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Letter to the Editor

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Implementing the flexible ACT model in an Italian residential facilities multidisciplinary team

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Over the last two decades, the Netherlands has transformed the American Assertive Community Treatment (ACT; Kent & Burns, 1996) into the Flexible ACT (FACT), which has gained widespread adoption (Firn et al., 2013; Trane et al., 2021). FACT efficiently coordinates care delivered to people with severe mental disorder (SMD) employing a flexible switching system of support to respond to varying needs. A multidisciplinary team of 11 to 12 professionals manages a caseload of 200 patients in catchment areas of approximately 40 to 50,000 inhabitants through daily 30 to 45 minute team meetings. These district-based teams collaborate closely with other services, adhering to the Dutch model of 'transmural care' combined with recovery-oriented care to ensure comprehensive support. FACT enhances transparency and information sharing via a digital board, boosting collaboration and tailored approaches for challenging situations (van Veldhuizen & Bähler, 2013).

In Italy, mental health services shifted to community-based care after deinstitutionalization, aiming to facilitate independent living for individuals with SMD who represent 3.5% of Italian patients. Italian Residential Facilities (RFs), classified into five main types according to rehabilitation and care intensity, provide support for the community integration of individuals with SMD. This is achieved through tailored programs and progressive care pathways, developed in collaboration with other services (de Girolamo et al., 2005; Martinelli et al., 2022).

In the South Verona Mental Health Service (Tansella et al., 2006), RFs play a vital role in post-deinstitutionalization care. Like FACT teams, South Verona RFs were managed by a multidisciplinary team with weekly meetings, and adapted care to evolving patient needs. However, these meetings, even though prolonged (2–3 hours each), were ineffective in gathering the most relevant information about the residents and lack in recovery-oriented practices, with an orientation to paternalism (Martinelli et al., 2022, 2024).

Acknowledging the need for improvement, the team decided to develop for the first time in Italy, a trial to integrate aspects of the FACT model into RFs. After consultation with the Dutch FACT promoters, the model was adapted within the South Verona multidisciplinary team overseeing seven RFs with varying levels of care for a total of 32 residents. The team underwent training on the FACT manual, appointing a designated chairperson (either the psychiatrist or psychologist responsible for RFs) and creating a personalized digital board for real-time updates. This adaptation resulted in improved information exchange, shorter meetings (1 hour each), and enhanced team dynamics. Additionally, the recovery-oriented perspective emphasized empowerment, encouraging residents' active participation in their programs. Overall, the experimentation was appreciated by staff and patients.

The trial spanned from January to September 2020, remarkably, during the SARS-CoV-2 pandemic. Despite the challenging circumstances (Lasalvia et al., 2023; Martinelli & Ruggeri, 2020), this trial showcased the adaptability of the FACT model in ensuring uninterrupted care through online data sharing.

To our knowledge, this marks the first attempt to integrate the FACT model into the Italian mental health system. Our results suggest that integrating FACT into Italian multidisciplinary teams could enhance coordination, collaboration, and service delivery outcomes, aligning with recovery principles.

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