ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

Assertive Community Treatment (ACT)

Fidelity Scale Instructions for Reviewers

Purpose: to Shape Mental Health Services Toward Recovery

Revised 3/20/15

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 section provides an overview of ACT and the scale that is used during the fidelity review. In addition, this section outlines activities to be conducted by review staff before, during, and after the fidelity review. These activities allow for 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 definition and rationale for each fidelity item. These items have been derived from a comprehensive review of evidence-based literature.
- A list of data sources most appropriate for each fidelity item (e.g., chart review, clinician interview, team meeting observation).
- Where appropriate, a set of probe questions to help elicit the critical information needed to score each fidelity item. These probe questions were specifically generated to help reviewers collect information from respondents that are free from bias such as social desirability.
- Decision rules that will help reviewers correctly score each item. As reviewers collect information from various sources, these rules will help them determine the specific rating to give for each item.

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 individuals with serious and persistent mental illness or co-occurring mental health and alcohol/substance abuse disorders. ACT uses a multidisciplinary team comprised of at least six (6) FTE staff, including a team leader, a Registered Nurse, and at least four case managers. There must also be a substance abuse specialist, a recovery specialist [Certified Recovery Support Specialist (CRSS) or Certified Family Partnership Professional (CFPP)] and a vocational specialist on the team. A psychiatrist and a program/administrative assistant are also required to be part of the team but in IL are not counted towards meeting the requirement for six FTE.

ACT is characterized by (1) low person served to staff ratios; (2) providing services in the community rather than in the office; (3) shared caseloads among team members; (4) 24-hour, 7 days per week staff availability, (5) direct provision of all services by the team (rather than referring persons served to other agencies or to other services within the agency); 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 individuals with serious and persistent mental illness or co-occurring mental health and alcohol/substance abuse disorders and for assessing adherence to evidence-based practices, specifically for an ACT team. The DACTS measures fidelity *at the team level* rather than at the individual or agency level.

How the Rating Is Done

ACT fidelity reviews are conducted at the provider site and are generally completed within one (1) day. The data collection procedures include chart review, team meeting observation, review of home visits information, and semi-structured interviews with the team leader, clinicians and persons served. Data may also be obtained through other sources (e.g., administrative records) 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 random sample of all ACT authorizations over a specific time period will be selected for the fidelity review. Authorization reports specific to each provider will be developed using the Collaborative's IntelligenceConnect reporting application. Ten (10) unique records will be pulled for each team being reviewed. An additional ten records will be pulled as alternative records to be used in the event that any of the original ten records are incomplete.

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 persons served during the last six months. Teams that have been established for less than one year will not be assessed on these items during FY15. Reviewers will score these items as "0", which is same for "N/A" and will not be counted in the score.

Who Does the Ratings?

A team of trained, licensed clinicians administer the fidelity assessment. In addition, reviewers will have an understanding of the nature and critical ingredients of ACT. All fidelity assessments will be conducted by at least two reviewers 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 reviewers obtain the required information for every item and record detailed notes of responses given by the interviewees.

Before the Fidelity Site Visit

ACT fidelity reviews are conducted in conjunction with Post-Payment, Clinical Practice and Guidance and, if applicable, Community Support Team fidelity reviews. Information regarding activities that are conducted before the fidelity visit can be found in the *External Protocols*, which is posted on the Collaborative website under the Provider Information tab.

Initial Provider Notification

During the notification call, the Training Coordinator will review the purpose of the fidelity review with the provider and briefly describe what information reviewers will need to complete the review and how long each visit will take to complete. The Training Coordinator will email the provider the *Information Needed for ACT Site Visit* document at the conclusion of the provider notification call. The Training Coordinator will inform providers that this information needs to be submitted to the reviewers at the Entrance Conference and will reassure them that reviewers will be able to conduct the fidelity assessment even if not all of the above information is available.

During Your Fidelity Site Visit

- Reviewers will tailor terminology used in the interview to the site.
  For example, if the site uses the term "member" for person served, they will use that term. If "practitioners" are referred to as clinicians, they will use that terminology. Every agency has specific job titles for particular staff roles. By adopting the local terminology, the reviewer will improve communication.

- During the interview, reviewers will record the names of all relevant programs, the total number of persons served, and the total number of clinicians.

- If discrepancies between sources occur, reviewers will 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.

- Before leaving, reviewers will, check for missing data.

- Both reviewers will independently rate the fidelity scale. Reviewers will then compare their ratings and resolve any disagreements. It is critical for the reviewers to come up with a consensus rating.

- Reviewers will enter data into an Access database designed for ACT fidelity reporting. This database will calculate findings and identify the level of implementation that was achieved.

- Exit Conference. Please refer to the *External Protocols* for information pertaining to the Exit Conference.

- Reports to be Left with Provider. Reviewers will leave the ACT Provider External Report with the provider at the Exit Conference. This document reports findings and includes related comments from the review process.

After Your Fidelity Site Visit

- Letter - Providers will receive a letter of findings within thirty (30) days of the review. This letter will explain the provider's scores on the fidelity scale, provide some interpretation of the assessment, highlighting both strengths and weaknesses, and will inform the provider if any of the items require the completion of a Plan of Improvement. The report is informative, factual, and constructive in nature. This letter is sent from the Illinois Mental Health Collaborative on behalf of DHS/DMH.

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

Item-Level Protocol

Human Resources: Structure and Composition

H1. Small Caseload

Definition*:* Person served/clinician ratio of 10:1

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

Sources of Information:

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 individuals are currently served by the team?

In counting the current caseload, include all individuals with an "active" status. The caseload totals should include any individual 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.

Agency Documents

- Roster of active persons served.
  If there is doubt about the precise count of the caseload, this type of record can be consulted as a crosscheck on the count.

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

- FORMULA: (# PERSONS 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 an extended leave for 31 days or longer.

H2. Team Approach

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

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

Sources of Information:

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 person served during this time. Determine the percentage of persons served who have seen more than one team member in the two-week period.

Team Leader Interview

- "In a typical two-week period, what percentage of individuals are seen by more than one member of the team?"

Clinician Interview

- During a review of documentation of a home visit, ask the case manager which ACT team members have seen the individual last week.
- "How about the week before?"
- "Is this pattern similar for other persons served?"

Interview of Person Served

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

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

H2, continued

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.

1. Look at each clinical record.
2. If the person was seen by more than one ACT worker in the 2 week period, score a 5.
   If the person was seen by only one ACT worker in the 2 week period, score a 1.
3. Add all your scores up for the entire review (10 records for 1 team review, 20 records for 2 team review and 30 records for 3 team reviews).
4. Divide by the number of records being reviewed.
5. This gives you an overall percentage for the provider for this item.
6. This overall percentage is the number used for scoring this item.

Example:

1 team being reviewed:
Record 1: scored 5
Record 2: scored 1
Record 3: scored 5
Record 4: scored 5
Record 5: scored 1
Record 6: scored 1
Record 7: scored 5
Record 8: scored 5
Record 9: scored 5
Record 10: scored 1

Totals 34

34 divided by 10 (the number of records reviewed) = 3.4
To determine percentage of a decimal number you move the decimal point one spot to the right = 34%.
You then look at the tool to determine where 34% falls.
34% would result in a score of "2".

H3. Program Meeting

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

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

Sources of Information:

Team Leader Interview

- "How often does the ACT team meet as a full group to review services provided to each individual?"
- "How many individuals are reviewed at each meeting?"
- "How does the team decide which individuals will be discussed during each team meeting?"
- "How often does the ACT Psychiatrist attend team meetings?"

Internal Documentation

- Confirm with attendance roster of team meetings and notes of individuals discussed

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 person served each time, a "5" is scored. If the team meets 4 or more days a week but does not discuss each person served 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 outcomes for individuals receiving ACT. Team leaders who also have direct clinical contact are better able to model appropriate clinical interventions and remain in touch with the individuals served by the team.

Sources of Information:

Team Leader Interview

- "Do you provide direct services to individuals receiving ACT?"
- If yes, "What percentage of your time is devoted to providing direct services to ACT recipients?"

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 individuals and providers.

Sources of Information:

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 (24 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.

For new teams (defined as teams with start dates in the past year), do not rate this item, this year. Score as a "0", same as an "N/A".

H6. Staff Capacity

Definition: Program operates at full staffing.

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

Sources of Information:

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?"]. Ask about all 12 months (or for the length of time the program has been operating, if less than 12 months).
- "Has anyone 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: There is a psychiatrist on staff that works on the ACT team a minimum of 10 hours/week for an average census of 60 persons served.

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:

Team Leader Interview

- Information regarding the number of psychiatric hours is obtained during the initial review of the staffing.
- "What is the psychiatrist's role on the team?"
- "Is s/he readily accessible?"
- "Does the psychiatrist ever provide services to individuals who are not on the ACT team?"

Clinician Interview

- "What is the psychiatrist's role on the team?"
- "Is s/he readily accessible?"
- "Does the psychiatrist ever provide services to individuals who are not on the ACT team?"

Interview of Person Served

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

Item Response Coding:

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.

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

H7, continued

Score	Number	60 participants	61-120 participants
5		10 hours	20 hours
4		7-9 hours	14-19 hours
3		5-6 hours	10-13 hours
2		3-4 hours	6-9 hours
1		0-2 hours	0-5 hours

As soon as an ACT goes over 60 consumers served, they would have to add another full 10 hours of psychiatric time. If they go over 120 consumers served, then they would have to add another full 10 hours of psychiatric time.

H8. Nurse on staff

Definition: At least one full-time RN is assigned to work with a team of 60 individuals.

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:

Team Leader Interview

- Information regarding FTE RNs is obtained during the initial review of the staffing.
- Calculate the FTE nurse time per 60 individuals (see formula, below)
- "What is the nurse(s)' role on the team?"
- "Does he/she attend ACT team meetings?"
- "Is she/he readily accessible?"
- "Does the nurse ever have responsibilities outside the ACT team?"

Clinician Interview

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

Interview of Person Served

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

Item Response Coding:

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

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

H8, continued

Score	Number	60 participants	100 participants (DACTS)
5		1 FTE	2 FTE
4		.76-.99 FTE	1.40-1.99 FTE
3		.51-.75 FTE	.80-1.39 FTE
2		.26-.50 FTE	.20-.79 FTE
1		Less than .25 FTE	Less than .20 FTE

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

Note for items H8-H11: Programs do not receive credit for having a specialist on staff (e.g., RN, Substance Abuse or vocational specialist) 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.

H9. Substance abuse specialist on staff

Definition: At least one staff member on an ACT team of 60 individuals has at least one year of training or clinical experience in substance abuse treatment and/or treating individuals with co-occurring mental health and substance abuse disorders.

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

Sources of Information:

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 persons served (see formula, below).
- "Does the Substance Abuse Specialist have at least one year of training and/or experience in substance abuse treatment?"

Item Response Coding:

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

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.

Score	Number	60 participants	100 participants (DACTS)
5		1 FTE	2 FTE
4		.76-.99 FTE	1.40-1.99 FTE
3		.51-.75 FTE	.80-1.39 FTE
2		.26-.50 FTE	.20-.79 FTE
1		Less than .25 FTE	Less than .20 FTE

H9, continued

IL Scoring: If one FTE or more with one year of substance abuse training or supervised substance abuse treatment experience is on a team of 60 persons served, 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 individuals to find and keep jobs in integrated work settings.

Sources of Information:

Team Leader Interview

- Information regarding FTE vocational specialist is obtained during the initial review of the staffing.
- Calculate the FTE vocational specialist time per 60 individuals (see formula, below)
- "Does the ACT team include at least one staff member with special training/experience in rehabilitation counseling, including vocational, work readiness and educational support?"

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

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 individuals on the ACT team; otherwise, give partial credit according to the percentage of time the vocational specialist works with persons served by ACT.

Score	Number	60 participants	100 participants (DACTS)
5		1 FTE	2 FTE
4		.76-.99 FTE	1.40-1.99 FTE
3		.51-.75 FTE	.80-1.39 FTE
2		.26-.50 FTE	.20-.79 FTE
1		Less than .25 FTE	Less than .20 FTE

IL Scoring: If one FTE or more with one year of vocational rehabilitation training or supervised vocational rehabilitation treatment experience are on a team of 60 individuals, 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 person served.

Sources of Information:

Staff Listing with Credentials and Roles/Titles

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 serious and persistent mental illness or co-occurring mental health and alcohol/substance abuse disorders 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:

Team Leader Interview

- "Does the ACT team have a clearly defined target population with whom it works?"
- "What formal admission criteria do you use to screen potential individuals?"
- "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 individuals onto the team?"
- "What recruitment procedures do you use to find individuals who have a need for ACT?"
- "Currently, are there individuals receiving ACT who you feel do not need the intensity of ACT?"

Clinician Interview

- "How does an individual begin to receive ACT services?"

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 individuals meet explicit admission criteria, the item is coded as a "5."

O2. Intake Rate

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

Rationale: In order to provide consistent, individualized, and comprehensive services to individuals, a low growth rate is necessary.

Sources of Information:

- Data run done by the Collaborative prior to the site visit.

Item Response Coding: If the highest monthly intake rate during the last six months was no greater than six individuals, the item is coded as a "5." **For new teams (defined as teams with start dates in the past year), do not rate this item, this year. Score as a "0", same as an "N/A".**

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: Persons served 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 person served.

Sources of Information:

Team Leader Interview
Through discussion with the team leader, determine which services are provided by the team, and for which services individuals are referred elsewhere. Determine the nature of services offered by the team.

- "Do individuals who receive ACT receive psychiatric services from other psychiatrist?"
- "Do any individuals receive case management services at their residences?"
- "Do any individuals live in supervised group homes? If yes, how many? [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 persons served receive additional (non-ACT) case management services?"
- "I am going to read you a list. Which of the following services do individuals 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. Psychotropic Medication Monitoring, Training and Education
3. Therapy/Counseling
4. Housing Support
5. Substance Abuse Treatment
6. Employment or other Rehabilitative Services (e.g., vocational counseling/support)

Clinician Interview

- Ask similar questions as for team leader

Interview of Person Served

- "Who helps you get your needs met (i.e., housing, employment)?"
- "Does anyone outside the ACT Team provide you with any services?"

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 persons served. If the team provides all five services in addition to case management directly to individuals, 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:

Team Leader Interview only

- "What 24-hour emergency services are available for individuals receiving ACT?"
- "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 a beeper), the item is coded as a "5". This relates to who handles/responds to the crisis, not who answers the phone. Do not count crises for which the ACT program staff is not made aware that they occurred.

O5. Responsibility for Hospital Admissions

Definition: Program is 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:

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 individual receiving ACT?"
- "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?"

Clinician Interview

- "How often is the team involved in the decision to admit an individual for a psychiatric hospitalization?"
- "Describe the process the team goes through when an individual needs to be admitted to a hospital."

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.

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: Program is involved in planning for hospital discharges.

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

Sources of Information:

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 individuals 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?"

Clinician Interview

- "How often is the team involved with discharge planning when an individual 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 rarely closes persons to ACT but remains the point of contact for all persons served as needed.

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

Sources of Information:

Team Leader Interview

- "How many individuals have "graduated" because they no longer needed services?"
- "What percentage of individuals receiving ACT are expected to be discharged from ACT within the next 12 months?"
- "Does the team use a level or step-down system for individuals who no longer require 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 individuals 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 individuals who are incarcerated or who are now deceased.

Note: If after reviewing policies and conducting interviews, reviewers have assessed that the provider does not have arbitrary time limits and the individuals that are graduating out of the program are doing so in response to achievements made towards recovery, a score of "5" should be coded. The word "graduation" in this item refers to closing a person to ACT services who still has an assessed need for ACT, not graduating because they no longer need the service.

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 individuals 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 person served 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*:*

- Data run done by the Collaborative prior to review (30 days, 6 months back from date report ran)

Item Response Coding:

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".

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.

S2. No Dropout Policy

Definition: Program retains a high percentage of persons receiving ACT.

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

Sources of Information:

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. This item begins with a data run of discharges in the program that is obtained prior to the review. Reviewers will review this information with clinical staff to determine how many of these individuals dropped out. For the individuals who have dropped out of ACT, reviewers should look for creative solutions and outreach attempts to re-engage the individual.

- *"*How many individuals dropped out of ACT during the last 12 months?"

- "For individuals 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.]

Clinician Interview

- "How often do you stop/close ACT services because individuals refused treatment or you lost track of them?"
- "What factors does the team consider when closing a person to ACT services?"

Item Response Coding:

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

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

Sources of Information:

Team Leader Interview

- Ask the team leader to think about 2-3 individuals who have been hard to engage or who have refused services. Review these questions with team leader:
- "What did the team do to reach out to each of these individuals?"
- "Was there anything more you could have done to retain them in services?"
- "What methods does the team use to keep persons served 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 an individual is enrolled in ACT, or other mechanisms [please name]."
- "How many individuals receive each of the above services?"

Clinician Interview

- "What happens if an individual says he or she doesn't want ACT services?"

Interview of Person Served

- "Have you ever stopped showing up for appointments?"
- "If no, what do you think would happen to someone that did?"
- If yes, what happened? How did the ACT team respond?"

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 total amount of service time as needed.

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

Sources of Information:

Chart Review

- Calculate the mean amount of service hours per individual served, per week, over a month-long period. (If applicable, the charts should proportionately represent the number of persons served 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.

Review of Management Information Reports, if available.

Item Response Coding:

In scoring this item, count face-to-face contacts with persons served. 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 individual served, 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 persons served per month.

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

Sources of Information:

Chart Review

- Calculate the mean number of face-to-face ACT service contacts for persons served, 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.

Review of internal reports/documentation, if available

Interview with Persons Served

- "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 persons served. Do not count phone calls and do not count contacts with collaterals or family members.** Reviewers 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 individuals served over a 4 week period, the item is coded as "5".

S6. Work with Informal Support System

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

Rationale: Developing and maintaining community support further enhances the integration and functioning of persons served.

Sources of Information:

Team Leader Interview

- Review the team roster with the team leader. Determine for how many individuals the ACT team has made at least one contact with an informal support network. Focus the discussion on this subgroup.

- *"*Among individuals 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)?"

Review of internal reports/documentation, if available.

Clinician Interview

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

Interview of Person Served

- "How often is there contact between the ACT team and your family? Your landlord? Your employer? Other persons you are close to in the community?"

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 individual, 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 individual served, 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 individuals diagnosed with substance use disorders.

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

Sources of Information:

Team Leader AND Substance Abuse Specialist Interviews

- "How many individuals have been diagnosed with a substance use disorder?"

- "Of these individuals, 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 home of the person served, 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 goals/treatment plan of persons served.

- 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 individual 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 individuals receiving substance abuse treatment. Calculate the total number of minutes per month for each of these individuals. Multiply the number of sessions by the number of minutes per month. Divide this product by the number of individuals with substance use problems. Divide by 4 (weeks/month). If individuals diagnosed 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 diagnosed with substance use disorders.

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

Sources of Information:

Team Leader Interview

- "How many individuals receiving ACT and diagnosed with dual disorders (identified in S7) attended at least one treatment group in the last month?"
- "How many groups are offered?"
- "Which staff on the ACT team leads 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.]

Substance Abuse Specialist 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 individuals diagnosed 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 persons served.

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:

Team Leader Interview

- "What is the treatment model used to treat individuals with substance abuse problems?" [Probe for whether confrontation is used]
- "Do you refer individuals 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."

Substance Abuse Specialist 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 persons in recovery on treatment team

Definition: Persons in recovery are involved as members of the team providing direct services.

Rationale: Some research has concluded that including individuals in recovery as staff on case management teams improves the practice culture, making it more attuned to the perspectives of persons served.

Sources of Information:

Team Leader Interview

- "What role do individuals in recovery have within the ACT team?"
- "Do any persons in recovery receive payment as staff members of the ACT team?"
- "Do these individuals work full or part-time?'
- "Are these individuals considered full -fledged clinicians? (Alternatively, are they considered aides?)"

Clinician Interview

- Ask similar questions as team leader.

Interview of Person Served

- "Are there ACT staff members who are also persons in recovery?"
- "How are these individuals involved on the team?"

Item Response Coding: This item refers to individuals who have disclosed that they are persons in recovery who have received treatment for a psychiatric disorder.

- Persons in recovery are employed as clinicians with equal status as other case managers, score "5".
- Persons in recovery work full-time but have reduced responsibility, score "4."
- Persons in recovery work part-time but do provide clinical services (e.g., co-lead a group), score "3".
- Person in recovery has no real purpose on the team other than meeting the requirement, score"2".
- Staff who are persons in recovery do not attend/participate in treatment team meetings, score a "2".
- Persons in recovery work in positions such as driver or administrative assistant, score a "2".