A brief history and the future of Flexible ACT (FACT) in an ecosystem of health in the Netherlands

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Abstract

Background: Flexible Assertive Community Treatment (FACT) teams are widespread in the Netherlands and abroad. Despite the presence of a model description and model fidelity scale, it is not well-known how and why these have been developed and their impact so far.

Objective: The main question investigated relates to a better understanding of the development of FACT in the past and present, considering model fidelity and quality improvement, and future implications.

Method: A multi-perspective reflection on quality improvement in FACT teams as part of networks of care for people with Severe Mental Illness (SMI).

Results: Research shows the need for a comprehensive, multidimensional approach to mental health care of people with severe mental health problems, where FACT teams play a vital role within integrated networks, fostering recovery, collaboration, and continuous quality improvement.

Conclusions: Enhancing quality of care in FACT teams through model fidelity has advanced faster than other changes within the FACT model itself. The FACTs 2017-R fidelity instrument offers a solid framework for model fidelity, emphasizing accountability for catchment areas and tangible recovery-oriented practices. We suggest generalist FACT teams in small catchment areas (30,000–50,000 inhabitants) using a multi-agency approach to ensure continuity and coordination of care for all individuals with SMI. The future challenge lies in improving quality of care within integrated networks to achieve genuine recovery.

Key words: Flexible Assertive Community Treatment, service delivery model, quality improvement, model fidelity

In the Netherlands, an estimated 1.7% of the population suffers from a severe mental illness (Dutch definition of Severe Mental Illness (dSMI) (Delespaul, 2013). dSMI is defined by Delespaul (2013) as the need for integrated care due to long-term (>2 years) mental disorders accompanied by severe social and societal limitations (both as a cause and effect)

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and are not transient. During the 90s Dutch mental health organizations used intensive clinical case management as a service for people with severe mental illness (SMI). Clinical case management from an individual case manager does not meet the needs of people with severe mental illness (Delespaul, 2013) and teams of individual case managers indeed struggled delivering one standard of care (Kroon et al., 2000). The ACT model was introduced simultaneously in different regions in the Netherlands to deliver integrated services to this population in 1999. The introduction and translation of the Dartmouth Assertive Community Treatment Scale (DACTS; Teague et al., 1998; Van Dijk et al., 2004) contributed significantly to the standardization of care for individuals with SMI in the Netherlands. The availability of a fidelity scale with clear, structured guidelines facilitated the widespread adoption of the ACT model. This was further reinforced by Dutch research (Van Vugt, 2015) confirming earlier findings from the United States (McGrew et al., 1994; McHugo et al., 1999; Latimer, 1999), suggesting that higher fidelity to the ACT model is associated with improved client outcomes.

The ACT model lived up to the expectation of integrated care up until 2003 (Van Vugt, 2015). A few years after the introduction of ACT in the Netherlands, the National Evidence Based Practices Movement caught on and Dutch mental health professionals called for adjustments to the ACT-model. These adjustments were needed to address two main concerns with the model. Firstly, Dutch professionals became aware of the narrow definition of the target group for ACT and wanted to provide the ACT ingredients to all people with SMI. Like the Northern American teams, ACT teams started out for people with severe psychosis and other issues and organizations developed their ACT teams from specialist clinics for psychosis. A more trans-diagnostic, recovery-oriented and human rights approach led to the Dutch concept of severe mental illness and the transition of ACT into Functional, later Flexible Assertive Community Treatment (FACT) in 2004 (Van Veldhuizen, 2007). Secondly, it seemed difficult to develop ACT teams in rural areas and less densely populated areas. Often the catchment area grew too large, due to the narrow target group, to deliver all services and not all clients needed the intensity of care all the time. This topic has been addressed in American literature on ACT as well. For instance, ACT was evaluated and found to be efficient in urban, densely populated areas (Bond et al., 2001) and less suited for rural settings (Bond & Drake, 2015). Rural areas do not need the intensity of care all the time and need to explore ways to deliver services to all people with dSMI, not just the most severe as in ACT. As indicated in earlier writings about ACT in America, it has been difficult to develop such teams in rural areas (McDonel et al., 1997; Bond & Drake, 2015). Although the second concern helped to create the FACT model, FACT teams were implemented in urban, rural and frontier areas alike

Just as ACT, FACT combines the principles of team case management with delivering services to a shared caseload as needed, together with all the other assertive and outreach services within one team. The main difference between ACT and FACT is that in FACT the upscaling and downscaling of care based on the current needs of the patient within the team has been structured and systematically organized. Due to this process, clients receive team case management from one or more case managers

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coordinating treatment or receiving intensive assertive outreach services from the team, being part of a shared caseload (Van Vugt et al., 2011; Van Veldhuizen et al., 2015). In doing so, FACT teams can deliver services up to 250 or 300 clients per team. From 2004, the number of new FACT teams increased rapidly to 300 certified teams in 2018 (Westen et al., 2020). FACT always delivers integrated treatment for people with interrelated problems on multiple domains of life within a network of care in a predefined catchment area. FACT is attributable to ACT in many ways and both models can exist side-by-side in larger cities, if needed. For instance, in some larger cities, an ACT team delivers services to people with SMI who wander across the whole city, mostly due to homelessness, and multiple FACT teams are appointed to smaller catchment areas. Being able to make an educated choice between the two models within a certain context is something that will improve quality of care for all people with severe mental illness (Westen et al., 2022).

Generalist FACT teams have been set up in most Dutch regions and FACT became the de facto standard community care for people with SMI from 2010 onwards. In some regions, in addition to generalist FACT teams, evidence has shown that specialist FACT teams deliver services with positive results for forensic clients (Smeekens et al., 2021), clients with mild cognitive disorders (Neijmeijer et al., 2019, 2020) and young clients (Broersen et al., 2020; Broersen et al., 2023). Other specialist teams serve clients with personality disorders, the elderly, clients with bipolar disorder and clients with an addiction as a primary diagnosis. Specialist Early Intervention Psychosis-teams using the FACT or ACT model with small adaptations were created as well (Verhaegh et al., 2007). This quick rise of up to 300-400 FACT teams in the Netherlands inspired many other countries to develop FACT teams as well. FACT teams have been created in Austria, Belgium, Bonaire, Canada, Croatia, Denmark, Finland, France, Hong-Kong, Iceland, Ireland, Moldova, Norway, the UK, the USA and Sweden for instances. Being mentioned as one of Europe's Good Practices in Community Mental Health (EU Compass Consortium, 2014) must have helped FACT to gain popularity too.

Although FACT holds the premise to improve recovery of people with SMI and teams are created to serve all people with SMI in rural and urban areas alike (Van Veldhuizen, 2007), research results on recovery are not conclusive (Nielsen et al., 2021; Nielsen et al., 2023). FACT teams support clients during times of crisis and provide treatment and recovery-oriented continuity of care that prevents dropout (Nugter et al., 2016). FACT has also shown to reduce (long-term) admissions for adult patients in the Netherlands (Nugter et al., 2016), the UK (Sood et al., 2017) and Denmark (Nielsen et al., 2021), but it lacks results on recovery (Van Vugt et al., 2018). Research shows that satisfaction is high amongst clients receiving FACT care (RET, 2015) and professionals delivering it (Lexén & Svensson, 2016) - what might be due to the expected effects found on citizenship as experienced by the client (Brekke et al., 2021) and closing the gaps in a fragmented care system (Trane et al., 2021). However, measuring recovery through randomized controlled trials (RCTs) remains challenging, as recovery is a deeply personal and multidimensional process and FACT teams need to adapt locally every time and continuously. A sole focus on quantitative outcomes risks oversimplifying the concept and numbers-driven decision-making creating

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perverse incentives. Therefore, it is crucial for FACT networks to collect and interpret both qualitative and quantitative data collaboratively, to continuously improve the quality of care at the local level.

For a long time, Dutch FACT teams delivered integrated care and most services from disciplines within the team. But, since 2015 services are scattered over many different agencies and professionals due to a transformation of mental health care and a stronger position of local governments in healthcare. Therefore, a modern Dutch FACT team needed to re-adapt to new situations and reconsider how to deliver integrated care within a network of care. At the baseline, FACT teams are using the same disciplines but working within the network of care has led to adding professionals from other organizations (multi-agency approach) and/or adding new disciplines, like occupational therapists, or more professionals from one discipline, like social workers and psychologists. In practice, FACT teams adapted the FACT model in many variations to meet local needs or for other, practical, reasons. FACT teams, organized within the mental health sector, needed to participate and open up for new collaborations with all kinds of local partners to create integrated networks of care within an ecosystem of (mental) health. Alternatives for FACT have been created to improve integrated care, like teams using a multi-agency approach sharing professionals from mental health and the municipality or from mental health, addiction services and the municipality and teams consisting of more mental health specialists to offer services to a broader target group. Mental health organizations reorganized externally or internally to create these adaptations. These teams are often named differently but with a very close resemblance to FACT, and these initiatives inspired the creation of a new conceptualization of FACT as the best possible community mental health service one can deliver.

All recent initiatives are centered around two major objectives, which have not yet been combined. One objective was to integrate specialist mental health services within or around a FACT team. Some teams grew really large and struggled to deliver ACT services. Others maintained the FACT model and are now able to deliver all specialist services, too. Another objective was to integrate more social services from the municipality within a FACT team. Some teams are just connected with social workers from the municipality; others are assigned social workers as a secondment from the municipality or provided finances to do so. During this time frame FACT+ teams started working with a multi-agency approach (including addiction care and the community), like Youth FACT teams, and moved their offices literally into the community, often together with other community parties. All the objectives make sense and many of these alternative practices were created for the local good.

The considerations about alternatives and adaptations led to existential dilemmas amongst FACT professionals, policy makers and FACT experts. Is one still a FACT team when one adapts to local conditions and thus drifts away from model fidelity? Or should this question be the other way around and does model fidelity need to rethink its meaning and purpose? A challenge (or a blessing?), considering the struggles FACT teams have already showed in demonstrating that they carry-out recovery-oriented care (Van Vugt et al., 2018).

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One way to ensure that key components of an intervention are not "lost in translation" is the use of fidelity scales (Mowbray et al., 2003). At first, a comparable model fidelity scale was created for FACT in 2008, adapting the Dartmouth Assertive Community Treatment Scale (DACTS; Teague et al., 1998). Researchers in the US developed a successor to the DACTS to enhance recovery-oriented practices and created the Tool for Measurement of ACT (TMACT; Monroe-Devitea et al., 2011) adding quantitative, recovery-oriented items to the scale. In the meantime, a lot happened in Dutch mental health care since 2015 that led us to deviate from the vast, in our opinion micromanaged, TMACT with little room to adapt for unique and frequent struggles Dutch FACT teams face in their local circumstances.

The struggle of using fidelity-consistent and fidelity-inconsistent modifications can be seen in Norwegian teams in frontier-like areas (Trane et al., 2022). They created smaller teams with very small caseloads and professionals working part-time for the team in very large catchment areas. By impression, they have low fidelity. However, enriching conversation and working on quality of care will help teams explain their rationale for modifications. These Norwegian teams do relate contribute to the understanding and relevance of the FACT fidelity scale, and their audits help to define what FACT is and isn't, a process similar to FACT adaptations in Danish and Swedish FACT teams as well (Westen et al., 2023). We now know that a team model as FACT can be enriched with the use of interventions, like network support from resource groups (Tjaden et al., 2021) or Open Dialogue (Seikkula et al., 2006), without the need to support structural changes to the model. On the other hand, the FACT model cannot be used for the coordination of services from professionals from multiple teams who meet only once every two weeks. In that case, a new model outside of FACT was eventually created to be able to coordinate care amongst professionals from different organizations for people with complex mental health issues (not-SMI) (Client-Centered Coordination Platform (3Cp) (Westen et al, 2021) In another part of Europe, Greek FACT teams also struggled with local innovations. However, their experiences led them to choose to create their own fidelity scale, because the teams could not meet all criteria in the old FACT scale from 2008 (Peritogiannis & Tsoli, 2021). Their focus on comparing 'achievements' between (international) teams made them step out of the international FACT community. By developing their own measurement scales, teams lowered the threshold for success, thereby achieving high scores. However, this approach can inadvertently discourage the pursuit of evidence-based standards or, very importantly, the creative adaptation of new working methods within the team to establish those standards in new ways. In the case of the Greek teams, the opportunity to engage in such creative processes was lost, as were the worthy conversations and growth opportunities for FACT.

And we do need those conversations! The initiatives mentioned challenge the model and model fidelity for FACT. The future will do that even more so. The future of mental health worldwide requires community-centric services, integrating all community and inpatient components within a catchment area (Rosen et al., 2020). Good, community-oriented services for people with (a risk of) SMI always require a cross-sectoral approach and thus the involvement of multiple service providers (Delespaul et al., 2017). FACT teams cannot

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deliver all services and support for people with SMI alone. For future development of the best possible community mental health care (e.g. FACT) it is of great importance for FACT teams to be able to adopt new innovations within a clear FACT model and adapt to the local context. The latest FACT 2017-R model fidelity scale (Westen et al., 2023) has been created to fit the process of quality improvement and appreciative inquiry (Westen et al., 2019).

We lowered the focus of strict model fidelity by replacing most quantitative questions, like in the FACTs 2008 fidelity scale version, for qualitative topics. Part A of the FACT model fidelity scale now consists of sixteen quantitative items for disciplines, team structure and some core items, like FACT board or team meetings and outreach, organized using a 5-point Likert scale. A qualitative Part B has been created to open up on creative and flexible adaptations to eight key deliverables for every FACT team. Teams need to adopt these new focus areas and adapt depending on their case-mix, network partners, interventions and local context. Adaptations in line with model fidelity are now key to quality of care. This choice was made following researchers supporting the position on items that are found to be non-essential in research may be more flexibly incorporated, as in part B of the new scale, while elements that are critical may not be changed, as those in part A (Leff & Mulkern, 2002; Kelly et al., 2000). This concept helps urban, rural and frontier teams adopt, without losing its main aim to deliver services to people with SMI using FACT and adapt by using fidelity-consistent modifications (Queri, 2022).

Interestingly, the new FACTs 2017-R promotes FACT teams to fit like a glove within their mental health service ecosystem and yet this undeniably challenges model fidelity itself. The scale needs to enhance and promote good quality of community care for people with SMI. But, what if… a high scoring FACT team functions as a terrible partner in a network; or, the other way around, a low scoring FACT team is in reality an excellent partner for its general practitioners, inpatient units and crisis resolution teams? The FACTs 2017-R does address the teams' responsibility for a network of care but cannot evaluate the relations within the network itself. The FACT scale was intended to primarily rate the factors that are under the team member's control and therefore be limited to aspects that the team can improve. For now the linkage between part A, the quantitative items on disciplines and team structure, and part B is our most important tool to address a FACT team's role in a network. This linkage might help future FACT teams in frontier areas or in areas with a shortage of staff or network. A clear linkage between Part A and Part B (using descriptions on key deliverables) will need to support local modifications instead of hindering it. For instance, many teams function well without a psychiatrist thanks to alternative practices within the team and their network. This only shows in Part B of the scale. This linkage between part A and B will support the continued calibration of the FACT model and its fidelity scale with new modifications and system and societal changes. FACT teams need to strive for optimal fidelity-consistency to both parts A and B if possible and make clear, monitored and deliberate choices when modifying the model if needed.

However, relying on fidelity scales might not be enough anymore. In an integrated network of care FACT teams will need to monitor its place within the network of care more closely. Taking on responsibility for all people with a current SMI in a network of care goes beyond a FACT

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team's boundaries (and its model fidelity). In recent years, FACT teams have transitioned from autonomous decision-making units to collaborative actors within broader care networks. Their decision-making processes now increasingly involve clients, relatives, and external professionals. This shift has also led to a move from team-centered outcome measures to shared goals and integrated indicators across the network (Michgelsen et al., 2022). Choices will need to be made to adapt to local situations. These choices have consequences for the teams and for a network of care. Organizing integrated care is a balancing act. Choices that narrow down the target population to more specialized teams will enlarge the catchment area and an enlargement of the catchment area will lead to more difficulty in accessing and collaborating with local resources. Choices will affect the ability to deliver assertive outreach services or the close availability of FACT in a local community. Enlarging the scope to include people with common mental health disorders will lead to larger teams and individual caseloads and difficulties to prioritize care and deliver assertive outreach and integrated care as a team. The need for support in all domains of life, as in people with SMI, will always rely on multiple agencies. So, choices that need to be discussed during an assessment of a FACT team in an integrated network of care are 1) being a generalist vs specialist FACT team, 2) creating integrated care in a network vs integrated care within a FACT team, and 3) the size of the catchment area for the FACT team. These three factors influence the work of a FACT team in a network of care, as well as its score on the model fidelity scale and can only be discussed in an inclusive and shared decision-making process in a network (Westen & Peeters, 2022). Although Dutch FACT teams appear to value their regained autonomy and responsibility for care quality, they are not consistently involved in local decision-making processes. Currently, this limits their influence on broader strategic choices within the care network.

A future for FACT

Enhancing quality of care in FACT teams using model fidelity is moving faster than the intrinsic changes made within the FACT model in recent years. The FACTs 2017-R seems to be a good effort for now. It steps across former boundaries of the original FACT model and demands a responsible and responsive approach within a network of care. The model and its fidelity scale will need adaptation when integrated care in a network will concretely unfold in the future. Important changes have been made to the FACTs 2017 model fidelity scale to promote the concept of taking responsibility in a certain catchment area and show, not only tell, about recovery-oriented activities enhancing recovery for people with severe mental illness. Recent literature on integrated care (Van Os et al., 2023; Delespaul et al., 2017) on the other hand shows a preference for generalist FACT teams in small catchment areas (30-50.000 inhabitants) instead of many specialized teams creating a fragmented landscape of care. We suggest generalist FACT teams, consisting of specialists customized to the team's case-mix, using a multi-agency approach in a small catchment area to take on the main responsibility for the coordination and continuation of service delivery for all people with an actual SMI in a network of care. An interesting challenge for the future of FACT will be the ability to improve

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quality of care in a network of care, in the service of achieving true recovery.

Inspiration for this article was drawn from my PhD thesis where many of the concepts and findings discussed here were originally developed. See: Westen, K. (2024). Does FACT have a future? A multi-perspective reflection on quality improvement in Flexible Assertive Community Treatment teams as part of networks of care for People with Severe Mental Illness [Unpublished doctoral dissertation]. Tranzo, Tilburg School of Social and Behavioral Sciences of Tilburg University].

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