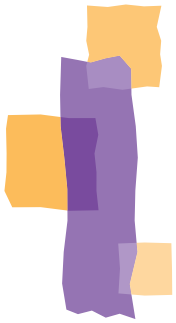

EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix C: ACT Fidelity Scale Protocol

ACT Fidelity Scale Protocol

Similar to the ACT Fidelity Scale, the ACT Fidelity Scale Protocol is divided into three categories:

- Human Resources (Structure and Composition),
- Organizational Boundaries, and
- Nature of Services.

Human Resources: Structure and Composition

H1. Small caseload

Definition: Consumer/team member ratio of 10:1

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

Sources of information:

1. **ACT leader interview**
   - Begin interview by asking ACT 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 ACT leader.
   - Possible questions include, "How many staff work on the ACT team?" and "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 team determines the definition of active status, but note that the count will affect other fidelity items, such as frequency of visits.

2. **Agency documents**
   - Some ACT teams have a Cardex or similar organization system, or the roster of active consumers is listed elsewhere. If doubt exists 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 countervailing reasons exist, count all team members providing direct services (including substance abuse specialist, employment specialist, and ACT leader), EXCEPT the psychiatrist.
   - Do not include administrative support staff when determining the caseload ratio.

Formula:

$$\frac{\text{Number of consumers presently served}}{\text{Number of FTE staff}}$$

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

Special case: Do not count team members who are technically employed by the team but who have been on extended leave for 3 months or more.

H2. Team Approach

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

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

Sources of information:

1. Chart review

- Review charts for 10 randomly selected consumers. Remember to use the most complete and up-to-date time period from the chart.
- Ask the ACT leader, team members, or an administrative person for the most recent, but complete, period of documentation. Data should be taken from the last 2 full calendar weeks before the fidelity visit (or the most recent 2-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 1 team member in the 2-week period.

2. **Team leader interview:** "In a typical 2-week period, what percentage of consumers sees more than 1 member of the team?"

3. **Team member interview**

- During 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?"

4. **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?"

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

- Use this data source if available, but ask the ACT 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 2-week period. For example, if > 90% of consumers see more than 1 case manager in a 2-week period, code the item a "5."

If the information from different sources does not agree, (for example, if the ACT leader indicates a higher rate of shared caseloads than the records do), then ask the ACT leader to help you understand the discrepancy. The results from a chart review are overruled if other data (e.g., ACT 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 team members to discuss consumers, solve problems, and plan treatment and rehabilitation efforts, ensuring all consumers receive optimal service.

Sources of information:

1. **ACT 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?"

2. **Internal documentation**

- The consumer service log (e.g., a Cardex that holds summary data for each consumer) may help determine 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, the psychiatrist should attend at least once a week). Part-time team members are expected to attend at least twice weekly to receive full credit on this item. Team members from all shifts should routinely attend.

If the team meets at least 4 days a week and reviews each consumer each time, score a "5." 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 ACT Leader

Definition: Supervisor of Frontline ACT team members provides direct services.

Rationale: Research has shown this factor was among the 5 most strongly related to better consumer outcomes. ACT 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:

1. **ACT leader interview**

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

2. **Productivity records**

- Some agencies require staff to track 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 on Accreditation of Healthcare Organizations (JCAHO) accreditation.

Item response coding: Give more weight to the actual records than to the verbal report. If a discrepancy exists, ask the ACT leader to help you understand it. If the ACT leader provides services at least 50% of the time, code the item 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:

1. **ACT leader interview**

- Before the fidelity visit, ask the ACT leader to have available a list of all employees over the past 2 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 2 years." [If the team has been in existence for a shorter period, use the formula below to adjust for the shortened timeframe.]

Item response coding:

Formula:

$$\frac{\text{Number of staff to leave}}{\text{Total number of positions}} \times \frac{12}{\text{Number of months}}$$

Examples:

There were 20 staff workers who occupied the nine line positions at West over 24 months, compared with seven staff workers for five line positions at South over 23 months. The annual turnover rate was 61.1% for West versus 20.9% for South.

West: 11/9 x 12/24 = 61.1%

South: 2/5 x 12/23 = 20.9%

If the annual turnover rate is 10% or less, then the item is coded as a "5." A team member who has been on an extended leave for 3 months or more is considered among the number of staff who have left, even if he or she technically remain in the position.

H6. Staff Capacity

Definition: Program operates at full staffing.

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

Sources of information:

1. **ACT leader interview**
   - Before the fidelity visit, ask that the ACT 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 ACT 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 1 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:

$$\frac{100 \times (\text{sum of number vacancies each month})}{\text{Total number of staff positions} \times 12}$$

Include the psychiatrist, but exclude 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, code the item 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: For 100 consumers, at least 1 full-time psychiatrist is assigned to work with 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:

1. **ACT leader interview**
   - Information about FTE psychiatrist is obtained during the initial review of the staffing.
   - Calculate the FTE psychiatrist time per 100 consumers (see formula, below).
2. **Team member interview**
   - "What is the psychiatrist's role on the team?"
   - "Does he or she come to meetings?"
   - "Is he or she readily accessible?"
   - "Does the psychiatrist ever see consumers who are not on the ACT team?"

3. **Consumer interview**

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

Item response coding:

Formula:

$$\frac{\text{FTE value} \times 100}{\text{Number of consumers served}} = \text{FTE per 100 consumers}$$

Examples:

West has .75 FTE psychiatrist for a 50-consumer program. South has .75 FTE for a 120-consumer program.

West: [(.75 * 100) / 50] = 1.5 FTE psychiatrist ➔ code item 5

South: [(.75 * 100) /120] = .63 FTE psychiatrist ➔ code item 3

If information across sources is inconsistent, ask for clarification during the ACT leader interview or follow up with the program. As with all scale items, base the rating on the most credible evidence available (e.g., even if the psychiatrist is reported as 1.0 FTE to a 100-person ACT team, if the consumers and ACT team members consistently report that he or she is unavailable for consultation, a lower score on this item is likely appropriate).

If at least 1 full-time psychiatrist is assigned directly to a 100-consumer program, code the item as a "5."

H8. Nurse on staff

Definition: At least 2 full-time nurses are assigned to work with a 100-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:

1. **ACT leader interview**
   - Information about FTE RNs is obtained during the initial review of the staffing.
   - Calculate the FTE nurse time per 100 consumers (see formula, below).
2. **Team member interview**
   - "What is the nurse's role on the team?"
   - "Does he or she come to meetings?"
   - "Is he or she readily accessible?"
   - "Does the nurse ever have responsibilities (or consumers) outside the ACT team?"
3. **Consumer interview**
   - "How often do you see the team nurses?"

Item response coding:

Formula:

$$\frac{\text{FTE value} \times 100}{\text{Number of consumers served}} = \text{FTE per 100 consumers}$$

If inconsistent, reconcile information across sources and score accordingly.

If 2 full-time nurses or more are members of a 100-consumer program, code the item as a "5."

H9. Substance abuse specialist on staff

Definition: At least 2 staff members on the ACT team with at least 1 year of training or clinical experience in substance abuse treatment, per 100-consumer program

Rationale: Concurrent substance-use disorders are common in consumers. Appropriate assessment and intervention strategies are critical.

Sources of information:

1. **ACT leader interview**

- Information about FTE substance abuse specialists is obtained during the initial review of the staffing.
- For each substance abuse specialist, determine if each has at least 1 year of training or experience in substance abuse treatment.
- Calculate the FTE substance abuse specialist time per 100 consumers (see formula, below)

Item response coding:

Formula:

$$\frac{\text{FTE value} \times 100}{\text{Number of consumers served}} = \text{FTE per 100 consumers}$$

Someone with 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 on loan 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 according to the percentage of time dedicated to the ACT team.

If 2 FTEs or more with 1 year of substance abuse training or supervised substance abuse treatment experience are assigned to a 100-consumer program, code the item as a "5."

H10. Vocational specialist on staff

Definition: Program includes at least 2 staff members with at least 1 year of training/experience in vocational rehabilitation and 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:

1. **ACT leader interview**

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

Item response coding:

Formula:

$$\frac{\text{FTE value} \times 100}{\text{Number of consumers served}} = \text{FTE per 100 consumers}$$

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

If, for a 100-consumer program, 2 FTEs or more with 1-year vocational rehabilitation training/supervised experience were assigned, code the item 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 to provide comprehensive, individualized service to each consumer.

Sources of information:

1. **ACT leader interview**

- Information about FTE vocational specialist is obtained during the initial review of the staffing.

Item response coding: If the program has at least 10 FTE staff, code the item as a "5." Count all staff, including psychiatrist (exclude 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 consumers who typically do not benefit from usual services. ACT teams are intended for adults with serious mental illness. In addition to these very general criteria, an ACT team should have further admission guidelines tailored to their treatment setting. Examples of more specific admission criteria that might be suitable include:

- Pattern of frequent hospital admissions
- Frequent use of emergency services
- Consumers discharged from long-term hospitalizations
- Co-occurring substance-use disorders
- Homelessness
- Involvement with the criminal justice system
- Not adhering to medications as prescribed
- Not benefiting from usual mental health services (e.g., day treatment)

Rationale: ACT is best suited to consumers who do not effectively use less intensive mental health services.

Sources of Information:

1. **ACT 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 about whether a consumer 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?"
2. **Team member interview:** "How does someone become a consumer of the ACT team?"
3. **Internal records:** Note documentation of application of explicit admission criteria

Item response coding: If the program serves a well-defined population and all consumers meet explicit admission criteria, code the item as a "5."

O2. Intake rate

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

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

Sources of Information:

1. **ACT leader interview**
   - Before the fidelity visit, ask that the ACT leader have a list of the new admissions for the last 6 months.

- "How many new consumers have you taken on, per month, during the last 6 months?"

Item response coding: If the highest monthly intake rate during the last 6 months was no greater than 6 consumers, code the item 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 operating 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:

1. **ACT leader interview**

- Through discussion with the ACT leader, determine which services the team provides and for which services consumers are referred elsewhere. Determine the nature of services the team offers.
- "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% live in a group residence and receive services that generally duplicate what the ACT team would otherwise be doing (e.g., if they are heavily staffed), then count this 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 from another agency, and which do your team provide directly?" (Ask for details on particular services as necessary.)
  - case management
  - medication prescription, administration, monitoring, and documentation
  - counseling/individual supportive therapy
  - housing support
  - substance abuse treatment
  - employment or other rehabilitative services (e.g., ADLs, vocational counseling/support)

2. **Team member interview:** Ask similar questions of the ACT leader.

3. **Consumer interview**

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

Item response coding: The ACT leader is the primary source. If discrepancies exist, follow up. In general, the team should offer these services in proactive, systematic, and inclusive fashion to all consumers. If the team is responsible for 90% or more of each type of services for its consumers, code the item as a "5."

O4. Responsibility for crisis services

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

Rationale: An immediate response can help minimize distress when consumers are faced with crisis. When the ACT team provides crisis intervention, continuity of care is maintained.

Sources of Information:

1. **ACT leader interview**

- "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 a beeper), code the item as a "5." If the team is not the first line of crisis intervention (e.g., they are notified of crises through the general crisis line for the mental health center), a lower score is appropriate. Code as "4" if the crisis line reliably calls the ACT team for any situation beyond routine.

05. Responsibility for hospital admissions

Definition: 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:

1. **ACT leader interview**

- Before the fidelity visit, ask that the ACT leader compile a list of the last 10 hospital admissions. Review each admission with the ACT 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 ACT consumers?"
- "Are any ACT team members in regular contact with the hospital?"
- "Does the ACT team policy differ from the rest of the agency regarding hospital admissions?"

2. **Team member interview**

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

Item response coding: Determine the percentage of admissions in which the ACT team was involved in admissions. If 95% or more of all admissions involved the ACT team, code the item as a "5."

06. Responsibility for hospital discharge planning

Definition: Program 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:

1. **ACT leader interview**

- Before the fidelity visit, ask that the ACT leader compile a list of the last 8-10 hospital discharges. Review each discharge with the ACT leader.
- "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?"
- "What was the percentage of cases in which the ACT team was involved in the decision or planning for discharge of consumers hospitalized in the last year?"
- "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?"

2. **Team member interview:** "How often is the team involved with discharge planning when consumers are 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, code the item a "5."

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:

1. **ACT leader interview**

- Before the fidelity visit, ask that the ACT leader compile a list of consumers who have been discharged from the program within the last 12 months. Review these discharges with the ACT leader.
- "How many of these consumers 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 require intensive services?" [If "yes"] Probe for specifics: what criteria are used, how contact is maintained, etc.

Item response coding: Calculate percentage of consumers discharged. Include only consumers who *graduated* (i.e., whose need for services was reduced); omit from the count any consumers who left because they relocated or dropped out of treatment—these are counted in Item S2.

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, code the item as a "5."

Nature of Services

S1. Community-based services

Definition: Program works to monitor status and develop skills in the community, rather than function as an office-based program.

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 because skills may not transfer well to natural settings. Furthermore, more accurate assessments of consumers can occur in their community setting because the team member can directly observe rather than relying on self-report. Medication delivery, crisis intervention, and networking are more easily accomplished through home visits.

Sources of information:

1. **Chart review** (See *During your fidelity site visit* under *Fidelity assessor checklist* for instructions how to choose charts.)

- Calculate the ratio of community-based visits to the total number of face-to-face contacts for each of the 10 charts reviewed.
- Determine the median value (the average of the 5th and 6th numbers when all values are ranked—see chart review worksheet).
- Remember to use the most complete and up-to-date time period from the chart. Ask the ACT leader, ACT team members, or an administrative person for the most recent but complete period of documentation.
- Review internal reports and documentation, if available.

2. **Team member interview:** "What percentage of your contacts with consumers are in the community and what percentage are in the office?"

3. **Consumer interview**

- "Where do you see people from the ACT team the most?"
- "How often do you go to the ACT office?"

Item response coding: See general instructions at beginning of *Nature of Services* in this 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. Use chart data as a primary data source. If the information from different sources disagrees (for example, if the ACT leader indicates a higher rate of community-based services than the records do), then ask the ACT leader to help you understand the discrepancy. If at least 80% of total service time occurs in the community, code the item as a "5."

S2. No dropout policy

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

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

Sources of information:

1. **ACT leader interview**

Refer to the data from O7 when completing this item. (In advance, ask the ACT leader to provide a list of all consumers discharged in the last 12 months. With the ACT leader, review the rationale for each consumer's discharge.) For this count, exclude consumers who graduated from 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.)

2. **Team member interview**

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

Item response coding:

Formula:

$$\frac{\text{Number of consumers discharged, dropped, moved without referral}}{\text{Total number of consumers}}$$

If 95% or more of the caseload is retained over a 12-month period, code the item 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 help 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:

1. **ACT leader interview**

Ask the ACT leader to think about two to three consumers who have been hard to engage or who have refused services. Review these with the ACT 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?"

2. **Team member interview:** "What happens if consumers say they don't want your services?"

3. **Consumer interview:** "What happens if consumers say they don't want ACT services any more?"

Item response coding: If the program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate, code the item as a "5."

S4. Intensity of service

Definition: High amount of face-to-face service time, as needed.

Rationale: To help consumers with serious symptoms maintain and improve their function within the community, high service intensity is often required.

Sources of information:

1. **Chart review** (See *During your fidelity site visit* under *Fidelity assessor checklist* for instructions how to choose charts)
   - Using the same charts as used for Item S1, 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.
   - From the mean values over a 4-week period, determine the median number of service hours across the sample (average of the 5th and 6th values when the mean service hours per week are ranked—see worksheet). Remember to use the most complete and up-to-date time period from the chart.
   - Ask the ACT leader, team members, or an administrative person for the most recent, but complete, period of documentation.

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

Item response coding: See general instructions at beginning of *Nature of Services* section. In scoring this item, count face-to-face contacts with consumers. Do not count phone calls. Do not count contacts with collaterals or family members.

Ask the ACT leader for the best data source to obtain this information, but the default is chart review, unless the ACT leader can make a case for a better source. If the median value is 2 or more hours per week, per consumer, code the item as a "5."

S5. Frequency of contact

Definition: High amount of face-to-face service contacts, as needed.

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

Sources of information:

1. **Chart review** (See *During your fidelity site visit* under *Fidelity assessor checklist* for instructions how to choose charts.)

- Using the same charts used for Item S1, calculate the mean number of face-to-face consumer-ACT service contacts, per week, over a month-long period.
- From the calculated mean values, determine the median number of service contacts across the sample average of the 5th and 6th values when the mean service contacts per week are ranked). Remember to use the most complete and up-to-date time period from the chart.
- Ask the ACT leader, team members, or an administrative person for the most recent but complete period of documentation.

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

3. **Consumer interview:** "How many times have you seen ACT team members during the past week?"

Item response coding: See general instructions at beginning of *Nature of Services* section. In scoring this item, count face-to-face contacts with consumers. Do not count phone calls. Do not count contacts with collaterals or family members. Ask the ACT leader for the best data source for this information, but the default is chart review, unless he or she can make a case for a better source. If the program averages four or more contacts per week, per consumer, code the item a "5."

S6. Work with informal support system

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

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

Sources of information:

1. **ACT leader interview**
   - Review the consumer roster with the ACT 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 have contact with the consumer's informal network (in cases where there has been contact within the past month)?"
2. **Review of internal reports/documentation, if available.**
3. **Team member interview:** "On average, how often do you work with the family, landlord, employer, or other informal support network members for each consumer?"
4. **Consumer interview:** "How often is there contact between the ACT team and your family? Your landlord? Your employer?"

Item response coding: Use ACT leader as primary data source. Include contacts with family, landlord, and employer; exclude those who are paid to help consumers, 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.

Example:

Suppose 100 consumers are on the team and the team has some contact with the network for 50 consumers. The average contact with this subgroup is 2 contacts a month. Therefore, the rate for the entire caseload is:

$$\frac{2 * 50}{100} = 1 \text{ time per month}$$

If the program makes 4 or more contacts per month, per consumer, code the item 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 consumers with serious mental illnesses; these co-occurring disorders require treatment that directly addresses them.

Sources of information:

1. **ACT 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 consumers' homes, or elsewhere, but it must be more than informal queries or "nagging."
- Ask the nature of the counseling. Ideally, the counseling should follow Integrated Treatment of Co-Occurring Disorders 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 team member who provides this counseling to gauge whether it qualifies as appropriate substance abuse counseling. To count for this item, the interventions must be structured and according to consumers' goals or treatment plan.

- "For each consumer who received substance abuse counseling in the last month, how many sessions did he or 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 who receive 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).

Example:

20 consumers with DD. 10 receive 50-minute counseling sessions every other week

$$\frac{(10 * 100 / 20)}{4} = 12.5 \text{ minutes per week per DD consumer}$$

If ACT team members provide DD counseling in the car and in the course of home visits, then code this more informal contact at level 3 if it roughly meets the time requirement. To score a 4 or 5, a more formal structure than simply counseling embedded within home visits must exist.

S8. Co-occurring 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 consumers with dual disorders.

Sources of information:

1. **ACT 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 are not connected to the ACT team. Only groups led by ACT team members or by team members who are integrated with the ACT team, i.e., have regular contact with the ACT team count.)
- "How many consumers attend these groups?"

2. **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 1 substance abuse tr eatment group meeting during a month, code the item as a "5."

S9. Co-occurring disorders model

Definition: Program uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions between mental illness and substance abuse, and has gradual expectations of abstinence.

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

Sources of information:

1. **ACT 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 use 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."
2. **Team member (substance abuse counselor) interview:** Repeat same questions as above.

Item response coding: Use ACT leader interview as primary data source. If the program is fully based in DD treatment principles, with the team providing treatment, code the item 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 team members on case management teams improves the practice culture, making it more attuned to consumers' perspectives.

Sources of information:

1. **ACT 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 ACT team members? (Alternatively, are they considered aides?)
2. **Team member interview:** Ask similar questions as for ACT leader.
3. **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 psychiatric disorders. If consumers are employed as ACT team members with equal status as other case managers, code the item as "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 or participate in treatment team meetings, for instance, this would likely be coded as a "2.") Also code the item as "2" if the consumer works in a position such as driver or administrative assistant.

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 3 months or more.

For estimates of several of the service items (e.g., S1, S4, S5, and S6), subjective estimates from the ACT leader or case managers are usually not very helpful. Often these staff will say, "It depends."

Written documentation is the primary source for these items. Ask the ACT leader for an opinion about the best data source to obtain this information, but the default is chart review, unless he or she can make a case for a better source.