CCAF

Fidelity scale FACT

The CCAF is intellectual owner of the FACT fidelity scale. The scale is developed by: Michiel Bähler, Remmers van Veldhuizen, Maaike van Vugt, Philippe Delespaul, Hans Kroon, John Lardinois, Niels Mulder. Mike Firn helped with the translation in English
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Certification Centre for ACT and FACT (CCAF), December 2010

(+ minor changes for 2015)

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)

TEAM STRUCTURE	**1**	**2**	**3**	**4**	**5**
1. SMALL CASELOAD: Consumer/provider ratio 15:1 (incl. Psychiatrist, psychiatrist in training 50% of FTE[1])	> 50 consumer/provider	35 - 49	25 – 34	16 - 24	Consumer /provider ratio 15 or less.
2. STAFF CAPACITY: The program operates at full staffing with minimal vacancies	Operates at less than 50% staffing in the past 12 months	50% - 64%	65% - 79%	80% - 94%	Operates at 95% or more of full staffing in past 12 months
3. FULL TIME STAFFING: Mean (average) part time staff (total of FTE / staff head count) excl. secretary	Less than <. 0.5 mean FTE	Between 0.5 and 0.59	Between 0.6 and 0.69	Between 0.7 and 0.79	Operates at mean FTE of staff is 0.8 or more.
4. PSYCHIATRIST: at least 1 fulltime psychiatrist to 200 consumers works with program.	Less than 0,10 FTE regular psychiatrist to 200 consumers	0,10 – 0,39 FTE psychiatrist to 200 consumers.	0,40 – 0,69 FTE to 200 consumer.	0,70 – 0,99 FTE to 200 consumers.	The team has at least 1 full time psychiatrist to 200 consumers.
5. PSYCHOLOGIST: at least 0,8 FTE to 200 consumers	The team has less than 0,2 FTE psychologist	0,2 – 0,39 FTE to 200 consumers.	0,4 – 0,59 FTE to 200 consumers.	0,6- 0,79 FTE to 200 consumers.	0,8 FTE psychologist or more
6. PEER SPECIALIST: at least 0,8 FTE to 200 consumers	No peer specialist	0,2 – 0,39 FTE to 200 consumers.	0,4 – 0,59 FTE to 200 consumers.	0,6- 0,79 FTE to 200 consumers.	0,8 FTE Peer specialist
7. SOCIAL WORKER: 0,8 FTE to 200 consumers	Less than 0,1 FTE social worker to 200 consumers	0,1 – 0,39 FTE social worker to 200 consumers	0,4 – 0,69 FTE to 200 consumers.	0,70 - 0,79 FTE to 200 consumers.	0.8 or more to 200 consumers.
8. PSYCHIATRIC NURSE: at least 4 FTE nurses (1 year experience) on the team to 200 consumers	The program has less than 0,40 FTE nurse to 200 consumers	0,40 –1,59 FTE to 200 consumers.	1,60 – 2,79 FTE to 200 consumers.	2,80 – 3,99 FTE to 200 consumers.	4 full-time or more nurses on the team to 200 consumers, 2 have extended experience
9. CASE MANAGER: the program has at least 6 FTE Casemanagement to 200 consumers.[2]	The program has less than 3 FTE CM to 200 consumers.	The program has less than 4 FTE CM to 200 consumers.	The program has less than 5 FTE CM to 200 consumers.	The program has less than 6 FTE CM to 200 consumers.	The program has at least 6.0 FTE CM to 200 consumers
10. DUAL DISORDER SPECIALIST: at least two fulltime specialist to 200 consumers (at least 1 year training or experience).	Less than 0,20 FTE DD knowledge to 200 consumers.	0,20 – 0,79 FTE to 200 consumers.	0,80 – 1,39 FTE to 200 consumers.	1,40 – 1,99 FTE to 200 consumers.	2 FTE or more DD specialist with at least 1 year training or experience with

[1] FTE = Full time equivalent (36 hours a week in the Netherlands)

[2] Can be all disciplines

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)
					substance abuse
11. SUPPORTED EMPLOYMENT SPECIALIST: to 200 consumers at least 1 FTE (at least 1 year training or experience).	The program has less than 0,10 FTE SE to 200 consumers.	0,10 – 0,39 FTE to 200 consumers.	0,40 – 0,69 FTE to 200 consumers.	0,70 – 0,99 FTE to 200 consumers.	At least 1 FTE SE-specialist to 200 consumers
12. REHABILITATION SPECIALIST: 2 FTE in staff. (role in team)	Less than 0,50 FTE to 200 consumers.	0,5 – 0,99 FTE to 200 consumers.	1,00 – 1,49 FTE to 200 consumers.	1,50 – 1,99 FTE to 200 consumers.	2 FTE Rehab specialist or more
PROGRAM PROCESS					
13. SHARED CASELOAD: all consumers in the FACT program have contact with at least 4 staff members in a year (include psychiatrist).	Less than 10% consumers had face to face contacts to 3 staff members in a year.	10% - 36%	37% - 63%	64% - 89%	90% or more of the consumers had face to face contacts with more than 3 staff members a year
14. TEAM APPROACH DURING ACT: the team will function as a team, not as separate professionals. All the team members know and work with the consumers who need ACT on the board.	Less than 10% consumers during ACT have face to face contacts with more than 2 team member in 2 weeks.	10% - 36%	37% - 63%	64% - 89%	90% of the consumers have face to face contacts with more than 3 team members in 2 weeks.
15.PROGRAM MEETING: the team meets during the week to plan and review services for all consumers for Flexible ACT care.	Service planning for ACT usually 1x a week or less	Service planning for ACT usually 2x a week.	Service planning for ACT usually 3x a week.	Service planning for ACT usually 4 x a week.	The team meets 5x a week to plan and review services for all consumers for ACT care.[3]
16. MULTIDISCIPLINAIRY FACT-MEETING: at the FACT meeting all working team members are present. (Score- instruction: if psychiatrist is not present while working, 1 point less).	At FACT meeting at least < 60% of staff including psychiatrist.	At FACT meeting > 60% of staff including psychiatrist.	At FACT meeting > 70% of staff including psychiatrist.	At FACT meeting > 80% of staff including psychiatrist	At FACT meeting > 90% of staff including psychiatrist
17. TREATMENT PLAN: the treatment plan is set in presence of at least 4	< 50% of the treatment plans is set	50%-69%	70%-79%	80%- 89%	90% of the treatment plans are set in

[3] Meeting at least 3x teams a week formal other days check of daily plans.

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)
different disciplines.	multidisciplinary				presence of at least 4 different disciplines
18 TREATMENT PLAN – CONSUMER: the treatment plan is being set in presence of the consumer. And in discussion with..	< 50% of the treatment plans is set in presence of the consumer	50-69% < 50% of the treatment plans is set in presence of the consumer	70-79%	80-89%	90 > or more plans are set in presence of at least 4 different disciplines
19.TEAMLEADER[4]: - Provides direct services (at least 30% of the time) - is active in stimulating the FACT philosophy/ model - is always present at the FACT-meeting - is present at the treatment plan-meetings.	Team leader scores on on none of the criteria.	Team leader scores on one criteria	Team leader scores two criteria.	Team leader scores on 3 criteria.	Team leader provides all 4 criteria.
20. CRITERIA FOR ADMISSION TO THE FACT-BOARD: The program has clearly defined criteria for placing consumers on the FACT-board: (1) Increase of symptoms/crisis, (2) disturbed or offending behavior, (3) severe self-neglect, (4) missed appointments, (5) hard to engage, (6) regular admissions, (7) post hospital discharge, (8) intensive treatment (e.g. new medication), (9) life events, (10) new consumers.	The program uses 1-3 criteria for placing consumers on the FACT-board.	The program uses 4-5 of the 10 criteria.	The program uses 6-7 of the 10 criteria.	The program uses 8-9 of the 10 criteria.	The program has defined all 10 criteria and uses them in daily practice.
21. PROCEDURE FOR ADMISSION TO THE FACT-BOARD: there is a well-defined procedure for placing consumers on the FACT-board, **for acute needs,**	The program has no defined procedure. but can explain their procedure which	The program has no well-defined procedure but can explain their procedure which	The program has no well-defined procedure but can explain their procedure which	The program has no well-defined procedure but all 5 practices are used.	The program has a well defined procedure and all 5 practices are used.

[4] Team leader can also be a shift manager with a well defined role in the team.

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)
and next steps: (1) Every team member can place a consumer on the FACT-board, (2) the program uses the existing crisis plan, (3) consumer and family are informed, (4) psychiatrist will see the consumer or discuss the situation within 2 days (medication and coercion), (5) if necessary hospital and 7 x 24 crisis services are notified	reveals 2 criteria	reveals 3 criteria out of 5 practices	reveals 4 criteria out of 5 practices		
22. PROCEDURE DISCHARGE FACTBOARD: There is a well-defined procedure to graduate the consumer from the FACT-board, with next steps: (1) the decision takes place during the FACT meeting (2) the consumer is informed (3) the ACT period is evaluated on effectiveness and satisfaction with the team (4) and with the consumer and family/relatives (5) if necessary the crisis plan is revised (6) and treatment plan is evaluated\and revised.	The program has no well-defined procedure, but reveals 2 out of 6 practices.	The program has no defined procedure but reveals 3 out of 6 practices	The program has no defined procedure but reveals 4 out of 6 practices	The program has no defined procedure but reveals 5 out of 6 practices	The program has a well-defined procedure and uses all 6 practices
23. INTENSITY OF SERVICES DURING ACT: (discuss 5 consumers on the FACT BOARD with high intensity)	Average 1 contact/week to consumer or less.	1 – 2 / week	2 – 3 / week	3 -4 / week	Average 4 of more contacts/week to consumers.
24. FREQUENCY OF CONTACT OF CARE AS USUAL: to CAU consumers the intensity should have face to face on a regular basis.	Less than 1 face to face contact in 4 weeks.	1 face to face contact in 4 weeks	1 face to face contact in 3 weeks	1 face to face contact in 2 weeks	1 face to face contact a week.
DIAGNOSTICS, TREATMENT AND INTERVENTIONS					
25. FULL RESPONSIBILITY FOR TREATMENT SERVICES: the program offers outreach for practical individual services: (1) household support, ADL (2) offer help and if necessary accompany to appointments, like social services (3), family, (4) neighbourhood, (5) finance and social security, (6) medication.	The program offers no case management services	Provides 2-3 out of 6 services and refers externally for others.	Provides 4 out of 6 services and refers externally for others	Provides 5 out of 6 services and refers externally for others	Provides all 6 services to consumer.

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)
26. NEW CONSUMERS: New consumers are placed on the FACT board and stay for 3 weeks to meet the different disciplines and that team members have their first impression.	No	Sometimes	Structured > impression by 3 team members	Structured with report from 3 team members	> 4 team members
27. INDIVIDUAL TREATMENT PLAN: Each consumer has a treatment plan less than one year old.	60% or less have a treatment plan.	70%	80%	90%	95% of consumers have a treatment plan less than one year old.
28. INDIVIDUAL CRISISPLAN: Each consumer has an actual crisis plan also available to crisis services.	20% of the consumers has an actual crisis plan.	21-40%	41-60%	61-80%	> 80% of the consumers has an actual crisis plan.
29. INDIVIDUAL REHABILITATION PLAN: each treatment plan has individual rehabilitation goals on several items and it is defined in stated goals and strengths.	20%	21-40%	41-60%	61-80%	More than 80% of the consumers has a treatment plan with individual rehabilitation goals
30. COPY TREATMENT PLAN: each consumer has a copy of his treatment plan (unless consumers declare they don't want it).	20% of the consumers has a copy	21-40%	41-60%	61-80%	More than 80% off the consumers has a copy of the treatment plans
31. MEDICATION	Medication will be adjusted when asked, or on as reaction to complaints	Minimal. Once a year there is a review of medication	Through the year there is attention to effects and side effects of medication and if necessary education about the meds takes place.	Three or more medication protocols are used	The program uses the toolkit for medication management
32. PSYCHO -EDUCATION	PE takes place on request by consumer or when required	For PE the consumer is referred to another program	Individual PE provided by the program , but consumer is referred for group PE	The program is responsible for PE, individual and group.	The program uses the toolkit / guideline PE.
33. COGNITIVE BEHAVIORAL THERAPY[5]: during last 2 years. +EMDR	CBT is not available for consumers of the program.	Consumers are referred to CBT but less than 10% uses CBT.	Less than 15%	CBT is offered in the program but less 15% of the consumers uses	CBT is available throughout and more than 15% of the

[5] Percentage of total caseload over last 2 years

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)
				CBT.	consumers uses CBT.
34. FAMILY PSYCHO EDUCATION: (e.g multi Family groups)	FPE is not available for family members	Less than 10% of the families uses FPE	Less than 20%	>20%.	The program uses the toolkit FPE and more than 20% of the family uses FPE
35. SUPPORTED EMPLOYMENT(IPS): there is consistent attention and focus on employment.	There is no attention for SE	For SE consumers are referred.	There is systematic attention for SE. Consumers are referred..	Vocation Rehabilitation programs are offered by a specialist in the team.	The program uses the toolkit SE / IPS.
36. DUAL DISORDER (DD) MODEL: uses a non confrontational stage wise treatment model, follows behavioral principles, considers interaction of mental illness and substance abuse and has gradual expectations of abstinence.	Fully based on traditional model: confrontation, mandated abstinence, etc.	Uses primarily traditional model e.g. AA uses inpatient detox & rehab; recognizes need to persuade consumers in denial or who don't fit AA.	Uses mixed model e.g.: DD-principles in treatment plans refers consumers to persuasion groups; uses hospitalization for rehab; refers to AA, NA.	Uses primarily-model: DD-principles in treatment plans; persuasion and active treatment groups, rarely hospitalizes for rehab of detox except for medical necessity.	Fully based in DD-treatment principles, with treatment provided by FACT staff members in transmural programme
37. INDIVIDUAL PHYSICAL HEALTH CARE	The program offers no screening for physical health co-morbidity	The program reacts sometimes to physical health problems, but there is no systematic screening nor referral to other services	The program reacts sometimes on physical health but there is no systematic screening. Referral are done to GP or other services	The program has systematic attention to physical health problems, yet, there is no systematic screening. Consumers are referred to GP or other services	The program offers systematic (metabolic) screening to physical health problems and if necessary are accompanied to other services

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)
ORGANIZATION					
38. EXPLICIT ADMISSION CRITERIA: the program has a clear procedure to identify the population who needs FACT.	There are no strict criteria for admission to the FACT team	There are criteria yet there is no procedure	There are clear criteria and procedures used	There is an admission committee who checks referrals	There is an admission committee who checks referrals which leads to < 5% inappropriate referrals
39. WAITING LIST: in the past 12 months new consumers never had to wait for admission to the program more than a month.	>6 months	5 months	3 months	2 months	1 months or less
40. SERVICE COVERAGE: maximum number of eligible consumers is served as defined by the ratio: # clients receiving FACT or other EBP # clients eligible for EBP (region inhabitants / services)	< 55% of eligible consumers has FACT	56 - 65% of eligible consumers has FACT	66 - 75%	76 - 85%	> 86%
41. 24 HOURS ACCESSIBILITY AND CRISIS. - Between 8.00 AM and 8.00 PM the program can react within 2 hours to crisis; - Between 8.00 PM and 8.00 AM there are well reported agreements with the acute crisis services; - Consumers of the program can call 7 x 24 hours to well informed workers; - The crisis plan is available for the acute crisis services	The program has no adequate response on crisis during office hours and has no defined agreement with the 7 x 24 hours acute crisis services.	The program scores on 1 item	The program scores on 2 items.	The program scores on 3 items.	The program scores on all 4 items.
42. RESPONSIBILITY FOR HOSPITAL ADMISSION	Involved in less than 5% decisions to hospitalize	5 % - 34%	35 % - 64%	65 % - 94%	95 % or more are arranged by the FACT team.
43. BED ON RECEIPT: there are arrangements with consumers that they can use a specially arranged bed in the hospital.	The program has no arrangements		Some consumers can in certain situations use a bed.		The program has well defined arrangements with the hospital ward.
44. INREACH DURING ADMISSION:	There is no contact	No visits take place,	During admission	Once in 2 weeks	Once a week

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)
all consumers of the program are frequently visited by team members during admission.	during admission.	just phone calls.	consumers are visited once in 3 to 4 weeks.		
45. RESPONSIBILITY FOR HOSPITAL DISCHARGE: is involved in hospital discharge of all consumers of FACT team.	Involved in less than 5% of the hospital discharges	5% - 34%	35% - 64%	65% - 84%	≥85% .
46. DISCHARGE FROM PROGRAM: if a consumer is discharged from the program, it is a mutual decision and the transfer to the GP or other service is gradual. An evaluation/check takes place if the transfer went well.	In > 50% of the consumers discharged from the program last year the decision was unilateral (by team or consumer).	36% - 50% Unilateral without aftercare	16% - 35%	5% - 15% Unilateral without aftercare	>95% in good consultation + aftercare + follow up check
47. NO DROP-OUT: there is no discharge from the program without a referral, or on negative arguments	> 50% of the caseload in the past 12 months is discharged without a proper referral.	36-50%. New: 9-50% without referral or lost	16-35%. New:> 8% dropout	5-15%. New: 8-3% dropout	< 5% New: <3% dropout
COMMUNITY CARE					
48. OUTREACH: training of skills takes place in the community, > 80% of the contacts are out of the office (excl. Psychiatrist / psychologist).	< 20% of face to face contacts take place in community	20% - 39%	40% - 59%	60% - 79%	80% or more of the F 2 F contacts take place in community.
49. MULTI AGENCY COOPERATION: the program has an active policy on cooperation with (1) homecare (2) local police (3) housing association (4) welfare (5) neighborhood/church etc.	In the last 6 month there was no contact	In the last 6 month there was contact with one organization	In the last 6 month there was contact with two organizations	In the last 6 month there was contact with three organizations	In the last 6 month there was contact with at least four organizations
50. ASSERTIVE ENGAGEMENT MECHANISMS: the program uses all kinds of strategies to retain consumers in the program, like distributing food, clothes, coffee, etc, financial programs, and street outreach and legal mechanisms (probation,/ parole, etc.) indicated and as available.	Passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms	Makes initial attempts to engage but generally focuses on the most motivated consumers	Active use of one of three assertive engagement assertive mechanisms	Active use of two of three assertive engagement assertive mechanisms	Active use of assertive engagement and legal mechanisms (probation,/ parole, etc.) indicated and as available
51. COOPERATION WITH SOCIAL SUPPORT SYSTEM DURING ACT	In last month < 20% ACT consumers, there	Last month 20-39% contact with support	Last month 40-59% contact.	Last month 60-79% contact	With ≥80% of the ACT consumers, last

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)
CARE: with or without presence of the consumer, the program offers support and skill training for the social support system (family, landlord, employer, etc.).	has been contact with the support system.	system			month there has been contact with the support system
52. COOPERATION WITH SOCIAL SUPPORT SYSTEM DURING CARE AS USUAL: with or without the consumer being present, the program offers support and skill training for the social support system (family, landlord, employer, etc.).	In last 6 month the program had contact with less than 20% of the support system.	In last 6 month 20 – 39% there was contact with support system.	40 – 59%.	60 – 79%.	In last 6 month the program had contact with ≥80% of the support system of the consumers
MONITORING					
53. ROUTINE OUTCOME MONITORING (ROM): the program uses ROM for all consumers of the program. The ROM uses instruments to measure mental and social functioning, needs of care and Quality of Life (if not all instruments 1 point less).	<20%	20 – 39%	40 – 59%	60 – 79%	80 > %
54. ROUTINE OUTCOME MONITORING (ROM): the program uses ROM in their shared decision about the treatment and as part of the program policy.	The program has no ROM.	ROM is been done by research department. Ther is no feedback to the program	The program uses ROM only for shared decision or team policy.	The program uses ROM only for shared decision and team policy.	The program uses ROM in their shared decision about the treatment and as part of the program policy
55. SERVICE IMPROVEMENT: project leader/ team leader monitor the process of FACT, use data to improve the program. The program uses a standard like the fidelity scale or another set of indicators. The PDSA (plan-do-study-act) cycle is followed.	There is no monitoring or improving of the process.	There is an informal check each year of the process	There is a formal check each year yet outcome doesn't result in improvement action	There is a formal check each year; outcome is used to improve the process.	Project leader/ team leader monitor the process of FACT, use data to improve the program. The program uses a standard like the fidelity scale or another set of indicators. The PDCA cycle is followed
PROFESSIONAL DEVELOPMENT					
56. REFLECTIVE PRACTICE: FACT-	≤ 20% of the FACT-	21-40%	41-60%	61-80%	> 80%

Program: **Date:**

CRITERIA	SCORES				
	(1)	(2)	(3)	(4)	(5)
team members attend Reflective team meetings about FACT practice at least 5 x 2 hours. (look only at real practices).	team members reflect on his own practice.(at least 5 x 2 hours)				
57. TRAINING: FACT and OTHER EVIDENCE BASED PRACTICES: All team members has had a training last year in FACT or any other EBP. 2 day pp	≤ 20% of the FACT-team members receive training.in FACT and EBP (2 days pppy)	21-40%	41-60%.	61-80%	> 80%
58. RECOVERY ORIENTED CARE TRAINING: 80% of the team has had training in rehab or recovery in the last 2 years.	No training on recovery in the last 2 years	1 - 29%.	30-59%.	60-79%.	80% or more has been trained in recovery in the last 2 years
59. RECOVERY FOCUSED PRACTICE: attention to recovery and recovery oriented care. The program is focused on recovery. This becomes obvious during the FACT board, treatment plans, goals consumer, etc.	The program is mainly focused on responding to crisis. There is no attention or recovery processes	A lot of the time is spend on responding on crisis. Some attention for other treatment than medication	The program is focused on crisis, treatment and recovery. Yet recovery goals are only there for the more or less stabilized consumers.	The program is focused on crisis, treatment and recovery. Recovery goals are in treatment plans and clearly identifiable.	The program is focused on crisis, treatment and recovery. Recovery goals are in treatment plans, clearly identifiable and defined in consumers pace. Consumers are referred to peer support and recovery groups
60. TEAM SPIRIT: - good atmosphere (pleasant, easy going) - cohesion in team - shared philosophy - program has a drive for quality and innovation) - burn out (less than 20% of team has signs of burn out)	0 - 1 point	2 points	3	4	5 points. Enthusiastic motivated team

FACTS Scoreblad

	FACTS Criteria	*B 1*	*B 2*	*Con-sensus*		*advices*
	TEAMSTRUCTURE					
1.	Small Caseload					
2.	Staff capacity					
3.	Full time staffing					
4.	Psychiatrist					
5.	Psychologist					
6.	Peer specialist					
7.	Social worker					
8.	Psychiatric Nurses					
9.	Case manager					
10.	Dual disorder specialist					
11.	SE specialist					
12	Rehab Specialist					
	Mean score teamstructure .. / 12 =					
	TEAMPROCESS					
13.	Shared caseload					
14.	Team approach during ACT					
15.	Program meeting					
16.	Multidisciplinary FACT meeting					
17.	Treatmentplan meeting multidisciplinair					
18.	Treatmentplan meeting consumer					
	19. Teamleader					
20.	Criteria admission FACT board					
21.	Procedure admission FACT board					
22.	Procedure Discharge FACT board					
23.	Contact frequency board					
24.	Contact frequency C A U					
	Mean score teamproces .. / 11 =					
	DIAGNOSTICS, TREATMENT, INTERVENTIONS					
25.	Full responsibility treatment services					
26.	New consumers					
27.	Individual treatment plan					
28.	Individual crisis plan					
29.	Individual rehab plan					
30.	Copy treatment plan					
31.	Medication					
32.	Psycho education					
33.	Cognitive Behavioral Therapy					
34.	Familie Intervention					
35.	Supported employment (IPS)					
36.	IDDT					
37.	Individual Physical health care					

	mean score diagnostics etc .. / 13 =					
	ORGANISATION					
38.	Explicit admission criteria					
39.	Waiting list					
40.	Service Coverage					
41.	24 hours accessibility and crisis					
42.	Responsibility for admission hospital					
43.	Bed op receipt					
44.	During admission					
45.	Responsibility for discharge					
46.	Discharge from program					
47.	No drop-out					
	Mean score organization .. / 10 =					
	COMMUNITY CARE					
48.	Outreach					
49.	Multi agency corporation					
50.	Assertive engagement					
51.	Cooperation with support system during ACT					
52.	Cooperation with support system CAU					
	Mean score community care .. / 5=					
	MONITORING					
53.	ROM instrument					
54.	ROM Use individual and team					
55.	Service Improvement					
	Mean score monitoring .. / 3=					
	PROFESSIONAL DEVELOPMENT					
56.	Reflective practise					
57.	Training FACT and EBP					
58.	Training recovery					
59.	Recovery orientation					
60.	Team spirit					
	Mean score .. / 5 =					
	Mean score total .. / 60=					
	Score FACTS					

Quick scan:

Five points scale:

1. Reception (how is the day organized , is all data available, does the team know the purpose of the visit)
2. Team spirit (mood, coorporation)
3. Cooperation with the rest of the organization (is the team supported or threatened)
4. Philosophy and team organization (written and verbal, do they know what they want)
5. Team structure / caseload (disciplines and fte)
6. Practice (outreach, Assertive, board)
7. PDSA quality feedback
8. Training and EBP: IPS, IDDT, etc.
9. Evaluation, ROM
10. Focus on recovery

Total/10=

First impression: FACT certificate: yes/ no/ doubts

First advices:

1. Short term/quick win
2. Long term