CCAF

Flexible ACT

WORKBOOK

FACT SCALE 2017-R

March 2022 revision

The FACT Workbook was developed to further develop good community mental health care for people with severe mental illness and to enable teams to adequately prepare for a CCAF FACT audit.

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FACT WORKBOOK

Preamble

This is the Flexible ACT Workbook or FACT Workbook to support the development and assurance of good community mental health care for people with severe mental illness. This 2022 version was created after a review based on the audit data from the 2010 FACTs and the 2017 FACTs, the review of the 2019 Over the Bridge document, consultation with the Human Rights Board, feedback from auditors, teams and stakeholders and the development of the For(F)ACTs, the 2020 Youth FACTs and the ACT Scale with experts from the various fields.

The FACT Workbook provides support for the ongoing development of FACT teams and promoting model fidelity according to the 2017 FACT Scale. You can do this by going through all chapters and record the outcome in an organic (always updated) ***Team Document*** (which includes a mission, vision, all background information, procedures, feedback from satisfaction surveys with clients, relatives and network partners, and the quality cycle regarding the topics in Parts A and B). Note that the consistency of the various components is perhaps the greatest test of quality of care: for what target population do you provide your services (case mix), what kind of services and do they fit your target population, and with whom do you provide those services, and have you adequately secured your resources in and around the client and/or FACT team?

Within the mental health and social domain, work is frequently done in a combined team with disciplines from multiple organizations, which is why we refer to a ***core team***. **The core team refers to the members who consistently belong to the team, are managed by the team leadership, and attend most of the related consultations (at least weekly). These can be employees from different organizations, as long as they are directly manageable from one central body and jointly, multidisciplinary, provide integrated care.** Any other staff and disciplines that are not part of the core team are not directly manageable (such as consultants, partial practitioners and other resources), but they are included in treatment plans and attend team meetings regularly or on indication and contribute to the multi-agency approach (the coordinated collaboration of staff from different organizations).

Before starting the (further) development of your FACT team or preparing for an audit, it is important to know whether you meet the minimum requirements for model-fidelity. For this purpose, the following entry criteria have been established:

1.	Length of existence of the team (in months).		≥ 12 months
2.	Number of clients in total caseload.		≤ 300 patients
3.	Client-to-professional ratio.		≤ 1:30 ratio
4.	A minimum of four different disciplines (as in A) are present on the core team.		≥ 4 core disciplines
5.	Number of FACT Board meetings.		≥ 3x/week
6.	The team can flexibly intensify care if necessary.		Flexible
7.	The percentage of clients seen annually by 4 or more disciplines on the core team.		≥ 50%
8.	The team has a clear focus on integral recovery in its vision and practices.		Recovery-orientation
9.	The percentage of face-to-face contacts that take place externally.		≥ 40%

We hope you enjoy working out the components of the FACT Workbook and recommend that you use the elaboration in your internal PDCA cycle and incorporate the data into a living ***Team document***.

Introduction

Flexible ACT (FACT) has put specialist outpatient mental health care for complex target groups (people with severe mental illness; SMI) on the map, has given the use of lived experience an enormous boost and can now play a prominent role in the development of network psychiatry and the connection of specialist mental health care with the Social Domain. This requires a new way of working, creative leeway and joint innovation. A new FACT model fidelity scale with respect for the past, an eye for the present and looking to the future is necessary to guarantee the quality of care for our target group in this new playing field.

The FACT model encourages a team to provide the most appropriate services, interventions and actions to people with a severe mental illness (and therefor a need for integrated and integrative care) in collaboration with various networks. Working with the FACT model allows a multidisciplinary team to scale up and scale down treatment intensity as the situation demands. FACT combines the power of a shared caseload with team case management. At the time of 'shared caseload', the team jointly carries out the scaled-up intensity of care, through the flexible deployment of several visits from multiple disciplines per week, using different care modalities (e.g. provided by e- and m-health) and resources from the network. Coordination and evaluation of scaled-up care takes place during the FACT board meeting. Care intensification may be necessary, for example, at the time of an (impending) crisis or decompensation, after discharge from the hospital or Penitentiary, or in the case of drastic positive or negative life events. The original American ACT model is well recognized in this. FACT has added the function of team case management, as one of the services of the FACT team, to the ACT model and thus created the possibility to treat and accompany 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 stages of the recovery process, and flexibility and integrated treatment is guaranteed. Process-oriented care is possible and opportunities for recovery are given more opportunity.

An individual case manager functions as a case manager and takes responsibility for coordinating the treatment plan process and keeping careful records. Often, the individual case manager also contributes to the treatment, but, working with team casemanagement, multiple disciplines from the team and other external professionals are involved in the stage-wise treatment plan and treatment plan process.

In recent years, the FACT model has gained a foothold in various organizations across the country and even beyond. It is used for various target populations and the number of FACT teams continues to grow. The FACT scale and audits by the CCAF have played an important role in the implementation of truly good care for people with severe mental illness in outpatient care. Until now, the FACT scale was very prescriptive in nature, which has certainly contributed to the use of peer workers, for example, and ambulatory care has become leading for our target group. For new FACT teams, the FACT scale 2010 was a helpful tool to properly implement the FACT model. On the other hand, the time now seems right to recognize new initiatives and innovations and to audit teams more appreciatively, without abandoning the core principles of FACT.

In this workbook, "treatment" is defined as all components that serve the client's recovery process, including diagnosis, counseling, care, nursing and support. Where appropriate, a substantive argument is used to make distinctions.

"Today the FACT team is a guest in the town hall of a small municipality. A community nurse from the Community Team, a legal officer from the municipality and an employee from the local housing association always join us here. This multidisciplinary FACT team consisting of core team members from mental health, addiction, youth and intellectual disability care, without an office, is a regular guest every day of the week at a centrally located community center or partner organization in their rural catchment area, and local partners join in each time to discuss shared clients in their catchment area. After the hand-over from the crisis service has taken place via Video-

calling and the FACT board has been reviewed by the core team, the local, shared clients are discussed with the network partners. Today, among other things, a visit by the psychiatrist with an employee from the Community Team to a client and his parents is planned in order to jointly formulate actions to previously set goals. This afternoon the Public Mental Health Nurse will visit the neighborhood association with two clients where they will join a cooking class. The somatic screening of a client will take place today at the client's general practice in consultation with a counsellor.. In consultation with the GP and the counsellor, somatic care is thus secured. In addition, the client is informed that FACT care is temporary and that personal recovery with a full return to the GP is the goal of treatment. Meanwhile, the relationship with the GP is maintained and the familial, voluntary and professional network around the client in his residence is built up, in order to effectively phase out FACT care and leave the direction of the network's actions more and more to the client. The core team itself provides integrative and integrated care when necessary and shares and coordinates care when possible with the perspective of self-management and full integration and participation in society. "

"The specialized Forensic FACT-MID team, the only one in this medium-sized city, consists of 15 employees from one organization and they meet four times a week in a room of the organization and once a week in the Safety House. There, network partners connect. An addiction specialist joins weekly for consultation. The team had previously described the entire process, case mix and PDCA cycle in a lively paper team document. Now they have their own Web page where all components can be found digitally. It allows clients, family members and network partners to look up information digitally, fill out the satisfaction survey, respond to new posts and provide feedback to the team. Once a year, on a fixed date, clients, family members and network partners meet with the team to discuss the feedback and create the action plan for the coming year. Right now, the transparent treatment offerings and public safety policies are seen as added value by externals."

In the past, the offer for people with (suspected) psychiatric and complex problems was fragmented and often offered sequentially, by successive organizations. With FACT, it becomes possible to treat our target group in their context in a comprehensive and integrated way, if necessary proactively and assertively when, for example, care is inadequate or care is avoided. The same counseling team remains available in successive stages with varying care needs. The team is able to flexibly and smoothly adapt care to needs by using the team's own resources (shared caseload) and network support. The team maintains focus and coordination, realizing continuity of care. Taking responsibility for this complex target group in a region requires an appropriate offer of consultation, targeted (client is known, but out of care) and untargeted (new clients) casefinding and integrated assertive and proactive interventions (the ACT portion of FACT). FACT teams of all shapes and sizes, diagnosis-specific or generalist, urban and rural, adapt rapidly and respond to the changes within all domains.

The emergence of the Mental Health Counsellor at the GP's (POH-GGZ) on the one hand and the development of High Intensive Care units (HIC), intensive home treatment (IHT), resource groups/YourInvolvedMentor (JIM)/Open Dialogue and Active Rehabilitation in the Triad (ART) on the other hand have secured opportunities for up- and downscaling of care across the mental health network. Previously, there were fewer step down alternatives (think GP or community teams). FACT resources were inadequate and this may have unnecessarily created barriers and delays in recovery processes. With the increase of mental health expertise at the GP, sharing somatic care is justified and possible. General practices becomes a logical extension of FACT.

At the past, during a crisis and possible admission, the FACT team lost control of treatment and an admission could last long or too long with mainly inpatient treatment goals. Now the outpatient FACT goals are leading and all partners are preventing admission. A HIC for example aims to keep an admission as short as possible, with continuous coordination with the client, his family and the FACT team.

In the Social Domain, the introduction of the Social Support ACT (Wmo) has led to the development of all kinds of Community Teams and other municipal initiatives to promote citizen participation and self-management. They share responsibility for important areas of recovery such as housing, living, finances, working and social

contacts. Implementation of these community teams takes on many forms, but this is undisputedly a new player in the neighborhood with potential. Cooperation between domains is crucial. The social domain plays a role in the network of possibilities (resources) around clients to enhance recovery of roles in the various domains.

Changes in the mental health system and in the Social Domain, require a broadening of the FACT vision of integrative and integrated care by one team in order to actually achieve the stated goal of 1/3 more recovery for people with severe mental illness (from: Across the Bridge, 2014). A network of different agencies now speaks the same recovery-oriented language and the network provides more opportunities to adequately address varying needs. FACT teams can now better open up and become part of the resources available in the local community or region. Their role is to reach out to the community to help clients with severe mental illness integrate, participate and, most importantly, connect with the local "normal" network of family, loved ones, volunteers and/or professionals.

The FACT Scale 2017-R was developed on behalf of the CCAF by M. Bähler, P. Delespaul, H. Kroon, M. v. Vugt and K. Westen in collaboration with the field, funders, client organizations and side stakeholders. An editorial update followed in March 2022.

Background information list

The information in the background information list is necessary for FACT teams to gain an overview of their target population (case mix) in relation to the context in which care is provided and in relation to available resources. The team has an overview of the target population, so that the team can match the goals of individual clients with appropriate interventions. The background information list is also used in this way by CCAF auditors in preparation for the audit. See the CCAF website (www.ccaf.nl) for the digital version that should also be completed in preparation for a CCAF audit.

Description	
1. Team name	
2. Length of existence (in months)	
3. Number of FTE	
4. Number of employees	
5. Number of clients	
6. Client-to-helper ratio	
7. Working area (zip codes/place name)	
8. Other similar providers in service area.	
9. Number of inhabitants	
10. A minimum of four different disciplines (as in A) are present on the core team	
11. Number of clients on the waiting list	
12. Turnaround time of waiting list in days	
13. Inclusion criteria	
14. Exclusion criteria	
15. Inflows past 6 months	
16. Outflow last 6 months including destination. (specify in consultation with client/without consultation with client, in case of death in natural/non natural/suicide, specify destination: GP, Community Team, etc.)	
17. Number of clients admitted in MH in past 6 months (voluntary/voluntary)	
18. % clients in detention	
19. % clients with a Community Treatment Order (specify outpatient coercive measures; coercive medication, urine monitoring, etc.)	
20. % clients with psychotic disorder	
21. % of clients with psychiatric and addiction diagnosis	
22. % clients with a forensic title	
23. % clients with personality problems	
24. % clients with MID	

25. % -18 years	
26. % +65 years old	
27. What social (multi)media, eHealth/mHealth and health technology interventions are used?	
28. Number of FACT Board meetings per week	
29. The team can flexibly intensify care if necessary	
30. % of clients seen annually by 4 or more disciplines on the core team	
31. The team's vision and practices have a clear focus on recovery	
32. % of f-t-f contacts external	

	In core team (directly controllable)	In network (structural cooperation)	Not present/not available	Comments
33. The team provides psychiatric and psychological interventions (name which ones).	Yes/No	Yes/No	Tick if absent/unavailable	
34. The team provides interventions related to addiction.	Yes/No	Yes/No	Tick if absent/unavailable	
35. The team provides trauma treatment.	Yes/No	Yes/No	Tick if absent/unavailable	
36. The team provides pathway to employment and training.	Yes/No	Yes/No	Tick if absent/unavailable	
37. The team provides experiential and family expertise.	Yes/No	Yes/No	Tick if absent/unavailable	
38. The team provides systemic therapy.	Yes/No	Yes/No	Tick if absent/unavailable	
39. The team provides interventions related to somatics.	Yes/No	Yes/No	Tick if absent/unavailable	
40. The team provides appropriate interventions for people with LVB.	Yes/No	Yes/No	Tick if absent/unavailable	
41. The team has judicial knowledge and support.	Yes/No	Yes/No	Tick if absent/unavailable	
42. The team has orthopedagogical or child and adolescent psychological/psychiatric knowledge and/or interventions.	Yes/No	Yes/No	Tick if absent/unavailable	
43. The team has guidance on living and self-care.	Yes/No	Yes/No	Tick if absent/unavailable	
44. The team offers.....	Yes/No	Yes/No		

Professionalization

It is important for a FACT team that the team composition, and the expertise of the team and the individual, matches with the target population and the treatment required. A detailed overview in the Team document can be provided using the table below. See the CCAF website (www.ccaf.nl) for the digital version to be completed in preparation for a CCAF audit.

Enter the gross number of FTE (including training time) that the core team member actually spends on the team.

Item	Team member 1	Team member 2	Team member 3	Team member 4	Team member 5	Etc.
Team member name						
Graduate Training(s).						
Function(s) in %.						
Number of FTE employed by the team						
Number of years on the team (Indicate: <1 yr, 1-3 yr, >3 yr)						
Caseload						
Still in training? If yes, for how many hours per week?						
Training attended in the past year						
Present at daily board discussion						
Also employed by:						

Part A: Structure Items

In Part A of the FACT scale, the actual monitoring of certain items that can be concretely measured begins. During a CCAF audit, the items from Part A as well as B will be tested.

- Scoring Expertise: A team member can possess multiple areas of expertise, however, this makes the team very vulnerable. It was chosen to allow a team member to score a maximum of 1 expertise in addition to items 1 through 7.
- The formula for item 1: Number of core team FTE/Number of clients
- The formula for item 2: Number of employees with ≥ 0.78 FTE/Number of employees X 100
- The formula for items 3, 4, 5, 6, 7, 8, 9, 10 and 11: FTE of the core team x 200/number of clients on the team.

1. Small caseload	**1**	**2**	**3**	**4**	**5**
The client-to-professional ratio of the core team is 15:1.	>30	30-26	25-20	19-16	≤15
2. Teamwork	**1**	**2**	**3**	**4**	**5**
At least 50% of core team members have a 0.78 FTE appointment with the team.	0-19%	20-29%	30-39%	40-49%	≥50%
3. Psychiatrist	**1**	**2**	**3**	**4**	**5**
At least one FTE psychiatrist is assigned to the core team for every 200 clients.	<0.20 FTE	0,20-0,39	0,40-0,69	0,70-0,99	≥1 FTE
4. Psychologist	**1**	**2**	**3**	**4**	**5**
For every 200 clients, at least 1.6 FTE psychologists are assigned to the core team.	≤0.66 FTE	≥0.67 FTE	≥1.2 FTE including GZP or FP	≥1.6 FTE, including 0.8 FTE GZP	≥1.6 FTE, including 0.8 FTE KP
5. Nursing	**1**	**2**	**3**	**4**	**5**
For every 200 clients, there are at least 4 FTE nurses, 3 having a bachelor degree and 0.89 FTE with a Master's degree.	≤3.9 FTE	≥4 FTE with min. 1 FTE HBO	≥4 FTE with min. 2 FTE HBO	≥4 FTE with min. 2 FTE HBO + 0.89 FTE SPV	≥4 FTE with min. 3 FTE HBO + 0.89 FTE US
6. Social/legal expert	**1**	**2**	**3**	**4**	**5**
For every 200 clients, there is at least 0.80 FTE social and/or legal expert.	<0.20 FTE	0,20-0,39	0,40-0,59	0,60-0,79	≥0.80 FTE
7. Employment Specialist	**1**	**2**	**3**	**4**	**5**
For every 200 clients, at least 1 FTE specialized in the field of supported employment is assigned.	<0.30 FTE	0,30-0,59	0,60-0,88	0,89-1	> 1 FTE
8. Expertise in the field of expertise by experience.	**1**	**2**	**3**	**4**	**5**
For every 200 clients, there are at least 1.2 (paid) FTE employees with lived experience, half of whom have formal education (diploma+). Expertise as a client and as a family member is present. A client, family member and a professional with lived experience are present.	<0.60 FTE	0,60-1,19	≥1,2	≥1.2, with min. 0.60 FTE formal education (diploma+)	≥1.2, with min. 0.60 FTE formal training (diploma+). A client, family member and professional

					with lived experience are present.
9. Expertise in somatic healthcare	**1**	**2**	**3**	**4**	**5**
At least 1 FTE with somatic expertise is assigned for every 200 clients.	<0.20 FTE	0,20-0,39	0,40-0,69	0,70-0,99	≥1 FTE
10. Expertise in addiction.	**1**	**2**	**3**	**4**	**5**
At least 1 FTE with addiction expertise is assigned for every 200 clients.	<0.20 FTE	0,20-0,39	0,40-0,69	0,70-0,99	≥1 FTE
11. MID expertise.	**1**	**2**	**3**	**4**	**5**
For every 200 clients, at least 0.80 FTE social workers with MID knowledge are assigned.	<0.20 FTE	0,20-0,39	0,40-0,59	0,60-0,79	≥0.80 FTE
12. Self-direction and autonomy	**1**	**2**	**3**	**4**	**5**
(1) The team has integrated management and coordination roles in the team. (2) Regular staff actively monitors the application of the FACT model. (3) Regular staff members chair FACT meetings. (4) A permanent staff member chairs treatment plan meetings.	The team does not meet any of the four criteria.	The team meets one criterion.	The team meets two criteria.	The team meets three criteria.	The team meets to four criteria.
13. Flexible Care	**1**	**2**	**3**	**4**	**5**
(1) The team systematically coordinates the scaling up and down of care throughout the network. (2) The team uses clear criteria for intensifying and terminating care. (3) The formal and informal network is involved in the implementation of flexible care. (4) The team is logistically and organizationally capable of independently scaling up care to daily client contact.	The team does not meet any of the four criteria.	The team meets one criterion.	The team meets two criteria.	The team meets three criteria.	The team meets to four criteria.
14. Team approach	**1**	**2**	**3**	**4**	**5**
All clients on a FACT team see at least 4 core team disciplines per year (including psychiatrist).	<50%	50-59%	60-73%	74-89%	≥90%
15. Daily FACT Board Meetings.	**1**	**2**	**3**	**4**	**5**
	3x per week		4x a week		5x per week
16. Outreach	**1**	**2**	**3**	**4**	**5**
The team focuses on skill development in the community, more than 70% of contacts take place outside the institution.	<40% of F-t-F contacts outside the home office.	40-49%	50-59%	60-69%	≥70%

Part B: The Topics

Part B of the FACT Scale gives a FACT team focus: what does a FACT team excel in, what topics should the team work on, and what topics should the team pay extra attention to given the case mix, resources, operating environment (region), and team composition? Part B of the FACT scale is measured on a scale from 1 (domain not implemented or poorly implemented) to 8 (sample implementation for other FACT teams).

1-2	3-4	5-6	7-8
Not visible	Under development	Properly executed	Example

A good quality cycle of a FACT team and an organic ***Team document*** (including a mission, vision, all background information, the procedures, the feedback from the client, caregiver and network satisfaction survey, and the quality cycle regarding the topics in Parts A and B) are supportive to show your clients, caregivers and your network partners what your FACT team stands for and what it is all about. Should your FACT team be part of a larger team or network in a neighborhood or region (together with a social work team, residential counseling team, and/or specialty outpatient clinic in the neighborhood), make it clear which clients belong to which part of the larger team or network, and make it clear that the prioritization of clients for FACT is well secured. In addition, the Team document provides helpful input in preparation for a CCAF audit.

For whom, with whom and what?
Some case examples where a FACT team relates to case mix and local context:

"FACT South, our team in the southern part of the city, did a case mix analysis which made clear that the total caseload included 30 clients diagnosed with PTSD. In response to this, action was taken to start offering EMDR from the FACT team by the psychologist with the appropriate training in the core team. Our FACT North team has fewer clients with this diagnosis and no appropriate staff and they are now using the psychologist from FACT South. Of course, the psychologist's actions are included in FACT North's treatment plan and she regularly joins FACT North's treatment plan meetings and FACT meetings to discuss progress."

"When our young people come on the FACT board to intensify care, we scale up the care in consultation and together with the parents, the involved school social worker and the involved social workers from the Center for Youth and Family. The involved social workers from these organizations are listed on the FACT board and are aware of the jointly set goals. Importantly, this allows us to see the young people several times a week through various disciplines, and there is intensive consultation in which the social workers involved join the FACT board meeting. In this way, as a relatively small team, we are able to scale up care and prevent care aggravation or admission."

"Thanks to monthly consultations, where the addiction specialist from our peer institution joins the consultation, I am able to prescribe anti-craving medication to our clients. In consultation with our social worker with addiction expertise, we have been able to actually treat the clients on our team with an addiction and psychiatric diagnosis both with medication and with appropriate interventions from the CRA methodology. One of our clients started a pre-contemplation group during her course with our support which we are very proud of."

"Thanks to mediation from the COC (LGBTI rights platform), I recently started working as a volunteer for a few hours a week on this team. I am an LGBTI expert by experience. My arrival was and is more than welcome after 10% of the recovery assessments revealed sexual identity questions, interests and issues. I find that with my arrival, cultural and spiritual identity has also become a focus and sexual side effects are being asked out more explicitly. In addition to individual contacts with clients, I attend the FACT board meeting once a week, as well as the treatment plan meeting, I run the photography group and organize theme-oriented movie nights. "

"Now that we are supporting many young people in their transition to independent living, we have been able to establish an open cooking group. And as with our running group, girls' night out, fitness hour and games afternoon, we've been able to do that together with volunteers and staff at the community center in Uitzicht. Their kitchen is fantastic, the cooking classes challenging and once a month, it's a great challenge every time to cook what we've learned together for the citizens of the Uitzicht neighborhood."

"Yes, we decided as a team to join the municipal Client-Centered Coordination Platform consultations once a month in varying composition. This has proved important to share expertise with other organizations, gain knowledge about the working methods of other organizations, network and so on..... and above all to keep our network partners informed about our capabilities and inclusion and exclusion criteria. For difficult referrals, we now find each other much more quickly and personally."

Topic 1: Flexibilization of care

A FACT team should be able to *flexibly adapt* care to the needs of the clients, especially, but not exclusively, in scaling up and down. To do so, they use their own expertise among their own team members *and* resources across the network (like a GP, Community Team or HIC). The team can perform care intensification itself or jointly with the involved network partners and/or the client's relatives, depending on the context, team composition and case mix. An approach in which *multiple team members* (from different perspectives) are involved in the treatment of a client is conditional. Both treatment-related and process-related for the entire caseload. It is important that the core team takes responsibility for the intensity of care and treatment to be scaled up or down as needed.

Intensification of care, ACT, is an important part of the working method and allows for flexibility at the time of higher need to prevent a crisis or in the event of life-events or positive developments in all life domains such as living, school, work, birth, etc. Securing unscheduled (free) time and space in staff schedules is necessary for this. It is also important to have good contacts in the network so that action can be taken and necessary resources organized. Flexibility becomes visible during the morning FACT-board meeting and in the described procedures and collaborations (in the Team document, for example).

Another component concerns the *staging of care*: accurately matching interventions to the stage the client is in in order to support the individual recovery process. This ensures tailored and proportionate care and promotes clients' own direction. It prevents the team from being too patronizing, too demanding or too wait-and-see too. Staging of care can be implemented using some recognized models, such as stage of recovery, stages of behavioral change or (addiction) treatment. The reasoned and responsible choice is made by mutual agreement, but is up to the team. It is certainly possible to simultaneously deploy interventions from different stages for different life domains.

A recovery process can be erratic over time, meaning a client may temporarily accelerate, enter a time of seclusion or seek stability. Being available and (proactively) engaging in dialogue with the client and loved ones and carefully matching interventions and intensity to client needs remains necessary, as personal growth can come from isolation, stability or rest. A present and deliberate wait-and-see attitude and (low) intensity is as valuable process-wise as a proactive assertive (high) treatment intensity. Staging is evident in treatment plans, in the procedures and practice of the treatment plan meetings, and during daily FACT meetings.

Staff in the team are expected to be aware of the working method with regard to flexibilization and staging of care and to use this knowledge appropriately during consultations.

In summary, the following items constitute the test:

1) Flexible care is visible during the FACT meeting.
2) Staging of care is visible in treatment plans and it is implemented.
3) There is a team approach, where the expertise of multiple team members is actively used.
4) The intensity of care is appropriate to the stage of the recovery process the client is in; care is scaled up and down as appropriate/necessary.

To achieve an optimal score, all of these items should be visible during daily FACT meetings and in treatment plans.

Topic 2: Personal Domain

The mission of a FACT team is to facilitate and support the recovery process of people with severe mental illness. The team accomplishes this by focusing on both the personal, social and symptomatic domains.

The FACT team is attentive to the *personal domain* of the client when the team recognizes and acknowledges the individuality and identity of the client and acts upon it collectively as a team. There is room for the individual development of the client and the client's own strengths. Similarly, there is room for struggling with one's own (cultural, sexual, spiritual) identity and with emotions such as grief and sorrow. Attention is paid to counteracting self-stigmatization. The team itself also pays explicit attention to their own attitude and the degree of stigmatization of their clients. The (normal) living environment of people and their autonomy form the reference for the treatment. It follows from this that the team dares to take responsible risks (from a caregiver's perspective) in proper consultation and discusses irresponsible risks with those involved as an ethical dilemma in order to reach a shared decision.

A hopeful, present attitude of the team can be seen as a basis. Supporting each other in this, calling each other to account and an appealing hopeful language during consultations makes this visible and is supported jointly. Naturally, this hopeful language and approach is reflected in the written texts of the team and in the offer of recovery-oriented and development-oriented interventions in the personal, social and symptomatic domain from the team and in the network.

In summary, the following items constitute the test:

2.1 The team recognizes and acknowledges the individuality of the client.

- The team assumes the client's own strengths.
- Struggling with cultural, sexual and spiritual identity and emotions such as grief and mourning are seen by the team and acted upon collectively.
- There is a focus on countering stigmatization by the team, loved ones and social context and self-stigmatization of the client.
- The team dares to take risks (and the client has the right to fail - and learn from it).
- The team has a hopeful attitude and uses hopeful language focused on an open and positive view of the future.

2.2 The client's strengths, desires and goals are visible.

- The team identifies and records the client's goals.
- The team facilitates and supports the achievement of goals with visible interventions.
- Guidance within this domain is available in the core team or in the directly manageable network.

To achieve an optimal score, all these items should be visible in the Team document and during the daily FACT Board meetings, as well as during the client and relatives satisfaction survey.

Topic 3: Social Domain

A FACT team provides support in the client's *social domain* by being mindful of the client's various social roles in life and providing appropriate care for them. This is practically possible through the use of participation and/or recovery support assessment tools. Support is based on the client's expressed wishes and goals in the different domains 'self-care and living', 'social network' and 'work and leisure'. Interventions are designed in conjunction with the client, their loved ones and professional network partners. If necessary, proactive assertive interventions are included in the treatment plan, aimed at both the individual client and his context.

The social context, the available resources of both the client, his environment, the team, and the case mix will determine the possible interventions, as well as the focus. Interventions can be coordinated by external partners, in conjunction with local partners, or by the team itself. When multiple clients have similar needs or goals, it may be helpful to develop (or have developed) individual or group offerings. For example, in some teams, the focus will be on obtaining shelter, preventing homelessness and getting finances in order, while in other teams, loneliness, pathway to work or study, self-care or safe living deserves focus.

In summary, the following items constitute the test:

3.1 Client roles within the self-care and living domain are visible

- The team identifies the client's goals and records the client's goals within the self-care and living domain.
- The team facilitates and supports the achievement of goals within the "self-care and living" domain with visible interventions.
- Guidance within this domain is available in the core team or in the directly manageable network.

3.2 Client roles within the 'social network' domain are visible

- The team identifies the client's goals and records the client's goals within the "social network" domain.
- The team facilitates and supports the realization of goals within the "social network" domain with visible interventions.

3.3 Client roles within the work, education and leisure domain are visible

- The team identifies the client's goals and records the client's goals within the "work, education and leisure" domain.
- The team facilitates and supports the realization of goals within the "work, education and leisure" domain with visible interventions, with the employment specialist playing an initiating role.

To achieve an optimal score, the items should reach all clients and be appropriate for the individual client. This is reflected during daily FACT meetings, in treatment plans, and in the intake and assessment procedure.

Topic 4: Symptomatic Domain

The team strives for the best possible mental health and somatic well-being of the client. To achieve this, the team has implemented a system in which screening, diagnostics, treatment and interventions take place according to the latest scientific insights. The experts present in the team are initiating and actively involved in the screening, diagnostics and evaluation of treatments in their specific area of expertise.

In summary, the following items constitute the test:

4.1 Psychiatric Interventions

- State-of-the-art and integrated screening, diagnosis, treatment and impact evaluation.
- Medication Management

4.2 Somatic health Interventions

- State-of-the-art and integrated screening, diagnosis, treatment and impact evaluation.
- Somatic health is treated in full breadth, with active referral and follow-up if necessary

4.3 Psychological and Pedagogical Interventions

- State-of-the-art and integrated screening, diagnosis, treatment and impact evaluation.
- The range of interventions is appropriate to the case mix.
- The MID expert visibly plays an initiating role.

4.4 Addiction interventions

- State-of-the-art and integrated screening, diagnosis, treatment and impact evaluation.
- Addiction interventions are explicitly named, described and flexibly/staged.
- The addiction expert visibly plays an initiating role.

To achieve an optimal score, all of these interventions should be available for the total caseload and these interventions should be appropriate to the case mix. A thorough analysis of the background information list in relation to supply is helpful here.

Topic 5: Planning and Control at the Individual Client Level.

The team has described a clear treatment planning cycle and adheres to the logistical process that a good procedure entails. Embedding routine outcome monitoring data is part of this. The team has made a reasoned choice from the available standardized measurement tools.

The information collected is periodically used to plan and evaluate care. Using shared decision making together with the client and the client's personal network, the goals in the treatment plan are established. The role of loved ones is specifically described in the treatment plans. Each partner in the triad (client, relatives and professionals) can contribute goals. The role of network partners is concretely described in the treatment plans. In this way, the FACT team assumes a directing coordination role and oversees the total care to promote recovery, prevent admissions, and restore the autonomy of those involved.

The interventions offered and described by the team, as in theme 4, should be available to the entire caseload. Availability is a prerequisite for motivating clients to engage in the most appropriate and appropriate form of intervention or treatment.

Of course, the evaluation and systematic follow-up of treatment takes place in consultation with the client, loved ones and the professional network.

In summary, the following items constitute the test:

5.1 Planning and Control Cycle

- The treatment planning cycle is described.
- Implementation and evaluation of the (progress of the) treatment takes place in collaboration; there is a collaborative relationship with the client, relatives, GP, professionals from the social domain and mental health counselling. Decision-making about the treatment is shared (team, network, client and relatives). Each party can contribute goals.
- Clinical outcome monitoring is conducted routinely and at least once a year for the purpose of individual policy and treatment plan, consisting of standardized instruments that measure (1) psychological and (2) social functioning, (3) care needs, and (4) quality of life and recovery.

5.2 Integrative Responsibility

- The team is integrative responsible for the course of treatment and assumes a directing coordination function.
- Active policies are in place to motivate and direct clients to appropriate interventions when necessary.

To achieve an optimal score, all of these items should be visible in the team's described practices and in treatment plans.

Topic 6: Crisis, Safety and Social Responsibility

The FACT team takes responsibility in their catchment area for all clients belonging to the target population of the respective team (always people with a severe mental illness in need of integrative and integrated care). Waiting lists and limited availability of treatment options in the region may require additional flexibility and responsibility from the team. The team coordinates with other FACT teams or other regional network partners for specific target populations to collaborate and smoothly and warmly refer or take over clients. It is also part of the team's work to provide consultation and (temporary) low-threshold (online and offline) availability and accessibility of support for clients, relatives and network partners. Readmission of clients can be done immediately when consultation is insufficient or risk increases. The team is committed to preventing social breakdown, relapse and crisis or supporting loved ones during difficult periods. Deployment of preventive assertive interventions, a shared process towards a crisis resolution plan/crisis plan, acute care intensification and cooperation with relevant partners are important here. In its catchment area the team is able to carry out targeted case finding when clients have dropped out of sight as well as unfocused case finding in order to make good, appropriate treatment available (e.g. preventively or in the context of early warning) to all clients with severe mental illness in its catchment area.

The team is able, even under the most difficult circumstances, to creatively develop, offer or release options for clients and/or families time and time again. This happens especially when escalation is imminent and participation and autonomy are under pressure. The focus is on possibilities, opportunities, alternatives, prevention, accessible communication (e.g. through social media) and scaling up (as opposed to an escalation in coercive measures leading to possible coercion). Safety can often be achieved in different ways. Acting together opens up creative solutions. It is therefore necessary to let more stakeholders (primarily the client, family and relatives) participate in planning and realizing solutions.

The team is attentive to the safety of the client, his environment and its staff. It develops an anticipatory and preventive policy, thus limiting the need for crisis intervention. This policy limits safety risks. To achieve this goal, the team continuously and consciously monitors risks. This provides opportunities for proactive action, allowing evidence-based crisis prevention and early warning interventions to be offered in a timely manner. The team implements a crisis policy that is cyclical, preventive and, if necessary, assertive and proactive. A structural relationship with regional facilities for safety and security (in and around the client's home) is part of the policy. Obviously, the offer must be appropriate to the case mix and the social context.

A gatekeeper role for FACT team clients on inpatient admission and discharge is desired. The team has a written safety policy and applies it. Clients can make use of forensic interventions and have an individually tailored crisis (prevention) policy.

The team periodically evaluates case histories through peer review, moral reflection or entering into consultation and supervision relationships. It strives to limit coercion and pressure and, within the framework of its responsibilities regarding safety, to comply with the CRPD (the United Nations Convention on the Rights of the Disabled).

In summary, the following items constitute the test:

6.1 Assertive Proactive Crisis Interventions

- The team is able to recognize the (early) signs of an (impending) crisis.
- The team is able to intensify care, implement creative solutions and expand options in conjunction with the network.

- The team is able, if necessary, to take the necessary (including protective Community Treatment Orders) measures to restore safety.
- The team is integrally and 24/7 responsible for directing the scaling up and down of care, including when inpatient departments, crisis services, family physician and community teams are involved with the client.
- The individual crisis resolution plan is drafted jointly with all involved and systematically evaluated with the client and stakeholders.

6.2 Safety and Risks

- Proactive assertive treatment and actions are put into practice to prevent dropout.
- Use of risk assessment (tools) appropriate to target population is applied. To prevent suicide, social breakdown, aggression and delinquency.
- A range of training courses in the areas of de-escalation, aggression regulation, impulse regulation or emotion regulation are available, used and evaluated for effect. This can be done in groups or individually. The team also has a forensic offer, e.g. for crime-specific problems such as domestic violence or moral problems, or actively refers to these in the network.
- There is a described safety policy focusing on the topics of (1) home visits (2) aftercare after an incident (3) reporting to the police (4) dealing with aggression and (5) network involvement.
- The team continuously questions its safety policy, uses external consultation, and the human rights framework provided by the Convention on the Rights of Persons with Disabilities (CRPD).

To achieve an optimal score, the items should reach all clients and appropriate policies should be developed for the individual client. This is reflected in the Team document, during daily FACT meetings, in treatment plans, and in the intake and assessment procedure.

Topic 7: Cooperation with the Network

A committed *collaboration with the client's network* is of utmost importance from the start of treatment in order to leave control of the recovery process with the client and his self-chosen sources of support as soon as possible. The team supports the client in naming and integrally involving the chosen informal and formal sources of support. The support network is part of the client's immediate environment and make the natural environment in which meaning and reciprocity take place in the triad. The need to receive care from the FACT team should be as long as necessary and as short as possible (but not determined solely by risk assessment, but also by recovery-oriented policies and the development of resilience). Personal and professional support from the client's network is of obvious importance during and after FACT treatment. The team involves the network in the treatment planning cycle and team evaluations. The team supports the personal network (family and caregivers) and the professional network with the most appropriate forms of treatment for the target group, and supports and facilitates the establishment of forms of self-help by the personal network.

A FACT team works for a certain target group in a certain social context in a certain region. It is important to achieve a good match between the chosen target group and the composition and intensity of cooperation with network partners in the community or region. Supporting full recovery in all areas requires a broad and active network of nearby stakeholders and professional internal and external resources. Each time in the relationship, formal and/or informal cooperation structures are deliberately chosen. The intensity of the collaborative relationship can vary depending on the goals and desires shared by the target group. One partner joins the FACT board meeting daily and is part of the team (a multi-agency approach in which staff from different organizations work together collaborative in one team), while another relation can be reached with ease by phone or email.

A positive working relationship is important both to external contacts, and to internal contacts. Actively managing networking relationships through informational meetings, offered consultations, attentions or attending Coordination of Care meetings with inpatient admissions departments is certainly part of this.

In summary, the following items constitute the test:

7.1 Involvement and Cooperation with the Client's Social Network

- The team works with a social network intervention to integrative engage external sources of support.
- There is an offer (individual and/or group) from the team to loved ones.
- The team facilitates and motivates the creation and implementation of self-help groups by loved ones.
- The team organizes cyclical satisfaction surveys of clients, relatives and network partners to systematically evaluate and adjust working methods where necessary.

7.2 Collaboration with the Professional Internal and External Network

- Internal and external cooperation partners and the form and intensity of cooperation are appropriate to the caseload, social environment and available resources.
- The social support system/social map is known to the team at the work area level.

To achieve an optimal score, all these items should be available to the total caseload, systematically implemented and evaluated, and these interventions should be appropriate to the case mix. The outcomes of the satisfaction surveys are documented in the team document with associated action plan.

Topic 8: Quality and Innovation

The FACT team pursues optimal quality of care and is open to new knowledge, initiatives and innovations. To achieve this, there is a coordinated training policy, of at least four half-days per team member, described in the Team Document and employees continue to develop themselves. The training policy is tailored to the target group, the working method and the treatment provided. The team is open to interns and other types of partnerships with educational institutions.

External experts are regularly invited or asked for help by the team. This can be supportive of an individual case, an ethical dilemma or in support of team processes. In a more formal sense, there should be the possibility to request a second-opinion.

A quality cycle is visible in the actions of the FACT team. As a team becomes more aware of its qualities, strengths and challenges, actions regarding quality and innovation can be adjusted accordingly. The knowledge and skills gained from this can be shared within and outside the organization to further the development of the FACT model.

The deployment of innovative initiatives can be in many areas, with large or small scope, large or small impact and more or less disruptive. What is important is that a platform is provided in which it is possible to experiment with innovations in healthcare of all kinds and that the team collectively carries and supports these developments. In summary, the following items constitute the review:

8.1 Schooling and Training

- Each team member has received training in EBPs relevant to the team within the past 2 years.
- Every team member has received training in recovery topics in the past 2 years.
- There is a described training and peer review policy appropriate to the case mix and it is periodically reviewed and updated.

8.2 Expert knowledge

- Experts are invited at least monthly (consultation).
- The team has a visible internal and external consultation function.
- A second opinion is used where appropriate.

8.3 Planning and Control Cycle at Team Level

- The team has included a described improvement plan in the Team document that includes goals and actions .
- The outcome data as well as the client satisfaction survey are used at the team level to systematically evaluate and adjust practices as needed.
- There is a periodic dialogue, including stakeholders, on the relationship between care policies and the Convention on Human Rights for Persons with Disabilities (CRPD).

8.4 Innovation of Care

- The team has alternative and/or innovative and/or health technology interventions or actions that positively distinguish it.

To achieve an optimal score, the team should make all these items visible in the written team documents and in the logistics process of the quality cycle.

Final score

The score is determined based on consensus of both auditors and by aggregation (addition) of the average item score on the A section (structure) where a maximum of 5 points can be obtained, the average item score on the B section (content themes) where a maximum of 8 points can be obtained. Scores are calculated to the nearest 1/10th of a point and rounded to the nearest decimal place. The score thus ranges between a minimum of 2 and a maximum of 13 points. Scores above 6 on the B section are awarded when there is 'exemplary function'. Thus, the realistic maximum is 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 above: an optimal certificate

Average score Part A:	
Average score Part B:	
Total score A + B:	