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CCAF

WORKBOOK

YOUTH FACT FIDELITY SCALE 2020

The Flexible ACT workbook has been created to ensure the ongoing development of good community-based care to develop care for children and adolescents with (a suspicion of) psychiatric and complex problems and to enable teams to prepare adequately for a Youth Flexible ACT audit by the CCAF.

Bähler, M., Delespaul, P., Kroon, H., Vugt van, M., Westen, K., & Platform FACT-Jeugd. (2020). *Youth FACT scale 2020*. CCAF, Utrecht

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FACT WORKBOOK

Foreword

The Youth Flexible ACT-workbook has been created to ensure the ongoing development of good community-based care for children and adolescents with (a suspicion of) psychiatric and complex problems and to enable teams to prepare adequately for a Youth Flexible ACT-audit by the CCAF.

This FACT-workbook provides supports for the ongoing development of Youth FACT-teams and facilitates model fidelity in accordance with the Youth FACT-scale 2020 (YFACTs 2020). You can monitor your team's development by working through all the chapters and record the results in a living ***Team Document*** **or portfolio** (which includes a mission statement, a vision statement, all the required background information, the team's procedures, the feedback from satisfaction surveys among clients, family and network partners, and the quality cycle regarding the areas covered in Sections A and B).

Remember that the relationships between the various components is the most important factor to deliver quality. It specifies the target group for your care (case mix), the services you deliver and the fit to the target population. It also describes the collaboration partners to deliver the services, and the resource safety nets to provide comprehensive recovery oriented care around the client and the Youth FACT-team.

In mental health, youth and social care team members are often recruited from several organizations. Therefore, we opt to use the term ***core team***. **This refers to the members who consistently belong to the team and are involved in all consultations. They may include employees who still belong to different services, but they act as one joint, multi-disciplinary integrated resource.** Of course, the core team can collaborate with outsiders. They can be included in the treatment plans and systematically or sporadically attend team meetings. They are valuable assets in a multi-agency approach (coordinated collaboration of employees of different organizations).

Before to engage in the process of a peer-reviewed audit, it is important to check whether your team meets the minimum requirements for model fidelity. The eligibility criteria listed below serve this purpose. teams are considered eligible for an audit when they meet at least 8 of the 9 requirements. If you doubt whether your team meets the criteria, please contact the CCAF desk (info@ccaf.nl). They will assess your specific situation and advice accordingly.

1. Team existence (in months)		≥ 12 months
2. Number of clients in the caseload		≤ 200 clients
3. Client/care provider ratio		≤ 1:20 ratio
4. Number of disciplines (as in A, item 3-8) in the core team		≥ 4 core disciplines
5. The team offers services from a medical-psychiatric, social-agogical and pedagogical perspective.		Integrated
6. Number of FACT-board meetings each week		≥ 3x/week
7. The team can upscale the intensity of care flexibly if required		Flexible
8. Percentage of clients in face-to-face contact with 4 or more disciplines of the core team annually		≥ 50%
9. In its vision and working procedures the team clearly focuses on multi-domain recovery		Developmental and recovery-oriented
10. Percentage of face-to-face contacts that takes place outside the team's office		≥ 40%

We hope you enjoy working through the components of this Youth FACT-workbook and advise you to use the results in your internal PDCA-cycle and to write up the details in a living ***Team Document*** that is updated periodically.

Introduction

For mental health and youth services, Youth Flexible ACT (FACT) has become the reference for specialist community-based psychiatric care for children and adolescents with (a suspicion of) psychiatric and complex problems (the most complex target group of young persons). It gave a boost to work with peer support workers and plays an eminent role in combined specialist mental health care and social services (employment, healthcare and youth services). This is important because the Netherlands adopted a policy of decentralizing and ambulatory care. This policy, backed with new legislation, calls for a change, creative space and joint innovation. The Youth FACTs 2020 reflects these changes with respect for the past, an eye for the present and a focus on the future. It is instrumental to safeguard the quality of care for the group of clients with severe mental illness in the changed context in the Netherlands.

Over the past years, the FACT-model was implemented in various care organizations across the Netherlands and abroad. It is the de-facto reference for intensive ambulatory care for different target groups. The number of FACT-teams is still growing. The first Youth FACT-scale and the CCAF audits have played an important role in disseminating this effective care for children and adolescents. The 2014 Youth FACT fidelity scale was normative and these standards contributed to the shift to community-based care and the use of peer support workers. The clear criteria of the 2014 FACT-scale were a blueprint for beginning FACT-teams. However, over time some criteria lost validity. The care context has changed and it is appropriate now to allow new qualitative initiatives and innovations. The audits should foster quality and innovation and therefore should assess teams in a more appreciative way, without jeopardizing the core principles of FACT.

The FACT-model encourages a team to deliver the most appropriate services, interventions, and actions to their target group in conjunction with the network. Working with the FACT-model allows a multidisciplinary team to scale up and scale down treatment intensity if the situation demands it. FACT combines the power of a shared caseload with case management. At the time of 'shared caseload', the team jointly supports the intensification of scaled up care intensity through the flexible deployment of several care providers per week and the corresponding coordination and evaluation during the FACT-board discussion. Care intensification may be necessary, for example, at times of (impending) crisis or decompensation, after discharge from hospital or correctional facilities, or in the event of major positive or negative life events. The originally American ACT-model is easily recognisable in this respect. FACT has added the function of case management, as one of the services of the FACT-team, to the ACT-model, thus making it possible to treat clients less intensively in the same team over a longer period of time. In this way, the client deals with the same team during the different phases of the recovery process, ensuring flexibility and integrated treatment. The case manager functions as case keeper and is for example responsible for coordinating the treatment planning process and carefully keeping the case file up to date. Often the case manager also makes a substantive contribution to the treatment as well as several other disciplines in the team and other external professionals are involved in the complete treatment.

FACT-teams exist in a large variety of types and sizes: they can be specialist or generalist, urban or rural. Local teams adapt rapidly to the changes in the Dutch mental health and social services (decentralization of several areas). Two developments have improved the options to up- and downscale the intensity of care throughout the continuum of mental health care. First, nurses specialized in mental health are now based in GP surgeries. Previously the Dutch mental health system could only downscale to GP's and consequently FACT often remained in charge for too long, impeding recovery. Now, more mental health expertise is available at the GP, allowing shared responsibility for clients' physical health. It now makes more sense that GPs take care of recovered former FACT-clients. Secondly, the development of High & Intensive Care (HIC) units, a Dutch model for modern inpatient mental health care which aims to reduce coercion and seclusion (see http://hic-psy.nl/about/). In the past, when patients were in crisis and upscaled care required a hospital admission, the FACT-team lost control of

the patient. Admissions could last for a long time and treatment goals primarily clinical. Now the ambulatory recovery goals are the reference, even during admission. The HIC-unit keeps admissions as short as possible and continually coordinate with clients, family and the Youth FACT-team.

The Dutch Social Support Act (2012) has led to the development of District Social Service Teams and other municipal initiatives to foster civic participation and self-management. These teams share responsibility for important recovery domains such as housing, work and social contacts. The implementations have local differences, but the teams have much potential and are a new force in the community. They will play a significant a role in the network around clients with severe mental illness and help recovery in various domains.

These changes – both in the Dutch mental health and general social services – required reconsidering the FACT vision of comprehensive integrated care provided by one team. The ambition to significantly reduce the burden of severe mental illness by 1/3 (from *Crossing the Bridge*, 2014) created a sense of urgency. All partners in the services providing continuity of care now speak the same recovery- and developmental oriented language and it is possible to scale care up and down when needed even when it requires crossing the borders of services. FACT-teams can now truly be open and can offer full outreach services in communities to help clients to integrate and participate, and above all to make connections with the 'normal' local network of family, friends, volunteers and professionals.

In child and adolescent psychiatry, Youth FACT-teams focus on recovery in the client system and bringing back into motion a (threatening) stagnating development in various areas of life. The members of the FACT youth team stimulate children, adolescents and their families in their development in areas such as personal identity, social contacts, school or work and leisure time. The focus is on using and strengthening one's own strength and the possibilities for development, rather than the symptoms of illness (Hendriksen-Favier, 2013).

This version of the Youth FACT-scale, the Youth FACT-scale 2020, has been commissioned by the CCAF and was authored by M. Bähler, P. Delespaul, H. Kroon, M. v. Vugt, K. Westen and the Platform FACT Jeugd in collaboration with practitioners in the field, stakeholders, client organizations, and family and close friends.

List of background information

The information that is compiled in this list is necessary to get an impression overview of the Youth FACT's team target population (case mix), the context in which the service is provided and the available resources to provide the service. We assess whether the team has a good picture of the target population, in order to provide interventions that match the goals of individual clients. The background information list is used by the CCAF auditors to prepare for the audit. A digital 'fill-in' version is available at the CCAF website (www.ccaf.nl).

Description	
1. Team name	
2. Team existence (in months)	
3. Number of FTEs	
4. Number of team members	
5. Number of clients	
6. Client/care provider ratio	
7. Catchment area (list of postcodes/towns)	
8. Other providers that service the same caseload in catchment area	
9. Number of inhabitants	
10. Number of disciplines (as in A, item 3-8) in the core team	
11. Number of clients on waiting list	
12. Average waiting time for clients on waiting list in days	
13. Inclusion criteria	
14. Exclusion criteria	
15. Number of intakes over past 6 months	
16. Number of discharges over past 6 months including destination	In consultation with clients: No consultation with clients: Death through natural causes: Death through unnatural causes/suicide: TOTAL : Check out destination: To GP: To (F)ACT (for adults): Other:
17. Number of clients admitted to psychiatric hospital/psychiatric ward of general hospital over past 6 months	Admissions to psychiatric hospital: Admissions to sheltered housing: Admission to somatic hospital: Other admissions: % Involuntary admissions % In detention:
18. % clients with developmental disorders	
19. % clients with (ambulatory) treatment orders	% = What forms of ambulatory treatment are delivered:

20. % clients with psychotic disorders	
21. % clients with dual diagnosis (psychiatric and addiction)	
22. % truancy and school drop-out rate	
23. % clients with reactive attachment/personality disorders	
24. % clients with mild intellectual disability	
25. % clients with trauma related disorders	
26. % 0-12, 12-18, 18-23 years of age	
27. Which social (multi)media, eHealth/mHealth and technological healthcare interventions are used?	
28. Number of FACT-board meetings a week	
29. The team can upgrade the intensity of care flexibly, when necessary	
30. % of clients seen within a year by 4 or more different disciplines from the core team	
31. The team has a clear focus on recovery and development in its vision and working procedures	
32. % of face-to-face contacts outside the team's office.	

	In core team (under direct control)	In network (in close collaboration)	Not present /not available	Comments
33. The team offers orthopedagogical, psychological and psychiatric interventions to children and adolescents.				
34. The team offers trauma treatment.				
35. The team offers peer support and family peer support.				
36. The team offers system therapy.				
37. The team offers family and parental counselling.				
38. The team offers services for employment and education.				
39. The team offers addiction-related expertise and interventions.				
40. The team offers expertise and interventions for people with developmental disorders.				
41. The team offers expertise and interventions to improve physical health.				
42. The team offers expertise and interventions relating to Mild Intellectual Disorders.				
43. The team has access to legal expertise and support.				
44. The team has access to assistance relating to housing and self-care.				
45. The team offers……				

Professionalization

The team composition and professional development of a Youth FACT-team should match the necessary expertise and needs of the target population (case mix). A detailed overview of the different team members is included in the living ***Team Document.*** It can be provided using the table below. A digital 'fill-in' version is available at the CCAF website (www.ccaf.nl). It must be completed in preparation for a CCAF audit.

The table lists the net number of FTEs that the core team member actually spends on the team (including time of interns spent in training).

Item	Team member 1	Team member 2	Team member 3	Team member 4	Team member 5	Etc.
Name of team member						
Qualifications						
% of a FTE						
Number of years employed by the team (Indicate <1 yr, 1-3 yrs, >3 yrs)						
Caseload (related to casemanagement)						
Still in training? If so, how many hours a week?						
Training over the past year						
Present at daily FACT-board meeting						
Also works for:						

Section A: Team Structure Items

Section A of the YFACTs 2020 check items that can be assessed by specific numbers. During a CCAF audit these items (often preliminarily scored using the above material) will be checked.

- Scoring domains of expertise: a team member can have several domains of expertise. However, in the FACTs each team member can only be attributed 1 domain of expertise in items 1 to 7.
- Formula for item 1: number of FTEs of the core team/number of clients
- Formula for item 2: number of employees with ≥ 0.67 FTE/number of employees x 100
- Formula for items 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13: FTEs of the core team x 100/number of clients the team has.

1. Small caseload	**1**	**2**	**3**	**4**	**5**
The core team's client/care provider ratio is 15:1.	>20 clients	20-17	17-15	14-11	Maximum of 10 clients
2. Team member employment	**1**	**2**	**3**	**4**	**5**
At least 50% of the core team members have a position of 0.67 FTE with the team.	0-19%	20-29%	30-39%	40-49%	Minimum of 50%
3. C&A Psychiatrist	**1**	**2**	**3**	**4**	**5**
The core team employs at least 0.6 FTE Child & Adolescent psychiatrist per 100 clients.	<0.2 FTE	0.2-0.29	0.30-0.39	0.40-0.59	>0.6 FTE
4. Psychologist	**1**	**2**	**3**	**4**	**5**
The core team employs at least 0.6 FTE child and adolescent psychologist/general remedial educationalist (with professional registration) per 100 clients.	<0.2 FTE	0.2-0.29	0.30-0.39	0.40-0.59	>0.6 FTE
5. Family Therapist	**1**	**2**	**3**	**4**	**5**
The core team employs at least 0.6 FTE Family Therapist per 100 clients.	<0.2 FTE	0.2-0,29	0.3-0.39	0.4-0.59	>0.6 FTE
6. Nurse	**1**	**2**	**3**	**4**	**5**
Per 100 clients the team employs at least 2 FTEs nurses, including 1 FTE with a bachelor's degree and 1 FTE mental health nurse practitioner.	<2 FTE	<2 FTE with at least. 1 FTE with bachelor's degree	≥2 FTE with at least. 1 FTE with bachelor's degree	≥2 FTE with at least. 1 FTE with bachelor's degree + 0.5 FTE MHNP	≥2 FTE with at least 1 FTE with bachelor's degree + 1 FTE MHNP
7. Social work	**1**	**2**	**3**	**4**	**5**
Per 100 clients the team employs at least 1 FTE social worker and/or welfare rights adviser.	<0.3 FTE	0.3-0.59	0.6-0.88	0.89-0.99	≥1 FTE
8. Employment specialist	**1**	**2**	**3**	**4**	**5**
Per 100 clients at least 1 FTE is specialized in vocational rehabilitation.	<0.3 FTE	0.3-0.59	0.6-0.88	0.89-0.99	≥1 FTE
9. Peer support expertise	**1**	**2**	**3**	**4**	**5**
Per 100 clients the team employs at least 0.6 (paid) FTE peer support workers, half of whom have formal qualifications (at least at vocational level). Workers with experience as a client and as family are both represented. A client peer support worker	<0.3 FTE	0.3-0.59	≥0.6	≥0.6 with at least 0.3 FTE with formal	≥0.6 with at least 0.3 FTE with formal

(PSW), family PSW and professional PSW are included.				qualificati ons.	qualificati ons. Client-, family- and profession al PSW are present.
10. Family and Parental counselling	**1**	**2**	**3**	**4**	**5**
Per 100 clients the team employs at least 1 FTE with Family and Parental counselling expertise.	<0.2 FTE	0.2-0.39	0.40– 0.69	0.70-0.99	≥1 FTE
11. Physical health expertise	**1**	**2**	**3**	**4**	**5**
Per 100 clients the team employs at least 1 FTE with physical health expertise.	<0.2 FTE	0.2-0.39	0.40– 0.69	0.70-0.99	≥1 FTE
12. Addiction expertise	**1**	**2**	**3**	**4**	**5**
Per 100 clients the team employs at least 1 FTE with addiction expertise.	<0.2 FTE	0.2-0.39	0.40– 0.69	0.70-0.99	≥1 FTE
13. Expertise relating to MID	**1**	**2**	**3**	**4**	**5**
Per 100 clients the team employs at least 0.8 FTE care provider with expertise relating to Mild Intellectual Disorders.	<0.2 FTE	0.2-0.39	0.4-0.59	0.6-0.79	≥0.8 FTE
14. Self-determination and autonomy	**1**	**2**	**3**	**4**	**5**
(1) The team has assigned steering and coordinating roles within the team. (2) Specific members actively monitor the application of the FACT-model. (3) Specific members chair the FACT-board meeting. (4) A specific member chairs the treatment plan meetings.	The team meets none of the four criteria.	The team meets one criterion.	The team meets two criteria.	The team meets three criteria.	The team meets four criteria.
15. Flexible Care	**1**	**2**	**3**	**4**	**5**
(1) The team systematically coordinates the upscaling and downscaling of care over the whole continuum of care. (2) The team has clear criteria for scaling up and terminating care. (3) The formal and informal networks are involved in the provision of flexible care. (4) The team has the resources and flexibility to scale up the intensity of care to daily client contacts.	The team meets none of the four criteria.	The team meets one criterion.	The team meets two criteria.	The team meets three criteria.	The team meets four criteria.
16. Team approach	**1**	**2**	**3**	**4**	**5**
All clients of a FACT-team see at least 4 different disciplines of the core team in a year (including the psychiatrist).	<50%	50-59%	60-73%	74-89%	>90%
17. Daily FACT-board meeting	**1**	**2**	**3**	**4**	**5**
	3x a week		4x a week		5x a week
18. Outreach services	**1**	**2**	**3**	**4**	**5**
The team focuses on the development of skills in the community. Over 70% of face-to-face contacts take place outside the team's office.	<40% of f-t-f contacts	40-49%	50-59%	60-69%	>70%

Section B: Focus areas

Section B of the YFACTs 2020 assesses the Youth FACT-team's frame of reference: domains of care provided by the team, and given the team's case mix, resources, context and composition, which areas should the team particularly focus on? Section B of the YFACTs 2020 is assessed on a scale from 1 to 8.

1-2	3-4	5-6	7-8
Not evident	In development	Correctly implemented	Exemplary

An adequate quality assurance cycle and a vivid ***Team Document*** (including a mission statement, a vision, all the background information, their strategy, feedback from the satisfaction survey and the PDSA cycle relating to the focus areas in Sections A and B) will help to show your clients, their family and friends, and your network partners what your Youth FACT-team represents and what its aims for. It too provides for a CCAF audit.

For whom, with whom and what?

'After the case mix analysis, our organization's Youth FACT-team A realized that in the total caseload there were 30 clients who had been diagnosed with PTSD. In response to this, action was taken to enable the team to offer EMDR. Our other Youth FACT-team B has fewer clients with this diagnosis and has no suitable staff member. They now use the psychologist from Youth FACT-team A. Of course the psychologist's actions are included in Team B's treatment plan and she frequently attends Youth FACT-team B's treatment plan meetings and FACT-board meetings to discuss progress.'

'When our clients are placed on the FACT-board to receive more intensive care, we upscale care in consultation with the parents, the school social worker and the care workers from the Child and Family Centre. The care providers from these organizations who are involved are listed on the FACT-board and are aware of the jointly set goals. This is important because it means that representatives of different disciplines can see the young people several times a week and there is close consultation with the team. The care workers attend ,if possible, the FACT-board meeting. This means that as a relatively small team we are able to upscale care and to prevent hospitalization or increasing the burden of care.'

'Thanks to the monthly consultations, which are also attended by the doctor of the substance abuse services, I can prescribe our clients anti-craving medication. In consultation with our addiction expert we have been able to treat our team's clients who have both addiction and a psychiatric diagnosis both with medication and with appropriate interventions based on the Community Reinforcement Approach. With our support, one of our clients set up a precontemplation group during her time with us, something we are very proud of.'

'Thanks to the mediation of the COC [Dutch association advocating the rights of LGBTs], since recently I have been working a few hours a week in this team as a volunteer. I am an LGBT-peer support worker. My arrival was and is more than welcome, since it has turned out that in 10% of the recovery assessments clients' questions, interests and problems related to sexual identity. I have observed that since I have been here, the cultural and spiritual identity of clients has become a focal point and that clients are asked more explicitly about sexual side effects.'

'Yes, as a team we decided to attend the community-meeting for the city centre area once a month, in different combinations of team members each time. All local stakeholders attend these meetings to discuss potential clients and citizens in distress. This has turned out to be an important opportunity to exchange expertise with other organizations, to gain knowledge about the working procedures of other organizations, in other words to network ... and above all to continue to tell our network partners about our possibilities and our inclusion and exclusion criteria. This means that when we have difficult referrals we can now find each other much quicker and on a more personal basis.'

Focus area 1: Making care flexible

A Youth FACT-team should be able to scale up and down care *flexibly* within the FACT-team and in the whole continuum of care, from GP, centre for family and child welfare and district social service team to inpatient care. The team can scale up the care itself or in collaboration with the network partners involved and/or the client's support system, depending on the context, the composition of the team and the case mix. An approach in which *several team members* (from different perspectives) are involved in a client's treatment is a prerequisite for both treatment and process, for the entire caseload. It is important that the core team is in charge if care needs to be scaled up or down.

It is necessary that time and space is left unscheduled in the team members' agenda's to be able to implement the ACT part of services delivered. It is essential for the team to maintain in charge of care when care is partly outsourced. Flexibility becomes evident during the morning FACT-board meeting and in the procedures described (in the Team Document, for instance),

Another component is the *staging of care*: ensuring that interventions are exactly right for the client at a particular point in time in order to support the individual recovery process. In this way customized and proportionate care is guaranteed, clients' own control is enhanced and the team is prevented from being too paternalistic or too demanding. Staging of care can be achieved with the help of methods such as the stages of recovery, behavioural change or treatment (including addiction treatment). It is up to the team to choose the approach which is the most appropriate for their team and best supported by evidence. The stages will be reflected in the treatment plan, the procedures and the implementation of the treatment plan, and during the daily FACT-board meeting.

Members of the team are expected to be aware of the working procedure in relation to flexibility and the adequate staging of care and to use their knowledge appropriately during meetings.

To summarize, the assessment will be based on the following items:

1) Flexible care is evident during the FACT-board meeting.
2) Staging of care is reflected in the treatment plans and is implemented.
3) There is a team approach, with several team members actively contributing expertise.
4) The level of care provided is appropriate to the stage in the client's recovery process; care is up scaled or down when necessary or desirable.

For an optimal score all of these items must be evident during the daily FACT-board meeting and in treatment plans.

Focus Area 2: Personal Domain

A Youth FACT-team facilitates and supports the initiation of recovery, participation and (impending) stagnating development. The members of the team stimulate children and adolescents in their development in the field of personal identity, social contacts, school or work and leisure. The team achieves this by focusing on three domains: the personal, the social and the symptomatic. These three domains, theme 2, 3 and 4, give, among other things, content to the described treatment plan and the treatment offered.

A Youth FACT-team is paying attention to the client's *personal domain* when it recognizes the client's individuality and identity and acts accordingly as a team.

There is space for the client's individual development and distinctive strengths, just as there is space for the client's struggle with their own cultural, sexual and spiritual identity and emotions such as grieving and sorrow. Attention is paid to combating self-stigmatization and the team members are also alert to any tendency they themselves, relatives and society may have to stigmatize their clients. As a consequence, after adequate consultation the team has the confidence to take positive risks (from a care provider's point of view) and to discuss irresponsible risks with those involved in order to reach a joint decision.

A positive and present attitude can be seen as a basic prerequisite for the team. Supporting each other, reminding each other and using hopeful language at meetings demonstrate that the whole team takes responsibility. Obviously this hopeful language and approach will also be reflected in the team's written material and in the provision of recovery- and developmental-oriented interventions in the personal, social and symptomatic domain from the team and other resources.

To summarize, the assessment will be based on the following items:

2.1 The team recognizes and acknowledges the client's individuality.

- The team takes the client's own strength as its starting point.
- The team perceives the client's struggle with their cultural, sexual and spiritual identity and emotions such as grief and sorrow and the team members act together accordingly.
- The team pays attention to combating stigmatization by the team, relatives and society and self-stigmatization by the client.
- The team is not afraid to take risks.
- The team has a hopeful attitude and uses hopeful language oriented towards an open and positive picture of the future.

2.2 Strengths, wishes and goals of the client are visible.

- The team makes an inventory of the client's goals and records the client's goals.
- The team facilitates and supports the realization of the goals with visible interventions.
- Guidance within this domain is available in the core team or in the direct controllable network.

For an optimal score all these items must be evident in the Team Document and during the daily FACT-board meeting, and also reflected in the satisfaction surveys completed by the clients and their family.

Focus area 3: Social Domain

A Youth FACT-team provides support in the client's *social domain* by being aware of and responsive to the various social roles the client has in life and by providing appropriate support. This is possible in practical terms thanks to the use of participation or recovery-oriented assessment tools. Support is provided according to the wishes and goals expressed by the client in relation to the domains of 'self-care and living', 'social network' and 'education, work and leisure'. Interventions are prepared in conjunction with the client, their family and the team's professional network partners. If necessary, the treatment plan includes proactive interventions (such as assertive outreach interventions), targeting both the individual client and their environment.

The possible interventions and the focus will depend on the social context, the available resources - both the client's and the team's – and the case mix. Interventions can be coordinated by external partners, in conjunction with local partners or by the team itself. When several clients have similar wishes or goals, it can be useful to develop (or have developed) individual or group offerings. For instance, in some teams the main focus will be on finding education, a side job, housing, preventing homelessness and sorting out financial issues, whereas other teams may need to focus on loneliness, pathways to work or training, self-care or safe living.

To summarize, the assessment will be based on the following items:

3.1 The client's roles within the 'self-care and living' domain are evident

- The team assesses the client's goals and formulates the client's goals within the 'self-care and living' domain.
- The team uses interventions clearly aimed at achieving the client's goals within the 'self-care and living' domain.
- Assistance in this domain is available in the core team or in the network directly controlled by the team.

3.2 The client's roles within the 'social network' domain are evident

- The team assesses the client's goals and formulates the client's goals within the 'social network' domain.
- The team uses interventions clearly aimed at achieving the client's goals within the 'social network' domain.

3.3 The client's roles within the 'education, work and leisure' domain are evident

- The team assesses the client's goals and formulates the client's goals within the 'education, work and leisure' domain.
- The team uses interventions clearly aimed at achieving the client's goals within the 'education, work and leisure' domain, with the employment specialist taking the initiating role.

For an optimal score the items must be applicable to all clients and be appropriate for the individual client. This is reflected at the daily FACT-board meeting, in treatment plans and in the intake and assessment procedures.

Focus Area 4: Symptomatic Domain

The team seeks to achieve the highest possible level of mental and physical well-being for the client. For this purpose, the team has implemented a system in which screening, diagnostics, treatment and interventions all take place in accordance with the most recent research findings. The experts in the team take the initiative and are actively involved in screening, diagnostics and the evaluation of treatments relating to their specific expertise.

The assessment is based on the following items:

4.1 Psychiatric interventions

- State-of-the-art and integrated screening, diagnostics, treatment and evaluation of effect.
- Medication management.

4.2 Physical health interventions

- State-of-the-art and integrated screening, diagnostics, treatment and evaluation of effect.
- The full range of physical health is treated, if necessary with active referrals and follow-up.

4.3 Psychological, family and pedagogical interventions

- State-of-the-art and integrated screening, diagnostics, treatment and evaluation of effect.
- The interventions offered are appropriate for the case mix.
- It is clear that the MID, developmental disorders and Family and Parental counselling experts play an initiating role.

4.4 Addiction interventions

- State-of-the-art and integrated screening, diagnostics, treatment and evaluation of effect.
- Addiction interventions are explicitly referred to and described, and are used in a flexible and phased way.
- It is clear that the addiction expert plays an initiating role.

For an optimal score all of these interventions must be available for the entire caseload and must be appropriate for the case mix. A thorough analysis of the background information list in relation to what is offered is helpful in this respect.

Focus Area 5: Planning and Monitoring at the Individual Client Level

The team has a clear treatment plan cycle and adheres to the logistical process according to good working procedures. Integration of the ROM (Routine Outcome Monitoring) data is part of this; the team has clearly made a well-reasoned choice from the available standardized measuring instruments.

In conjunction with the client and the client's personal network the team lists the goals in the client's treatment plan. The client's family can also contribute goals. The role of the family is set out explicitly in the treatment plans.

In conjunction with the client and the professional network goals are identified and the professional network may also contribute goals. The role of the network partners is set out explicitly in the treatment plans. This means that the Youth FACT-team takes a managing and coordinating role and oversees all of the care provided to support development and recovery, prevent hospital admissions and reduce the duration of any admission.

The interventions offered and described by the team, as referred to under Focus Area 4, must be available for the whole caseload; this motivates clients – if necessary – to agree to the most suitable and appropriate forms of treatment or interventions.

Obviously the evaluation and systematic follow-up of the treatment must take place in consultation with the client, their family and the professional network.

The assessment is based on the following items:

5.1 Planning and Monitoring cycle

- The treatment plan cycle is described.
- The implementation and evaluation of treatment and its progress takes place collectively; there is a collaborative relationship between the team and the client, their family, the GP and external (youth) care partners. A collaborative and shared decision-making process is in place for treatment planning (team, network, client and family). Each party may contribute goals.
- At least once a year clinical Routine Outcome Monitoring (ROM) takes place for the benefit of individual strategies and treatment plans. Standardized instruments are used to measure (1) psychological and social function, (2) needs and (3) quality of life and recovery.

5.2 Integrated responsibility

- The team as a whole is responsible for the outcome of the treatment and assumes a managing and coordinating role.
- Policy is pursued to motivate clients and guide them towards suitable interventions if necessary.

For an optimal score all of these items must be evident in the procedures the team has documented and in the treatment plans.

Focus Area 6: Crisis and Societal Responsibility

A Youth FACT-team takes responsibility in their area of work for all clients belonging to the target group of the team in question. Waiting lists and limited availability of treatment options in the region can appeal to the flexibility and responsibility of the team. The team liaises with FACT-teams or other network partners for subsequent target groups in the region to pull together and refer or take over clients flexibly and friendly. Providing consultation and easy access (online and offline) to clients, loved ones and network partners for (temporary) support is part of the team's work. Acquisition of clients can take place immediately when consultation does not produce sufficient results or when the risk increases. The team supports the client in his development and is committed to prevent social breakdown, relapse and crisis or to support loved ones during difficult periods. Deployment of preventive proactive and assertive (meddling) interventions, a joint process towards a crisis signalling plan, acute care intensification and cooperation with relevant partners are important here. In the team's own catchment area, the team is able to carry out targeted case finding when clients are out of the picture and is also able to comply with unfocused case finding in order to make good, appropriate treatment available to all children and adolescents in the team's catchment area (e.g. preventive or in the context of early detection).

The team is able, even under the most difficult circumstances, to develop, offer or release options to clients and/or families, and when escalation threatens to maintain or promote participation and autonomy. This focuses on possibilities, opportunities, alternatives, prevention, low-threshold communication (e.g. via social media) and upscaling (as opposed to an escalation in coercive measures leading to possible coercion). In order to realise safety, creativity in the solutions is necessary. Creativity is achieved by allowing more people involved (in the first place the client and his family) to participate in the planning and realisation of solutions.

The team keeps a watchful eye on safety of clients, their environment and the members of the team. Its goal is to minimize safety risks and the need for crisis intervention. To achieve this the team has implemented policy consisting of risk assessment and the provision of evidence-based interventions relating to crisis prevention and early detection. It can be expected for the team to have a structural relationship with regional services such as the police force and other health and safety services to ensure personal safety in and around homes. Obviously the range of interventions and measures must be appropriate for the case mix and the social context.

The team should act as a gatekeeper as regards hospital admission and discharge. The Youth FACT-team constantly monitors the safety of the client, the team itself and the environment, and is responsible for intervening if necessary. The team has documented safety policy and adheres to it. Clients can make use of forensic interventions and have individually tailored crisis (and crisis prevention) plans.

The assessment is based on the following items:

6.1 Assertive Proactive Crisis Interventions

- The team is able to identify the signs of a crisis or imminent crisis.
- The team is able to intensify care, create alternative and creative interventions and increase treatment options collaboratively.
- The team is able to take the necessary measures (including judicial measures such as compulsory admission or treatment orders) to restore safety.
- The team is, as a whole and 24/7, responsible for upscaling and downscaling care, even when hospital wards, crisis services, the GP and community social service teams are involved with the client.
- A client’s individual crisis plan is drawn up systematically with input from the client, their family and the team and is evaluated with the client and their network.

6.2 Safety and Risks

- Binding, proactive and assertive care provision is possible to prevent drop-out.
- Risk assessment tools appropriate to the target group are used with the aim of preventing suicide, social decline, aggression and crime.
- Forensic interventions are available and are used. Their effect is evaluated. Group and individual training sessions on aggression management, impulse control or emotional regulation are provided. The team also provides interventions for offence-specific problems such as domestic violence or sexual offences and actively refers clients to them.
- The team has a documented safety policy which covers the following topics: (1) home visits, (2) follow-up care after an incident, (3) reporting incidents , (4) dealing with aggression and (5) network collaboration.

For a team to be given the highest score the items must be applicable to all clients and must be appropriate to the individual clients. This is reflected in the Team Document, during the daily FACT-board meeting, in treatment plans and in the intake and assessment procedures.

Focus Area 7: (Social) Network Collaboration

Committed *collaboration with the client's network* is of crucial importance to ensure that control of the recovery process lies with the client and his resources of choice as quickly as possible. During the period when the client receives care from the Youth FACT-team this should be as long as necessary, but as short as possible, and personal and professional support from the client's network is obviously important during and after FACT treatment. The team involves the client's network in the team evaluations, supports the network with the most appropriate forms of treatment for the target group and supports and facilitates the creation of forms of self-help by the client's personal network.

A Youth FACT-team works for a particular target group in a particular social context in a particular region. It is important to ensure a good match between the chosen target group and the range and intensity of collaboration with network partners in the neighbourhood or region. Supporting full recovery in all areas calls for a broad and active network of professionals, including team members but also including care providers from outside the team. The intensity of the collaborative arrangement may vary depending on the goals and wishes shared by the target group. One partner may attend the FACT-board meeting every day and be part of the team, whereas another can be reached easily by phone or email. Positive working relationships with both external and internal contacts is essential. Active management of network relationships through arranging information meetings, offering consultation opportunities, giving tokens of appreciation and attending coordination of care meetings with psychiatric wards are certainly part of this.

Intensive relationships can be expected with the Child and Adolescent Centres, education officials, community teams, local police officials, sheltered housing, street coaches and other youth care providers in the region. Each time a conscious choice is made in the relationship for formal and/or informal cooperation structures. Think of the inter-agency approach, the systematic involvement of external partners during FACT-board meetings and/or the systematic organisation of coordination of care meetings with all parties involved.

The assessment is based on the following items:

7.1 Engagement and Collaboration with the Client's Social Network

- The team offers individual and/or group interventions for family.
- The team supports and motivates the setting up and running of self-help groups by family.
- The team conducts regular satisfaction surveys for clients, family and network partners to evaluate its work systematically and to modify its working procedures if necessary.

7.2 Collaboration with Internal and External Professional Networks

- The team is aware of the social support system and the care services, organizations and facilities available in their catchment area.
- The internal and external collaborative partners and the form and intensity of collaboration are appropriate for the caseload, the social context and the available resources.

For a team to be given the highest score all of these items must be available for the entire caseload, must be implemented and evaluated systematically and must be appropriate for the case mix. The outcomes of the satisfaction surveys are recorded in the team document along with an accompanying action plan.

Focus Area 8: Quality and Innovation

A Youth FACT-team seeks to provide the highest quality of care and is open to new knowledge, initiatives and innovations. To achieve this the team has specially designed training policy requiring at least four half-day training sessions per team member, which is set out in the Team Document. Team members continue to develop additional expertise in their field. The training policy is geared towards the target group, the working procedure and the treatment offered. The team is willing to take students on placement and to cooperate in other ways with educational institutions. The team regularly invites external experts or asks for their help. This may be for support in an individual case, in relation to an ethical dilemma or to support team processes. In a more formal sense, the team must make it possible to ask for a second opinion and must actively offer this option.

In addition, there is evidence the team works with a PDSA-cycle to improve their quality. If a team is well aware of its own qualities, strengths and challenges, this will be a starting point for all actions relating to quality and innovation. The knowledge and expertise gained in this way can be shared within and outside the organization to enhance the qualitative development of the FACT-model.

Innovative initiatives can be taken in many areas; their effects may be far-reaching or more limited in scope, their impact major or minor, and they may be more or less disruptive. It is important for the team that it is possible to experiment with all kinds of care innovations and the team jointly supports these developments.

The assessment is based on the following items:

8.1 Training

- Over the past 2 years each team member has had training in evidence-based practices that are relevant to the team
- Over the past 2 years each team member has had training in developmental and recovery-related issues
- A written team document is present and shows a training and peer supervision policy which is appropriate to the case mix. This team document is regularly evaluated and modified.

8.2 Expert knowledge

- Experts are invited at least once a month (consultation).
- The team has a clear consultation role.
- A second opinion is offered when necessary.

8.3 Planning and Control Cycle at the Team Level

- The Team Document contains an improvement plan which includes goals and actions.
- The outcomes of the Routine Outcome Monitoring and the client satisfaction surveys are used at team level to systematically evaluate and, if necessary, modify the team's working procedures.
- A regular dialogue is held, including stakeholders, on the relationship between healthcare policy and the Convention on Human Rights for Persons with Disabilities (CRPD).

8.4 Care Innovation

- The team has alternative and/or innovative and/or health technology interventions or actions which set it apart in a positive sense.

For a team to receive the highest score all of these items must be clearly present in the written Team Document and in the logistical process of the quality assurance cycle.

Final score

The score is determined on the basis of consensus of both auditors and by combining the average item score on the A part (structure) on which a maximum of 5 points can be obtained with the average item score on the B part (content themes) on which a maximum of 8 points can be obtained. Scores are calculated to the nearest 1/10th point and rounded off to the nearest decimal place. The score thus ranges from a minimum of 2 to a maximum of 13 points. The scores above 6 on the B part will be awarded when the team is exemplary. The realistic maximum is therefore 11 points.

- A score of 6.6 or less: no certificate

- A score between 6.7 and 7.4: a provisional certificate

- A score between 7.5 and 8.7: a certificate

- A score from 8.8 and up: an optimal certificate

Mean score Section A:	
Mean score Section B:	
Total score A + B:	