Flexible Assertive Community Treatment Team

FACTT

STANDARDS ONTARIO

Version 2

Feb 2023

Flexible Assertive Community Treatment Team (FACTT) Standards Ontario Version 2 (Feb 2023)

EXECUTIVE SUMMARY

The Ontario Association for ACT and FACT (OAAF) recognises opportunities to integrate existing Intensive Case Management (ICM) with ACT principals to develop FACTT (Flexible Assertive Treatment Team) in Ontario. The Case Management Service standards from MOHLTC (Ministry of Health and Long Term Care) were implemented in 2005, and was focused on a 1:1 care model. Since this time some areas have creatively developed their own iterations of inter-disciplinary teams. ICM has been gaining knowledge about the needs of those within the SPMI (serious and persistent mental illness) population since the late 1980s with the introduction of after-care teams and community case management. In many areas, the work has included developments within housing and supported employment services, both within teams and with external partners. Some teams have been integrated with psychiatry and nursing and Occupational Therapy and Social Work resources.

ICM teams target population is all people with a serious persistent mental illness which is wider than the intended target population of ACTT. FACTT in Ontario has the opportunity to offer care and treatment to people who on occasion would require ACTT level of intensive care, as well as the target population of ICM. FACTT naturally developed out of the long history of a recovery-based approach to person-centred planning and care while treating SPMI in ACTT and ICM.

According to J. Remmers van Veldhuizen, the FACTT model was developed with the following aims:

- Recovery-oriented care
- Evidence- based medicine and best practice
- Integrated community and hospital care

These standards are based on current knowledge of FACTT from the Netherlands as well as experiences of implementing the model in a Canadian context (New Brunswick and Ontario). As with the ACTT standards, we believe these standards will evolve over time with accumulated experience to better meet the needs of those with SPMI.

FACT teams operate in the Netherlands (where the model was developed) against a backdrop of 150 inpatient psychiatric beds per 100,000 people. This means that many of the individuals with severe and persistent mental health issues in the Netherlands are in hospital. In Ontario, with a reported bed ratio of 33 per 100,000, these same people live in the community and need ACT level service to be supported in the community. The OAAF position is that it is a misunderstanding for LHINs to believe that the FACT Team model is directly transferable to the Ontario setting, or that FACT teams have capacity advantages or are more cost effective than ACT level services. However, research has indicated that embedded (active, integrated, fully participating team member as per Ontario ACT standards v. 3.0) psychiatry in addition to nursing and intensive case

management in a team model is effective and can eliminate the outcome differences between intensive case management and ACTT teams with the respective populations. As such, FACTT teams are being implemented with new government funding in order for existing ICM teams to evolve with principles of ACT in order to become FACTT.

Following careful LHIN level regional service reviews it may be appropriate for case management/ICM services/hospital outpatient services to be reorganized and funded as FACTT teams. FACTT is appropriate in addition to ACT teams in an ACT saturated urban area, and in rural areas with a catchment of under 80,000.

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INTRODUCTION

FACTT (Flexible assertive community treatment team) target population is all individuals with SPMI in a given catchment area intensive and case management services. For those individuals supported by FACTT, 80% of clients with SPMI would require regular case management supports, while 20% at any given time would require more assertive or intensive level of supports. The level of care needed and type of support provided is coordinated through the daily FACTT meetings and FACTT Board (a digital whiteboard tool for highlighting who is in greatest need on any given day) with its flexible service intensity and prioritization system. Meetings consist of team discussions regarding the group requiring the most intensive care and the team adopts a shared care model. Clients are listed on the digital FACTT board and moved into the 20% when they require a team based approach or attention regarding lack of engagement. For people requiring less intensive care, the team provides individual case management with interdisciplinary treatment and team consultation. When people become more stable, they can be transitioned to their primary care team and informal/lower intensity community supports as needed. This flexibility to switch between the two modes of service delivery (high and low intensity care) within the same team enhances continuity of care and reduces drop-out from programming

This flexible switching system provides better opportunities for recovery. As soon as a client receiving individual case management is at risk (mental health status, psychosis, crisis or hospitalization or becomes disengaged from treatment), the team immediately switches to intensive ACTT level of care. This combination of flexibility and continuity ties in well with the natural course of SPMI with its recurring episodes.

This model also works well when psychiatry resources are scarce as people who have reached a level of stability can return to their primary care provider and less formal community supports. Primary care providers can monitor and treat the person with the understanding that if symptoms reoccur they can rapidly reengage with intensive services. FACTT supports the client in the relationship with their primary health care team, by attending appointments and collaborating during times when symptoms are more severe and stepping back when they are more stable allowing people to self- manage their illness.

COMPARE AND CONTRAST

Netherlands FACTT teams are interdisciplinary teams with the same staffing numbers and mix as one might find on an ACTT with similar budget and costs. They operate with day to day review, address emerging issues, titrating the service intensity of treatment needs, and support needs by adjusting the service plan in a dynamic way.

FACTT Netherlands operate on the weekdays only. After hours and weekend coverage is an ACTT standard and some provision for after hours crisis support is included in Ontario Case Management Standards. Many ACT teams in Ontario have partnered with after hours/crisis services to provide this care.

FACTT Netherlands, like ACTT, are expected to have small caseloads. ICM teams in Ontario have generally had ratios of 1:20 while ACTT is 1:8. FACTT is expected to be a much less intense

service then ACTT. While ACTT have a mandate to serve those who are among the most compromised and ill in our mental health system, who can be safely considered for community placement, FACTT serve the broad spectrum of clients.

In the Netherlands, there are more than o triple the numbers of psychiatric beds per 100,000 general population compared to Ontario (~ 150 beds per 100,000, Netherlands, compared to 33 beds per 100,000, Ontario). This helps explain why most FACTT clientele in the Netherlands are more comparable to individual case management with only about 20% of the FACTT case load being more tertiary in nature. In the Netherlands, the rural “neighbourhoods” are earmarked for one FACTT per 40,000 general population, while the figure for the urban jurisdictions is variable at a team per 35-50,000. The most severely mentally ill in the Netherlands seem to be served in long term care hospital settings in much greater numbers than in Ontario, where our dozens of ACTT teams allowed for significant deinstitutionalization. (That said, we still need many more ACTT in Ontario because there are still several thousand more individuals in Ontario who meet criteria for ACTT level services, who are accumulating many bed days in hospital over a given year, including frequent crises and emergency room visits, housing instability, street involvement and incarceration.

STAFFING REQUIREMENTS

Staff understands community inclusion and integration values, Psychosocial Rehabilitation (PSR) principles and practices, and the recovery model. In addition, clinical staff must embrace attitudes and embody values that are compatible with the FACTT philosophy of compassion and respect for persons with severe mental illness and their experiences. It is important to acknowledge concurrent disorders and plan for integrated treatment. Teams need to be trained and staffed to ensure a broad area of expertise, skills and knowledge to address the needs of the service population. An understanding and belief in people's’ rights to determine their own goals and recovery journey, as well as client and family involvement, are critical components for maintaining the quality of FACTT services.

While disciplines on a team may vary, clinical experience to date supports the position that the staffing ratio should not exceed 1:16 and may be as low as 1:13 if a team has a higher acuity service mix. The individual staff caseloads may vary depending on available disciplines and additional duties or workload of each staff (# of intensive clients, group facilitation, management of crises and complex family support needs, discipline specific duties, etc.). Team Coordinators will work with the team members to ensure overall equitable workload.

The psychiatrist, psychologist, team coordinator and administrative assistant may not carry a regular caseload.

There are 12.5 FTE, with 8 FTE carrying a roster (8 x 16) which would support 128 individuals. A mature team (with at least 2 years of operating experience) may expand (as fluctuating service needs vary) to 1:20, but not exceed 160 on the total team roster in order to ensure flexibility for continuous intake, as well as adequate resources to focus on intensive treatment. A 160 roster would include people seen monthly, for limited service (injection only), who are in the process of service completion, who are focused on reconnecting with primary care and other generic

community supports, and who would need limited monitoring to ensure client flow and team responsiveness for crisis. **It is important to consider the upper limit of capacity in the development of FACTT as well as the need to have a continuous intake and transition to primary care.**

Position	Required FTE
Psychiatrist	1 FTE
Team Coordinator	1 FTE
Program/Administrative Assistant	1 FTE
Psychologist	.5 FTE
Registered Nurse/Registered Practical Nurse	3 FTE
Social Worker /Psychotherapist	1 FTE
Occupational Therapist	1 FTE
Peer Specialist	1 FTE
Other clinicians as need warrants	1 FTE
Concurrent Disorders/Addiction Specialist	1 FTE
Nurse/Flow Through Care Coordinator	1 FTE
Total	12.5 FTE
Alternates based on Need/Specialization Nurse Practitioner PSW Behaviour Therapist Developmental Service Worker Vocational Specialist Geriatric Specialist ABI Specialist Forensic/Court Support Workers Youth Workers Housing Worker Refugee or Settlement Workers Social Recreation Therapist	

Notes:

Teams unable to fill mandatory position must continuously advertise vacancies and may not hire another clinician to fill the vacancy for longer than twelve month contracts to allow for the filling of the mandatory position, should a skilled clinician become available.

All job vacancies must be advertised on the central OAAF website bulletin board. Each team is responsible for keeping listings current. Every person on an FACTT must only work for the FACTT. For example: the team coordinator has full time responsibility with his/her team and must not manage other programs; the program assistant must work full time with the FACTT and not be assigned work responsibilities outside of FACTT work.

Nurse Practitioners (NP) and Physician Assistants (PA) potentially have important and helpful roles to play on FACT Teams (monitoring more stable clients, physical medicine challenges). The scopes of practice for both disciplines are not yet clearly defined or well developed for tertiary psychiatric care in Ontario. What is clear in the present and will remain true in the future

is that psychiatrists on FACT Teams cannot be replaced or have reduced working hours because a NP or PA is also working on, or closely with, the team.

Staff Supervision

Supervision for staff occurs in a Shared Leadership Model with Psychiatry/Psychology and Team Lead. It is critical that the Psychiatry and Psychology are compensated on a salary based structure to promote the importance of the leadership and supervision components of the role. Psychiatry and Psychology hold a clinical leadership role providing feedback and recommendations to the Team Lead regarding staff development and performance including identifying and recommending training needs for the team. The Team Lead directs the daily operations, staffing and scheduling as well as individual staff development and performance planning.

The FACTT team establishes medication policies and procedures which identify processes to:

- Ensure All FACTT members assess and document the client's mental illness symptoms and behaviour in response to medication and monitor for medication side effects.

Order medication:

- Arrange for client medications, as required, to be organized by the team and integrated into clients' weekly schedules and daily staff assignment schedules
- Provide security for medications (e.g., daily and longer-term supplies) and set aside a private designated area for set up of medications by the team's nursing staff; and
- Administer medications per regulations in Ontario to clients.

Roles

Team Lead/Coordinator

A full-time Team Lead/Coordinator is the senior clinician on the team responsible for clinical and administrative support to the team. The Team Lead works in a tri-leadership role with the Psychiatrist and Psychologist.

Leadership skills are imperative for the Team Lead position. They should be someone with a very affable and patient personality who is able to think quickly on their feet. The Team Lead is a health professional with substantial experience in the care and treatment of individuals with serious and persistent addictions, mental health disorders. They would have a diploma or degree in a relevant discipline, and be committed to the philosophy and operating fidelity of FACTT services. The Team Leads education can be from a variety of disciplines: nursing, social work, occupational therapy, counselling, or a combination of experiences and academics.

The role requires a competent clinician who leads client-centred assessments and individualized treatment planning by working side-by-side with clients and team members, and provides in vivo supervision. It is very difficult to direct service delivery without having firsthand knowledge of each client and their family. First hand knowledge of clients makes clinical supervision far more effective and credible.

Examples of the Team Coordinator's responsibilities:

- Directs the day to day clinical operations of the FACT team, including scheduling staff work hours to assure appropriate coverage for the day, evening, weekend and holiday shifts and on-call hours.
- Continually evaluates the status of clients and does appropriate planning and coordination of treatment activities to ensure immediate attention to their changing needs.
- Directs and coordinates the client admission process. The ideal situation is where the team coordinator meets the potential client after receiving a referral and determines suitability of FACT to meet treatment needs.
- Participates in staff recruitment, interviewing, hiring, termination, work assignments, orientation and performance supervision.
- Develops and administers the FACT program budget. It is important for the team coordinator to have a thorough understanding of the available financial resources at all times in order to manage the program accordingly. Many teams have higher level administration oversee their budgets; this is not an adequate approach because it is critical for the team coordinator to be aware of the team's financial resources at all times and to be a meaningful participant in all allocation decisions. The team coordinator ensures FACTT funding is allocated appropriately, according to the Standards, and according to team needs. Team coordinators should also have responsibility to apportion resources for travel and staff education.
- Develops and maintains program policies, and reviews and revises as necessary.
- Providing a thorough orientation of the expectations for this position when an individual is hired reinforces the required skill set for directing an FACT team. Team coordinators are the individuals who ultimately have to make quick and sometimes, very difficult decisions. Flexibility is highly valued and having the ability to collaborate regularly with the team psychiatrist and psychologist works best for success in this position.

Program/Administrative Assistant

The program/administrative assistant is responsible for organizing, coordinating, and monitoring all non-clinical operations of FACTT, including: managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for client and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and clients. The program/administrative assistant is a proactive, problem solving team member who works in close collaboration with all team members and receives guidance and support from the Team Lead.

- It is the role of the program/administrative assistant on an FACT team to:
- Greet people at the FACTT offices and answer telephone calls, book meetings.
- Triage and coordinate communication between team and clients.
- Liaise with the CTO coordinator and support timely completion of tasks in the process
- Obtain answers to questions for clients, families, community resources and agencies.
- Work with callers to relieve urgent situations or to temporarily manage them until other staff are available.

- Assess and report behaviours that are out of the ordinary for that particular client.
- Order and maintain unit supplies, equipment, and furniture, and arrange for repairs when necessary.
- Record important statistical requirements such as client admissions and discharges.
- Inform and consult with FACT team members for the proper maintenance of the clinical client records.
- Prepare letters, memos and reports using word processing equipment.
- Collect necessary data and prepare reports.

Psychiatrist

The FACTT psychiatrist operates as an integrated member of the team and co-leads with the Team Lead and Psychologist. FACTT psychiatrist have designated hours in sufficient blocks of time on consistent days in order to carry out their clinical, supervisory and administrative responsibilities. It is necessary to arrange for and provide alternative back-up for all hours the psychiatrist is not regularly scheduled to work. Alternative psychiatric back up may include the local mental health centre's psychiatrist, or an emergency room's psychiatrist. They must not operate in an external consultative manner. In the event of psychiatry shortages it may on occasion be necessary to access external psychiatry but a return to internal psychiatry with FACTT operating practices should occur as soon as possible. A FACTT psychiatrist has a unique and sophisticated community psychiatry skillset including specializations in forensic, consultation-liaison, addiction, or dual diagnosis psychiatry. FACTT psychiatrists must be paid on a salary/compensation model out of specific FACTT funding dollars rather than bill OHIP. The salary/compensation model is essential to provide the service flexibility and crisis response time that the variability of FACTT client needs demand.

To support continuity of care, collaboration between primary care physicians and hospital inpatient teams is required. Where FACTT psychiatrists have privileges at hospital for teams who have service agreements with the admitting hospital, FACTT psychiatrists provide continuity of care by following clients through admission to discharge from hospital and offer consultation to primary care physicians monitoring psychiatric medications of clients who may still require team based support but no longer require ongoing psychiatry.

Other specific responsibilities of the FACTT team psychiatrist are:

- Attend clinical rounds and scheduled treatment/recovery review meetings to offer direction and support to the team
- Conducts psychiatric assessments, including psychiatric history, course of illness and response to treatment(s), mental status examination and DSM 5 diagnoses. Psychiatrists present their assessment results at daily team meetings and treatment/recovery plan meetings.
- Collaborate with Registered Nurses/Registered Practical Nurses in assessment of clients' physical health, making appropriate referrals to general practitioners or specialists for further assessment and treatment, when required.
- Make accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist will follow;

- Provide individual, group, and family therapy, as well as illness education.
- Provide on-site crisis assessment and management of clients during regular work hours, and over the phone, during other hours when it has been negotiated.
- Provide home based visits as appropriate or when required
- Be actively involved in inpatient admissions where staff privileges are available for continuity of care in transitions from hospital to community and vice versa.
- Submit written reports and documentation in a timely fashion within the standard guidelines for the agency or hospital practice that is in place.
- Assist the team coordinator, where appropriate, in the administration of the clinical program.
- Work with the team coordinator and psychologist to monitor client's clinical status and response to treatment
- Provide ongoing training to the FACT team members in the knowledge and skills basic to the treatment of persons with severe and persistent mental illness/addictions.
- Offer treatment tools to clients to enable them to manage their own illness to help each client identify/target the symptoms and occurrence patterns of their mental illness and developing methods (internal, behavioural, or adaptive) to help lessen the effects.
- Psychotherapeutic interventions such as Cognitive Behavioural Therapy and individual psychotherapy (or supervision and/or assistance if appropriate when these are delivered by other trained/skilled clinicians).
- Provide education about medication, benefits and risks, and obtain informed consent for treatment

Psychologist

The Psychologists position is unique to FACT and is not part of the Ontario standards for ACT Teams. It is an important position for Flexible ACT given the focus on evidence based treatment needs for populations with complex presentations and difficulties in functional abilities in addition to SPMI diagnosis. Psychologists can be helpful where clinical expertise in psychotherapy and behavioural therapy is indicated in addition to pharmacological interventions. The psychologist provides a full range of psychology services including evidence-based assessment, diagnosis, consultation, and intervention, including the controlled act of psychotherapy in various modalities. Psychology works closely with all members of the interdisciplinary team to integrate assessment findings and assist in the development of evidence-based treatment plans responsive to client needs. Psychology staff with relevant training provide oversight on Behaviour Therapy assessments and interventions. Along with other team members, Psychologists develop and provide community education specific to the client population being supported. Psychology consults and liaises with key community agencies, service providers, and family members for the purpose of improved client care. Psychology staff members can also conduct program evaluation and research activities and provide clinical supervision and training to team members individually and in groups.

Registered Nurses/Registered Practical Nurses

FACT teams may employ a blend of Registered Nurses and Registered Practical Nurses. Practice guidelines stipulate that Registered Nurses may care for anyone, including complex and

unstable patients. Registered Practical Nurses are partially limited insofar as their primary role is in the care of clients who have reached some level of stability in illness presentation. This distinction may be of little practical significance in the day to day work of FACTT, but it bears mentioning that each team must have at least one Registered Nurse and that there is a special burden of responsibility that falls to Registered Nurses when dealing with more complex clients.

The Registered Nurses/Registered Practical Nurses on an FACT team are expected to:

- Instruct FACTT clients and their families in health education and disease prevention, educate, support and advocate for clients and their families about their rights and preferences around treatment and recovery.
- Coordinate, schedule, and administer medical assessments of clients' physical health, making appropriate referrals to community physicians for further assessment and treatment, and coordinate psychiatric treatment with medical treatment, in collaboration with the team psychiatrist.
- Provide assistance in the maintenance of clients' physical health through collaboration with family physicians or nurse practitioners to ensure that clients' primary care needs are being met.
- Nurses may conduct home visits to determine the clients' needs, which may result in first aid, treatments such as medication administration, glucometer readings, monitoring of vital signs, and observation for changes in clients' conditions that require physical attention, with an ongoing duty to record information in the client file.
- Assume responsibility for developing, writing, implementing and evaluating, and revising overall treatment goals and plans, in collaboration with the client.
- Provide individual supportive therapy and symptom management, ensuring that immediate changes are made in the treatment/recovery plans as clients' needs change.
- Develop, revise, maintain and supervise team psychopharmacologic and medical treatment and medication policies under the direction of the psychiatrist, by transcribing, administering, evaluating and recording psychotropic medications prescribed.
- Evaluate and chart psychotropic medication effectiveness, complications, and side effects, and arrange for required lab work, according to protocol.
- Organize with other team members to manage a system of providing medication to clients and integrating medication administration tightly into clients' individual/recovery plans.
- Manage pharmaceutical and medical supplies, under the direction of the team psychiatrist and in collaboration with other nurses on the team.
- Participate in treatment, rehabilitation, and support services.

Social Worker/Psychotherapist

The social worker is a registered allied health professional who possesses a BSW, MSW or Masters level clinical psychology degree.

The Social Worker/Psychotherapist is an integral member of the team who provides counselling and guidance to FACTT clients. They counsel individuals and family members regarding behavioural modifications, symptom management, rehabilitation, social adjustment, and financial assistance, family psychoeducation facilitate family groups.

The Social Worker/Psychotherapist is responsible for:

- Counselling and educating families about severe and persistent mental illness/addictions.
- Interviewing individuals, families and significant others to assess clients' social, emotional, physical and mental impairments, as well as financial needs.
- Assisting clients in obtaining appropriate community resources for financial support, such as ODSP, Ontario Works, supportive housing, etc.
- Determining clients' eligibility for financial assistance, where appropriate.
- Leads group counselling sessions and plans psychosocial programming for clients in need of specific services, essentially serving as a liaison between social service agencies and clients.
- Developing program content, organizing, and leading activities planned to enhance the social development of individual FACTT clients.
- Investigating and monitoring home conditions to determine safety and avoid harmful living conditions, in partnership with the rest of the clinical team.
- Obtaining a thorough social history in a timely manner with each new client and bringing relevant concerns to the attention of all team members.
- Demonstrate a strong family engagement ability to assist with service quality improvement
- Provide family support and include family members in service planning as appropriate
- Individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process.
- Intervention (including mediation) to restore contact, resolve conflict, and maintain relationships with family and/or other significant people.
- Ongoing communication and collaboration, face-to-face and by telephone or electronic media, between the FACT team and the family.
- Introduction and referral to family self-help programs and advocacy organizations that promote recovery.
- Assistance to clients with children (including individual supportive counselling, parenting training, and service coordination) including but not limited to:
    a) services to help clients throughout pregnancy and the birth of a child.
    b) services to help clients fulfill parenting responsibilities and coordinate services for the child/children.
    c) services to help clients restore relationships with children who are not in the client's custody.

An essential core activity of FACTT is supporting client self-determination in relation to legal matters (charges, diversion, probation, CTOs, SDMs, PGT- guardianship, POA, Mental Health Advance Directives and PHIPA). The social worker should have special knowledge and expertise in these areas and should support team members with knowledge sharing and advice.

Peer Specialist

The peer specialist provides expertise that professional training cannot replicate. Peer specialists can provide essential expertise and consultation to the entire team that assists clients with self-determination and decision-making. The peer specialist must be paid a salary commensurate with

other staff members bearing in mind that lived experience with mental illness is a credential, while the individual who fills this position will also have qualifications that would be required of any mental health clinician on the team (e.g., degree, diploma, relevant prior mental health service delivery experience).

Peer specialists provide mutual support, including the sharing of experiential knowledge and skills and social learning, which plays an invaluable role in clients' recovery. Individuals with lived experiences encourage and engage clients in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community. FACT teams are expected to promote client-centred practices by integrating the peer role as a specialized clinician, and by encouraging the active participation of clients in service planning and development.

Duties of a Peer Specialist include:

- Receive role-specific training.
- Provide case management support for a full caseload and facilitate peer groups
- Validate clients' experiences and guide and encourage them to take responsibility for and actively participate in their own recovery
- Help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce self-imposed stigma.
- Judicious utilization of self-disclosure and sharing of life experience to serve as a mentor and role model.
- Assist clients to recognize and develop coping mechanisms to deal with symptoms of mental illness, and social stigma.
- Educate staff within the team regarding the consumer perspective on the mental health system, and assist the team in maintaining a client-centred approach that maximizes client participation and empowerment.
- Advocate for the development of consumer initiatives within the community and identify opportunities for client empowerment.
- Introduce and refer clients to consumer self-help programs and advocacy organizations that promote recovery.

Occupational Therapist

The occupational therapist plans, organizes and conducts individualized functional assessments, provides case management and facilitates groups. Their role is particularly important during the first few months of a client's assessment and admission to a team. It is useful to have both an informal, and formal assessments completed to distinguish the level of severity in functional impairments that an FACTT client has. The occupational therapist should assist with individual activities of daily living. It is important that the client is able to have the skills required to live in an environment of their own choosing. Some clients have had the skills prior to the disruption of their lives, to live independently, and may need to be re-taught. The occupational therapist must work in partnership with the other clinicians to adjust treatment plans that accommodate the clients' needs. It is important for FACTT clients to maximize their independence by gaining new skills and adapting existing skillsets required for independent living.

Other duties the Occupational Therapist is responsible for include:

- Support clients to find and maintain safe, stable housing that is affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing and decorating; and procuring necessities such as telephones, linens, food, and cleaning supplies)
- Support clients to perform household activities: house cleaning, cooking, grocery shopping, and laundry; develop healthy eating habits; carry out personal hygiene and grooming tasks, develop or improve money-management skills; use available transportation; and have, and effectively use a family physician and dentist.
- Problem solving for tasks associated with activities of daily living (i.e., bill payments).
- Individual assistance and support on a face-to-face basis, as needed.
- Skills training.
- Ongoing functional supervision (e.g., providing prompts, assignments, monitoring, and encouragement).
- Environmental adaptations to assist clients in gaining or using existing skills to perform the above activities.

Concurrent Specialist

The Concurrent Specialist is responsible for assisting with assessment, education and addiction treatment from a Harm Reduction perspective for individuals, in groups and offer family support and education. They share their assessment findings as well as their expertise to the team in consultation as well as at the treatment/service-planning meeting.

The Concurrent Specialist duties include:

- collaborate with the individual, family and team
- Use standardized assessment tools and monitor outcomes
- Provide a stage-based, integrated treatment/service model that is non- confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals.
- Engages in motivational interviewing/counselling (e.g., stages of change, developing discrepancies, decisional matrix);
- Conduct active treatment/service (e.g. counselling, cognitive skills training, community reinforcement);
- Develop and deliver relapse prevention resources (e.g., trigger identification, building relapse prevention action plans); and
- Refer to withdrawal management and residential services as needed.

Other Clinical Staff (Case Managers)

Each team may hire individuals to provide rehabilitation and clinical support functions based on the unique needs for each team (see list of potential disciplines above). These individuals can have education and experience in a variety of fields. They will have abilities to face challenging experiences and be extremely flexible, patient, compassionate and empathetic. Staff must have expertise working with persons with serious mental illness and/or addictions.

Other clinical staff may have a variety of responsibilities which may include, but are not limited to, providing assistance with:

- Medical and dental care.
- Securing safe, clean and affordable housing.
- Financial support and/or benefits counselling (e.g., social assistance, ODSP, CPP, federal disability tax credit).
- Accessing social services.
- Transportation (e.g., navigating public transportation).
- Legal advocacy and representation.
- Supportive individual therapy and coaching (e.g., problem-solving, role-playing, modeling).
- Social-skill teaching and assertiveness training.
- Planning, structuring, and prompting of social and leisure-time activities
- Organizing individual and group social and recreational activities to help structure clients' time, increase their opportunities for social experiences, and provide them with opportunities to practice social skills and receive feedback and support to develop those skills.

These services support clients to improve their social/interpersonal relationships and use leisure time effectively, including: improving communication skills, developing assertiveness, and increasing self- esteem; developing social skills, increasing social experiences, and developing meaningful personal relationships; planning appropriate and productive use of leisure time; relating to landlords, neighbours, and others effectively; and familiarizing themselves with available social and recreational opportunities and increasing their involvement in community living.

Flow-Through Coordinator

The flow through coordinator is a clinical staff role. This role is unique to Ontario FACT. This role is important to assist with transitioning in and out of service in line with the episodic nature of illness and recovery and to assist with continuity of service from primary care to tertiary care. The flow through coordinator performs duties such as liaising with referral sources (including clients and families) in order to provide intake assessments and recommendations to services within and outside of FACT. The flow through coordinator can assist with the operation of the daily team meetings as facilitator. They hold a unique perspective in treatment planning because they are involved in initial contact at entry for the client and this historical knowledge can help inform the team in treatment decisions. They are also involved in system planning to reduce wait times and can provide some short term planning and intervention. This clinical staff can also provide short term intervention and support while clients are waiting to join the team, are needing support while they are in the team based care phase (20% ACT service) as well as assistance linking to less intensive supports when transitioning out of active service.

Duties of the Flow-through Coordinator include:

- Collaborate with the individual, family and team

- Intake functions including assessment to determine care needs, file reviews, seek and compile collateral information (clinical records, family concerns, history)
- Present the referral package to the team to initiate service or seek alternative recommendations
- Communicate clinical recommendations from intake to the client and referral sources
- Complete community referrals for services needed at intake that are not available within the team
- Triage requests for services from previous FACT clients requesting re-entry and referral sources
- Short term case management or service coordination (when no other service in place)
- Manage the referrals process, processing incoming and outgoing referrals as well as requests for priority service
- Identify/communicate issues to leadership (client needs, system gaps, and challenges)
- Coordinate morning meetings, update the FACT board

Orientation and Training

Orientation for all FACTT members will include (not an exhaustive list):

- FACTT model and service delivery
- History of ACTT and FACTT
- Key components of FACTT; Seven C's (Cure, Care, Crisis Prevention, Client Expertise, Community Collaboration, Control, Check), FACTT board use and functions
- FACTT fidelity scale
- Assessments including comprehensive assessment
- Evidence based tools and Routine Outcome Measures
- Inter-professional Practice Guidelines: Collaboration and Teamwork Principles
- Privacy/Risk and Health Information Management
- Clinical Documentation Best Practices
- Medication Management, Interactions, Side Effects Awareness
- Mental health legislation in Ontario

Additional training:

- Recovery, strength based, resilience, evidence based practice
- Dual diagnosis treatment
- Early psychosis intervention
- Trauma Informed Practice
- Concurrent Disorder Training
- Motivational interviewing
- Stages of Change
- Risk assessment and management
- CBT
- ASIST, suicide intervention
- Principles of Collaborative Care: Working with primary care

FACTT Hours of Operation and After Hours Service Provision

FACTT needs adequate evening and weekend provisions for care, especially for those requiring ACTT level of intensity. Many current ACTT teams make use of after hours crisis services which may be acceptable for FACTT however all teams must at a minimum include an on-call person who would have access to the client comprehensive assessment, treatment plan, and crisis plan and recent staff notes in order to adequately direct clients and families to appropriate after hour supports.

Collaborative Intake

Each geographical catchment area will develop a collaborative intake process primarily including representation from ACTT and FACTT. Partners who may refer or advocate for FACTT may be invited to participate; these may include the client, families or informal supports, substitute decision makers, primary care, hospital, social service organizations, Early Psychosis Intervention, Public Guardian and Trustee, Geriatric, Youth, Acquired Brain Injury, Addictions, Counselling, Home and Community Care, Developmental Services, Community Service Resolution, Street Outreach or Housing. The intake group may meet monthly or as needed to communicate quickly and prioritise care for those needing service or respond to pressures identified within the community and ensures the person receives the most appropriate service. The group will have clear written and accessible protocols and accountabilities outlining access to the services of each partner.

Eligibility Criteria

Client intakes should be staggered or paced especially in the early phase of team development. Each client must have a complete referral package in order to be thoroughly screened. It is important to ensure all of the client's relevant medical, clinical and historical information is received and understood before beginning initial intake.

The intended population is ALL people with SPMI needing intensive mental health services. ***Until ACT and FACTT teams are well coordinated to provide FACTT services to all people with SPMI the priority target population is:***

- 18 years or older (exceptions may apply for youth or adults "aging in place")
- Must meet criteria #1 and #2 (below); functional difficulties are the consequence of psychopathology and not transient in character (i.e. systemic/long term, not less than 6 months)
- Person requires a Coordinated Care/ Assertive Team based approach

1. Psychiatric Condition requiring care and treatment

- Persons with severe and persistent mental illness (SPMI)
- Any person with a confirmed or suspected psychiatric diagnosis experiencing severe functional impairment that requires, and can be ameliorated by, a coordinated team service model

- Some persons with certain primary psychiatric diagnoses usually have greater recovery potential when treated by other specialized services or treatment modalities e.g. first episode psychosis (EPI Team), personality disorder (DBT Team), organic disorders (specialty clinic), autism (specialty services), ADHD (specialty clinic), intellectual disability (DSO services), addiction (addiction rehab services)

2. Functional Difficulties

- Psychosocial/environmental problems including ability to maintain stable housing, difficulty with activities of daily living
- Severe limitations in social and community functioning (involvement with criminal justice services or community policing, social isolation)
- significant history of hospitalization or emergency room visits

Note: In Communities with ACTT and FACTT, FACTT can mitigate the service or flow through limitations of ACT teams where the stepped care service level is full or non-existent. The two service types will work in fully integrated partnership. People with long term intensive team based needs are more appropriately supported in the ACTT model.

Admission/Re-Admission and Priority Status if Wait Listing

Ideally FACTT would not require waiting lists with adequate teams in place for the geographic area and population density as well as optimal treatment provision. FACTT treatment is based on recovery and strengths philosophies, working collaboratively with primary care, community partners and hospitals to coordinate care, thus client flow would be optimal.

However, in the event conditions are not optimal, priority status for entry to service would be based on:

1. Returning clients after being assessed to require rapid engagement to intensive team based services.
2. Clients requiring a Community Treatment Order (CTO) and treatment team but not requiring ACTT level of care ongoing
3. Critical Time Intervention principles: discharge from hospital and still requiring intensive supports to maintain stabilization of symptoms
4. Risk related to harm to self or others
5. Community concern including frequent presentations to emergency and community policing or criminal justice involvement, risk of homelessness
6. ***Stable clients being discharged from ACTT teams who still require intensive services to continue to improve in their recovery***
7. Transitional Aged Youth (18-30), who are not eligible for Early Psychosis Services
8. Chronological order on waitlist (community based)

Assertive Engagement and Consent

Service is primarily voluntary. We recognise people may require assertive engagement to build rapport during difficult times. The teams will support involuntary clients and their

families/substitute decision makers where there has been a determination of impaired capacity for treatment decision making (in these instances the FACT team may also be identified as a service partner within a CTO if a community plan is in place.

People may self-refer, or be referred by family or community. The Flow-Through Coordinator reviews referrals and initiates a comprehensive assessment beginning with the client's history and collateral information. The coordinator reviews the complete referral package and has an initial meeting with the person (with or without their supports). The information is then presented to the team for review and acceptance or further recommendations/alternatives. When the team accepts the admission, the person is added to the FACTT Board, assigned an intake team and begins service. The prime worker completes the comprehensive assessment with the input of the team, client and clients supports including the initial psychiatric assessment. This assessment forms the foundation for treatment planning.

Refusal of FACTT Services

Documentation and communication of the rationale for refusal or discharging a person must be clearly documented and communicated to the client and as appropriate their referral source/other supports. Alternative recommendations must also be provided. If a voluntary client declines treatment and support (verbally or behaviourally) all attempts to engage must be clearly documented and the rationale clearly documented and communicated to clients and referral source in writing.

Program Organization and Communication: FACTT Board

The team meets daily for a clinical/scheduling meeting to review the 20% of clients on the FACTT board. Staff are assigned to client mini-teams based on treatment needs and client goals, starting initially with the most appropriate prime worker and nurse. Team members share expertise and clinical impressions, and successes and difficulties; this process enhances team spirit by encouraging reflective practice and a supportive environment.

The FACTT board is a digital white board or spreadsheet that provides a quick view of the 20% and critical information needed for scheduling, service coordination, treatment planning and monitoring, sharing of information, tracking hospitalizations, life events, treatment approaches, evidence based practice interventions, and routine outcome monitoring (ROM).

Ideally this board will be imbedded in the Electronic Health Record or Database. The details on the FACTT Board would include the date placed on the board, short diagnosis, legal status, reason for being on the board, client's wishes, goals and qualities, contact persons in the family, planned actions, name of client's case manager, home visits appointments, specific appointments, other details as needed. Additionally, reasons for placing a client on the board are indicated such as "new to team" (3 weeks), "crisis prevention" (1 week), "admission to hospital" (1 week review),"engagement/treatment avoiders" or "high risk treatment avoiders"(4 week review), "risk concerns" (ongoing review), "short term intensive" (4 week review), long term intensive" (8 week review), "legal". These are approximate time frames except for "new to the team" and "CTO" which is flagged for every six months. The board can alert for a review at each

of these intervals. During the meeting, the team discusses if clients need to remain in ACTT level care (“on board”) as well as which category is most appropriate.

A team member chairs the meeting and navigates the FACTT board. The meetings are 30- 45 min. Primary workers may also request consultation for those in “care as usual” (the 80%). Placing individuals on the board and removing them is a decision made jointly by team quorum (50% +1) including the prime and psychiatrist or team lead and the decision is made during the meeting. For decisions to switch a person’s care to more or less intensive services teams may use a variety of tools (LOCUS, ATR) in conjunction with clinical judgment and discussions with people about their recovery needs. Reasons for less intensive services may include low frequency of contact, no complex medication needs, adequate social support, engaged successfully in work or daytime activities, stable housing or independent accommodation, financial situation well organized, etc.

Staff are expected to keep time available in their schedules to respond to crisis situations discussed in the FACTT meetings; coverage is also available at the office for client’s that stop in at the agency.

Service Coordination and Treatment

New clients are introduced to at least 3 team members in the initial 3 weeks of service. Team members are chosen for the client's team based on individual treatment needs/ identified goals and disciplines needed to accomplish that goal. The prime worker can be changed when the focus of the goal work changes and a more appropriate discipline is indicated. FACTT’s offer a full service, coordinating and planning for individual treatment, crisis planning, individual rehabilitation and medication support, psychosocial education, cognitive behavioural therapy (CBT) and family education and support. A copy of the treatment plan is provided to each client and each client is included in their treatment planning.

The FACTT has two methods of monitoring and supporting clients; individual supervision and intensive team care with a caseload shared by the whole team. Most clients are supported by 1 prime worker, other members of the team are involved in treatment planning. When clients are in ACTT level care (20%) they are monitored with the help of the FACTT board and supported in a shared care model.

FACTT supports people and their families through transitions into and out of hospital, playing an active role in admission and discharge planning as required. Written protocols for collaboration will be developed and followed with hospitals. Team members will continue to work with the client through their hospitalization to ensure continuity.

Transition to primary care will also have written protocols. Transition to primary care is decided by the psychiatrist and prime worker and team coordinator. This transition is most appropriate when the client requires less than 1-2 visits per month, have not had any recent medication changes, demonstrated stability on the current medication regime, have adequate support, stable housing, finances are well organized, and meets criteria of the discharge checklist. The team will collaborate with the individual and their natural supports (family, friends, and community social

and recovery groups) to put a plan in place for their primary care team to monitor them and it is understood that if they require intensive services for stabilization, the team will rapidly re-engage.

Care as Usual: ICM on FACTT

ACTT standards capture the nature of the service for the 20% of clients needing high level intermittent intensive services; the majority of those supported on a FACTT will require ICM care as usual. A single worker would coordinate with primary care in consultation with the Psychiatrist/Psychologist. The prime worker may request team input with or without highlighting the person on the board at the daily meeting.

Intensive case management service standards for Ontario (guidelines from the MOHLC, 2005) fit with FACTT and are divided into five functions, and must be documented and begin within 10 days of being identified for service:

1. Outreach and consumer identification
2. Assessment and planning
3. Direct service provision and intervention
4. Monitoring, evaluation and follow up
5. Information, liaison, advocacy, consultation and collaboration

Compliance with standards will ensure services are comprehensive, coordinated and based on consumer need and best practices" (Intensive case management service standards, 2005, p. 7). Case Management Standards are consistent with FACTT Standards in the expectation of assertive outreach to engage consumers in an environment of their choice in the least intrusive manner possible to meet their needs. If referrals to additional services are needed, this will be in consultation with the consumer. A comprehensive individualized service plan must be developed with consumer input which identifies other resources to meet needs. Service delivery must be predominantly focused in the community in a way that responds to fluctuating consumer needs. Case managers have typically had staff client ratios of 1:20, and service is expected to be available eight hours a day, five days per week along with written protocols for 24 hour a day, 7 day a week access to additional supports as needed. Clients are expected to participate in a review of their service plan at least annually which is also reviewed by a supervisor. Consumer satisfaction must also be surveyed regularly. Organizations must evaluate their programs using best practices and published standards, a written discharge plan must be developed upon the completion of service, a written complaint process must be in place and an annual review of standards must be undertaken. Additionally, the service provider must develop partnerships or service agreements with other agencies/community services or primary care providers to ensure continuity of service provision. The case manager must be knowledgeable about services that are accessible to consumers to provide up to date information. The case manger must also advocate on behalf of the client for services that are accessible. The service provider agency must develop a written plan that identifies community resources, with links to be established. Staff training requirements are to be reviewed annually.

Client-Centred Assessment and Treatment/Goal and Service Planning

Completion of the initial comprehensive assessment in a timely manner ensures that the best possible information on a client is available to the interdisciplinary team members as well as after-hours crisis support for transfer of accountability. The primary clinician will develop a crisis plan with the client, family and informal supports as identified by the client, and this will be shared with the interdisciplinary team.

The client is at the center of all planning and will be present at planning meetings whenever possible. The initial Comprehensive Assessment is to be completed within 30 days of admission. The intake worker ensures the collection of all historical and collateral information (onus on referral source when possible), including an up-to-date medication profile. The prime worker then works with the team disciplines adding team impressions and assessment information. This is then combined with the initial psychiatric assessment and is the basis for the treatment planning with the client and/or their family.

Individual Treatment/Service Plan/Recovery Plan is a combination of the Initial Comprehensive Assessment & Ontario Common Assessment of Need (OCAN). However, other methods and modalities may be incorporated to assist in making the process more meaningful for the client, such as Motivational Interviewing principles, client goals, stages of change work, visual prompts etc. Individuals can also invite their support people to treatment planning meetings. Support workers can encourage them to engage with their treatment planning in a variety of ways (laminate, artistic representations of the goals, etc.).

A comprehensive assessment must be completed by a FACTT team member in collaboration with the client. Any FACTT staff person may be designated to complete the comprehensive assessment, provided they are skilled and knowledgeable in the areas to be assessed. It is acknowledged that further, in-depth assessment can be added to the initial comprehensive assessment at any time. The initial assessment is based upon all available information, including but not limited to, that from client interview/self-report, family members, primary care and other significant parties, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. Consent to the collection, use and disclosure of this information must be obtained, particularly if consent is required to comply with legislation. The team member who conducts the assessment presents the findings at the first treatment/service planning meeting, along with the psychiatrist. A comprehensive assessment is initiated and completed as soon as possible and may be done prior to a client starting service, but ideally, no later than one month after a client's admission. The comprehensive assessment includes an evaluation in the following areas:

Psychiatric History, Social Function History, Mental Status and Diagnosis

The psychiatrist is responsible for completing the psychiatric history and admission note (includes mental status, and diagnostic assessment). FACTT team member(s) supporting the completion of the comprehensive assessment may assist in the collection of information for the psychiatric history. The psychiatrist presents the assessment findings at the first treatment/service planning meeting. The psychiatric history, mental status, diagnosis, assessment, and treatment-decision

capability assessment involves careful and systematic collection of information from the client, family, and past treatment records regarding the onset, precipitating events, course and effect of illness, past treatment and treatment responses, risk behaviours, recent life events and current mental status. The purpose is to effectively plan with the client, family and primary care providers, the best treatment approach to eliminate or reduce symptomatology and ensure accuracy of the diagnosis. Upon completion and presentation of the psychiatric history, mental status, and diagnostic assessment to the team, the psychiatrist prepares a psychiatric history narrative for the client's medical record. Coordination with primary care providers is also important during the orientation to FACTT as well as transitioning from FACTT.

Physical Health

Initial physical health information may be obtained by the FACTT member(s) designated to complete the comprehensive assessment. It is recommended that the registered nurse/registered practical nurse assists in obtaining a family physician/ NP for the client if they do not have one. The registered nurse/registered practical nurse can then coordinate any physical treatments and prevention care with the family physician. The purpose of the physical assessment is to thoroughly evaluate the client's physical health status and identify any medical conditions present to ensure appropriate treatment, follow-up and support are provided. Due to the potential urgency of some physical conditions, the physical health assessment should be done prior to, or immediately at, the start of service.

Substance use

Initial substance use information may be obtained by the FACTT member(s) designated to complete the comprehensive assessment. The addiction specialist is responsible for reviewing information (where applicable) and completing (where applicable) the substance use assessment, and presenting these assessment findings at the first treatment/service planning meeting.

Education and Employment

Initial education and employment information may be obtained by the FACTT member(s) designated to complete the comprehensive assessment. The vocational specialist is responsible for reviewing information and completing (where applicable) the education and employment assessment and presenting their assessment findings at the first treatment/service planning meeting. Employment is of great importance for people with mental illness and is a normalizing structure that can be helpful in symptom management. FACTT excludes no one from work opportunities or support because of an inconsistent work history or because of ongoing symptoms or impairments related to mental illness. The purpose of the education and employment assessment is to identify with clients how they currently structure their time, current school or employment status, interests and preferences regarding school and employment. This assessment begins the working relationship between the client and vocational specialist to establish educational and occupational goals.

Social Development and Functioning

Initial social development and functioning information may be obtained by the FACTT member(s) designated to complete the comprehensive assessment. The social worker is responsible for reviewing the information, completing (where applicable) the social development and functioning assessment, and presenting these assessment findings at the first treatment/service planning meeting. The purpose of the social development and functional assessment is to obtain information from clients about their childhood experiences, early attachments, and roles in their family of origin, adolescent and young adult development, culture, religious beliefs, leisure activities, interests, and social skills. This allows the FACT team to evaluate how symptomatology has interrupted or affected personal and social development. It also includes information regarding any client involvement with the criminal justice system. In addition, it identifies social and interpersonal issues appropriate for supportive therapy.

Activities of Daily Living (ADL)

Initial ADL information may be obtained by the FACTT member(s) designated to complete the comprehensive assessment. The occupational therapist, social worker, or nurse may be responsible for reviewing the information, completing (where applicable) the ADL assessment and presenting these assessment findings at the first treatment/service planning meeting. The purpose of the ADL assessment is to evaluate: the individual's current ability to meet basic needs (e.g., personal hygiene, adequate nutrition, medical care); the quality and safety of the client's financial resources; the effect that symptoms and impairments of mental illness have had on self-care; the client's ability to maintain an independent living situation; and the client's desires and individual preferences. This allows the FACTT to determine the level of assistance, support, and resources the client needs to re-establish and maintain activities of daily living. Good ADL function is basic to successful community adjustment for persons with serious mental illness. Consistent assistance to meet ADL needs helps clients feel more confident and less vulnerable about living in the community. While occupational therapists, social workers and nurses have the specific training to complete the ADL assessment, other staff with an interest in this area can be trained accordingly.

Family Structure and Relationship

Initial family structure and relationship information may be obtained by the FACTT member(s) designated to complete the comprehensive assessment. The social worker is responsible for reviewing the information, carrying out the family structure and relationships assessment and (where applicable) presenting these assessment findings at the first treatment/service planning meeting. Historically, many people with serious mental illness have received the majority of their support and care from their families. The best way to engage families from diverse communities is to respect and work within their beliefs and values. Many clients have children, and clients' ability to parent may be compromised by their mental illness. Mental health providers have not always included or welcomed the participation of families or other significant people in clients' lives. The purpose of the family structure and relationships assessment is to obtain information from the client's family and other significant people about their perspective on the client's mental illness, to determine their level of understanding about mental illness and their expectations of

FACTT services. This information allows the team to define, with the client, the contact or relationship FACTT will have with the family in regard to the client's goals, treatment, and rehabilitation. This assessment begins at the initial admission meeting with the client and the family members or significant others who are participating in the admission. Due to the importance of natural supports (family, peers, community including neighbours) psycho-education is important in working with these supports (caregiver support network, counselling) so they can be engaged or re-engaged as part of an individual's recovery and success.

Client Record

All client interactions and community collaboration are documented in the client health record. Consents are gathered for third party information as needed and collateral information is gathered from agencies in the circle of care. Participation in groups is also noted on the client file.

FACTT Fidelity Scale and Certification

As discussed in the Netherlands FACT manual by J Remmers van Veldhuisen, the scale was inspired by the Dartmouth Assertive Community Treatment fidelity scale. A fidelity scale was developed for FACTT in the Netherlands which was first published in 2007 and revised in 2010 by the centre for ACT and FACT (CCAF) certification. It consists of 60 items which are rated on a 5 point scale and touch on all aspects of FACTT; team structure, team process, diagnostics and treatment, mental health care organization, social care, monitoring (ROM), and professionalism. CCAF utilizes this scale when determining if agencies meet the criteria for certification. Research has now shown that greater model fidelity does have an effect on implementation of evidence based practice and treatment outcomes at the patient level.

Program Evaluation and Performance Improvement

The FACTT fidelity scale has eight domains, each being rated 1-5 (5 being the highest fidelity) and the eight domains include team structure; program process; diagnostics, treatment and interventions; organization, community care; monitoring and professional development. FACTT fidelity evaluation determines whether clients are achieving their goals and identifying areas of strength and improvement.

In New Brunswick, FACTT fidelity evaluators have been trained and certified by CCAF. Every two years the evaluators interview staff, conduct file audits and review the programs with a focus on eight domains, and rating them 1-5 (5 being the highest fidelity). When teams are implemented, the progress is expected to be incremental with the goal of achieving high fidelity (as compared with the Netherlands FACTT model. Action plans are developed and teams review them to plan areas needing further development.

New FACT teams will have staged fidelity reviews after year 1, 2, and 3, then at 2 year intervals thereafter (in accordance with the same review and oversight protocol established for ACT teams.)

Client outcomes

Core client outcomes reflect the primary goals of FACTT including decreased psychiatric hospitalization, less incarceration, increased employment, movement through stages of change, housing stability, independent living, education, family/natural support involvement, and community integration.

Conclusion

Collaboration between service providers to creatively address the needs of persons living with SPMI is essential. The flexibility in approach to service provision with FACTT (incorporating elements of ACTT and intensive case management) allows for a customized recovery based approach utilizing best practices and evidence based strategies.

This essential service level must be thoughtfully developed and strategically implemented and integrated across Ontario, in accordance with these standards.

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