Reviewer's report

Title: A real-life observational study of the effectiveness of FACT in a Dutch mental health region

Version: 2 Date: 2 October 2008

Reviewer: J.Remmers van Veldhuizen

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08 10 Review of revised manuscript ms: 4298778771980055

A real life observational study of the effectiveness of FACT; Marjan Drukker et al

Review by J. Remmers van Veldhuizen

Dear authors,

I'm very impressed by your revised manuscript; the suggestions of Gary seem to have inspired you!

I have only a few small remarks

* At page 5: the study of Sytema et al (17) is cited by you as a “FACT” study. The authors always have stated that they have worked with a model fidelity ACT model.

* Also page 18: studies 12 and 17 are now cited as FACT studies, but they are “ACT” studies

* (page 15-16) Perhaps it is informative to add that in the FACTs (2008, Bähler, van Veldhuizen, van Vugt et al) some items regarding addiction and IDDT (Integrated Dual Diagnosis Treatment) already have been integrated. For example two teammembers have to be specialist addiction worker (possibly in combination with their original profession as casemanager, psychologist or psychiatrist).

* page 16 *“a specific FACT scale etc (personal communication) etc. Maaike van Vugt is not the first author of the FACTs. Field tests are being conducted by CCAF (see text proposal here under)

FACT fidelity scale: FACTs (2008) M. Bähler, J. R. van Veldhuizen, M. van Vugt, Ph. Delespaul, H. Kroon, J. Lardinois, N. Mulder;

The most recent version will be published in October 2008 at internet (www.ccaf.nl) and in:


* And following the former revisions:
Major Compulsory revisions:
My former remarks have been integrated rather well, but perhaps not sufficiently to make it clear for the reader who isn’t informed on the Dutch situation. My suggestion is to mention first the service for the 100% SMI group (versus 20% for ACT): see under

Page 5, second paragraph:
In The Netherlands, a Dutch variant of ACT was developed: ‘function-ACT’ (FACT) [7]. FACT teams are delivering service for the total group of SMI in a region (where ACT only covers the 20% most severely of the SMI). Members of FACT teams conduct a style of assertive outreach by paying both announced and unannounced home visits, and by using supportive legal measures when needed [8]. The difference with ACT is that FACT can be a comprehensive care system. FACT combines two approaches for SMI patients within one multidisciplinary recovery-oriented team: (a) individual case management and home visits for extensive care SMI-patients who are mostly stable; (b) shared caseload with intensive full ACT approach for patients in need for intensive care. The b) group is se are discussed in daily staff meetings similar to the practice conducted in ACT. When, over time, the care needs of these patients change, they remain in the same multidisciplinary team (continuity of care). These teams are also in charge of admission and discharge between outpatient service and hospital. the transition between various intramural and extramural institutions [7]. Members of FACT teams conduct a style of assertive outreach by paying both announced and unannounced home visits to both groups of patients, and by using supportive legal measures when needed [8]. The difference with ACT is that FACT can be a comprehensive care system with more possibilities for continuity care. In Maastricht, the FACT teams remain responsible for care even when patients are admitted. Thus, FACT teams serve a diverse population of SMI patients with various levels of need for care. On the other hand, “classic” ACT serves only those SMI patients who are in crisis or have the highest needs for care. As patients in crisis need more guidance than more stable patients do, the average frequency of contacts etc

Discussion page 15, line 5, 6
Because of the continuity-of-care principle these interventions are continued when treatment by the psychiatrist is finished. In some phases less intensive

In addition, in FACT the focus of treatment is the community rather than the clinic, not only for the 80% less intensive SMI patients but for all SMI patients. In addition, in FACT the focus of treatment is the community rather than the clinic, not only for the 80% less intensive SMI patients but for all SMI patients. The aim is that the more severely ill SMI patients also benefit from social inclusion in the community [7]. In addition, ambulatory SMI patients can access resources needed for recovery and rehabilitation that were often only available for clinical patients.

Page 16, line 8-10:
A Dutch expert group is evaluating working ingredients and formulates fidelity criteria to maximize the development of a standard for care in the Centre for Certification Act & FACT (www.ccaf.nl). In this centre, a FACT Fidelity Scale (FACTs) has been developed by Bähler, van Veldhuizen, van Vugt and others.

Conclusion:

Congratulations with this revised version. If you should have any questions re CCAF or FACT model, please don’t hesitate to keep in touch by telephone 0031653233193

Remmers van Veldhuizen

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.