Comparison of ACT, FACT, and FOCUS (our team)
Adapted from van Veldhuizen J and Bahler M, 2013.

	ACT Standards in Ontario, Canada (Ministry of Health and Long Term Care, 2004)	**FACT in the Netherlands (van Veldhuizen J and Bahler M, 2013)**	**IST (integrated services team): our local Adaptation of FACT**
Target group	Clients with severe mental illnesses (SMI) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder.	All patients with SMI in a particular district or region.	Patients meeting ACT admission criteria as well as all patients who are experiencing serious mental health problems impairing their community functioning, with high utilization of emergency or inpatient psychiatric services. These patients must have at least two additional active problems which may include: homelessness or housing instability, criminal justice involvement, substance use disorder, and acute or chronic medical illness requiring intensive community support.
Number of patients per team	60–100	220–250	190
Size of region	Often targets large areas, for example with 250,000 residents, although Ontario ACT standards also provide guidelines for smaller rural teams.	Rural: 50,000 residents Urban: 40-45,000	Urban area: 130,000 residents
Team composition	Broadly multidisciplinary: case managers with different expertise, social workers, occupational therapist, nurses, peer support worker, and psychiatrist.	Similar to ACT, with extra emphasis on psychologist, employment worker, sometimes independent living support, and with more rehabilitation specialists. FACT teams in the Netherlands include many nurses.	Similar to ACT, with extra emphasis on psychologist, employment worker, independent living support, and addictions specialists.
Caseload (number of clients/staff)	1:10 in Urban ACT Teams* 1:8 in Rural ACT Teams*	1:20	1:13
Psychiatrist	1: 100	0.8:200	1.3:190
Psychologist	Not part of the model	0.6:200	1:190

Team leader provides direct client care	Compulsory.	Sometimes, but can be replaced by 2–3 FACT board chairs.	Team leader provides direct care to shared care clients with the rest of the team (ie ACT-level clients), but does not carry a personal caseload.
On ACT/FACT board for daily discussion	All 100 clients.	Only 20–30 clients who need daily care and attention at that particular point; also ‘cases to discuss.’	Only 20–30 clients who need daily care and attention at that particular point; also ‘cases to discuss’ eg. patients who are incarcerated or hospitalized.
Contact frequency	> 3–4 times a week	If necessary, 4–5 a week is possible, but in many cases the frequency is much lower and based on their need.	>3-4 a week for between 40-60% of clients; for other cases the frequency is lower and based on their need.
Focus on EBM interventions	At times difficult since some clients are not stable and not yet open to psychological interventions. ACT guidelines in Ontario name a number of evidence based medical (EBM) interventions such as Cognitive Behavioral Therapy and Motivational Interviewing as the types of services that should be provided to patients. However, there are no specific instructions on how frequently and by whom these services are administered.	More feasible due to clients with changing levels of need. In addition, the FACT model of care utilizes a psychologist who must be trained in providing a number of EMB interventions. The delivery of some of these EBM interventions is evaluated as part of FACT fidelity scales including an evaluation of the team function.	Similar approach to the FACT model. In addition to having a psychologist on the team who is providing a number of EBM interventions, a number of team members have been trained in providing Cognitive Behavioral Therapy and Dialectic Behavioral Therapy.
Focus on recovery and empowerment	In the past to a lesser extent, but this is now changing rapidly.	One of FACT’s basic principles.	One of the team’s basic principles.
Discharge policy	Clients are discharged when they: 1) Have successfully reached individually established goals for discharge or demonstrated an ability to function during a gradual reduction in services (over approximately 2 years). Program staff will arrange for transfer to a less intensive service and maintain contact with the client until transfer is complete. **or**	Only clients who have been functioning stably for a long time (2–3 years) in all areas of life and who no longer want care. Then clients are transferred to a General Practitioner.	Clients are discharged when they: 1) Have been functioning stably for a long time (2–3 years) in all areas of life and no longer want care. Then clients are transferred to lower intensity of care **or** 2) Move outside the geographic area of our team. The team partners with the client to arrange for transfer of mental health service responsibility to a local ACT program or another provider. Our team remains involved

	2) Move outside the geographic area of ACT's responsibility. The team shall partner with the client to arrange for transfer of mental health service responsibility to a local ACT program or another provider. The ACT team maintains contact with the client until this service transfer is implemented. **or** 4) Decline or refuse services and request discharge, despite the team's intensive and persistent efforts to develop an acceptable treatment/service plan with the client.		with the client until this service transfer is implemented. **or** 3) Decline or refuse services and request discharge, despite the team's intensive and persistent efforts to develop an acceptable treatment/service plan with the client when there are no acute safety issues or concerns.
Relapse	Can return to ACT, but sometimes there are waiting lists.	Can go straight back to being listed on FACT board.	If removed from ACT-level services, but still on team, can go straight back to being listed on FACT board. If fully discharged, the team would prioritize bringing them back into service.

*However, according to a study of Ontario ACT teams by George and Colleagues (3) the average case load of ACT teams during their study period of 2007 and 2008 was reported to be 1:6 for large urban ACT teams and 1:4 for small rural ACT teams. These numbers are obviously far below general ACT standards and Ontario Specific ACT Criteria.