

Dennis R. Jones
Office of Dixon Court Monitor

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November 2, 2010

Stephen T. Baron, Director
Department of Mental Health
64 New York Avenue NE
Fourth Floor
Washington, DC 20002

Re: Evidence of Compliance with Exit Criterion #11 – Demonstrated Provision of Assertive
Community Treatment (ACT) to Adults with Serious Mental Illness

Dear Mr. Baron,

This letter is in response to your letter of September 2, 2010, which requested that the Court Monitor find that the District has achieved the required performance levels for Exit Criteria #11 and cease active monitoring.

I have reviewed all the relevant documents relating to Exit Criterion #11 and also had the recent opportunity to discuss policy compliance issues with DMH ACT staff. Based on the entirety of my review, I have concluded as follows:

1. As noted in my April 19, 2010 letter, I believe that the DMH has demonstrated a strong commitment to expand the capacity for ACT services. This capacity growth has resulted in an expansion from five (5) ACT teams to eleven (11) – and with a twelfth team in the start-up phase. DMH has exceeded its own performance targets – with 939 consumers enrolled as of August 12, 2010; this number is roughly double the historic levels of ACT services.
2. DMH has made concerted efforts to target high-need consumers. DMH data confirm that 47% of the total referrals for the period of April 1, 2009 – March 31, 2010 come from specific DMH-targeted initiatives or from community-operated homeless services (e.g. Miriam's Kitchen, N Street Village, etc.).
3. DMH has continued to meet and exceed the requirement that 85% of adults (age 18 and over) with serious mental illness who are referred for ACT services will receive ACT services within 45 calendar days. The September 2, 2010 letter documents that DMH has – for the four quarters beginning on April 1, 2009 and ending on March 30, 2010 – accepted and served referrals to ACT at an annualized rate of 86.6%.

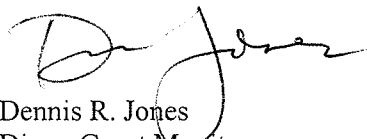
4. DMH has taken specific steps to implement and enforce its December 9, 2009 policy on ACT. DMH has trained 12 staff who have conducted on-site reviews of each ACT team – utilizing the Dartmouth ACT Scale (DACTS). For each of the 28 reviewed ACT areas, teams are required to submit a plan of improvement for any score of 3 or below on a 5-point Likert Scale. DMH has expressly communicated that it reserves the right to suspend referrals or place a provider on probationary status if an ACT team does not show adequate overall quality or fails to demonstrate responsiveness to needed improvements. The fidelity assessments are to be conducted on an annual basis.

As part of the overall annual ACT workplan for FY 2011, DMH has developed several strategies to support and improve the overall quality and consistency of ACT services. These include: a) targeted training for ACT providers in areas that systemically scored lower on the fidelity reviews, b) implement a monthly reporting process for all ACT teams; and c) attend all ACT team-monitoring meetings at least quarterly.

5. DMH has created both internal and external groups that monitor and advise on ACT services. Specifically, DMH has created an internal work group on ACT that meets quarterly and focuses on cross-DMH consistency in monitoring ACT services. An external Advisory Committee likewise meets quarterly and provides community-based input on critical ACT service issues e.g. cultural competence of ACT teams. DMH also meets monthly with all ACT providers to address operational and policy issues.

Based on the above findings, I believe that DMH has met the Court-approved criterion for ACT and should move to inactive monitoring status.

Sincerely,



Dennis R. Jones
Dixon Court Monitor

cc: Anthony Herman, Counsel to the Dixon Plaintiffs
Iris Gonzalez, Counsel to the Dixon Plaintiffs
Grace Graham, Counsel for the District of Columbia
Robert Duncan, Counsel for the Dixon Court Monitor

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH



Office of the Director

September 2, 2010

Dennis R. Jones, Monitor
1111 10th Street, Suite 201
Indianapolis, Indiana 46202

Re: Dixon et al. v. Fenty, et al.
CA No. 74-285 (TFH)
Evidence of Compliance with Exit Criterion #11 – Demonstrated Provision of
Assertive Community Treatment to Adults With Serious Mental Illness

Dear Mr. Jones:

I am pleased to report that DMH has met and exceeded the performance target for Exit Criterion #11 – Demonstrated Provision of Assertive Community Treatment (ACT) to Adults with Serious Mental Illness (“Exit Criterion #11”) for the four quarter period beginning April 1, 2009 and ending March 31, 2010. Accordingly, DMH hereby requests that the Dixon Court Monitor: (1) find that DMH has achieved the performance levels required for Exit Criterion #11; (2) report on the performance levels to the U.S. District Court; and (3) cease active monitoring of Exit Criterion #11.

This letter responds to your letter of April 19, 2010 denying our request to find that the Department of Mental Health (“DMH”) had met the performance target for Exit Criterion #11 and supplements my letters of December 9, 2009, February 4, 2010, February 12, 2010 and February 23, 2010 regarding Exit Criterion #11 and the provision of ACT services in the District of Columbia. In your April 19, 2010 letter, you found that DMH satisfied the performance target requirement to provide ACT services within seven (7) days of referral to over 85% of the adults with SMI referred for the service. However, you also found that DMH had not met the requirement for demonstrating policy compliance. This letter addresses the policy compliance concerns outlined in your April 19, 2010 letter, as well as additional questions you raised during recent meetings with the DMH ACT staff, and to provide current performance data for the period from April 1, 2009 through March 31, 2010 demonstrating continued compliance with the performance target.

ACT Capacity and Referrals of Eligible Individuals

As discussed in my letter of December 9, 2009, DMH has set a goal to continue to increase the capacity of the public mental health system to provide ACT services.¹ To meet this goal, the ACT programs expanded from five (5) ACT teams operated by three (3) providers to eleven (11) ACT teams operated by six (6) providers². DMH memorialized its expansion goal in the annual Performance Management Plan for FY 2009, continued the goal in its Performance Management Plan for FY 2010 and proposes to continue this goal in FY2011. The target for FY 2009 was enrollment of 500 consumers. The target for FY 2010 was enrollment of 650 consumers. The target for FY 2011 is enrollment of 850 consumers. The target for FY 2012 is enrollment of 1,000 consumers.³ As of August 12, 2010, there are 939 consumers enrolled in ACT services, exceeding our goal for FY 2010 and FY 2011.

As you know, ACT is a service that is to be provided to individuals most in need. The expansion of services is intended to ensure that individuals with high needs have access to ACT services. Therefore, we have put in place a number of systemic processes to ensure that those individuals with high needs are routinely assessed for potential referral to ACT. As previously discussed, DMH encourages ACT referrals from a variety of sources whose services are targeted to individuals most in need of high intensity mental health services. These include the DMH's High-Utilizer projects (frequent users of CPEP and inpatient services), the Saint Elizabeths discharge project, the Homeless Outreach Program and community organizations or advocacy organizations, such as Miriam's Kitchen, N Street Village, the New Hope Ministry and University Legal Services.

Analysis of the ACT referral source data for the period from April 1, 2009 – March 31, 2010 shows that 47% of the total referrals for ACT services came from a combination of the DMH processes for identifying consumers eligible for and needing ACT services and various sources outside the public mental health system. Thirty-two percent (32%) came from a combination of the DMH High-Utilizer projects, Saint Elizabeths discharge project or the Homeless Outreach program. An additional fifteen percent (15%) of the referrals came from sources designated as "other." For this reporting period, "other" sources include non-CSAs, such as Miriam's Kitchen, University Legal Services and New Hope Ministry. A chart with detailed information about referral sources is attached for your reference and marked as **Exhibit A**.

To ensure that individuals most in need receive ACT services, LOCUS scores are used by DMH as a qualifier for ACT services. Individuals referred to ACT services must have a LOCUS score

¹ National prevalence data indicated that the District needed to increase its capacity to provide ACT services. DMH also received requests for expanded ACT services from stakeholders, including judges, homeless providers and Saint Elizabeths Hospital staff.

² Current ACT providers are Anchor, Community Connections, Green Door, Family Preservation, Hillcrest, Pathways to Housing. A twelfth team, operated by Capital Community Services is in start-up.

³ A copy of DMH's FY 2010 Performance Management Plan is available on the District's website (www.dc.gov). Click on the CapStat link. The Key Performance Indicators, including the indicator for ACT capacity are included in the annual Performance Management Plan and include performance targets for FY 2011 and FY 2012.

of 20 – 22 or higher to initially receive ACT services. *See* DMH Policy 340.6A, para. 5d. However, a LOCUS score alone does not qualify an individual for ACT services, nor are CSA's required to refer all individuals with a LOCUS score between 20 -22 to ACT. As you know, DMH has implemented a web-based LOCUS/CALOCUS application, which will facilitate analysis of LOCUS data for a variety of quality improvement purposes, including an overall evaluation of the level of services provided to all individuals in comparison to LOCUS scores. DMH is working with providers to fully adopt the use of the web-based application, so that data about LOCUS scores and level of services provided, including ACT, can be examined in the aggregate by program staff.

ACT Fidelity

On November 7, 2007, DMH adopted Policy 340.6, Provision of Assertive Community Treatment (ACT) to Adult Consumers. *See* January 2008 Report to the Court, page 10. In 2009, DMH amended the 2007 policy by incorporating the practice guidelines and standards already implemented and in use by DMH and MHRS providers in the provision of ACT services. The Dartmouth ACT Scale ("DACTS"), used to conduct fidelity assessments of ACT teams, was formally adopted in the 2009 policy but had already been in use since the 2008 ACT fidelity assessments. *See* DMH Policy 340.6A.

DMH has developed and implemented a program of annual fidelity assessments for each ACT team, using the DACTS fidelity tool (described below). This process began in 2008, when the New York State ACT Institute was contracted to conduct baseline fidelity assessments of the then existing five (5) ACT teams.⁴ The DACTS was used to conduct the assessment and the FY 2008 fidelity assessment and subsequent activities contributed to the development of the FY 2010 ACT work plan which addressed quality improvement strategies, reporting structures and the development of an internal DMH Fidelity Assessment team.

As DMH moved the ACT fidelity assessments internally to DMH staff, we contracted with the ACT Center of Indiana to provide training to all ACT Team Leaders and the DMH Fidelity Assessment Team⁵ in March 2010. In March 2010, the DMH Fidelity Assessment team began conducting fidelity assessments using the DACTS.

The DACTS is a twenty-eight (28) item scale that assesses the degree of fidelity to the ACT model along three (3) categories: Human Resources (caseload ratios, staffing patterns, team member specialties etc.), Organizational Boundaries (admission criteria, responsibility for admission and discharge from inpatient facilities, team admissions and discharges etc.) and Nature of Services (e.g. services provided in the community, intensity of services, frequency of contact etc.). A copy of the DACTS scoring protocol is attached for your reference and marked

⁴ In FY 2008, ACT teams were operated by three (3) providers: the District of Columbia Community Services Agency ("DCCSA"), Family Preservation and Pathways to Housing.

⁵ The DMH Fidelity Assessment team includes the ACT Coordinator and Adult Systems of Care Manager, as well as representatives from the Integrated Care Division, the Office of Accountability and Provider Relations.

as **Exhibit B**. A copy of a chart containing detailed DACTS scoring by provider and domain is attached for your reference and marked as **Exhibit C**.

Each ACT team received a report about the results of the fidelity assessment. A sample report is attached for your reference and marked as **Exhibit D**. The results were discussed with each ACT team either during a meeting or via conference call. Each ACT team submitted a performance improvement plan for those domains scored three (3) or less as required by DMH.

The ACT coordinator and Adult Systems of Care Manager reviewed each performance improvement plan and gave feedback to each provider. Each ACT provider is required to prepare and submit monthly updates on the status of implementation of its performance improvement plan to the ACT Coordinator and Adult Systems of Care Manager.

In addition, the FY 2011 ACT workplan includes a number of activities which will support improving fidelity scores across teams. The FY 2011 work plan for ACT focuses on five (5) areas identified as needing system-wide improvement based upon the results of the fidelity assessment. Those five (5) areas are: (1) supported employment (H10); (2) co-occurring disorders (H9, S7 and S9); (3) participation of peer specialists on ACT teams (S10); (4) staff retention (H5) and (5) dual diagnosis groups (S8). The provision of dual disorder treatment groups requires the establishment of an ACT group billing rate and this process is underway and anticipated to be in place in early FY 2011.

In order to assist the ACT teams to improve services in preparation for the next fidelity assessment, the ACT Coordinator and Adult Systems of Care Manager will develop training and consultative opportunities for those ACT staff providing specialized services in the area of supported employment and co-occurring disorders. This training will occur throughout FY 2011. In addition, there will be two ACT Core Trainings in the Fall FY 2011 (September 15 and a date in late October/Early November) and two in the Spring/Summer of FY 2011. A copy of the FY 2011 ACT work plan is attached for your reference and marked as **Exhibit E**.

ACT Oversight

The Adult Systems of Care Manager and ACT Coordinator have been working with multiple stakeholders ensure that the ACT teams provide quality services to ACT consumers. DMH has three active groups that have distinct responsibilities in ensuring that District residents have access to high functioning ACT programs. These are:

- (1) **The ACT Workgroup.** This is an internal DMH workgroup that focuses primarily on quality issues. Members include representatives from Provider Relations, the Integrated Care Division, Office of Accountability, Access Helpline and the Comprehensive Psychiatric Emergency Program. Each program interacts with the ACT Providers. The ACT Workgroup provides a forum for sharing information between the different divisions to support comprehensive monitoring and oversight of the ACT providers and meets quarterly. The ACT

Workgroup has reviewed the results of the recent fidelity assessment. A copy of the minutes from the July 13, 2010 meeting is attached for your reference and marked as **Exhibit F**.

(2) **ACT Advisory Committee.** The ACT Advisory Committee continues to meet quarterly. The committee includes representatives from each of the ACT providers, advocates and consumers. The primary purpose of the group is to provide feedback to the ACT providers from primary consumers and organizations who serve individuals with complex needs. For example, members of the ACT Advisory Committee have raised concerns about ACT services for forensic consumers. The ACT Advisory Committee has advocated for DMH to develop a Forensic ACT team (FACT) team in the District and in the short term designating members of each ACT team to concentrate on consumers with forensic issues. Another issue of concern is the present cultural and language capability of the ACT teams.

Recently, the ACT Advisory Committee voiced concerns about consumers who have or will be transitioning (from one ACT team to another ACT Team, from the ACT team to the traditional Community Support Team, or relocating from the District to another jurisdiction). The committee wanted to know how this is being done and monitored to ensure a successful transition.⁶

(3) **The ACT Provider Workgroup.** This group is comprised of the certified ACT providers and meets monthly to discuss ACT operational issues. Topics discussed include: the quality of ACT Services; and improving relationships with the inpatient providers, CPEP and local social service organizations. Difficult and challenging cases are reviewed and discussed with the group, to promote problem-solving while enhancing and promoting the delivery of quality services. Training continues to be a concern for the ACT providers, so the Adult Systems of Care Manager and the ACT Coordinator are working with the Training Institute to develop and offer training on Motivational Interviewing and Integrated Dual Disorders Treatment.

During your August 12, 2010 meeting with the ACT staff, you asked about the process for resolving complaints about ACT. Complaints about ACT are referred to Eugene Wooden and Michele May, who identify a plan of action. When these issues appear to be system related problems, they are addressed at the appropriate level. For example, a complaint was received that a consumer no longer wanted to receive ACT services, although his treatment team felt that

⁶ DMH requires the ACT team to schedule a formal meeting to discuss the transition and ensure that transitional planning is completed. Generally a shared caseload is implemented for thirty (30) days, so the teams involved in transition (both the transferring team and the receiving team) can work with each other to ensure a smooth transition. If a consumer is relocating out of the District, DMH works with the new jurisdiction to arrange connection with a local mental health provider.

the level of care was necessary. Mr. Wooden convened a meeting with the consumer, the consumer's advocate, the CSA and the ACT team to discuss and resolve the issue.

In addition, DMH has the authority to intervene if there are performance concerns. DMH's Deputy Directors of Programs and Accountability are responsible for making those determinations. In the past, we have exercised this level of authority in suspending new admissions for several months with one provider. DMH worked closely with the provider on its ACT services until the quality of services was acceptable, at which time new referrals were allowed.

ACT Action Plans and Organizational Plans

As discussed in my letter of December 9, 2009 and above, DMH adopted the DACTS as part of the revision of its ACT Policy. *See* DMH Policy 340.6A. Generally, DMH requires providers to submit a plan of action that describes how they plan to implement new or revised policies. Since the fidelity assessment process was scheduled to begin in March 2010 (approximately 90 days after the issuance of the revised ACT Policy), DMH did not require providers to submit a plan of action because the fidelity assessment was expected to identify specific areas requiring improvement. As discussed above, each provider is required to submit a plan of improvement to address the results of the fidelity assessment. Those plans will be used to ensure compliance with applicable policy, as well as the DACTS scale.

The MHRS certification regulations require each ACT provider to adopt an ACT Organizational Plan. *See* 22-A DCMR Section 3423.8. The ACT Organizational Plans are required to include three (3) specific elements: (1) a description of the particular treatment models utilized, types of intervention practice, and typical daily curriculum and schedule; (2) a description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and (3) a description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

The Adult Systems of Care Manager and ACT Coordinator have reviewed the ACT Organizational Plans for all the certified ACT providers that are on file with the Office of Accountability. The ACT Organizational Plans vary in the description of service delivery and implementation. To improve consistency of service delivery, the Adult Systems of Care Manager, ACT Coordinator and staff from the Office of Accountability are developing a new format for the ACT Organizational Plans, which will be implemented as each provider is newly certified or recertified. The timeframe for ACT provider recertification is attached for your reference and marked as **Exhibit G**.

Performance Data.

DMH has achieved and exceeded the 85% performance target required by Exit Criterion #11 since January 2009 (six consecutive quarters). Most recently, DMH achieved an 86.6%

performance level for the four (4) quarter period beginning on April 1, 2009 and ending on March 31, 2010. A chart showing the performance level by quarter is set forth below:

EXIT CRITERIA #11 – ASSERTIVE COMMUNITY TREATMENT⁷					
PERFORMANCE TARGET: 85.00%					
	FY 09 Q3	FY09 Q4	FY10 Q1	FY 10 Q2	TOTAL
ACT SERVICE PROVIDED⁸	92	60	75	78	305
ACT AUTHORIZED⁹	102	69	84	97	352 ¹⁰
PERFORMANCE LEVEL	90.1%	86.9%	89.2%	80.4%	86.6%

Conclusion

DMH has demonstrated its commitment to the provision of ACT services throughout the District, in accordance with the DACTS model. As discussed above, DMH has fully implemented a system for addressing the policy compliance concerns raised in your April 19, 2009 letter. DMH has met and exceeded the performance target for Exit Criterion #11 for the four quarter period beginning April 1, 2009 and ending March 31, 2010. Accordingly, DMH hereby requests that the Dixon Court Monitor: (1) find that DMH has achieved the performance levels required for Exit Criterion #11; (2) report on the performance levels to the U.S. District Court; and (3) cease active monitoring of Exit Criterion #11.

If you have any questions or wish to discuss this matter further, please feel free to call me.

Sincerely,



Stephen T. Baron
Director

Cc: Anthony Herman, Counsel to the Dixon Plaintiffs
Grace Graham, Counsel for the District of Columbia

⁷ The Exit Criteria Order defines the performance target for this exit criterion as “the number of adults (aged 18 and over) with serious mental illness served within the reporting period who received assertive community treatment within 45 days of referral as a percentage of all adults with serious mental illness referred for assertive community treatment during the reporting period.” For purposes of the calculation, DMH uses the definition of serious mental illness included in the operational definition of Exit Criterion #7 (a primary mental health diagnosis of 295-297.1, 298.9, 300.4, 309.81, or 311).

⁸ Based upon submitted claims approved for payment as of June 24, 2010.

⁹ The number of persons who satisfied the requirements for authorization to receive ACT services.

¹⁰ See footnote #6 above.

EXHIBIT A

EXHIBIT A
ACT REFERRAL SOURCE DATA

April 1, 2009 - March 31, 2010

REFERRING PROVIDER	FY 09 Q3	FY 09 Q4	FY 10 Q1	FY 10 Q2	TOTAL REFERRALS
Anchor	0	10	21	7	38
Community Connections	64	41	33	40	178
Family and Child	0	3	0	0	3
Family Preservation	1	1	2	3	7
Fihankra	0	0	0	1	1
Green Door	20	7	9	10	46
Hillcrest	0	0	0	3	3
Latin American Youth	0	0	0	1	1
Life Stride	0	1	3	0	4
DC CSA/Mental Health Services Division	7	1	2	1	11
McClendon Center	2	0	12	8	22
Other ¹	14	15	13	21	63
Pathways to Housing	0	0	0	0	0
Psychiatric Center Chartered	0	1	0	0	1
Scrupes	1	0	0	0	1
Universal	0	1	0	1	2
Washington Hospital Center ²	10	7	9	11	37
TOTAL	119	88	104	107	418³
OTHER REFERRALS AS A PERCENTAGE OF TOTAL	12%	17%	12%	20%	15%

¹ Other referral sources during this reporting period include the inpatient psychiatric units at the George Washington University Medical Center, the Georgetown Hospital, Sibley and Washington Hospital Center; the Georgetown Ministry for the Homeless, Rachel's Women's Center, Father McKenna Center, University Legal Services, Christ House, N Street Village, Miriam's Kitchen and the New Hope Ministry.

² Washington Hospital Center also operates the New Directions Program, which is an initiative focusing on transitioning long term patients from Saint Elizabeths Hospital to the community.

³ ACT admission criteria do not mandate that a consumer have a serious mental illness as a pre-requisite to receipt of ACT services. Consumers referred for ACT are required to meet certain functional criteria and may have a deferred diagnosis (799.9) or a non-SMI diagnosis at the time of referral. Therefore, the total number of referrals to the ACT program may differ from the number of referrals included in the calculation of the performance measure for Dixon Exit Criterion 11, which requires the inclusion of only consumers with a specified SMI diagnosis at the time of referral.

REFERRING DMH INITIATIVE	FY 09 Q3	FY 09 Q4	FY 10 Q1	FY 10 Q2	TOTAL REFERRALS
High Utilizers	14	8	2	14	38
CPEP High Utilizers	8	7	6	10	31
Saint Elizabeths Discharge Project	5	8	6	12	31
Homeless Outreach Program	10	12	7	8	37
TOTAL REFERRALS FROM SPECIFIC DMH INITIATIVES	37	35	21	44	137
TOTAL REFERRALS	119	88	104	107	418
REFERRALS AS A PERCENTAGE OF TOTAL	31%	40%	20%	41%	32%

EXHIBIT B

**Protocol for Assertive Community Treatment Fidelity Scale
(Dartmouth Assertive Community Treatment Scale – DACTS)**

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

- 1) Introduction:** This gives an overview of ACT and a who/what/how of the scale. Plus there is a checklist of suggestions for before, during, and after the fidelity assessment that should lead to the collection of higher quality data, more positive interactions with respondents, and a more efficient data collection process.
- 2) Item-Level Protocol:** The protocol explains how to rate each item. In particular, it provides:
 - a) A *definition* and *rationale* for each fidelity item. These items have been derived from a comprehensive review of evidence-based literature.
 - b) A list of *data sources* most appropriate for each fidelity item (e.g., chart review, clinician interview, team meeting observation).
 - c) Where appropriate, a set of *probe questions* to help elicit the critical information needed to score the fidelity item. These probe questions were specifically generated to help you collect information from respondents that is free from bias such as social desirability.
 - d) *Decision rules* that will help you correctly score each item. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.
- 3) Cover sheet:** This form obtains background information about the study site. The data are not used in determining fidelity, but provide important information for classifying programs, such as size and duration of program, type of parent organization, and community characteristics.
- 4) Worksheets and Summary Table:** These sheets can be used or adapted for tallying the chart review.
- 5) Score Sheet:** The sheet provides instructions for scoring, including how to handle missing data; plus cut-off scores for full, moderate, and inadequate implementation.

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.

Assertive Community Treatment (ACT) Fidelity Scale: Introduction

ACT Overview

As an evidence-based psychiatric rehabilitation practice, ACT provides a comprehensive approach to service delivery to consumers with severe mental illness (SMI). ACT uses a multidisciplinary team, which typically includes a psychiatrist, a nurse, and at least two case managers. ACT is characterized by (1) low client to staff ratios; (2) providing services in the community rather than in the office; (3) shared caseloads among team members; (4) 24-hour staff availability; (5) direct provision of all services by the team (rather than referring consumers to other agencies); and (6) time-unlimited services.

Overview of the Scale

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

What Is Rated

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

Unit of Analysis

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

How the Rating Is Done

To be valid, a fidelity assessment should be done in person, i.e., through a site visit. The fidelity assessment requires a minimum of 6 hours to complete, although a longer period of assessment will offer more opportunity to collect information; hence, it should result in a more valid assessment. The data collection procedures include chart review, team meeting observation, home visits, and semi-structured interview with the team leader. Clinicians who work on the ACT teams are also valuable sources of data; most frequently the assessors obtain this information when accompanying them on home visits. Data may be obtained through other sources (e.g., supervisors, consumers) as appropriate.

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

For some items that require chart review for rating, the intent is to use charts selected at random. Some processes for randomly selection are suggested below; assessors should feel free to use whatever method is most convenient or practical for the particular visit.

- Prior to site visit, request the team leader select 20 charts for review; from these 20 charts, assessors select 10 at random.
- Center provides a de-identified list of clients (i.e., ID numbers) and the assessors use random selection to choose 10.

- It is important to select the most representative sample of charts; if a team assigns clients to different levels of service intensity, the sample should reflect this (e.g., a team with 30% of its clients on Level 1, 60% of clients on Level 2, and 10% on Level 3, 30% of reviewed charts should come from Level 1 clients, 60% of reviewed charts from Level 2, and so on).

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 clients during the last six months. Assessors should prorate time frames for teams that have been in operation for a shorter amount of time than specified in the individual items. (Specific instructions given for pertinent items.)

How to Rate Programs Using Other Program Models

The DACTS is designed to assess programs following the ACT model. If a case management or other program is rated on the DACTS, some items do not apply. This protocol does not cover every possible case of program model. In most instances, if an item cannot be rated, the assessor should assign a value of "1" for that item.

Who Does the Ratings

The scale can be administered internally by an agency/program or by an external review group. If it is administered internally, it is obviously important for the ratings to be made objectively, based on hard evidence, rather than made to "look good." Circumstances will dictate decisions in this area, but we encourage agencies to choose a review process that fosters objectivity in ratings, e.g., by involving a staff person who is not centrally involved in providing the service. With regard to external reviews, there is a distinct advantage in using assessors who are familiar with the program, but at the same time are independent. The goal in this process is the selection of objective and competent assessors.

Fidelity assessments should be administered by individuals who have experience and training in interviewing and data collection procedures (including chart reviews). In addition, raters need to have an understanding of the nature and critical ingredients of ACT. We recommend that all fidelity assessments be conducted by at least two raters in order to increase reliability of the findings.

Missing Data

The scale is designed to be filled out completely, with no missing data on any items. It is essential that raters obtain the required information for every item. It is critical that raters record detailed notes of responses given by the interviewees. If information cannot be obtained at time of the site visit, it will be important for the raters to collect it at a later date.

Fidelity Assessor Checklist

Before the Fidelity Site Visit:

- 0 *Review the sample cover sheet.* This sheet is useful for organizing your fidelity assessment, identifying where the specific assessment was completed, along with general descriptive information about the site. You may need to tailor this sheet for your specific needs (e.g., unique data sources, purposes for the fidelity assessment).
- 0 *Create a timeline for the fidelity assessment.* Fidelity assessments require careful coordination of efforts and good communication, particularly if there are multiple assessors. Therefore, it may be useful to list all the necessary activities leading up to and during the visit. For instance, the timeline might include a note to make reminder calls to the program site to confirm interview dates and times.
- 0 *Establish a contact person at the program.* You should have one key person who arranges your visit and communicates beforehand the purpose and scope of your assessment to program staff. Typically this will be the ACT team leader. Exercise common courtesy in scheduling well in advance, respecting the competing time demands on clinicians, etc.
- 0 *Establish a shared understanding with the site being assessed.* It is *essential* that the fidelity assessment team communicates to each program site the goals of the fidelity assessment; assessors should also inform the program site about who will see the report, whether the program site will receive this information, and exactly what information will be provided. The most successful fidelity assessments are those in which there is a shared goal among the assessors and the program site to understand how the program is progressing according to evidence-based principles. If administrators or line staff at the study site fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised. The best agreement is one in which all parties are interested in getting at the truth.
- 0 *Indicate what you will need from respondents during your fidelity visit.* In addition to the purpose of the assessment, you will need to briefly describe what information you will need, who you will need to speak with, and how long each interview or visit will take to complete. The fidelity visit will be most efficient if the team leader gathers in advance as much as possible of the following information:
 - o Roster of ACT staff – (roles, full-time equivalents (FTEs))
 - o Staff vacancies each month for last 12 months (or as long as program has existed, if less than 12 months)
 - o Number of staff who have left the team over the last two years (or since program started if less than two years old)
 - o A written description of the team's admission criteria
 - o Roster of ACT clients
 - o Number of clients with dual disorders
 - o Number of clients admitted to ACT program, per month, for last six months
 - o How many clients have terminated from the program in the last year, broken down in these categories:
 - Graduated (left because of significant improvement)
 - Left town
 - Closed because they refused services or team cannot find them
 - Deceased
 - Other (explain)
 - o List of the last 10 clients admitted to psychiatric hospital
 - o List of the last 10 clients discharged from psychiatric hospital
 - o Number of clients living in supervised group homes
 - o Number of clients for whom the ACT team contacts their informal support network (e.g., family member, landlord, etc.) at least once. (Helpful for team leader to have a list of names at the time of interview.)

Note: Reassure the team leader that you will be able to conduct the fidelity assessment even if not all of the above information is available. You should indicate that some information is more critical (e.g., staffing and number of active clients).

- 0 *Inform the contact person that you will need to observe at least one team meeting during your visit.* This is an important factor in determining when you should schedule your assessment visit to the program.
- 0 *Alert your contact person that you will need to sample 20 charts.* It is preferable from a time efficiency standpoint that the charts be drawn beforehand, using a random selection procedure. Obviously, a program can falsify the system by hand picking charts and/or updating them right before the visit. If there is a shared understanding that the goal is to better understand how a program is implementing services, this is less likely to occur.

During Your Fidelity Site Visit:

- 0 *Tailor terminology used in the interview to the site.* For example, if the site uses the term “member” for consumer, use that term. If “practitioners” are referred to as clinicians, use that terminology. Every agency has specific job titles for particular staff roles. By adopting the local terminology, the assessor will improve communication.
- 0 *During the interview, record the names of all relevant programs, the total number of consumers, and the total number of clinicians.*
- 0 *Obtain a random sample of charts:*
 - For the chart review, select 10 charts at random. One appropriate method is to examine the roster of client names. Divide the number of clients by 10 and round down. Suppose there are 65 clients, then the number would be 6. Starting at an arbitrary name, select every 6th name on the roster.
 - If the caseload is known to be stratified, for example if the team uses a level of care system in which every client is classified, and if this level of care is related to intensity of services, then a preferred sampling method is to stratify the sample according to the level of care. Example: Suppose the team has 50 Level 1, 30 Level 2, and 20 Level 3 clients. Then select 5 Level 1, 3 level 2, and 2 level 3 clients, using a random sampling strategy.
 - In some cases, there may be a lag between when a service is rendered and when it is documented in the client’s chart. When sampling chart data, try to gather data from the most recent time period where documentation is completed in full to get the most accurate representation of services rendered. The most up-to-date time period might be ascertained by asking the team leader, clinicians, or administrative staff. The point is to avoid getting an inaccurate sampling of data where office-based services (e.g., nurses visits or weekly groups) might be charted more quickly than services rendered in the field (e.g., Case manager progress notes).
- 0 *If discrepancies between sources occur, query the team leader to get a better sense of the program’s performance in a particular area.* The most common discrepancy is likely to occur when the Team leader interview gives a more idealistic picture of the team’s functioning than do the chart and observational data. For example, on item S1, the chart review may show that client contact takes place largely in the office; however, the team leader may state that the clinicians spend the majority of their time working in the community. To understand and resolve this discrepancy, the assessor may say something like, “Our chart review shows xx% of client contact is office-based, but you estimate the contact at yy%. What is your interpretation of this difference?”
- 0 *Before you leave, check for missing data.* It is a good idea to check in with the program leader at the end of the visit to review and resolve any discrepancies if possible.

After Your Fidelity Site Visit:

- 0 If necessary, *follow up on any missing data* (e.g., by phone calls or email to the program site). This would include a discussion with the team leader about any discrepancies between data sources that arise after the visit has been completed.
- 0 Assuming there are two assessors, *both should independently rate the fidelity scale*. The assessors should then compare their ratings and resolve any disagreements. Come up with a consensus rating.
- 0 *Tally the item scores and determine which level of implementation was achieved* (See Score Sheet).
- 0 *Send a follow-up letter to the site*. In most cases, this letter will include a *fidelity report*, explaining to the program their scores on the fidelity scale and providing some interpretation of the assessment, highlighting both strengths and weaknesses. The report should be informative, factual, and constructive. The recipients of this report will vary according to the purposes, but would typically include the key administrators involved in the assessment.
- 0 If the fidelity assessment is given repeatedly, it is often useful to *provide a visual representation of a program's progress over time* by graphing the total fidelity scale using an EXCEL spreadsheet, for example. This graph may be included in the fidelity report.

ITEM DEFINITIONS, RATIONALES, AND SCORING

Human Resources: Structure and Composition

H1. Small Caseload

Definition: Client/clinician ratio of 10:1

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

Sources of Information:

a) 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 work on the ACT team?"*
- *"How many consumers are currently served by the team?"*

In counting the current caseload, include all "active" clients. The caseload totals should include any client 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.

b) Agency documents

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

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

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

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

Special case: Do not count staff 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; clinicians know and work with all clients.

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

Sources of Information:

✦ a) Chart review

- Review charts for 10 randomly selected clients. 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 client during this time. Determine the percentage of clients who have seen more than one team member in the two-week period.

b) Team leader interview

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

c) Clinician interview

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

d) Client 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?"*

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

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

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

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

H3. Program Meeting

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

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

Sources of Information:*act team calendar***a) Team leader interview**

- "How often does the ACT team meet as a full group to review services provided to each client?"
- "How many clients are reviewed at each meeting?"

b) Internal documentation

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

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

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

Sources of Information:**a) Team leader interview**

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

b) 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 JCAHO 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 clients and providers.

Sources of Information:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader have available a list of all employees over past two years (or for the duration of the existence of the program)
- *"What is the total number of staff positions on the ACT team?"*
- *"Name the team members who have left in the past two years."* [if the team has been in existence for a shorter period, use the formula below to adjust for the shortened time frame].

Item Response Coding:

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

EXAMPLES: There were 20 staff workers who occupied the 9 line positions at West over 24 months, compared with 7 staff workers for 5 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 staff 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 they technically remain in their position.

H6. Staff Capacity

Definition: Program operates at full staffing.

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

Sources of Information:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader have available a list of unfilled positions for each month over past year (or for the duration of the existence of the program)

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

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

FORMULA:

$$100 * (\text{SUM OF \# VACANCIES EACH MONTH}) / (\text{TOTAL \# STAFF POSITIONS} \times 12)$$

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, 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.

for new team look for vacancy

H7. Psychiatrist on staff

Definition: Per 100 clients, at least one 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:

a) Team leader interview

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

b) Clinician interview

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

c) Client interview

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

Item Response Coding:

FORMULA: $[(\text{FTE value} \times 100) / \text{\# clients served}] = \text{FTE per 100 clients}$

EXAMPLES:

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

WEST: $[(.75 * 100) / 50] = 1.5$ FTE psychiatrist → item coded as a “5”

SOUTH: $[(.75 * 100) / 120] = .63$ FTE psychiatrist → item coded as a “3”

If information across sources is not consistent, the assessor should ask for clarification during the team leader interview or make follow-up contact with the program. As with all scale items, the rating should be based on the most credible evidence available to the assessor (e.g., even if the psychiatrist is reported as 1.0 FTE to a 100-person ACT team, if the clients and clinicians consistently report that she is unavailable for consultation, a lower score on this item is likely appropriate).

If at least one full-time psychiatrist is assigned directly to a 100-client program, the item is coded as a “5.”

NOTE FOR ITEMS H8-H11: PROGRAMS DO NOT RECEIVE CREDIT FOR HAVING SPECIALISTS ON STAFF (e.g., RN, substance abuse or vocational specialists) IF THE PERSON ASSIGNED TO THAT POSITION IS ON LEAVE AT THE TIME OF THE FIDELITY VISIT AND HAS BEEN ON LEAVE FOR 3 MONTHS OR MORE.

H8. Nurse on staff

Definition: At least two full-time nurses are assigned to work with a 100-client 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:**a) Team leader interview**

- Information regarding FTE RNs is obtained during the initial review of the staffing.
- Calculate the FTE nurse time per 100 clients (see formula, below)

b) Clinician interview

- “What is the nurse(s)’ role on the team?”
- “Does he/she come to meetings?”
- “Is she/he readily accessible?”
- “Does the nurse ever have responsibilities (or clients) outside the ACT team?”

c) Client interview

- “How often do you see the team nurses?”

Item Response Coding:

FORMULA: $[(\text{FTE value} \times 100) / \# \text{ clients served}] = \text{FTE per 100 clients}$

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

If two full-time nurses or more are members of a 100-client program, the item is coded as a "5."

H9. Substance abuse specialist on staff

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

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

Sources of Information:**a) Team leader interview**

- Information regarding FTE substance abuse specialists is obtained during the initial review of the staffing.
- Regarding each substance abuse specialist, determine if each has at least one year of training and/or experience in substance abuse treatment.
- Calculate the FTE substance abuse specialist time per 100 clients (see formula, below)

Item Response Coding:

FORMULA: $[(\text{FTE value} \times 100) / \# \text{ clients served}] = \text{FTE per 100 clients}$

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.

If two FTEs or more with one year of substance abuse training or supervised substance abuse treatment experience are assigned to a 100-client program, the item is coded as a "5."

H10. Vocational specialist on staff

Definition: Program includes at least one staff member with at least one 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 clients to find and keep jobs in integrated work settings.

Sources of Information:

a) Team leader interview

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

Item Response Coding:

FORMULA: $[(\text{FTE value} \times 100) / \# \text{ clients served}] = \text{FTE per 100 clients}$

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

If, for a 100-client program, two FTEs or more with one year vocational rehabilitation training/supervised experience were assigned, 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 client.

Sources of Information:**a) Team leader interview**

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

Item Response Coding: If the program has at least 10 FTE staff, the item is coded 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 the individuals who typically do not benefit from usual services. ACT teams are intended for adults with severe mental illness. 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 might be suitable include:

- Pattern of frequent hospital admissions
- Frequent use of emergency services
- Individuals discharged from long-term hospitalizations
- Co-occurring substance use disorders

- Homeless
- 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 clients who do not effectively use less intensive mental health services.

Sources of Information:

a) Team leader interview

- *“Does your ACT team have a clearly defined target population with whom you work?”*
- *“What formal admission criteria do you use to screen potential clients?”*
- *“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 clients onto your team?”*
- *“What recruitment procedures do you use to find clients for the ACT team?”*
- *“Do you have some ACT clients who you feel do not really need the intensity of ACT services?”*

b) Clinician interview

- *“How does an individual become a client of the ACT team?”*

c) Internal records

- Note documentation of application of explicit admission criteria

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

O2. Intake rate

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

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

Sources of Information:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader have a list of the new admissions for the last six months.
- *“How many new clients have you taken on, per month, during the last six months?”*

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

O3. Full responsibility for treatment services

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

Rationale: Clients 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 client.

Sources of Information:

a) Team leader interview

- Through discussion with the team leader, determine which services are provided by the team, and for which services clients are referred elsewhere. Determine the nature of services offered by the team.
- *“Do your clients see other psychiatrists outside of the ACT team?”*
- *“Do some clients receive case management services from their residences?”*
- *“Do any clients live in supervised group homes? If yes, how many? What is the nature of the case management/rehabilitation services?”* [If more than 10% are living in a group residence and receiving services that generally duplicate what the ACT team would otherwise be doing – e.g., if they are heavily staffed, then this should be counted as brokered residential services.]
- *“What percentage of clients receives additional (non-ACT) case management services?”*
- *“I am going to read you a list. Which of the following services do your clients receive from another department within your agency (or to another agency), and which do your team provide directly?”* (Query for details on particular services as necessary)
 1. case management
 2. medication prescription, administration, monitoring, and documentation
 3. counseling/individual supportive therapy
 4. housing support
 5. substance abuse treatment
 6. employment or other rehabilitative services (e.g., ADLs, vocational counseling/support)

b) Clinician interview:

- Ask similar questions as for team leader

c) Client interview.

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

Item Response Coding: Team leader is the primary source. If there are discrepancies, follow up. In general, the team should offer these services in proactive, systematic, and inclusive fashion to all clients. If the team is responsible for 90% or more of each of these types of services for its clients, the item is coded 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 persons with severe mental illness are faced with crisis. When the ACT team provides crisis intervention, continuity of care is maintained.

Sources of Information:

a) Team leader interview

- *"What 24-hour emergency services are available for ACT clients?"*
- *"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." 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 crisis line reliably calls ACT team for any situation beyond routine.

O5. 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:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader compile a list of the last 10 hospital admissions. Review each admission with the team leader.
- *"What happened on this admission (i.e., describe the process as it involves the ACT team)?"*
- *"Was the team aware of the admission in advance?"*
- *"In general, what role does the ACT team play in the decision to hospitalize an ACT client?"*
- *"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?"*

b) Clinician interview

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

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

O6. Responsibility for hospital discharge planning

Definition: Program is involved in planning for hospital discharges.

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

Sources of Information:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader compile a list of the last 8-10 hospital discharges. Review each discharge with the team 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?"*
- *"For clients 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?"*

b) Clinician interview.

- *"How often is the team involved with discharge planning when a client 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."

O7. Time-unlimited services/Graduation rate

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

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

Sources of Information:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader compile a list of clients who have been discharged from the program within the last 12 months. Review these discharges with the team leader.

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

Item Response Coding: Calculate percentage of clients discharged; include only clients who “graduated” (i.e., whose need for services became reduced—omit from the count any clients who left due to relocation or dropping out of treatment – these are counted in Item S2). The intent of this item is to gauge the program philosophy about graduation. If all clients 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”.

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 clients 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 client 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:

a) Chart review (See “During Your Visit” on Page 7 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 rank-ordered – see chart review worksheet). 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.

b) Review of internal reports/documentation, if available.

c) Clinician interview

- *“What percentage of your contacts with clients are in the community and what percentage are in the office?”*

d) Client 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 Services Section. In scoring this item, count face-to-face contacts with clients. 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 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.”

S2. No dropout policy

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

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

Sources of Information:

a) Team leader interview

- The data from O7 should be referenced when completing this item. [In advance, ask team leader to provide a list of all client discharged in the last 12 months. Review with team leader the rationale for each person’s discharge.] For this count, exclude individuals who graduated the program (See Item O7). Count people who have dropped out, i.e., refused services, cannot be located, or have been closed because the team determined that they could not serve them. Also include those who have left the geographic area IF the ACT team did not provide referrals for services for continuing care in the new location.
- *“How many clients dropped out during the last 12 months?”*
- *“For the clients 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.]

b) Clinician interview.

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

Item Response Coding:

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

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

Sources of Information:**a) Team leader interview**

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

b) Clinician interview.

- *“What happens if a client says he or she doesn’t want your services?”*

c) Client interview

- *“What happens if a person says they don’t want ACT services anymore?”*

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

S4. Intensity of service

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

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

Sources of Information:**a) Chart review (See “During Your Visit” on Page 7 for instructions how to choose charts)**

- Using the same charts as used for Item S1, calculate the mean amount of service hours per client, per week, over a month-long period. (If applicable, the charts should proportionately represent the number of clients 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 rank-ordered – see worksheet). 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.

b) Review of management information reports, if available.

Item Response Coding: *See general instructions at beginning of Services Section.* **In scoring this item, count face-to-face contacts with clients. 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 client, the item is coded as a "5."

S5. Frequency of contact

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

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

Sources of Information:

a) Chart review (See "During Your Visit" on Page 7 for instructions how to choose charts)

- Using the same charts as used for Item S1, calculate the mean number of face-to-face client-
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 rank-ordered – see tally sheet). 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.

b) Review of internal reports/documentation, if available.

c) Client interview

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

Item Response Coding: *See general instructions at beginning of Services Section.* **In scoring this item, count face-to-face contacts with clients. 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 program averages four or more contacts per week, per client, the item is coded as a "5."

S6. Work with informal support system

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

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

Sources of Information:

a) Team leader interview

- Review the client roster with the team leader. Determine for how many clients the ACT team has made at least one contact with an informal support network. Focus the discussion on this subgroup.
- *"Among clients 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)?"*

b) Review of internal reports/documentation, if available.

c) Clinician interview.

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

d) Client interview

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

Item Response Coding: Use team leader as primary data source. Include contacts with family, landlord, and employer; exclude persons who are paid to provide assistance to the client, 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 there are 100 clients on the team and the team has some contact with the network for 50 clients. The average contact with this subgroup is 2 contacts a month. Therefore the rate for the entire caseload is:

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

If the program makes four or more contacts per month, per client, 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 clients with substance use disorders.

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

Sources of Information:

a) Team Leader AND Substance Abuse Specialist interviews

- *"How many clients have a substance use disorder?"*

- *“Of these clients, 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 clients home, or elsewhere, but it must be more than informal queries or “nagging.”*
- *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 client’s goals/treatment plan.
- *“For each client who received substance abuse counseling in the last month, how many sessions did he/she have? How long were the sessions?”*

Item Response Coding: The substance abuse counselor interview is the primary data source. Calculate the total number of sessions for the clients receiving substance abuse treatment. Calculate the total number of minutes per month for each of these clients. Multiply the number of sessions by the number of minutes per month. Divide this product by the number of clients with substance use problems. Divide by 4 (weeks/month).

Example: 20 clients with DD. 10 receive 50-minute counseling sessions every other week.

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

If clinicians are providing DD counseling in the car and in the course of home visits, then this more informal contact can be coded at level 3 if it roughly meets the time requirement. To score a 4 or 5, there must be more formal structure than simply counseling embedded within home visits.

S8. Dual disorder treatment groups

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

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

Sources of Information:

a) Team leader interview

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

b) 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 clients 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.

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:**a) Team leader interview**

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

b) Clinician (Substance Abuse Counselor) interview.

- Repeat same questions as above.

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

S10. Role of consumers on treatment team

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

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

Sources of Information:**a) Team leader interview**

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

- *If they are paid employees, are they full time?*
- *Are they considered full-fledged clinicians? (Alternatively, are they considered aides?)*

b) Clinician interview.

- Ask similar questions as for team leader.

c) Client interview

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

Item Response Coding: This item refers to disclosed mental health consumers who have received treatment for a psychiatric disorder. If consumers are employed as clinicians with equal status as other case managers, the item is coded as a "5." If they work full time but at reduced responsibility, code as "4." If part time, but providing clinical activities (e.g., co-lead a group) code as "3." If their participation is "token" involvement on team, code as "2." (If consumer staff does not attend/participate in treatment team meetings, for instance, this would likely be coded as a "2.") Also code the item as a "2" if the consumer works in a position such as driver or administrative assistant.

ACT Fidelity Scale Cover Sheet

Date: _____

Rater(s): _____

Program Name (or Program Code): _____

Parent Agency: _____

Address: _____

Contact Person: _____

Telephone: _____

E-mail: _____

Sources Used:

_____ Chart review

_____ Team Leader interview

_____ Program Staff Interview(s) (# interviewed) _____

_____ Consumer Interview(s) (# interviewed) _____

_____ Family Member Interview(s) (# interviewed) _____

Number of clinicians: _____

Number of consumers served last year: _____

Funding source: _____

Urban or rural? _____

Date program was started: _____

DACTS Score Sheet

Program: _____ Date of Visit: _____ Rater 1 initials: _____ Rater 2 initials: _____

		Rater 1	Rater 2	Consensus	ACTUAL VALUE
H1	Small Caseload				
H2	Team Approach				
H3	Program Meeting				
H4	Practicing Team Leader				
H5	Continuity of Staffing				
H6	Staff Capacity				
H7	Psychiatrist on Staff				
H8	Nurse on Staff				
H9	Substance Abuse Specialist on Staff				
H10	Vocational Specialist on Staff				
H11	Program Size	*	*	*	
	HUMAN RESOURCES MEAN:				
O1	Explicit Admission Criteria				
O2	Intake Rate				
O3	Full Responsibility for Treatment Services				
O4	Responsibility for Crisis Services				
O5	Responsibility for Hospital Admissions				
O6	Responsibility for Hospital Discharge Planning				
O7	Time-Unlimited Services				
	ORGANIZATONAL BOUNDARIES MEAN:				
S1	In-Vivo Services				
S2	No Drop-Out Policy				
S3	Assertive Engagement Mechanisms				
S4	Intensity of Service				
S5	Frequency of Contact				
S6	Work with Support System				
S7	Individualized Substance Abuse Treatment				
S8	Dual Disorder Treatment Groups				
S9	Dual Disorders (DD) Model				
S10	Role of Consumers on Treatment Team	*	*	*	
	NATURE OF SERVICES MEAN:				
	TOTAL MEAN SCORE				

* denotes item not included in original DACTS; do not include in score summary

EXHIBIT C

EXHIBIT C

DACTS Score Sheet 2010

		CC1	CC2	CC3	A	GD	FP	HC	P1	P2	P3	P4
H1	Small Caseload	5	5	5	5	5	5	5	5	4	5	5
H2	Team Approach	5	3	5	3	3	3	3	3	5	4	5
H3	Program Meeting	5	5	5	5	5	5	5	5	5	5	5
H4	Practicing Team Leader	4	4	4	4	5	3	5	5	5	5	5
H5	Continuity of Staffing	4	5	5	3	1	1	4	2	1	2	3
H6	Staff Capacity	5	4	5	5	4	4	5	4	3	4	5
H7	Psychiatrist on Staff	3	3	3	3	4	4	5	4	4	4	4
H8	Nurse on Staff	3	3	3	4	3	3	4	4	4	4	4
H9	Substance Abuse Specialist on Staff	3	3	3	5	1	5	5	4	4	5	4
H10	Vocational Specialist on Staff	3	1	3	1	1	3	1	5	4	5	5
H11	Program Size	5	4	5	4	5	4	4	4	4	4	4
	HUMAN RESOURCES MEAN:	4.1	3.6	4.2	3.8	3.4	3.6	4.2	4.0	3.9	4.3	4.4

		CC1	CC2	CC3	A	GD	FP	HC	P1	P2	P3	P4
O1	Explicit Admission Criteria	5	5	5	5	5	5	5	5	5	5	5
O2	Intake Rate	5	5	1	5	5	5	3	5	5	5	5
O3	Full Responsibility for Treatment Services	3	4	4	4	4	4	4	5	5	5	4
O4	Responsibility for Crisis Services	2	2	2	5	5	3	4	4	4	4	4
O5	Responsibility for Hospital Admissions	4	4	4	4	4	5	2	4	4	4	5
O6	Responsibility for Hospital Discharge Planning	4	5	4	4	4	5	5	4	4	4	4
O7	Time-Unlimited Services	5	5	5	5	5	5	5	5	5	5	5
	ORGANIZATIONAL BOUNDARIES MEAN:	4.0	4.3	3.6	4.6	4.6	4.6	4.0	4.6	4.6	4.6	4.6

		CC1	CC2	CC3	A	GD	FP	HC	P1	P2	P3	P4
S1	In-Vivo Services	3	4	4	2	4	5	1	4	4	4	4
S2	No Drop-Out Policy	5	5	5	5	5	5	5	5	5	4	5
S3	Assertive Engagement Mechanisms	4	4	4	4	3	3	3	3	3	3	3
S4	Intensity of Service	5	4	4	4	3	4	4	4	4	3	5
S5	Frequency of Contact	4	2	3	2	2	3	2	3	3	2	4
S6	Work with Support System	4	3	3	1	2	4	4	2	2	3	1
S7	Individualized Substance Abuse Treatment	4	5	3	4	3	4	2	4	4	3	4
S8	Dual Disorder Treatment Groups	1	1	1	1	2	1	1	3	3	3	2
S9	Dual Disorder (DD) Model	4	4	4	2	2	3	3	4	4	4	4
S10	Role of Consumers on Treatment Team	1	1	1	5	1	5	3	1	1	1	1
	NATURE OF SERVICES MEAN:	3.5	3.3	3.2	3.0	2.7	3.7	2.8	3.3	3.3	2.9	3.3

		CC1	CC2	CC3	A	GD	FP	HC	P1	P2	P3	P4
	TOTAL MEAN SCORE:	3.9	3.7	3.7	3.7	3.4	3.9	3.6	4.0	3.9	3.9	4.0

EXHIBIT D

EXHIBIT D

Department of Mental Health
Assertive Community Treatment
Fidelity Report-Template
Spring 2010

Team:

Team Leader:

Fidelity Assessment Date:

Fidelity Team:

Caseload:

Timeframe for Chart Review:

Team Start Month:

On _____, 2010 the District of Columbia Department of Mental Health conducted a fidelity assessment of the XXXXX (XXX) Assertive Community Treatment Team using the Dartmouth ACT scale. This fidelity assessment is part of a planned assessment of the ACT system at DMH. This fidelity assessment process began in _____ 2010 and will be completed in _____ 2010. The XXX fidelity assessment is considered a second assessment. It is anticipated that the scores for a second assessment will be higher than the baseline assessment.

The DACTS is a 28 item scale that assesses the degree of fidelity to the ACT model along 3 dimension: Human Resources (caseload ratios, staffing patterns, team member specialties etc.), Organizational Boundaries (admission criteria, responsibility for admission and discharge from inpatient facilities, team admissions and discharges etc.) and Nature of Services (e.g. services provided in the community, intensity of services, frequency of contact etc.)

Data was gathered through the following mechanisms:

Site Visit

Morning Meeting Attendance

Staff Interviews of Team Leader, Substance Abuse specialist, SE/Voc Specialist and Consumer

Chart Reviews – 10 randomly selected charts

Reports submitted by Team Leader

Fidelity scores are listed below and include comments in each criterion.

DACTS Criterion/Scores/Comments

DACTS Criterion	Score	Comments
Human Resources		
H1: Small Caseload (Ratio 10:1)		

[Type text]

H2: Team Approach (Providers function as a team rather than as individual practitioners.)		
H3: Program Meeting		
H4: Practicing Team Leader		
H5: Continuity of Staff (Program Maintains same staffing over time)		
H6: Staff Capacity (Program operates at full staffing)		
H7: Psychiatrist on Staff (There is at least one full time psychiatrist per 100 consumers on the team)		
H8: Nurse on Staff (There are at least 2 FTE RNs assigned to work with 100 consumers)		
H9: Substance Abuse Specialist on Staff (There are at least 2 substance abuse specialists with 1 year of training/ experience in substance abuse treatment for 100 consumers)		
H10: Vocational Specialist (The program includes at least two staff members with 1 year training/experience in vacation and rehab support.		
H11: Program Size		

[Type text]

(The program is of sufficient absolute size to provide the necessary diversity of specialists and coverage)		
Subtotal		HR Score:
Organizational Boundaries		
O1: Admission Criteria (Program has clearly identified mission and operationally defined criteria to screen out inappropriate referrals.)		
O2: Intake Rate (Program admits consumers at a low rate to maintain a stable service environment)		
O3: Full Responsibility for Treatment Services (Psychiatric Services, Counseling/Therapy, Housing support, SA TX, Emp/Voc services)		
O4: Responsibility for Crisis Services (Program has 24 – Hour responsibility for crisis services)		
O5: Responsibility of Hospital Admissions		
O6: Responsibility for Hospital Discharges		
O7: Time-Unlimited Services (Program rarely graduates		

[Type text]

consumers)		
SubTotal		
Nature of Services		
S1: Community-Based Services (Program monitors status, develops community living skills out of the office)		
S2: No Drop Out Policy (Program retains a high percentage of its consumers)		
S3: Assertive Engagement Mechanisms (Use of Street outreach, Visits to jail, special engagement strategies, use of legal mechanisms: commitment, payee ship, guardianship, Hours of operation)		
S4: Intensity of Services (High Total amount of face to face time)		
S5: Frequency of contact (Number of face to face service contacts)		
S6: Work with Informal Support System (Number of contacts with collateral sources)		
S7: Individualized Substance Abuse Treatment (One or more members of the staff provide direct treatment for consumers)		
S8: Dual Disorders		

[Type text]

Treatment Groups		
S9: Dual Disorders Model (Program uses a stage-wise model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse and considers gradual abstinence)		
S10: Role of consumers on Treatment Team		
Subtotal		
Total Team Score		

EXHIBIT E

D.C. Department of Mental Health
Assertive Community Treatment
ACT Performance Improvement Workplan – FY 2011

Area of Concern	Strategy	Person Responsible	Timeline	Status	Documentation
Complete Annual Fidelity Assessment	1)Identify Fidelity Team 2)Provide Refresher Training to Fidelity Team 3)Develop schedule 4)Provide refresher training to ACT teams	Eugene/Michele	Assessments to be completed 7/11-9/11	Not Done	<p>Reports including recommendations will be finalized and circulated to all teams as of 10/1/11.</p> <p>Improvement plans will be submitted by each team by the end of December 2011.</p> <p>Status reports will be required as part of the monthly report process.</p>
Improve Evidence based practice in Dual Diagnosis services	Provide and training and coaching to substance abuse counselors and ACT staff	Eugene/Michele/Providers	Second and Fourth Quarter	Not Done	
Improve Evidence based practice in SE services	Provide SE training and coaching to Voc specialists and ACT staff	Eugene/Michele/Steve Baker	First and Third Quarter	Not Done	
Improve Evidence based practice in peer specialists	1)Provide information to ACT Team Leaders on Peers 2)Provide training to Peers Specialists and ACT staff 3)Meet with office of consumer Affairs/Training Institute	Eugene/Michele/Vivi Smith	First and Second Quarter	Not Done	
Clarify role of psychiatrist on ACT service	1)Provide training to ACT psychiatrists and Team Leaders on role of psychiatrist.	Eugene/Michele/consultant	Second Quarter	Not Done	
Improve skills of ACT staff in	1)Provide/refer ACT staff to MI	Eugene/Michele/others	Ongoing through FY	Not Done	

MI	training.		2011		
Priority Cases	1. Develop criteria 2. Develop spreadsheet 3. Document actions	Eugene/Michele	Ongoing	Not Done	Follow-up form to be completed.
Site Visits to All Teams	Attend Morning Mtgs for all	Eugene, Michele, Steve Miller	Quarterly	All Meetings have been attended.	Follow up-Form to be completed.
Referral Sources	Track Referral Sources	Eugene	Twice Annually	Not Done	Ecure Reports
Reconvene Internal Stakeholder Group	1)Identify participants 2)Develop standing agenda items 3)Set meeting dates 4)Identify facilitator and note taker	Michele, Eugene, Provider Relations, Integrated Care, Care coordination, OA, SHE, CPEP	Quarterly	First Mtg 7/15/10	Agenda and Minutes
Establish ACT group billing rate	1) Prepare language for approval to Health care finance agency	Michele/Suzanne Fenzel	Done April 2010	In process	

Updated 6/29/10

EXHIBIT F

EXHIBIT F

DMH
ACT Work Group
7/13/10
Minutes

Present: Venida Hamilton/Provider Relations; Steve Steury, MD/Chief Clinical Officer, Atiya Frame/Office of Accountability; Randy Raybon/ AccessHelpline-Care Coordination; Eugene Wooden/ACT Coordinator and Michele May /Adult Services. Not Present: Office of Integrated Care

- I. ACT fidelity assessment scores were presented and the fidelity assessment process was described. Eugene and Michele apprised the group on the training provided to prepare Fidelity Assessment to complete assessments and specific scores were reviewed. Michele and Eugene highlighted area of strength for the ACT system and areas of weakness.
- II. Michele and Eugene shared the FY 2011 draft ACT workplan with the group and the performance improvement plan required for each team score of 3 or below.
- III. Work group members discussed experiences related to working with ACT providers. Dr. Steury stated that required documentation for ACT providers whose consumers were at CPEP seemed to be provided as needed and that teams were participating in rounds at CPEP when requested.
- IV. Michele told the group that Suzanne Fenzel was working with Healthcare Finance to establish a group billing rate for the dual diagnosis groups required by the DACTS scale and for other groups the teams might like to do. It is anticipated that by the end of the fiscal year this rate will be in place.
- V. Michele also stated that she and Eugene are working on some amendments to the MHRS language for ACT.
- VI. Lastly, the group discussed needing to establish criteria and protocols for putting a team on probation and for determining when a team/provider should be recertified.
- VII. The ACT workgroup will meet on a quarterly basis to 1) review progress and share information on ACT 2) plan for ACT system improvement.

Next Meeting: October 2010.

EXHIBIT G

EXHIBIT G
ACT RECERTIFICATION SCHEDULE

No.	Provider Name	Recertification Date
1.	Anchor Mental Health	09-14-2011
2.	Capital Community Services	04-30-2011
3.	Community Connections	09-10-2011
4.	Family Preservation	07-30-2012
5.	Green Door	07-14-2011
6.	Hillcrest Children's Center	03-30-2012
7.	Pathways to Housing	09-13-2011