DHS/Division of Mental Health

Assertive Community Treatment

Fidelity Scale Instructions

Purpose: to Shape Mental Health Services Toward Recovery

These instructions are intended to help guide your administration of the Assertive Community Treatment (ACT) Fidelity Scale. With a few minor modifications, this scale is the Dartmouth Assertive Community Treatment Scale (DACTS) developed by Teague, Bond, and Drake (1998). In this document you will find the following:

1) **Introduction:** This gives an overview of ACT and a who/what/how of the scale. Plus there is a checklist of suggestions for before, during, and after the fidelity assessment that should lead to the collection of higher quality data, more positive interactions with respondents, and a more efficient data collection process.

2) **Item-Level Protocol:** The protocol explains how to rate each item. In particular, it provides:
   a) A *definition* and *rationale* for each fidelity item. These items have been derived from a comprehensive review of evidence-based literature.
   b) A list of *data sources* most appropriate for each fidelity item (e.g., chart review, clinician interview, team meeting observation).
   c) Where appropriate, a set of *probe questions* to help elicit the critical information needed to score the fidelity item. These probe questions were specifically generated to help you collect information from respondents that are free from bias such as social desirability.
   d) *Decision rules* that will help you correctly score each item. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.

3) **ACT Worksheet:** The paper version allows reviewers a place to insert comments and make notations related to scoring and is used prior to entering information into the ACT database.

Reference: Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. American Journal of Orthopsychiatry, 68, 216-232.

Introduction

ACT Overview

As an evidence-based psychiatric rehabilitation practice, ACT provides a comprehensive approach to service delivery to consumers with severe mental illness (SMI). ACT uses a multidisciplinary team comprised of at least 6 staff members, including a team leader, a psychiatrist, a nurse, and at least four case managers (one of whom is a licensed clinician and operates as the team lead). There must also be a substance abuse specialist, a recovery specialist and a rehabilitation specialist on the team. ACT is characterized by (1) low consumer to staff ratios; (2) providing services in the community rather than in the office; (3) shared caseloads among team members; (4) 24-hour staff availability, (5) direct provision of all services by the team (rather than referring consumers to other agencies); and (6) time-unlimited services.

Overview of the Scale

The ACT Fidelity Scale contains 28 program-specific items. The scale has been developed to measure the adequacy of implementation of ACT programs. Each item on the scale is rated on a 5-point scale ranging from 1 ("Not implemented") to 5 ("Fully implemented"). The standards used for establishing the anchors for the "fully-implemented" ratings were determined through a variety of expert sources as well as empirical research. The scale items fall into three categories: human resources (structure and composition); organizational boundaries; and nature of services.

What Is Rated

The scale ratings are based on current behavior and activities not planned or intended behavior. For example, in order to get full credit for Item O4 ("responsibility for crisis services"), it is not enough that the program is currently developing an on-call plan.

Unit of Analysis

The scale is appropriate for organizations that are serving consumers with SMI and for assessing adherence to evidence-based practices, specifically for an ACT team. If the scale is to be used at an agency that does not have an ACT team, a comparable service unit should be measured (e.g., a team of intensive case managers in a community support program). The DACTS measures fidelity *at the team level* rather than at the individual or agency level.

How the Rating Is Done

To be valid, a fidelity assessment should be done in person, i.e., through a site visit. The fidelity assessment requires a minimum of 6 hours to complete, although a longer period of assessment will offer more opportunity to collect information; hence, it should result in a more valid assessment. The data collection procedures include chart review, team meeting observation, review of home visits information, and semi-structured interview with the team leader. Clinicians who work on the ACT teams are also

valuable sources of data; most frequently the assessors obtain this information when accompanying them on home visits. Data may be obtained through other sources (e.g., supervisors, consumers) as appropriate.

Some items require calculation of either the mean or the median value of service data (e.g., median number of community-based contact contacts); specific administration instructions are given as needed for individual items (see below).

Chart Selection/Sampling Methodology

A statistically sound random sample of all paid claims will be selected for the ACT review. A provider specific claims run will be developed using ValueOptions' Intelligence Connect reporting application. A flat ten (10) unique records will be pulled for each provider.

How to Rate a Newly-Established Team

For ACT teams in the start-up phase, the time frame specified in individual items may not be met. For example, item H5 asks for the turnover rate during the last two years; Item O2 asks for the number of new consumers during the last six months. Assessors should prorate time frames for teams that have been in operation for a shorter amount of time than specified in the individual items.

Who Does the Ratings

A team of trained clinicians consisting of Collaborative Regional Liaisons and DHS/DMH staff will administer the fidelity assessment. In addition, raters will have an understanding of the nature and critical ingredients of ACT. It is recommended that all fidelity assessments be conducted by at least two raters in order to increase reliability of the findings.

Missing Data

The scale is designed to be filled out completely, with no missing data on any items. It is essential that raters obtain the required information for every item. It is critical that raters record detailed notes of responses given by the interviewees.

Fidelity Assessor Checklist

Before the Fidelity Site Visit

X *Review the Agency Information Sheet provided by the Training Coordinator.* This sheet is useful for identifying where the specific assessment is to be completed, along with general descriptive information about the site.

X *Create a general timeline for the fidelity assessment.* Determine appropriate arrival time at site and coordinate with fellow assessor. Fidelity assessments require careful coordination of efforts and good communication. Therefore, it may be useful to list all the necessary activities leading up to and during the visit and ensure both assessors are aware of the requirements. Timelines may need to be modified to accommodate staff interviews, as clinicians may be engaged in direct services during review process.

X *Ensure you have all necessary materials and resources to conduct your site visit.* This includes ACT instructions, ACT worksheet, Rule 132, Evaluation Form, business cards, etc. Make enough copies of the ACT worksheet for all 10 charts that will be reviewed and ensure you have copies of talking points and protocols for your Entrance and Exit Conferences.

Initial Provider Notification

In addition to the purpose of the assessment, the Training Coordinator will briefly describe what information reviewers will need and how long each interview or visit will take to complete. The Training Coordinator will request that the provider gathers in advance as much as possible of the following information:

- Roster of ACT staff – (roles, full-time equivalents (FTEs))
- Staff vacancies each month for last 12 months (or as long as program has existed, if less than 12 months)
- Number of staff who have left the team over the last two years (or since program started if less than two years old)
- A written description of the team's admission criteria
- Roster of ACT consumers
- Number of consumers with dual disorders
- How many consumers have terminated from the program in the last year, broken down in these categories:
  - Graduated (left because of significant improvement)
  - Left town
  - Closed because they refused services or team cannot find them
  - Deceased
  - Other (explain)
- Number of consumers living in supervised group homes
- Documentation of substance abuse groups already completed.

Note: The Training Coordinator will reassure the provider that reviewers will be able to conduct the fidelity assessment even if not all of the above information is available. The Training Coordinator will also inform the provider that reviewers will *need to observe at least one team meeting* during the visit.

During Your Fidelity Site Visit

X *Tailor terminology used in the interview to the site.* For example, if the site uses the term "member" for consumer, use that term. If "practitioners" are referred to as clinicians, use that terminology. Every agency has specific job titles for particular staff roles. By adopting the local

terminology, the assessor will improve communication.

X During the interview *record the names of all relevant programs, the total number of consumers, and the total number of clinicians.*

X *If discrepancies between sources occur, query the team leader to get a better sense of the program's performance in a particular area.* The most common discrepancy is likely to occur when the Team leader interview gives a more idealistic picture of the team's functioning than do the chart and observational data. For example, on item S1, the chart review may show that consumer contact takes place largely in the office; however, the team leader may state that the clinicians spend the majority of their time working in the community. To understand and resolve this discrepancy, the assessor may say something like, "Our chart review shows xx% of consumer contact is office-based, but you estimate the contact at yy%. What is your interpretation of this difference?"

X *Before you leave, check for missing data.*

X *Both reviewers are to independently rate the fidelity scale.* The assessors should then compare their ratings and resolve any disagreements. It is critical for the reviewers to come up with a consensus rating.

X *Tally the item scores and determine which level of implementation was achieved* (See Score Sheet).

X *Exit Conference.* Review talking points during your exit conference. The ACT External Report will be reviewed with the provider for each item. Ensure you leave business cards with provider and query them regarding a need for a follow-up phone call to ensure full understanding of the review process and outcomes. If the provider requests a follow-up phone call, schedule this with the provider and DMH Contract Manager. Leave the evaluation and self-addressed stamped envelope with provider. Ensure provider has signed report, exit conference attendance sheet and returned records sheet.

X *Reports to be Left with Provider.* The assessor will leave the ACT Report with the provider that demonstrates scale scores and related comments from review process. This report is entitled "ACT Provider External" and is accessed through ACT database.

After Your Fidelity Site Visit

X *Letters.* This letter will include a fidelity report, explaining their scores on the fidelity scale and providing some interpretation of the assessment, highlighting both strengths and weaknesses. The report is informative, factual, and constructive in nature. This letter identifies for the provider

whether or not a Plan of Improvement is needed.

X *Provider Follow-up.* The DHS/DMH Contract Manager is responsible for all follow-up with the provider. At times, Collaborative Regional Liaisons will be asked to assist with follow-up.

X *Uploading Data to the Master Database.* Within 24 hours of the conclusion of the ACT Review, provider data must be uploaded to the master database. This is best done in the office with direct connection to the Value Options server. This can be completed by opening the ACT Provider database and selecting "Transmit Data". Once completed, you will receive a message on the screen demonstrating successful upload. You may also choose to verify data first to ensure data is complete prior to upload.

Item-Level Protocol

Human Resources: Structure and Composition

H1. Small Caseload

Definition*:* Consumer/clinician ratio of 10:1

Rationale: ACT teams should maintain a low consumer to staff ratio in the range of 10:1 in order to ensure adequate intensity and individualization of services.

Sources of Information:

X **Team leader interview**

- Begin interview by asking team leader to identify all team members, their roles, and whether they are full time. From this roster, calculate the number of full-time equivalent (FTE) staff and confirm with team leader. Possible questions include:
- *"How many staff works on the ACT team?"*
- *"How many consumers are currently served by the team?*
  In counting the current caseload, include all "active" consumers. The caseload totals should include any consumer who has been formally admitted, even if it is as recent as the last week. The definition of active status is determined by the team, but note that the count will affect other fidelity items, such as frequency of visits.

X **Agency documents**

- Some ACT teams have a Cardex or similar organization system (electronic), or the roster of active consumers will be listed elsewhere. If there is doubt about the precise count of the caseload, then these documents can be consulted as a crosscheck on the count.

Item Response Coding*:* Count all team members who conduct home visits and other case management duties. Unless there are countervailing reasons, count all staff providing direct services (including substance abuse specialist, employment specialist, and team leader) EXCEPT the psychiatrist. Do not include administrative support staff when determining the caseload ratio.

FORMULA: (# CONSUMERS PRESENTLY SERVED) / (# FTE STAFF)

If this ratio is 10 or less, the item is coded as a "5."

Special case*:* Do not count staff that are technically employed by the team but who have been on extended leave for 31 days or longer.

H2. Team Approach

Definition: Provider group functions as a team; clinicians know and work with all consumers.

Rationale: The entire team shares responsibility for each consumer; each clinician contributes expertise as appropriate. The team approach ensures continuity of care for consumers, and creates a supportive organizational environment for practitioners.

Sources of Information:

X **Chart review**

- Remember to use the most complete and up-to-date time period from the chart. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation. Data should be taken from the last two full calendar weeks prior to the fidelity visit (or the most recent two-week period available in the charts if the records are not current). Count the number of different ACT team members who have had a face-to-face contact with the consumer during this time. Determine the percentage of consumers who have seen more than one team member in the two-week period.

X **Team leader interview**

- *"In a typical two-week period, what percentage of consumers see more than one member of the team?"*

X **Clinician interview**

- During a review of documentation of a home visit, ask the case manager which ACT team members have seen this consumer this week.
- *"How about the previous week?"*
- *"Is this pattern similar for other consumers?"*

X **Consumer interview**

- *"Who have you seen from the ACT team this week? How about last week?"*
- *"Do you see the same person over and over, or different people?"*

X **Other data sources (e.g., computerized summaries)**

- Use this data source if available, but ask the team leader for information about how it is compiled and how confident one can be in its accuracy.

Item Response Coding: Use chart review as the primary data source. Determine the number of different staff who have seen each consumer. The score on the DACTS is determined by the percentage of consumers who have contact with more than one ACT worker in the two-week period. For example, if > 90% of consumers see more than one case manager in a two-week period, the item would receive a "5."

If the information from different sources is not in agreement, (for example, if the team leader indicates a higher rate of shared caseloads than do the records), then ask the team leader to help you understand the discrepancy. The results from a chart review are overruled if other data (e.g., Team leader interview, internal statistics) conflict with or refute it.

H3. Program Meeting

Definition: Program meets frequently to plan and review services for each consumer.

Rationale: Daily team meetings allow ACT practitioners to discuss consumers, solve problems, and plan treatment and rehabilitation efforts, ensuring all consumers receive optimal service.

Sources of Information:

X **Team leader interview**

"How often does the ACT team meet as a full group to review services provided to each consumer?"

- *"How many consumers are reviewed at each meeting?"*

X **Internal documentation**

- Confirm with attendance roster of team meetings, if available. The consumer service log (e.g., a Cardex that holds summary data for each consumer) may be helpful in determining whether each consumer is discussed (even briefly) at each meeting.

Item Response Coding: This count includes clinical review meetings only; **exclude administrative and treatment planning meetings** from the count for this item. The expectation is that all full-time team members should attend all meetings; the team psychiatrist may attend fewer meetings (to receive full credit, psychiatrist should attend at least once a week). Part-time team members are expected to attend at least twice weekly in order to receive full credit on this item. Team members from all shifts should be routinely in attendance.

If the team meets at least 4 days a week and reviews each consumer each time, a "5" is scored. If the team meets 4 or more days a week but does not discuss each consumer each time, they would earn a "4" for this item.

Poor attendance at the team meeting does not count against the score on this item if the program holds the *expectation* that all team members attend; however, poor attendance is something to note in the

fidelity assessment report.

H4. Practicing Team Leader

Definition: Supervisor of front line clinicians provides direct services.

Rationale: Research has shown this factor was among the five most strongly related to better consumer outcomes. Team leaders who also have direct clinical contact are better able to model appropriate clinical interventions and remain in touch with the consumers served by the team.

Sources of Information:

X **Team leader interview**

- *"Do you provide direct services to consumers?"*
- [if "yes"] *"What percentage of your time is devoted to direct services?"*

X **Productivity records**

- Some agencies require staff to keep track of direct service time. Ask if this applies at this agency and ask to see the information for the last calendar month (or some similar unit of time). Make sure that the chosen period of time is typical; e.g., exclude a week in which the center was undergoing Joint Commission accreditation.

Item Response Coding: Give more weight to the actual records than the verbal report. If there is a discrepancy, ask team leader to help you understand it.

If the team leader provides services at least 50% of the time, the item is coded as a "5."

H5. Continuity of Staffing

Definition: Program maintains the same staffing over time.

Rationale: Maintaining a consistent staff enhances team cohesion; additionally, consistent staffing enhances the therapeutic relationships between consumers and providers.

Sources of Information:

X **Team leader interview**

- In advance of the fidelity visit, request that the team leader have available a list of all

employees over past two years (or for the duration of the existence of the program)

- *"What is the total number of staff positions on the ACT team?*
- *"Name the team members who have left in the past two years."* [if the team has been in existence for a shorter period, use the formula below to adjust for the shortened time frame].

Item Response Coding*:*

FORMULA: (# STAFF TO LEAVE/TOTAL # POSITIONS) X (12/#MONTHS)

If the turnover rate is less than 20% over the past two years, then the item is coded as a "5." A staff member who has been on an extended leave for 31 days or longer is considered among the number of staff who left, even if they technically remain in their position.

H6. Staff Capacity

Definition: Program operates at full staffing.

Rationale: Maintaining consistent, multidisciplinary services requires minimal position vacancies.

Sources of Information:

X **Team leader interview**

- In advance of the fidelity visit, request that the team leader have available a list of unfilled positions for each month over past year (or for the duration of the existence of the program)
- Ask the team leader to go through the past 12 months, month by month.
- *"Did you have any position vacancies in January?* [if "yes", ask *"How many?"].* Continue through all 12 of the previous months (or for the length of time the program has been operating, if less than 12 months).
- *"Have you had anyone who has been on leave for more than one month during the last 12 months?"* [Count any extended absences, e.g., sick leave or leave after the birth of a child, in the same fashion as months of vacancies]

Item Response Coding: For each month, calculate the vacancy rate:

~~FORMULA:~~

100* (SUM OF # VACANCIES EACH MONTH) / (TOTAL # STAFF POSITIONS x 12)

Exclude the psychiatrist and any administrative support staff when determining total staff positions. Calculate the mean monthly vacancy rate (given by the above formula) for the 12-month period. Subtract from 100%.

If the program has operated at 95% or more of full staffing capacity for the last 12 months, the item is coded as a "5." If a member of the team is on extended leave for 1 month or more, this counts as a position vacancy.

H7. Psychiatrist on staff

Definition: Per 60 consumers, at least 10 hours of psychiatric time is assigned to work with consumers in the program.

Rationale: The psychiatrist serves as medical director for the team; in addition to medication monitoring, the psychiatrist functions as a fully integrated team member, participating in treatment planning and rehabilitation efforts.

Sources of Information:

X **Team leader interview**

- Information regarding FTE psychiatrist is obtained during the initial review of the staffing.
- Calculate the FTE psychiatrist time per 60 consumers (see formula,below)

X **Clinician interview**

- *"What is the psychiatrist's role on the team?"*
- *"Does he/she come to meetings?"*
- *"Is s/he readily accessible?"*
- *"Does the psychiatrist ever see consumers who are not on the ACT team?"*

X **Consumer interview**

- *"How often do you see the team psychiatrist?"*
- *"Do you use the ACT team psychiatrist for medications?"*

Item Response Coding:

FORMULA: [(FTE value x 60) / # consumers served] = FTE per 60 consumers

If information across sources is not consistent, the assessor should ask for clarification during the team leader interview or make follow-up contact with the program. As with all scale items, the rating should be based on the most credible evidence available to the assessor (e.g., even if the psychiatrist is reported as 1.0 FTE to a 60-person ACT team, if the consumers and clinicians consistently report that she/he is unavailable for consultation, a lower score on this item is likely appropriate).

IL Scoring: If the program has 10 hours of psychiatric time for 60-consumer program, the item is coded as a "5".

NOTE FOR ITEMS H8-H11: PROGRAMS DO NOT RECEIVE CREDIT FOR HAVING SPECIALISTS ON STAFF (e.g., RN, substance abuse or vocational specialists) IF THE PERSON ASSIGNED TO THAT POSITION IS ON LEAVE AT THE TIME OF THE FIDELITY VISIT AND HAS BEEN ON LEAVE FOR 31 DAYS OR LONGER.

H8. Nurse on staff

Definition: At least one full-time RN is assigned to work with a 60-consumer program.

Rationale: The full-time RN has been found to be a critical ingredient in successful ACT programs. The nurses function as full members of the team, which includes conducting home visits, treatment planning, and daily team meetings. Nurses can help administer needed medications and serve to educate the team about important medication issues.

Sources of Information:

X **Team leader interview**

- Information regarding FTE RNs is obtained during the initial review of the staffing.
- Calculate the FTE nurse time per 60 consumers (see formula, below)

X **Clinician interview**

- *"What is the nurse(s)' role on the team?"*
- *"Does he/she come to meetings?"*
- *"Is she/he readily accessible?"*
- *"Does the nurse ever have responsibilities (or consumers) outside the ACT team?"*

X **Consumer interview**

- *"How often do you see the team nurses?"*

Item Response Coding:

FORMULA: [(FTE value X 60) / # consumers served] = FTE per 60 consumers

If inconsistent, the assessor should reconcile information across sources and score accordingly.

IL Scoring: If the program has one full-time nurse (or more) on a team with 60 consumers, the item is coded as a "5".

H9. Substance abuse specialist on staff

Definition: At least one staff member on the ACT team with at least one year of training or clinical

experience in substance abuse treatment and/or treating consumers with co-occurring mental health and substance abuse disorders, per 60-consumer program

Rationale: Concurrent substance use disorders are common in persons with severe mental illness. Appropriate assessment and intervention strategies are critical.

Sources of Information:

X **Team leader interview**

- Information regarding FTE substance abuse specialists is obtained during the initial review of the staffing.
- Calculate the FTE substance abuse specialist time per 60 consumers (see formula, below).

Item Response Coding:
FORMULA: [(FTE value X 60) / # consumers served] = FTE per 60 consumers

A person who has state certification or licensure in substance abuse counseling meets the training/experience requirements; such credentialing is sufficient, but not necessary to obtain full credit on this item. If a substance abuse counselor is "loaned" from another program or otherwise works part time on the team (e.g., he or she has another role at the center), give partial credit in accordance with the percentage of time dedicated to the ACT team.

IL Scoring: If one FTE or more with one year of substance abuse training or supervised substance abuse treatment experience are assigned to a 60-consumer program, the item is coded as a "5".

H10. Vocational specialist on staff

Definition: Program includes at least one staff member with special training/experience in rehabilitation counseling, including vocational, work readiness and educational support.

Rationale: ACT teams emphasize skill development and support in natural settings. Fully integrated ACT teams include vocational services that enable consumers to find and keep jobs in integrated work settings.

Sources of Information:

X **Team leader interview**

- Information regarding FTE vocational specialist is obtained during the initial review of the staffing.
- Calculate the FTE vocational specialist time per 100 consumers (see formula, below)

Item Response Coding:
FORMULA: [(FTE value X 60) / # consumers served] = FTE per 60 consumers

Full credit may be given even if the team's vocational specialist belongs to a separate supported employment team IF she or he sees only ACT consumers; otherwise, give partial credit according to the percentage of time the vocational specialist works with ACT consumers.

IL Scoring: If one FTE or more with one year of vocational rehabilitation training or supervised vocational rehabilitation treatment experience are assigned to a 60-consumer program, the item is coded as a "5".

H11. Program size

Definition: Program is of sufficient size to consistently provide necessary staffing diversity and coverage.

Rationale: The ACT team provides an integrated approach to mental health services, through which the range of treatment issues are addressed from a variety of perspectives; it is critical to maintain adequate staff size and disciplinary background in order to provide comprehensive, individualized service to each consumer.

Sources of Information:

X Staff listing

Item Response Coding*:*

IL Scoring: If the program has at least 6 FTE staff, the item is coded as a "5". Count all staff; (Excluding psychiatrist and administrative support staff.)

Organizational Boundaries

O1. Explicit admission criteria

Definition: The program has a clearly identified mission to serve a particular population; it uses measurable and operationally defined criteria to screen out inappropriate referrals. Admission criteria should be pointedly targeted toward the individuals who typically do not benefit from traditional services and modes of delivery. ACT teams are intended for adults with severe mental illness who require assertive outreach and support in order to remain connected with the necessary mental health and supportive services and to maintain stable community living. In addition to these very general criteria, an ACT team should have some further admission guidelines tailored to their treatment setting. Examples of more specific admission criteria that are suitable include:

- Pattern of frequent and multiple psychiatric inpatient readmissions
- Excessive use of crisis/emergency services with failed linkages
- Individuals discharged from long-term psychiatric hospitalizations
- Co-occurring substance use disorders
- Chronic homelessness
- Involvement with the criminal justice system - repeated arrests and incarcerations
- Multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers
- Functional deficits in maintaining treatment continuity, self-management of prescription medication (including non-adherence), or independent community living skills
- Persistent or severe psychiatric symptoms, serious behavioral difficulties, a mentally ill/substance abuse diagnosis or dual-diagnosis, and/or high relapse rate.

Rationale: ACT is intended for adults who do not effectively use less intensive mental health services.

Sources of Information:

X **Team leader interview**

- *"Does your ACT team have a clearly defined target population with whom you work?"*
- *"What formal admission criteria do you use to screen potential consumers?"*
- *"How do you apply these criteria?"*
- *"Who makes referrals to the ACT team?"*
- *"Who has the final say as to whether or not a person is served by the ACT team?"*
- *"Are there circumstances where you **have to** take consumers onto your team?"*

- *"What recruitment procedures do you use to find consumers for the ACT team?"*
- *"Do you have some ACT consumers who you feel do not really need the intensity of ACT services?"*

X **Clinician interview**

- *"How does an individual become a consumer of the ACT team?"*

X **Internal records**

- Note documentation of application of explicit admission criteria
- Collaborative authorization forms

Item Response Coding: If the program serves a well-defined population and all consumers meet explicit admission criteria, the item is coded as a "5."

O2. Intake rate

Definition: Program takes consumers in at a low rate to maintain a stable service environment.

Rationale: In order to provide consistent, individualized, and comprehensive services to consumers, a low growth rate of the consumer population is necessary.

Sources of Information:
X Data Run

Item Response Coding: If the highest monthly intake rate during the last six months was no greater than six consumers, the item is coded as a "5." For new teams, this score may be low if the team is under pressure to serve a full caseload; their rating on this item will likely improve once they have been in operation for a period of time.

O3. Full responsibility for treatment services

Definition: ACT team directly provides psychiatric services and medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services, in addition to case management services.

Rationale: Consumers benefit when services are integrated into a single team, rather than when they are referred to many different service providers, furthermore, an integrated approach allows services to be tailored to each consumer.

Sources of Information:

X **Team leader interview**

- Through discussion with the team leader, determine which services are provided by the team, and for which services consumers are referred elsewhere. Determine the nature of services

offered by the team.

- *"Do your consumers see other psychiatrists outside of the ACT team?"*
- *"Do some consumers receive case management services from their residences?"*
- *"Do any consumers live in supervised group homes? If yes, how many? What is the nature of the case management/rehabilitation services?"* [If more than 10% are living in a group residence and receiving services that generally duplicate what the ACT team would otherwise be doing – e.g., if they are heavily staffed, then this should be counted as brokered residential services.]
- *"What percentage of consumers receives additional (non -ACT) case management services?"*

"I am going to read you a list. Which of the following services do your consumers receive from another department within your agency (or to another agency, and which do your team provide directly?"

(Query for details on particular services as necessary)

1. *case management*
2. *medication prescription, administration, monitoring, and documentation*
3. *counseling/individual supportive therapy*
4. *housing support*
5. *substance abuse treatment*
6. *employment or other rehabilitative services (e.g., ADLs, vocational counseling/support)*

X **Clinician interview**

- Ask similar questions as for team leader

X **Consumer interview**

- *"Who helps you get your services for housing? For employment?"*
- *"Who helps you besides the ACT team?"*

Item Response Coding: Team leader is the primary source. If there are discrepancies, follow up. In general, the team should offer these services in proactive, systematic, and inclusive fashion to all consumers. If the team provides all five services in addition to case management directly to consumers, the item is coded as a "5." **Exclude any services provided outside of ACT team that is authorized by the Collaborative. These services will not count against the fidelity score.**

O4. Responsibility for crisis services

Definition: Program has 24-hour responsibility for covering psychiatric crises.

Rationale*:* An immediate response can help minimize distress when persons with severe mental illness are faced with crisis. When the ACT team directly provides crisis intervention, continuity of care is maintained.

Sources of Information:

X **Team leader interview only**

- *"What 24-hour emergency services are available for ACT consumers?"*
- *"What is the ACT team's role in providing 24-hour emergency services?"*

Item Response Coding: If the program provides 24-hour coverage directly (i.e., an ACT team member is on-call at all times, typically by carrying aa beeper), the item is coded as a "5". This relates to who handles/responsds to the crisis, not who answers the phone. Do not count crises for which the ACT program staff are not made aware that they occurred.**O5. Responsibility for hospital admissions**

Definition: When notified in advance, the ACT team is closely involved in hospital admissions.

Rationale*:* More appropriate use of psychiatric hospitalization occurs, and continuity of care is maintained, when the ACT team is involved with psychiatric hospitalizations.

Sources of Information*:*

X **Team leader interview**

- In advance of the fidelity visit, request that the team leader compile a list of the last 10 hospital admissions. Review each admission with the team leader.
- *"What happened on this admission (i.e., describe the process as it involves the ACT team)?"*
- *"Was the team aware of the admission in advance?"*
- *"In general, what role does the ACT team play in the decision to hospitalize an ACT consumer?"*
- *"Are any ACT team clinicians in regular contact with the hospital?"*
- *"Does the ACT team policy differ from the rest of the agency with regard to hospital admissions?"*

X **Clinician interview**

- *"How often is the team involved in the decision to admit a consumer for psychiatric hospitalization?"*

Do

not count hospitalizations/discharges that the ACT program staff was not made aware that they occurred. If this appears to be occurring on a frequent basis, the ACT team may need to develop a plan for increasing communication with area hospitals in order to be more involved in crisis interventions, hospitalization and/or discharge planning.

- *"Describe the process the team goes through when a consumer needs to be admitted to a hospital."*

Item Response Coding: Determine the percentage of admissions in which the ACT team was involved admissions. If 95% or more of all admissions involved the ACT team, the item is coded as a "5."

O6. Responsibility for hospital discharge planning

Definition: When notified in advance, ACT program staff is involved in planning for hospital discharges.

Rationale: Ongoing participation of the ACT team during a consumer's hospitalization and discharge planning allows the team to help maintain community supports (e.g., housing), and continuity of service.

Sources of Information:

X **Team leader interview**

- *"What happened on this discharge?" (i.e.,* describe the process as it involves the ACT team)
- *"Was the team aware of the discharge in advance?"*
- *"For consumers hospitalized in the last year, what percentage was the ACT team involved in the decision/planning for discharge?"*
- *"What role does the ACT team play in psychiatric or substance abuse discharges?"*
- *"Does the ACT team role in hospital discharges differ from the general agency policy?"*

X **Clinician interview**

- *"How often is the team involved with discharge planning when a consumer is hospitalized for psychiatric or substance abuse reasons?"*

Item Response Coding: Determine the number of discharges where the ACT team was involved. If 95% or more of all discharges were planned jointly between the ACT team and the hospital, the item is coded as a "5."

Do not count hospitalizations/discharges that the ACT program staff was not made aware that they occurred. If this appears to be occurring on a frequent basis, the ACT team may need to develop a plan for increasing communication with area hospitals in order to be more involved in crisis interventions, hospitalization and/or discharge planning.

O7. Time-unlimited services/Graduation rate

Definition: Program does not have arbitrary time limits for consumers admitted to the program cases but remains the point of contact for all consumers indefinitely as needed.

Rationale: Consumers often regress when they are terminated from short-term programs. Time unlimited services encourage the development of stable, ongoing therapeutic relationships.

Sources of Information:

X **Team leader interview**

- *"How many of these individuals have you graduated because they no longer needed services?"*
- *"What percentage of ACT consumers are expected to be discharged from their team within the next 12 months?"*
- *"Does your team use a level or step-down system for consumers who no longer required intensive services?"* [if "yes"] Probe for specifics: what criteria are used, how contact is maintained, etc.

Item Response Coding: The intent of this item is to gauge the program philosophy about graduation. If all consumers are served on a time-unlimited basis, with fewer than 5% expected to graduate from the program annually, the item is coded as a "5". Exclude any consumers who are incarcerated or who are now deceased.

Nature of Services

Overall instructions: For estimates of several of the service items (e.g., S1, S4, S5, and S6) subjective estimates from team leader or case managers are usually not very helpful. Often these staff will say, "It depends." Consequently, written documentation is the primary source for these items. The fidelity assessors should ask the team leader for their opinion about the best data source to obtain this information, but the default is chart review, unless they can make a case for a better source.

S1. Community-based services

Definition: Program works to monitor status, develop skills in the community, rather than in office.

Rationale: Contacts in natural settings (i.e., where consumers live, work, and interact with other people) are thought to be more effective than when they occur in hospital or office settings, as skills may not transfer well to natural settings. Furthermore, more accurate assessment of the consumer can occur in his or her community setting because the clinician can make direct observations rather than relying on self-report. Medication delivery, crisis intervention, and networking are more easily accomplished through home visits.

Sources of Information*:*

X Data run done prior to review

Item Response Coding:

In scoring this item, count community contacts with consumers. Do not count phone calls and do not count contacts with collaterals or family members. Use data run as a primary data source. If the information from different sources disagrees (for example, if the team leader indicates a higher rate of community-based services than do the records), then ask the team leader to help you understand the discrepancy.

If at least 80% of total service time occurs in the community, the item is coded as a "5." Review service time over 4 weeks.

IL Scoring: Determine fidelity by looking at services that are off site vs. on site. Dartmouth fidelity tool recommends looking at face to face contacts to measure contacts in natural settings; Illinois providers document contacts in natural settings as "off site".

S2. No dropout policy

Definition: Program engages and retains consumers at a mutually satisfactory level

Rationale: Outreach efforts, both initially and after a consumer is enrolled on an ACT team, help build relationships and ensure consumers receive ongoing services.

Sources of Information:

X **Team leader interview**

- The data from O7 should be referenced when completing this item For this count, exclude individuals who graduated the program (See Item O7). Count people who have dropped out, i.e., refused services, cannot be located, or have been closed because the team determined that they could not serve them. Also include those who have left the geographic area IF the ACT team did not provide referrals for services for continuing care in the new location.
- *"How many consumers dropped out during the last 12 months?"*
- *"For the consumers who have moved, what efforts did the ACT team make to connect them to services in their new location?"* [Check for documentation of referrals, if available.]

X **Clinician interview**

- *"How often do you close cases because they refuse treatment or you lose track of them?"*
- *"What factors does the team consider when closing a case?"*

Item Response Coding:

FORMULA: (# CONSUMERS DISCHARGED, DROPPED, MOVED WITHOUT REFERRAL)/ TOTAL # CONSUMERS

If 95% or more of the caseload is retained over a 12-month period, the item is coded as a "5."

S3. Assertive engagement mechanisms

Definition: Program uses street outreach, legal mechanisms (e.g., probation/parole, OP commitment) or other techniques to ensure ongoing engagement.

Rationale: Consumers are not immediately discharged from the program due to failure to keep appointments. Retention of consumers is a high priority for ACT teams. Persistent, caring attempts to engage consumers in treatment helps foster a trusting relationship between the consumer and the ACT team. Assertive outreach is considered a critical feature of the ACT team.

Sources of Information:

X **Team leader interview**

- Ask the team leader to think about 2-3 consumers who have been hard to engage or who have refused services. Review these with team leader.
- *"What did the team do to reach out to each of these consumers?"*
- *"Was there anything more you could have done to retain them in services?"*
- *"What methods does the team use to keep consumers involved in ACT?"*
- *"Which, if any, of the following methods, does the team use? Representative payee services, outpatient commitment, contacts with probation or parole officers, street and shelter outreach after a consumer is enrolled in ACT, or other mechanisms [please name]."*
- *"How many consumers receive each of the above services?"*

X **Clinician interview**

- *"What happens if a consumer says he or she doesn't want your services?"*

X **Consumer interview**

- *"What happens if a person says they don't want ACT services anymore?"*

Item Response Coding: If the program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate, the item is coded as a "5."

S4. Intensity of service

Definition: High amount of face-to-face service time.

Rationale: In order to help consumers with severe and persistent symptoms maintain and improve their function within the community, high service intensity is often required.

Sources of Information:

X **Chart review**

- Calculate the mean amount of service hours per consumer, per week, over a month-long period. (If applicable, the charts should proportionately represent the number of consumers who have "stepped down" in program intensity.) Include only face-to-face contacts in your tally. Remember to use the most complete and up-to-date time period from the chart. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation.

X **Review of management information reports, if available.**

Item Response Coding:

In scoring this item, count face-to-face contacts with consumers. Do not count phone calls and do not count contacts with collaterals or family members. The fidelity assessors should ask the team leader for the best data source to obtain this information, but the default is chart review, unless they can make a case for a better source. If the median value is two or more hours per week, per consumer, the item is coded as a "5."

S5. Frequency of contact

Definition: High number of face-to-face service contacts. IL requires 4 face-to-face contacts per week for all consumers per month.

Rationale: ACT teams are highly invested in their consumers, and maintain frequent contact in order to provide ongoing, responsive support as needed. Frequent contacts are associated with improved consumer outcomes.

Sources of Information:

X **Chart review**

- Calculate the mean number of face-to-face consumer-ACT service contacts, per week, over a month-long period. Remember to use the most complete and up-to-date time period from the chart. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation.

X **Review of internal reports/documentation, if available.**

X **Consumer interview**

- *"How many times have you seen ACT staff during the past week?"*

Item Response Coding: *See general instructions at beginning of Services Section.* **In scoring this item, count face-to-face contacts with consumers. Do not count phone calls and do not count contacts with collaterals or family members.** The fidelity assessors should ask the team leader for the best data source to obtain this information, but the default is chart review, unless they can make a case for a better source.

IL Scoring: If the program has at least four contacts per week for all consumers over a 4 week period, the item is coded as "5".

S6. Work with informal support system

Definition: Program provides support and skills for consumer's informal support network (i.e., persons not paid to support consumer, such as family, landlord, shelter staff, employer or other key person).

Rationale: Developing and maintaining community support further enhances consumer's integration and functioning.

Sources of Information:

X **Team leader interview**

- Review the consumer roster with the team leader. Determine for how many consumers the ACT team has made at least one contact with an informal support network. Focus the discussion on this subgroup.
- *"Among consumers with whom you have had at least one contact with their informal network in the last month, how frequently does the team work with his or her informal support network (including family, landlord, employer, or other key person)?"*

X **Review of internal reports/documentation, if available.**

X **Clinician interview**

- *"How often do you work with the family, landlord, employer, or other informal support network members for each consumer, on average?"*

X **Consumer interview**

- *"How often is there contact between the ACT team and your family? Your landlord? Your employer?"*

Item Response Coding: Use team leader as primary data source. Include contacts with family, landlord, and employer; exclude persons who are paid to provide assistance to the consumer, such as Social Security Disability or Department of Human Services representatives. Tabulate the rate for the subgroup for which the team has at least some contact. From this, calculate the rate for the entire caseload.

If the program makes four or more contacts per month, per consumer, the item is coded as a "5."

S7. Individualized substance abuse treatment

Definition: One or more members of the team provide direct treatment and substance abuse treatment for consumers with substance use disorders.

Rationale: Substance use disorders often occur concurrently in persons with SMI; these co-occurring disorders require treatment that directly addresses them.

Sources of Information:

X **Team Leader AND Substance Abuse Specialist interviews**

- *"How many consumers have a substance use disorder?"*
- *"Of these consumers, how many received structured individual counseling for substance use from the substance abuse counselor on the team or another ACT team member this last month?* The counseling can be in the office, at the consumer's home, or elsewhere, but it must be more than informal queries or "nagging."
- *"What strategies are used for individuals in pre-contemplative stage (through all stages) to keep them engaged in services?"*
- *Ask the nature of the counseling.* Ideally, the counseling should follow integrated DD counseling principles – see item S9, but for this item, the criterion is more lenient. It must relate specifically to substance use, it cannot be generic counseling. If the person providing the counseling is not a substance abuse counselor, then you should interview the staff providing this counseling to gauge whether it qualifies as appropriate substance abuse counseling. To count for this item, the interventions must be structured and in accordance with the consumer's goals/treatment plan.

  Note: The Training Coordinator will ask for documentation prior to site review of substance abuse groups already completed for additional review on substance abuse services.
- *"For each consumer who received substance abuse counseling in the last month, how many sessions did he/she have? How long were the sessions?"*

Item Response Coding: The substance abuse counselor interview is the primary data source.

Calculate the total number of sessions for the consumers receiving substance abuse treatment. Calculate the total number of minutes per month for each of these consumers. Multiply the number of sessions by the number of minutes per month. Divide this product by the number of consumers with substance use problems. Divide by 4 (weeks/month). If consumers with substance abuse disorders spend on average, 24 minutes/week or more in formal substance abuse treatment, the rating is "5".

S8. Dual disorder treatment groups

Definition: Program uses group modalities as a treatment strategy for people with substance use disorders.

Rationale: Group treatment has been shown to positively influence recovery for persons with dual disorders.

Sources of Information:

X **Team leader interview**

- *"How many of the consumers with DD* (identified in S7) *attended at least one treatment group in the last month?"*
- *"How many groups are offered?"*
- *"Who offers these groups?"* **[Do not count groups offered by organizations that have no connection to the ACT team. Only groups led by ACT staff or by staff who are integrated with the ACT team, i.e., have regular contact with the ACT team count.]**
- *"How many consumers attend these groups?"*

X **Substance abuse counselor interview**

- Repeat same questions as above.

Item Response Coding: Use substance abuse counselor interview as primary source of data. If 50% or more of all consumers with substance use disorders attend at least one substance abuse treatment group meeting during a month, the item is coded as a "5."

S9. Dual disorders (DD) model

Definition: Program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions between mental illness and substance abuse, and has gradual expectations of abstinence, while being individualized to the needs of the consumer.

Rationale: The DD model attends to the concerns of both SMI and substance abuse for maximum opportunity for recovery and symptom management.

Sources of Information:

X **Team leader interview**

- *"What is the treatment model used to treat consumers with substance abuse problems?"* [Probe for whether confrontation is used]
- *"Do you refer consumers to AA? What about detox programs?"*
- *"Do you see the goal as abstinence?"*
- *"How does your team view abstinence versus reduction of use?"*
- *"Does your team employ harm reduction tactics?"* [if "yes"] *"What are some examples?"*
- *"Are you familiar with a stage-wise approach to substance use treatment?* [if "yes"] *"Give some examples of how your program uses this approach."*

X **Clinician (Substance Abuse Counselor) interview**

- Repeat same questions as above.

Item Response Coding: Use Team leader interview as primary data source. If the program is fully based in DD treatment principles, with the team providing treatment, the item is coded as a "5." A program can receive full credit for this item if it includes self-help (e.g., AA) referrals as additional support, rather than in place of team-based interventions.

S10. Role of consumers on treatment team

Definition: Consumers are members of the team who provide direct services.

Rationale: Some research has concluded that including consumers as staff on case management teams improves the practice culture, making it more attuned to consumer perspectives.

Sources of Information:

X **Team leader interview**

- *"How are consumers involved as members of your team? (e.g., employed, volunteer, not at all, etc.)"*
- *If they are paid employees, are they full time?*
- *Are they considered full -fledged clinicians? (Alternatively, are they considered aides?)*

X **Clinician interview**

- Ask similar questions as for team leader.

X **Consumer interview**

- *"How are consumers involved as members of your team? (e.g., employed, volunteer, not at all, etc.)"*

Item Response Coding: This item refers to disclosed mental health consumers who have received treatment for a psychiatric disorder. If consumers are employed as clinicians with equal status as other case managers, the item is coded as a "5". If they work full time but at reduced responsibility, code as "4." If part-time, but providing clinical activities (e.g., co-lead a group) code as "3". If their

participation is “token” involvement on team, code as “2”. If consumer staff does not attend/participate in treatment team meetings, for instance, this would likely be coded as a “2”. Also code the item as a “2” if the consumer works in a position such as driver or administrative assistant.