provision (WMO, 2015). The consequence of this decentralisation is that municipalities are responsible for their own social support policy. They receive a budget from the state to implement the tasks that previously were executed on a national scale. The reform has firmly changed the role of the local government based on the assumption that municipalities are the best informed about their local population. Besides, they are assumed to be the most capable provider of an efficient, tailor-made and integrated package of services in the social domain (Maarse & Jeurissen, 2016).

Deinstitutionalisation is the movement from mental healthcare arranged in hospitals and care institutions to mental healthcare in communities (Salisbury, Killaspy & King, 2017). This is not a new phenomenon, and exists already since the 1950's in England and the USA (Novella, 2010). Back then an international consensus arose about the need to change the way psychiatric care is applied. Mental healthcare changed from a hospitalization vision to a more consumer-based and community-

based service. The reform of mental healthcare systems is based on a care philosophy of social inclusion and personal freedom. Shen and Snowden (2014) adds to this that community-based care is more humane and more cost-effective compared to care provided in institutions. Changing this focus of care proved to be complicated looking at the overburdening of services and overt exclusion of potential users who do not fit in the new model (Novella, 2010). However, to respond to the new phenomena of revolving door patients, outpatient care models such as Assertive Community Treatment (ACT) were developed (Stein & Santos, 1998).

As a consequence of the shift in responsibility and procedure for social support, municipalities are faced with a change of culture that has not been studied much yet. The municipalities have access to a variety of policy instruments and treatments that care professionals can use to give the right psychiatric support to formerly homeless persons (Ministry of Health, Welfare and Sports, 2018). At the same time municipalities have the freedom to design their own vision on the provision of psychiatric support (Maarse & Jeurissen, 2016). This leads to large differences in the approach of psychiatric support for formerly homeless persons and raises the question if municipalities are able to provide for adequate psychiatric support. The interpretation of the approach to ambulant psychiatric support is compared within two regions in the Netherlands (Waterland and Gooi en Vechtstreek). This research fills a scientific gap, because little research is done to the policy arrangements from Dutch municipalities. The lack of empirical research to the influences of the Social Support Act (WMO, 2015) on psychiatric support makes this research a valuable addition to existing body of literature that could help to find new insights and do some policy recommendations. This lacuna resulted in the question: ***What are the factors that contribute to the 'good practise' of ambulant psychiatric support for former homeless persons from the perspective of care professionals?*** Recent literature provides sufficient guidance in what factors can contribute to psychiatric support, but the question remains if this is applicable for the Dutch mental healthcare system and the regions where it is executed.

2. Theoretical Framework

2.1 Policy Instruments of Ambulant Psychiatric Support

This study zooms in on Social District Teams and FACT-teams because they are the most common used instruments to support psychiatric patients in their own home. The focus is on the missing compatibility between the municipalities and the Mental Health Care (GGZ), because at the moment this is the most urgent issue related to the provision of adequate ambulant psychiatric support (Ministry of Health, Welfare and Sport, 2018). For that reason Social District Teams (Municipal organisation) on the one hand and FACT and Crisis Response Teams (Mental Health Care organisations) on the other hand are subject of this study.

2.1.1 Social District Teams

Since 2015 social district teams (SDT) are increasingly playing a role in providing ambulant support with a more integrated approach for homeless persons. Besides, the focus is on people who are in need for care, but trying to avoid care, because of their lack of trust in the municipality or care institutions. Arum and Schoorl (2015) found out that already 69 percent of the 224 municipalities in the Netherlands are working with the SDT's. Alternative names are social teams, frontline teams or neighbourhood teams, but in this research the terminology will be SDT. The idea of ambulant support is that people receive the adequate care in their own home setting to improve the quality of recovery instead of inside an inpatient care institute. The critique on this approach is that the conditions within certain neighbourhoods in the Netherlands are not suitable to recover from psychological, social, economic and physical problems, because of the demotivating and challenging environment (Ministry of Health, Welfare and Sports, 2018). The SDT's are often located in central buildings in a neighbourhood and their support is accessible for everyone in that area. Questions about housing, welfare and care can be asked and people can be helped with those issues. However the support is on a voluntary, self-motivated basis and the questions must be well defined. The self-reliance of people with a mental illness could be questionable, because of the severity of their psychological problems (Hoijtink, Tonkens, & Duyvendak, 2018). So, a SDT might be a less suitable instrument for clients with a severe mental illness.

The variety in the SDT's are substantial which makes them more difficult to compare with each other. However some characteristics can be distinguished that are similar in all teams. The two main components are the availability of multidisciplinary care and an integral approach. Care professionals are working together in a team with multiple disciplines such as health, welfare, but also youth care. The variety of issues that the SDT's have to solve can result in a large caseload with complex problems combined with single requests for aid. This requires a lot of expertise from social workers that are possibly not familiar with severe mental issues (van Arum & Schoorl, 2016). The realisation of an integral approach is one of the main goals of the SDT's. Besides that, two major goals are the improvement of the self-reliance of the clients and the prevention of problems in certain neighbourhoods. Another goal is the more efficient approach to reduce costs and to create a buffer for specialised care. The improvement for participation of the client and the improvement of the accessibility of the support is of a lesser concern than the other goals (Arum & Schoorl, 2015).

Because of the novelty of this approach that was introduced four years ago, the municipalities have to be aware that social districts teams are not becoming a concept without a clear instrumental and societal vision. Van Arum and Lub (2014) are advising municipalities to indicate where a social district team is needed and which goals are pursued. They do not plea for a standardized method, but a flexible, reachable and feasible approach. The budget cuts and decentralisation are providing for a thorough revision of care for vulnerable groups that must not result in an insufficient approach to help this group. De Waal (2016) adds that the municipalities do not have blue prints to realize the social district teams. At the moment they use trial-and-error methods to see what works to improve the concept of a SDT.

2.1.2 (Flexible) Assertive Community Treatment

Municipalities also make use of Flexible or Functional Assertive Community Treatment (FACT) that is a Dutch development on the Assertive Community Treatment (ACT) and started in 2004. ACT is an intensive outpatient mental health program model in which a multidisciplinary team of professionals tries to help clients who are at high risk of psychiatric hospitalization but are not willing to use clinic-based services (Lauriks, de Wit, Buster, Arah, & Klazinga, 2014). FACT is a Dutch addition to this and can be seen as an addition on the social district teams but more specialised in psychiatric illnesses. In total 400 FACT-teams are available in the Netherlands to provide care for about 70.000 people with

severe mental illnesses (van Vugt, Mulder, Bähler, Delespaul, Westen & Kroon, 2018). The differences between the ACT and FACT is that FACT covers all aspects of mental healthcare (GGZ) instead of only parts of it. Besides that, it is more district focused which makes it applicable for ambulant support for homeless persons with a psychiatric illness. The FACT is a method that combines different social support actors and integrate it in an assisting network for the client. The method involves general or state of the-art-treatment, so it could cover all needs of a client with psychiatric issues (Sytema, Wunderink, Bloemers, Roorda & Wiersma, 2007). The treatments are imposed through so called 'bemoeizorg' what can best be translated as intrusive care. The treatments are not mandatory, but the 'bemoeizorg' teams are operating side by side with the FACT-teams to reach the people who are isolated or refuse to receive care. At the same time the method helps to improve the social network of the client.

FACT is tested yearly through Routine Outcome Monitoring, to make the treatment results transparent and investigate the effectiveness (Van Veldhuizen, Bähler, Polhuis, & van Os, 2008). Model fidelity measurements are done to test the quality and transparency of the FACT. The fundaments for the teams are solid and provided for continuity of care (also when people are admitted to a psychiatric hospital). However, the method lacks on criteria such as participation and support after recovery (van Vugt et al., 2018). Social district teams could fill this gap because of the focus on community building and participation (Arum & Schoorl, 2015). The data from van Vugt et al. (2018) points to sufficient implementation of the FACT in the Netherlands. A remark is that the implementation is under pressure because the focus is too much on cutting back institutionalized protected shelters instead of the improvement of ambulant support. There are signals that the caseload is increasing and that relatively less home inspections are executed. Nugter and Bähler (2016) add that the implementation of FACT is time consuming and takes minimal one year to be completed. Besides the attention for social participation of the clients within the method could be improved.

2.2 Accessibility of Ambulant Psychiatric Support

To assess the accessibility and effectiveness of the policy instruments, the quality of output is analysed by using the theoretical model of Boesveldt (2015). In this case the policy instruments for psychiatric ambulant support are the outputs shaped by the different municipalities.

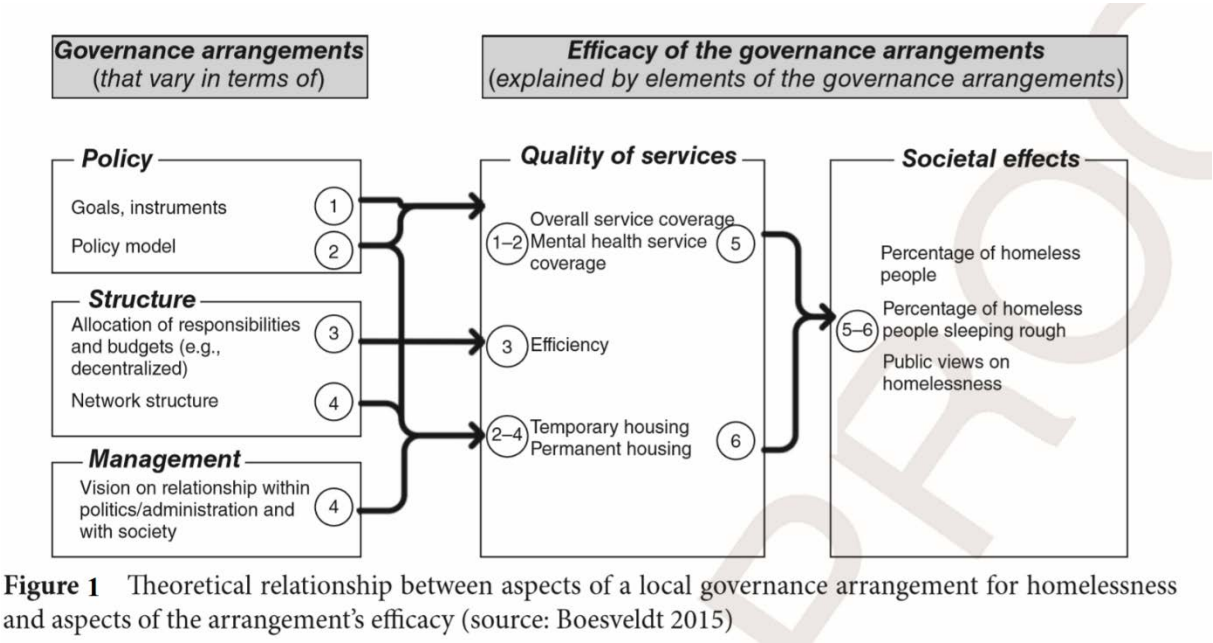

Figure 1 Theoretical relationship between aspects of a local governance arrangement for homelessness and aspects of the arrangement's efficacy (source: Boesveldt 2015)

In figure 1 the whole model of Boesveldt (2015) is presented that shows the theoretical relationship between aspects of a local governance arrangement for the homeless and aspects of the efficacy of those arrangements. This study focusses on the policy components of the model regarding psychiatric support for the homeless and how policy can influence the quality of services. In this research the influences of policy, structure and management on overall service coverage is assessed. The policy models of Gooi en Vechtstreek and Waterland are used in the interviews to assess the quality of services. The structure is exposed through asking question about the structure within the network and to understand how care professionals work together. Finally a connection is made between the relationship of the management and the ambulant workers to see in what way those two influences the mental health service coverage.

On the basis of the performance indicators for Public Mental Health Care (PMHC) the accessibility and effectiveness of the quality of services are assessed (Lauriks, de Wit, Buster, Arah, & Klazinga, 2014). The concept accessibility is regarded from a structural and policy level what implies

that care professionals define the accessibility of the services. So what are the barriers that withhold people from the right care and does anyone receive sufficient care? The most common reasons for not receiving the right treatment are low perceived need and perceived ineffectiveness of the treatment. The lack of accessibility could be divided into structural and attitudinal barriers (Andrade et al., 2014). Besides that, other components are lack of trust, the availability of support and service reach (Busch-Geertsema, Edgar, O'Sullivan & Pleace, 2010).

Attitudinal barriers are most commonly-reported with an average of 56,4%. The report of the structural barriers emerged on the second place after the attitudinal barriers. Perceived ineffectiveness and need are attitudinal barriers are involved with the perspective of the client. This applies also for the concept lack of trust (Andrade et al., 2014). A Japanese research concluded that the most common reason for delaying access to help, was willing to solve the problem on one's own. Perceived need was the most common reason for dropping out (Kanehara, Umeda & Kawakami, 2015). Lack of trust is also a major barrier for people to use mental health services, they only will seek help if they are absolutely obliged to it. Building trust is the first step to let people access the support programs (Andrade et al., 2014). Those attitudinal barriers are not directly affected by the policy instruments. Though in the policy goals the approach to overthrow those attitudinal barriers are addressed as well. So it is important to account for the attitudinal barriers in understanding the quality of services.

The structural barriers are more focussed on the environment of the client regarding psychiatric support coverage. This could mean that the municipality is not compensating treatments or could not provide for shelter or healthcare (Andrade et al., 2014). Structural problems that are creating barriers for the accessibility underlie in policy instruments. The accessibility of psychiatric support in this case relies on adequate crisis intervention and flexible support services. To understand what is accessible two concepts are playing a relevant role: what are the internal policy goals and are they offering integrated ambulant psychiatric support (Busch-Geertsema, Edgar, O'Sullivan & Pleace, 2010). The structural barriers are retrievable in the critiques on the staircase model. In this model clients receive more freedom if they develop themselves through certain stages. Sahlin (2005) sees this as one of the largest barriers to a successful service delivery, because clients have to commit to standards they are not able to reach.

Accessibility of psychiatric support is described as an open system with in mind the attitudinal and structural barriers. The delivered support must be perceived as effective and there must be a certain amount of trust. Regarding the structural barriers, accessibility must account for unavailability of treatment and shelter. Adequate crisis intervention and flexible and integrated support services are decreasing the barriers. For a successful service delivery the staircase model could be revised, because it causes barriers instead of taking them away.

2.3 Effectiveness of Ambulant Psychiatric Support

In this chapter the concept effectiveness will be operationalised to apply it on the assessment of ambulant psychiatric support for formerly homeless persons. When homeless people lived on the street, but have a house now, psychiatric support is still needed. After housing and after receiving psychiatric support what factors determine the effectiveness of the psychiatric support? What can contribute to a sustainable life after being homeless that can protect people for a relapse? The literature suggests that the main elements that contribute to the effectiveness of support programs for formerly homeless persons are: involvement of experts, integrated and continuity of offered services, improvement of autonomous life of the client, adherence to treatment, close monitoring of the client and understanding cultural differences.

Since deinstitutionalisation one of the biggest challenges with people with severe mental illnesses is disengagement form services (Shen & Snowden, 2014). Adults experiencing homelessness and mental illnesses with co-occurring substance abuse are the hardest group to reach and retain in services. Building trust is considered to be the most difficult within this group and is seen as essential to successful engagement. The clients are trapped into an institutional circuit moving between shelter, hospital, jail and the street with scattered mental healthcare from social workers. In determining the effectiveness two features are important where social workers and care providers have to account for. On the one hand they have to build trust and give the appropriate care, but on the other hand they have to be careful that they do not make the client depend from the care givers (Stanhope, Henwood, & Padgett, 2009). Slade (2010) adds to this that health services are to give primacy to increasing well-being, instead of solely treating the illness.

Shen and Snowden (2014) found two indicators that contribute to the effectiveness of ambulant psychiatric support. Close monitoring of patient status and adherence to treatment have been demonstrated to be effective for clients with severe mental illnesses. Adherence to treatment and building trust can be improved through shared decision making to empower clients during their treatment. A condition for success is the information stream that has to be from good quality. The effective agents in this case are the care givers who have to be well trained to give good quality information (Metz, Franx, Veerbeek, de Beurs, van der Feltz-Cornelis & Beekman, 2015). In the research from Kilbourne and her colleagues (2018) they also found that lack of provider training and support are common barriers to the success of ambulant psychiatric support. They also found that cultural barriers are not integrated in mental healthcare and the healthcare environments around

the client. Effective treatment can be managed through better training of care givers into understanding cultural differences and sharing their knowledge with clients.

The qualitative performance indicators: involvement of experts and integrated and continuity of offered services are derived from the study of Boesveldt (2015) These indicators can assess the integrated nature of the offered services, in this case the mental health support services. Also the supply of the services is included to assess the effectiveness. Priebe et al. (2012) found similar indicators in their search for good practises in mental healthcare. They advocate for strengthening the collaboration between different services and the improvement of exchanging information on services.

To conclude, effectiveness is a broad concept, but some assessable indicators are derived from the literature. Important in understanding what is effective or not, two concepts are important The integrated and continuity of the services and a client-centered approach. An approach with the client in the middle surrounded with care professionals that are closely monitoring the clients. The instruments are implemented more effective if the stakeholders have enough expertise and have a good quality of information stream.

3. Methods

3.1 Research Design

To expose the best practises within specific regions in the Netherlands a qualitative research strategy was used. Since the introduction of the SSA in 2015 a lot of changes have occurred within the field of social support and this is not studied yet. As a consequences of this it is unknown if the implemented instruments are working as they should and what works the best and why. So an exploratory research has been done on the perspective of the care professionals to understand what they observe an what they think that could be improved or not.

The research has a comparative case study design. The current situation in the Netherlands shows a fragmented field where all districts have their own policies and where districts are not learning from each other. The case study will be conducted in two specific regions in the Netherlands, Gooi en Vechtstreek and Waterland. They both have a different approach on the interpretation of the SSA (WMO, 2015). Besides within their interpretation of the SSA in the Regio visons (see appendix 4) it seems that Waterland regards the homelessness issue more as a housing crises and Gooi en Vechtstreek as care problem. Another difference is that Gooi en Vechtstreek is one of the richest regions in the Netherland with the most income inequality between the inhabitants. Waterland has an income distribution that is below average what means that the inequality is lower (CBS, 2019).

3.2 Research Sampling and Population

Convenience sampling is used to approach care professionals in the regions Gooi en Vechtstreek and Waterland. The respondents are found through participating municipalities in the research of Boesveldt (2019). The municipalities provided a list with email addresses so an invitation could be sent via e-mail to the stakeholders. The invitation email includes an extensive letter with the explanation and the purpose of the research. The participants were completely free to participate and could quit the research at any time. The remainder of the sample is recruited through network sampling. The inclusion criteria were that the respondents needed to be professionals and that they have to work together with the municipality and a mental healthcare organisation.

The target group is specific, because it only concerns stakeholders in the municipalities of Waterland en Gooi en Vechtstreek. They have the requisite knowledge to enable this research and they can give insights to answer the research question. The participants have minimal one week and maximal two weeks' time to decide if they want to participate or not. Eventually one respondent was unable to reach and another one did not want to participate because the interview would be too time-consuming. Nobody dropped out during the interviews or after the transcripts were returned to the participants. When they decide to participate they had to sign an active informed consent and they received information about their rights before the interview again. Participation was on voluntary base and no rewards are given in return to the stakeholders.

The sample exists of 22 semi-structured interviews with care professionals, in each region 11 stakeholders. The participants are working in 14 different care organisations including welfare, day-care, psychiatric care, ambulant care, addiction care and the Municipal Health Services. Four woman and seven men are interviewed in Waterland and five woman and six men are interviewed in Gooi en Vechtstreek. In total three persons from the salvation army have been interviewed, one ambulant employee, two from a FACT-team, three managers from sheltered housing and three from protected living. One person that works in sheltered housing, a manager from a welfare company and also two mental health care employees, one from a day-care organisation and two from Municipal Health Service (GGD). Finally two people that work in addiction care and someone from a health insurance company.

3.3 Research Method and Data analysis

In total twenty-two semi-structured interviews with care professionals are conducted in two regions to answer the research question. The interviews lasted on average 1,5 hour with outliers of 57 minutes and 112 minutes. Because of the explorative character of this study the use of semi-structured interviews have been chosen. Bogner en Menz (2009) argue that an interview with experts is a valid research instrument in explorative research. Through interviews with experts the playing field can be mapped and possible problems are coming forward. The theoretical framework supports the questionnaire that is used in the research of Boesveldt (2015) because it is based on the same model. The questionnaire is a topic list that queries the policy model and policy approach in the municipality. There are also questions about the organisational structure of the care for homeless including the mental healthcare service providers. Finally question will be asked about the delivered support and the outcomes of that support.

The direction of the interviews was on forehand flexible and through an iterative process the results emerged from the data. After 22 interviews a saturation point was reached because the final interviewees confirmed the statements previously heard in the interviews. The aim was to do 20 interviews however for more scientific saturation it was necessary to conduct two more interviews. The interview with the respondent from the Municipal Health Service (GGD) was disorderly, because the person arrived too late and did not reserved time for a proper interview. The respondent from the health insurance company provided a lot of interesting information however not much on the subjects that are central to this research. Although their data is included in the research. The questionnaire can be found in appendix 1.

The coding of the interviews is done through the qualitative data analysis program: AtlasTi. At the start of the coding process, the available codes from the research of Boesveldt (2015) were used. A combination of open coding and the use of existing codes shaped the structure of the support network around clients with psychiatric problems. After that axial coding was used and three main components emerged from the data: SDT, FACT-teams and Crisis Response Teams (CRT), a new requirement for effective and accessible ambulant psychiatric support is found. Those three forms were most commonly brought forward during the interviews. Finally through a selective coding process connections between the three forms of support have been made. The cooperation and communication between care organisations are scrutinized what resulted in a thorough analysis of the opinions and believes of care professionals.

4. Results

4.1 Where are the Social District Teams?

The research into social districts teams (SDT) was complex because of the ambiguous framework around the concept. The abstraction of the concept was defined in the theory with as main components: multidisciplinary care and an integral approach (van Arum & Schoorl, 2016). Compared to the national implementation the findings in those regions are not in line with the multidisciplinary and integral way of working found in the theory. This makes the concept of the SDT difficult to research in both regions. In Waterland a SDT is located in for example the public library and works barely with outreach care while in Gooi en Vechtstreek the SDT is located in the town hall and does not have outreach care at all. Besides, in many cases the definition of a SDT was also not clear for the stakeholders. There was confusion between the municipal social offices and the ambulant care teams that work actually in the neighbourhood.

In Gooi en Vechtstreek and Waterland both 11 care professionals were asked about Social District Teams and their cooperation with them. In Gooi en Vechtstreek six care professionals that are playing an important role in the provision of ambulant psychiatric support, indicated that they barely have contact with the SDT's. Four care professionals pointed out that they never have contact with the SDT, what could mean that an integral approach is still missing. Also in Waterland not much contact was made in general with the SDT, actually there was no respondent that has a lot of contact with the SDT. A mental healthcare employee in Gooi en Vechtstreek describes it as follows: *We have contact with the 'social square' every week,(…) but mostly when it is busy, the contact is insufficient.* However if clients must be directed to care, the social offices cannot be circumvented so it is remarkable that the contact is so minimal.

An important observation is that in three interviews the social office at the city hall, was not recognized as a SDT. A respondent (Male) of the FACT-team in Waterland acknowledges that they sometimes have contact with the SDT, but that the aim of the partnership is not clear: *it's more a kind of partnership. I have to say, I ask myself always, why am I sitting here right now.* So the confusion about what a SDT is, could have led to a different level of visibility by stakeholders. The impression of both regions is that care professionals have not much contact yet with the SDT. Furthermore the concept

of a SDT is rather vague for care professionals what indicates that the distribution of information could be improved.

4.2.1 Contact with Social District Teams

From the viewpoint of other care professionals the aim and expertise of the teams are not enough clear. Care professionals that seek contact with a SDT are often not aware of the capabilities. They know, if necessary, how to contact them and receive the right application form to receive the desired care. The accessibility is affected by the lack of knowledge about the approach of the SDT. A respondent from the Municipal Health Services (GGD) mentioned that it is difficult because of the different approaches within different teams and social offices. Finally the care organisation knows where to go and where the best chances are to receive sufficient resources to help certain clients.

Every district team is different. And also in the district teams, it depends on who is in front of you. Eventually, we know: okay I need an application, real quick. Without difficulties, filling in papers, because he refuses care, so help is needed quick. Then I need that person instead of the other. Male, GGD, 'intrusive care', Waterland

So on the one hand, care professionals have to find their (not always easy) ways to work together with the SDT. On the other hand the accessibility for residents with psychiatric problems is not ensured. Mostly because the services in both regions are not focused on the outreach. The service-users have to go to the 'social square' themselves, what could be a barrier to receive the right care. The research of Hoijtink et al. (2018) confirms this lack of accessibility from SDT because of the questionable self-reliance of people with severe mental illnesses.

A respondent sees that the municipal policy is not in accordance with reality, because:

The wish is there (The client at the center), *but the implementation is very difficult (...), I know at this moment the outreach services are very limited.* Female, Salvation Army, Gooi en Vechtstreek

A stakeholder from addiction care) adds to this that people are ashamed to go to the social office, because it is not a private area:

If your neighbour is standing next to you and you have to tell that it is not safe at home, so help me. That is not very private and you can imagine that it is difficult to take that step. Female, Addiction Care, Gooi en Vechtstreek

In Waterland the social offices are more protected and easy to access however the scope of issues they can solve is very limited. They only redirected people to care or help them with filling in papers to claim social security benefits. The teams are not thriving yet, because it is not clear to most care providers what their role is and how to deploy their expertise. So the teams are in theory accessible for everyone, but in practise the care providers and probably clients have difficulties to find them.

4.2.2 Expertise within Social district teams

A common problem with the SDT is that the employees receive questions that lay outside their expertise. The service is in theory open to all questions around care, housing and welfare, but in practice they struggle to directly help individuals with more complex issues. A care stakeholder from Gooi en Vechtstreek explains that their organisation takes over the role of the SDT's in the neighbourhood, because they do have the right expertise. Another respondent that works in addiction care sees the same problem concerning the expertise of the municipal employee that is involved in the SDT. The complaint is that the people working at the 'Social Square' are often deploying specialised care too late.

I think that they do not deploy a professional organisation soon enough, was it only for short deliberation. They think they have all the wisdom to solve the problem and then we have to come as the problem has become really big. Female, Addiction Care, Gooi en Vechtstreek

Where this inability to act comes from is still vague, because it might be a high workload, but it could also be due to lack of expertise that results in a lesser quality of services. Besides, a respondent feels that she does not know which way to go when a client is losing it, because no one knows what to do. In contrary to the policy goals that the municipality has drawn up. She explains:

So this 'real social commitment', I don't notice it. We are screaming into the air if someone goes crazy now. And I suspect that that it actually the same in the neighbourhood, if someone becomes psychotic. I mean, nobody knows what to do! Female, Salvation Army, Gooi en Vechtstreek

In Waterland the SDT's are more integrated into the neighbourhood than in Gooi en Vechtstreek however they also seem to have to little expertise about psychiatric problems. A respondent that works in a FACT-team says about the expertise of SDT's:

I think that it (psychiatry) must come up for discussion in the district teams. Because there is no supply, no input, so nobody talks about it. And I think that there is too little expertise about psychiatry here in Waterland. Male, FACT-team, Waterland

It seems that the core business of SDT is not psychiatry, but more an office that redirect people to care. There is no psychiatric support from the SDT, but also other care or guidance is not provided in those two regions.

During the interviews it became clear that the reach of a SDT is yet limited, what does not contribute to the effectivity of the teams. A stakeholder mentioned that in some national teams, social workers are working, but in those two regions that is not the case. It is not the intention to care for people, but to help them with more institutional problems and the redirection of care. So care professionals indicate that the lack of collaboration is result of the insufficient adjustment between them and the SDT. Besides, the missing confidence in the expertise of the SDT could lead to an inability to work together. Although the SDT are relatively new so this level of expertise could grow which could eventually improve the collaboration.

4.2 FACT a Panacea?

FACT is implemented in both regions and takes care of a part of the psychiatric patients that live independently (and sometimes in protected living or sheltered housing). The aim of FACT-teams do not differ much between regions and is mainly focussed on giving ambulant specialised psychiatric care. The results will not focus on what the effects are concerning the giving care to the clients. It is targeted on how effective FACT works together with other care professionals and how accessible the teams are to clients and professionals. A couple observations can be pointed out, for example the long waiting lists and the approachability of FACT. In the research the effectivity of FACT was described with mixed feelings, some respondents appraised it, while others could not find their way with them yet.

A stakeholder (Male, Waterland) that works in protected housing sees that the pressure on the FACT-teams is high. *The caseloads are enormous and you can notice that. And we try to help each other teamwise.* Van Veldhuizen (2012) describes as an advantage of FACT that intensive upscaling is possible when relapse is threating the client. This also applies for interventions with clients that are not on the radar yet. In Waterland the FACT-team explains that clients have to wait two to three weeks to have an intake with a maximum of four weeks. On the contrary the waiting list in Gooi en Vechtstreek is much longer and clients often have to wait two to three months. The Crisis Intervention Team can sometimes provide the support while waiting. The FACT-team responds to this:

The de-institutionalisation and the reduction of clinics have not risen alongside one another. I think the need for ambulant care is increased more than the capacities of FACT. Male, FACT, Gooi en Vechtstreek

This leads to frustration and incomprehension of other care professionals, because the intervention is not available while they see a client declining.

An integral approach based on social psychiatry is also essential for the success of FACT (van Veldhuizen, 2012). However the difficulty with FACT, but also SDT's and regular forms of ambulant care is that an integral approach is often missing. A client sees different caregivers every day, but does not have one central point of contact. This is a concern that is often raised in the interviews:

So we work together with FACT-teams, but one integral approach for a certain client, that you only have with things go awry and then the municipality, (…) is interfering. Male, Salvation Army, Waterland

Besides, the division of tasks is often not clear. Veldhuizen (2012) suggest that FACT includes the whole client system but in practise it is mostly focussed on treatment. One respondent from protected housing (Male, Waterland) pointed out that the reason for this individual approach could be the difference in funding. The FACT is not funded by the municipality, but they receive their budgets from the health insurance, what makes them less forced to participate in the municipality.

A recurring claim made by the interviewees is that often the members of a FACT-team did not take the other care professionals serious. The FACT-team is a specialised care provider that bears care for a relatively large group of psychiatric clients. However the FACT-team is not seeing those clients regularly instead of other ambulant workers or colleagues in sheltered housing or protected living. Those caregivers have to report signals of psychosis to a FACT-team and they can scale up the amount of psychiatric care. For four respondents in Waterland this was a common issue. One said:

If we call, (…), they ask who are you, and why do you want to talk to that person? It's like an interrogation, (…), I don't call to know what you are having for dinner. This is serious! Female, Day-care, Waterland

In addition the same respondent explained that they eventually had a good conversation with the FACT team and that they are working on those issues together. An ambulant worker also explained that sometimes other colleagues want to take over the role of the FACT-team, what could lead to unpleasant cooperation.

Interesting is that three care professionals in Gooi en Vechtstreek pointed out the same issues with accessibility of the FACT-teams.

They do not listen to what our experience or image is from that person. That you see a person in a community centre. That's just ignored. That was the situation then, when I called with the FACT-team. Female, Welfare Gooi en Vechtstreek

A manager added to this: *I often hear that the psychiatry has a high threshold, difficult to approach, are not helping fast enough.* Male, Protected Housing, Gooi en Vechtstreek

Those statements however need to be placed in context, because the overall satisfaction between the different care organisation and the FACT-teams is reasonable. Though the communication and a more integral approach can in some cases be improved. A recommendation could be to create less distance between FACT-teams and other care professionals in the field to have a strong single

approach to the signalling of psychiatric clients. The request for a less ambiguous approach applies also to the cooperation with crisis response teams.

4.3 Crisis Response Team

Another recurrent theme, which was regularly brought up by all interviewees, was the accessibility of Crisis Response Teams (CRT). If the reduction of clinical beds is not accompanied with the necessary arranged care within an independent living setting this could lead to an increase in the amount of crisis interventions. The fast development of dismantling institutional care was one of the biggest concerns of the respondents. Mostly because there is no alternative for people in a crisis than to stay at home. They cannot be admitted into a clinic, because there is a limited capacity, so other solutions need to be found. A conclusive approach can only be achieved if a CRT is available that is focussed on a broad perspective on crisis. With this broad perspective is meant that the CRT is not only available for clinical admissions, but also to defuse a crisis situation. Someone from the salvation army explained that they recently had a discussion with the CRT and the police. They both are pointing fingers at each other and do not act because it is not clear who's responsibility it is and in which case. He explained that twenty years ago they had the same discussion and yet not a real solution is found. However he added:

Do you want to help this complex group ambulant, then a conclusive approach is needed, so with the GGZ, with mentally disabled care and police, that is essential to let it succeed. Male, Salvation Army, Waterland

In both regions it is possible to call in a CRT in a situation where a psychiatric patient is going out of control. Those teams can set up a triage and indicate if a person is dangerous enough to bring to a mental hospital. In many cases the person is maybe dangerous or out of control, but not dangerous enough for clinical admission. However, problematic is that all respondents that can call the CRT and are not working in a mental hospital, think that the threshold for the CRT is too high. Seven of the eleven stakeholders in Gooi en Vechtstreek indicated that they had problems accessing the CRT, because the situation was not severe enough to help. Although the care professionals felt that this was a of major importance to them and in three cases the situation became dangerous. In Waterland a comparable conclusion can be drawn, eight care professionals explained that the CRT is not accessible enough to them.

The respondents are asked about their experiences with the CRT's and how they have arranged their resources to defuse a crisis situation. Though three of the four stakeholders that said that the CRT is very accessible are from the same organisation of the CRT what influences their statements. The general impression was that the accessibility and approachability from CRT's could

be improved. Moreover because there is a necessity, seen from the perspective of the caregivers, for complex clients that live in a neighbourhood to have a safety net. The response from the GGZ is:

It is an expensive service, what you only use if there are GGZ problems. And not, guys we have a crisis, because someone is pissing in the doorway. That is absolute nonsense! I know those things, yes a CRT has to go there. Yes, only if there are real psychiatric problems. Male, Mental Healhtcare, Gooi en Vechtstreek

Nevertheless, a gap exists now between what to do in a situation as the regular ambulant support is not sufficient anymore. If it is not feasible for a CRT to intervene in a crisis situation than they have to be more transparent about it and improve their communication to other care professionals. This will contribute to a greater satisfaction among stakeholders. Because of the differences in expectations among stakeholders frustration can built up and trust can be corrupted. A manager in Gooi en Vechtstreek that works in protected living has to express strongly the urgency to call the CRT more often, because they lost their confidence in the CRT completely. This because not only they are difficult to reach, but also not willing to help. The context is difficult to draw, because the most stories are conclusions about the functioning of the CRT in general and are not focussed on specific teams.

Yet some narratives are pointing about some persistent issues that are concerning the practises of CRT. As someone in Waterland pointed out:

So I could eventually force the CRT to come because I knew the practitioner. If the practitioner had not trusted me than I could not have done anything. Than I had a problem, because he (the client) would not be here anymore (death). Female, Ambulant Worker, Waterland

In Gooi en Vechtstreek a similar lack of confidence appeared during the interviews.

We have professional personal tutors and if they call, then it is necessary, then you have to come. Meanwhile agreed upon better cooperation. But there was a time that the assessment was through the phone. And then they listened the story and told us: we don't have to come for this! Male, Protected Housing, Gooi en Vechtstreek

As a result cooperation between GGZ and other care professionals could be improved in some respects. As seen in the quote, organisation working on it however there is room for improvement. Also in the previous chapter it became clear that FACT was difficult to reach and that other professionals not working in GGZ have a lesser role in the decision-making process. This again can result in a situation where a lot of organisations have a role in the process, but everyone

redirects the problems to the other responsible organisation. In Gooi en Vechtstreek a respondent (female) from a welfare organisation addressed this at an advisory committee. The quote is very clarifying on how the situation works:

At that meeting multiple stakeholders were present, one person said, (when there is a crisis) you just have to call the FACT-team. The other said: no, he has to call the general practitioner. Someone else said: yes, we have 112 for that kind of situations. Then I had such a case, and I started calling all the different stakeholders. How does it work, if you call the FACT-team: no response. General practitioner: no response. It was a blind alley. So now we have 1 person from a care organisation, that is open to all question (about crises).

In Gooi en Vechtstreek the care professionals are working together to close this gap with a pilot study for a 24/7 crisis services for ambulant clients. One keyperson worked for several years as a crisis director, but from the 1st of April (2019) a whole team starts to help in case of crisis. If it is acute psychiatry they redirected the client to the CRT, but in other cases they are trying to defuse the crisis. This could be a best practise that makes the approach for psychiatric support in the neighbourhood conclusive. However research have to indicate if the 24/7 crisis intervention services works or not. Although prudence is needed on this issue, because an extra organisation can make the care system around the client even more complex.

5. Discussion

This study aimed to find factors that can contribute to the best practise of ambulant psychiatric support. The focus was on the missing compatibility between the municipalities and the Mental Health Care (GGZ), because at the moment this is the most urgent issue in the support for psychiatric clients that live in the neighbourhood concerning the rapport of the Ministry of Health, Welfare and Sport (2018). First of all from the perspective of the care professionals much can be achieved in the cooperation with the SDT's. Their role is not clear and the level of expertise is not sufficient enough to support clients with severe mental illness. In contrary to the policy goals of the two regions, the SDT's are not always accessible for the group that is less self-reliant and assertive. The involvement of the municipality is evident though the means of support have to be extended combined with a more outreach approach.

The FACT-teams, in contrast, have a strong outreach approach with sufficient expertise. However, an integral approach with other care providers is not strongly developed. A factor that can contribute to the best practise is that the FACT-team has to be more cooperative with other stakeholders and be more clear in their communication. Intensive upscaling of care is sometimes not feasible or necessary and if this is not communicated clear, it could lead to incomprehension by other care professionals. This connects with the complaint that care professionals feel that they are not taken seriously by the FACT-team when they approach them for support. A conclusion that not correspondents with the conclusive approach proposed in the region visions.

Crisis Response Teams created even a higher threshold to be approached than the FACT-teams. The barrier is two-sided, because on the on hand the CRT is an exclusive service only for psychiatric confinement so not for 'regular' crises. On the other hand the accessibility and approachability from CRT's could be improved because the communication with other care professionals is too minimal for a conclusive approach. Besides, clear adjustment between police, care organisations, CRT and General Practitioner in crises situations is important for the success of ambulant psychiatric care. Concluding five factors can be distinguished that contribute to the best practise of ambulant psychiatric support: sufficient expertise, clear adjustment between partners, an out-reach approach, enough labour capacity and approachability.

Van Rooijen and her colleagues (2016) are confirming these results in their research to the collaboration between FACT-teams and SDT's. The qualitative approach of this research adds, but is also in according with the quantitative data that is available around SDT's and FACT (Kok & Briels, 2014). The conclusion was that on an operational level the cooperation was not yet established or growing. FACT-teams are a key agency in flexible and intensive psychiatric care, but when the crisis is alleviated the support has to focus on other parts of the life domain. In more stable periods the SDT can provide additional or replacement care. The transfer of care from the FACT-team to a SDT must be done with appropriate speed and a high level of trust. This is in line with the current research that shows that barriers are standing in between the smooth cooperation of the care professionals with the municipalities.

In both regions the intention for a conclusive approach regarding ambulant psychiatric support is present however not yet achieved. In the interviews the care professionals seemed benevolent to work together, but in some ways the SSA and Region visions are not implemented to their full extent. An alternative explanation from a governance perspective can be added to understand this conclusion. Maarse and Jeurissen (2016) describe that that when a reform (in this case SSA) with large implications has been introduced in a short period of time it comes with many uncertainties and risks involved. The implementation of a reform with such a pace entails always risks even if the reform seemed well-prepared on paper. Time is needed to adapt a system what also brings hope in the development of the ambulant support provision. However in the last four years the government already had to take many temporary accompanying measures to lessen these uncertainties and risks.

An addition to this could be found in a more micro-scale theory about the behavioural intention of organization members towards implementations of modification in the structure of an organisation. If care professionals have a positive attitude towards modifications of the current procedures so for example the implementation of the SSA, than this will result in the enhancement of the change process (Supper, Catala, Lustman, Chemla, Bourgueil & Letrilliart, 2015). Further research must be done to the positive behavioural intention of care professionals towards the SSA and the effects on the network of care organisations.

The diversity of the sample made it possible to understand the comprehensive network of stakeholders in both regions. Though a limitation of the study is there might be a selection bias what

could be a result of the purposeful sampling. The two participating regions provided a list with possible respondents. This therefore implies that the municipalities must give more thought to the name of the care professional to nominate what can (unintendedly) result in stakeholders who are in favour of the municipality. Although, the sample is divers and the intentions of the keypersons from the municipalities are also to obtain a representative sample, because they will use the data to improve their own policy. This limitations is also overcome through the selection of extra respondents that were not provided by the municipality. Besides, convenience sampling was the only option regarding project funding and time constraints.

Another limitation is that the SDT's are not interviewed within this research. So their perspective is missing and that is unfortunate because it could have been a relevant addition to the data. The reason is that in the first inventory of care professionals in both regions the SDT's were not stressed by the municipalities. In the composition of the professional network, municipalities do not point out SDT's as remarkably researchable. One conclusion based on the results of this study could be the unfamiliarity with the SDT by care professionals, but probably also the municipality. And that SDT have, concerning the municipalities, a minor role in the care provision. However, these limitations are outweighed by the fact that this is the first exploratory study that convincingly shows that improvement can be made in the cooperation with SDT. A recommendations is to incorporate the SDT in future research

The strength of the study is that this is the first qualitative research that combines the structural and policy level with the outcomes on the ambulant psychiatric support provision. Frustrations and trust issues are exposed with the help of a useful method that is particularly suitable for researching this topic. A lot of rich data about a sensitive and complex topic is collected. The feelings within the professional care network are captured and combined to receive an in-depth understanding of the common issues. The care professionals showed that they need to have more trust in each other's expertise and that the communication between them has to be improved.

Municipalities have to keep thinking how this complex group can be supported in the best possible way. Local practises could led to a variety of designations regarding SDT's. Learning from each other is essential in the improvement of the SDT. The process of decentralisation mentioned in the beginning of the research is an ongoing process that still has to find it is way. Another recommendation is to create less distance between FACT-teams and other care professionals in the

field. Expertise of psychiatric support is subdivided under different care professionals and they need to trust upon each other's expertise. If the stakeholders are brought together more often than a conclusive approach can possible be achieved.

In this study is discovered that a gap exists between the CRT and the regular ambulant psychiatric support. Regular ambulant psychiatric support is not always sufficient on moments when clients are in crisis. In those cases they are able to call the CRT, however in some cases it is not possible for the CRT to do a clinical admission. In the first place it is recommended to improve their communication and be open and transparent about the reasons. This will contribute to less frustration and greater satisfaction among stakeholders. Besides, a best practise learned in Gooi en Vechtstreek is to create an extra service that is in between the CRT and regular care. The pilot has started and further research have to show if this will be an effective solution.

To conclude, the rapid change and extended responsibility for the municipality could lead to an inability to act and cooperate with care professionals, what eventually is at the costs of vulnerable clients. A conclusive approach is a desirable goal, but all stakeholders should have to make an effort to provide all clients with adequate ambulant psychiatric support. The will to change is present in those two regions however the recommendations should be executed first to entirely serve the needs of psychiatric clients that have their own home.

6. Literature

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7. Appendix

Appendix 1: Questionnaire English

Topic list interviews stakeholders (Boesveldt, 2015).

Intro interview

1. Background respondent

1.1 What is your professional background?

1.2 What do you do, what is your job?

2. Policy

2.1 Policy model

2.1.1 What are the general causes for and characteristic of homelessness in *Region*

2.1.2 What do you feel explains homelessness in *Region*? What can you base this impression on?

2.2 Strategy

2.2.1 Are you familiar with the *Region* strategy on homelessness?

2.2.2 Where are you positioned in the *Region* homelessness strategy? What is your place, your role?

2.2.3 The *Region* strategy sets specific goals and employs specific instruments SHOW GOALS AND INSTRUMENTS/ ASK: are you familiar with these goals, instruments?

2.2.4 Does the *City* strategy on homelessness influence your daily work? How? In what way?

2.2.4.1 E.G. (IV3.5 *City*) How/ to which extent is 'cooperation with the NGO's in the local districts of the Region' realised?

2.2.4.2 E.G. (*other Regions*)

2.2.5 According to you, are the goals being set in the strategy (IV2 below) met by these instruments (IV3)?

2.2.6 How is the strategy related to the wider policy area of homelessness? Is there a

distinction between the strategy and the wider policy area or does the strategy cover the whole policy area?

2.2.7 *Intro* I am also interested in how well you need to know whether these are met. To what extent do you know the goals set in this strategy are met? What instruments do you/ does your organisation have available? (Accountability mechanisms, also IV 6)?

2.2.8 In general, do you feel the strategy addresses the main problems with homelessness in the region?

3. Structure: Mapping multi-levels of homelessness

Intro

(Since the needs of homeless people can be complex,) the financial sources for support can come from several departments or levels in the government structure, and beyond.

3.1 Together with you, I would like to draw a picture of the different levels that are involved.

SHOW/ COMPOSE A SKETCH OF the horizontal and vertical levels involved in the *City* strategy

TOGETHER FILL IN POSSIBLE 'GAPS'

3.1.1 Where are funds and policy for addiction situated?

3.1.2 Also, mental health policy and means.

3.1.3 Housing policy?

3.2 What expertise is available at what level?

3.2.1 In your everyday job, where and how do you get informed about what you need to know about homeless or homelessness (information position; sources)?

3.3 (with homelessness as a potentially wicked problem;) What financial risks are positioned at what level?

3.4 How is the position of the region in this (broader) picture?

3.4.1 And how does this impact your work?

3.4.1.1 More specific, is there an impact on the network (THINK: STEERING CAPACITY, IT'S RELEVANCE)?

3.4.2 IF NOT DISCUSSED UNDER 1.2.4.1: what does the network on a local level look like?

3.4.2.1 How is this managed? By whom? In what way? And to what effect? What is the effect on participants of this network?

4. **Working together**

(IF NOT ALLREADY DISCUSSED BEFORE) What is your relation to, how do you work together with:

- (other) homeless people (Peer support)
- (other) practitioners,
- (other) policy makers (IV1 en IV6a),
- (other) politicians (IV6a),
- the public (monitoring data available)?

Do you know of any studies that describe the effect on individual clients (such as a cohort study) and or effects on certain city areas that I need to know about?

5. **Output TALK ABOUT**

5.1 Mental health service coverage homeless

5.2 Overall service coverage homeless

5.3 Temporary housing

5.4 Permanent housing

5.5 Homeless with income

5.6 Homeless registered with care providers

Anything else you would like to share about the topic of this intervie

Appendix 2: Questionnaire Dutch

1. Achtergrond respondent

1.1 Wat is uw professionele achtergrond?

1.2 Wat doet u, wat is uw werk?

2. Beleid

2.1 Beleidsmodel

2.1.1 Wat zijn de kenmerken van personen in beschermd wonen of maatschappelijke opvang in *Gemeente*

2.1.2 Wat leidt volgens u tot opname in Beschermd Wonen of Maatschappelijke Opvang in *Gemeente*? Waarop baseert u deze indruk?

2.2 Beleidsaanpak

2.2.1 Bent u bekend met het beleid inzake beschermd wonen en maatschappelijke opvang in de gemeente …?

2.2.2 Wat is uw rol, plaats binnen dit beleid?

2.2.3 Dit beleid stelt specifieke doelen en hanteert specifieke instrumenten zoals: DOEL DOELSTELLINGEN EN INSTRUMENTEN noemen VRAGEN: bent u bekend met deze doelen, instrumenten?

2.2.4 In hoeverre hebben deze doelen, dit beleid invloed op uw dagelijkse werk? Hoe? Op welke manier?

2.2.4.1 E.G. (IV3.5 Gemeente) op welke manier en/ in welke mate wordt *het beleidsdoel* van Gemeente volgens u gerealiseerd?

2.2.4.2 E.G. (ander doel)

2.2.5 In hoeverre kunnen volgens u, de doelen die worden gesteld (geef voorbeeld) worden gerealiseerd door het hier beschreven instrumentarium (geef voorbeeld, bekijk samen)?

Waarom wel? Niet?

2.2.6 Hoe verhoudt dit beleid zich tot het bredere beleidsterrein waarop de ambulantisering en regionalisering van de beoogde doelgroep betrekking heeft?

In hoeverre is er een onderscheid tussen de beleidsaanpak en het bredere beleidsterrein of bestrijkt de strategie het gehele beleidsterrein?

2.2.7 *Inleiding.* Wij zijn ook geïnteresseerd in de mate waarin gestelde doelen worden behaald.

In hoeverre heeft u er zicht op of de hier gestelde doelen worden behaald?

Welke instrumenten heeft u/ heeft uw organisatie beschikbaar om dit te weten? (Verantwoordingsmechanismen, ook IV 6)?

2.2.8 Vindt u in het algemeen dat dit beleid de belangrijkste problemen in *gemeente* die te maken hebben ambulantisering en regionalisering van de beoogde doelgroep adresseren?

3. Structuur: multi-niveaus van betrokkenheid op de doelgroep MO/BW in kaart brengen

Intro

(Aangezien de behoeften van de beoogde doelgroep MO? BW complex kunnen zijn), kunnen voorzieningen die tegemoetkomen aan deze ondersteuningsbehoeftes en de financiële bronnen voor deze ondersteuning afkomstig zijn van verschillende afdelingen binnen de gemeente, of daarbuiten, denk aan de zorgverzekeraar, of het UWV.

3.1 Samen met u wil ik een beeld schetsen van de verschillende niveaus die hierbij betrokken zijn.

MAAK samen EEN SCHETS VAN de horizontale en verticale niveaus die betrokken zijn bij de Gemeente-strategie

SAMEN VULLEN MOGELIJKE 'GAPS'*

3.1.1 Waar zijn middelen en beleid voor verslaving gesitueerd?

3.1.2 Ook beleid en middelen voor geestelijke gezondheidszorg.

3.1.3 Huisvestingsbeleid?

Maatschappelijk werk?

Werk en inkomen?

Participatie? Dagbesteding, re-integratie?

3.2 Welke expertise is beschikbaar op welk niveau?

3.2.1 In uw dagelijkse werk, waar en hoe wordt u geïnformeerd over wat u moet weten over de beoogde doelgroep MO/BW (informatiepositie, bronnen)?

3.3 Welke financiële risico's zijn er op welk niveau?

3.4 Hoe is de positie van Gemeente in dit (bredere) beeld?

3.4.1 En welke invloed heeft dit op uw werk?

3.4.1.1 Meer specifiek, is er een impact op het netwerk (THINK: STUURCAPACITEIT, IT'S RELEVANCE)?

3.4.2 INDIEN NIET BESPROKEN ONDER 1.2.4.1: hoe ziet het netwerk op lokaal niveau eruit?

3.4.2.1 Hoe wordt dit aangestuurd? Door wie? Op welke manier?

4. Samen werken

(INDIEN NIET ALLERLEI BESPROKEN VOOR) Wat is uw relatie met, hoe werkt u samen met:

• (andere) daklozen (peer-ondersteuning)

• (andere) beoefenaars,

• (andere) beleidsmakers (IV1 en IV6a),

• (andere) politici (IV6a),

• het publiek (controlegegevens beschikbaar)?

Kent u studies die het effect op individuele cliënten beschrijven (zoals een cohortonderzoek) en of effecten op bepaalde stadsgebieden waarover ik moet weten?

5. Resultaten, output

Wat is bekend over, bijvoorbeeld op basis van ondersteuningsplannen, over:

5.1 de mate waarin ggz zorg daar waar dit nodig is wordt geleverd aan de beoogde doelgroep?

5.2 de mate waarin er een (gecontinueerd) aanbod wordt gedaan aan de doelgroep?

5.2 de mate waarin er meer dan 1 zorgverlener aanwezig is (integrale zorg)

5.3 Tijdelijke huisvesting

5.4 Stabiele, permanente huisvesting

5.5 De mate waarin in het inkomen is voorzien

5.6 Daklozen geregistreerd bij zorgverleners

6. Outcome

6.1 Participatie doelgroep

6.2 Inkomen

6.3 Gezondheid

6.4 Stabiel gehuisvest/ huisuitzettingen

6.5 Contact met politie of justitie (overlast)

6.6 Dakloze personen die zich melden

6.7 Personen die buitenslapen

6.8 Publieke opinie

Appendix 3: Code Tree

0. Introductie*
0.1. Introductie: professionele achtergrond/beschrijving werk.
1. Beleidsmodel
1.1. Beleidsveronderstellingen
1.1.1. Beleidsveronderstellingen: causale/empirische veronderstellingen.
1.1.2. Beleidsveronderstellingen: normatieve veronderstellingen.
1.2. Beleidsrelaties
1.2.1. Beleidsrelaties: doelen perspectieven belangen
1.2.2. Beleidsrelaties: strategie gerelateerd aan bredere beleidsterreinen
1.3. Beleidsdoelen
1.3. Preventie
1.3.1. Beleidsdoelen / preventie: Wet Verplichte GGZ (WPGGZ)*
1.3.2. Beleidsdoelen / preventie: vroegsignalering huisuitzettingen (?)
1.3.3. Beleidsdoelen/preventie: ondersteuning in de wijk (basis,wijkteam, crisisteam, aansluiting FACT ed.)
1.4. Beleidsinstrumenten
1.4.1. Preventie
1.4.1.1. Instrumenten / preventie: vroeg erop af, vroegsignalering huisuitzetting
1.4.1.2. Instrumenten / preventie: ondersteuningen in de wijk (basis, buurtteams, crisisteams, aansluiting FACT ed)
1.4.1.3. Instrumenten / preventie: hulp gemeente
1.4.2. Instrumenten: regionalisering
1.4.3. Instrumenten: doelbereik
1.4.3.1. Instrumenten / doelbereik: doel niet bereikt door instrument*
1.4.3.2. Instrumenten / doelbereik: mogelijk doelbereik*
1.4.3.3. Instrumenten / doelbereik: mogelijke belemmeringen doelbereik*
1.4.5. Instrumenten: ervaringen
1.4.5.1. Instrumenten / ervaringen: succesfactoren, wat gaat er al goed?*
1.4.5.2. Instrumenten / ervaringen: wat moet er nog gebeuren?*
2. Beleidsstructuur
2.1. Tekening structuur
2.2. Fondsen en beleid
2.2.2. Fondsen en beleid
2.2.2.1. Fondsen en beleid: Verslavingszorg (VZ)
2.2.2.2. Fondsen en beleid: GGZ
2.2.2.2.1. Fondsen en beleid / GGZ: Dwang, suicide
2.2.2.2.2. Fondsen en beleid / GGZ: Mentale gezondheid
2.2.2.3. Fondsen en beleid: Algemeen Maatschappelijk Werk (AMW)
2.2.2.4. Fondsen en beleid: verantwoordelijke participatie/dagbesteding
2.2.2.5. Fondsen en beleid: Huisvesting, corporaties.
2.2.2.6. Fondsen en beleid: Politie, blauwe dwang
2.2.2.7. Fondsen en beleid: Sociale Integratie (SI)
2.2.2.8. Fondsen en beleid: Werk en Inkomen (W&I)
2.2.2.9. Fondsen en beleid: Financiële risico's en onregelmatigheden
2.2.2.10. Fonsen en beleid: Lichamelijke gezondheid

2.3. Expertise
2.3.1. Expertise: politiek niveau
2.3.2. Expertise: administratief niveau
2.3.3. Expertise: praktijk niveau
2.3.4. Expertise: theoretisch niveau
2.4. Impact op dagelijks werk respondent
2.4.1. Structuren
3. Management
3.1.1. Management: rekenschap/aansprakelijkheid beleid
3.2. Compositie network
3.2.1. Compositie netwerk: heterogeen network
3.2.2. Compositie netwerk: homogeen network
3.2.3. Compositie netwerk: instrumenten lokaal netwerk
3.2.4. Compositie netwerk: management network
3.2.5. Compositie netwerk: betrokkenheid stakeholders
3.2.6. Compositie netwerk: positie gemeente binnen niveaus
3.2.7. Compositie netwerk: toewijzing van verantwoordelijkheden
3.2.8. Compositie netwerk: rol in strategie
4. Samenwerking stakeholders
4.1. Samenwerking actoren
4.1.1. Samenwerking actoren: daklozen
4.1.2. Samenwerking actoren: taskforce (bijzondere doelgroepen)
4.1.2.2 Samenwerking FACT
4.1.2.3 Samenwerking CRT
4.1.3. Samenwerking actoren: uitvoerders
4.1.4. Samenwerking actoren: beleidsmakers
4.1.4.1. Samenwerking actoren / beleidsmakers: gemeenten, corporaties, zorginstellingen
4.1.4.2. Intergemeentelijke samenwerking
4.1.5. Samenwerking actoren: politici
4.1.6. Samenwerking actoren: publiek
4.1.7. Samenwerking actoren: Sociale Wijk Teams
4.2. Ervaringen samenwerking
4.2.1. Leren van onderzoek en/of andere gemeenten
5. Output beleid
5.1. Toelichting op data
5.2. Output: GGZ
5.2.1. Output / GGZ: Continuiteit GGZ zorgaanbod
5.2.2. Output / GGZ: Zorgaanbod
5.2.2.1 FACT Team (NEW CODE)
5.2.3. Output / GGZ: Ambulante zorg
5.3. Output: integratie in de buurt; making it work
5.4. Output: extramuralisatie
5.5. Output: in kaart brengen vraag en aanbod
5.6. Output: inzicht vraag en aanbod woningmarkt
5.7. Output: conflicten in samenwerking
5.8. Output: HF
5.9. Output: regionalisering
5.10. Output: herstelondersteunende,- gerichte zorg

5.11. Output: inzet ervaringsdeskundigheid in zorg
5.12. Output: inzet mantelzorg, informele zorg
5.13. Output: algemene dekking zorgaanbod
5.14. Output: Tom in de buurt
5.15. Output: wijkzorg
5.16. Output: tijdelijke huisvesting
5.17. Output: stabiele huisvesting
5.17.1. Output / stabiele huisvesting: Skaeve Huse
5.18. Output: trainingen/curssen mbt verhogen zelfredzaamheid
5.19. Output: (voorkomen) huisuitzettingen
5.20. Output: beschikbaarheid betaalbare, passende woonvormen
5.21. Output: daadwerkelijke, cijfermatige beschikbaarheid woningen voor uitstroom
5.22. Output: monitoring
5.23. Output / monitoring: aantallen clienten (PMHC)
5.24. Output: verdeling woningvoorraad
5.25. Outcome: cijfers buitenslapen
5.26. Output: data publieke opinie

*The **bold** codes are used in this research

Appendix 4: Regio visions

The Region Vision on Social Support: Waterland

In Waterland the social support for civilians with a handicap will be approachable and recognizable organised. The municipality directs this process from the perspective of the social district teams. The role of the municipality is to facilitate this in an optimal way. At the same time the task that needs to be executed is precisely followed by the municipality. They do this through monitoring the targeted goals considering their mission, vision and societal consequences. The vision of Waterland consists of four assumptions. The first is that the most civilians with a handicap do not need help and are able to care for themselves. The focus is on letting people live independently and the final solution is supported housing. Another assumption is that the growing up with a handicap is special and at the same time normal. The vision is that a handicap is not strange and that everyone needs help once in a while. They want to create a positive climate where everyone can ask for help or could express their concerns about their fellow man. The third is that within Waterland there is a strong social cohesion and that improving that is one of their main goals. Social networks around people with handicaps or mental illnesses are important and the municipality focusses on stimulating and improving those networks. Neighbours, but also professionals must work together and learn from each other to help the people who need it. The municipality wants to create a civil society where everyone contributes to the society in a way that is valuable in their manner. The last assumption is that the environment of the civilian (with a handicap) is central. To improve the quality of life it is important to invest in directed support. The wellbeing of civilians must be central and the handicap of someone must not exclude them from society. Waterland's vision is that people cannot be put in different domains with all different kinds of support. The danger is that the wishes of clients are becoming out of sight. The most important pillar is an integral approach that looks critical at the fragmentated approach that they had in the past (Waterland, 2018).

The Region Vision on Social Support: Gooi en Vechtstreek

The municipality of Gooi en Vechtstreek noticed that the capacity for supported housing and shelter of the homeless is under pressure. To reduce the waiting lists the municipality introduced some new initiatives to expand their supply of policy instruments. The focus is on a strong base quality care with a focus on outflow and a life as normal as possible. The first part of the vision includes 'real involvement'. It is in the interest of the clients that their environment is involved in solving the problem. Also the clients themselves must have the freedom to decide over their own treatment and they can choose what kind of care suits them the best. The municipality suggests that the most suitable approach for the client is integrated in the social environment together with welfare institutes. Besides that the focus lies on prevention and picking up signals in an early stage, so that problems are not worsening. Vulnerable civilians receive as much autonomy as possible so that they can have control over their own life. This must improve the quality of life and makes them defensible for physical, emotional and social challenges. The final part of the vision of Gooi en Vechtstreek is based on the idea that people need to have 24 hours a day and 7 days a week access to care in case of emergency. It is the mission of the municipality to react adequately to prevent escalation and provide the suitable care on the right moment. The focus in Gooi en Vechtstreek is also on a more integrated approach where care professionals work together to deliver the right treatment (Regio Gooi en Vechtstreek, 2017*).*