Dartmouth Assertive Community Treatment Scale (DACTS)

This document is intended to help guide your administration of the Assertive Community Treatment (ACT) fidelity scale. The starting point for this document was the original Dartmouth Assertive Community Treatment Scale (DACTS) developed by Teague, Bond, and Drake (1998); the DACTS measure and protocol from the SAMHSA Knowledge Informing Transformation (KIT – SAMHSA, 2008); as well as an annotated version of the SAMHSA Protocol developed by the ACT Center of Indiana (2011).

The original and annotated DACTS Protocol contains some item anchors and scoring instructions that were ambiguous to its users. In order to provide clarity for those using the DACTS, its authors were consulted by the Center for Evidence Based Practices in January 2017. This document represents a synthesis of the original DACTS measure and protocol from the SAMHSA KIT with input from the authors. Additional instructions, coding clarifications, formulas for rating, and other notations are included in this document for greater consistency in its use for evaluation purposes.

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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 ACT Teams, such as size and duration of ACT Team, 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). ACT Team 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 ACT Team-specific items. The scale has been developed to measure the adequacy of implementation of ACT Teams. 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 ACT Team 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 ACT Team). 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 during semi-structured interviews or 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 contacts); specific administration instructions are given as needed for individual items (see below). Round all calculation values to the units on the DACTS scale item itself before making the rating.

Some items require chart review for rating. Assessors should review a sample of either 10 charts or 10% of caseload (whichever is larger). The intent is to use charts selected at random. Some processes for random selection are suggested below; assessors should feel free to use whatever method is most convenient or practical for the particular visit.

- Agency/team provides a de-identified list of clients (i.e., ID numbers) and the assessors use random selection to choose 10.
- Agency/team provides 20 charts – from which the assessors select 10 to review.
- 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., for 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 ACT Teams Using Other ACT Team Models

The DACTS is designed to assess ACT Teams following the ACT model. If a case management or other ACT Team is rated on the DACTS, some items do not apply. This protocol does not cover every possible case of ACT Team 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 by an external review group or internally by an agency/ACT Team. There is a distinct advantage in using assessors who are external to the agency and are familiar with the ACT Team, but at the same time are independent. 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. 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:

- ❑ *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).

- ❑ *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 ACT Team site to confirm interview dates and times.

- ❑ *Establish a contact person at the agency*. You should have one key person who arranges your visit and communicates beforehand the purpose and scope of your assessment to ACT Team 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.

- ❑ *Establish a shared understanding with the site being assessed.* It is *essential* that the fidelity assessment team communicates to each ACT Team site the goals of the fidelity assessment; assessors should also inform the ACT Team site about who will see the report, whether the ACT Team 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 ACT Team site to understand how the ACT Team 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.

- ❑ *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:

    - Roster of ACT staff – (roles, full-time equivalents (FTEs))
    - Staff vacancies each month for last 12 months (or as long as ACT Team has existed, if less than 12 months)
    - Number of staff who have left the team over the last two years (or since ACT Team started if less than two years old)
    - A written description of the team's admission criteria
    - Roster of ACT clients
    - Number of clients with dual disorders
    - Number of clients admitted to ACT Team, per month, for last six months
    - How many clients have terminated from the ACT Team 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)
    - List of the last 10 clients admitted to psychiatric hospital
    - List of the last 10 clients discharged from psychiatric hospital
    - Number of clients living in supervised group homes
    - 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).

- *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 ACT Team.

- *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, an ACT Team 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 an ACT Team is implementing services, this is less likely to occur.

<u>During Your Fidelity Site Visit:</u>

- *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.

- During the interview, *record the names of all relevant ACT Teams, the total number of consumers, and the total number of clinicians*.

- *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 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).

- *If discrepancies between sources occur, query the team leader to get a better sense of the ACT Team'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?"

- *Before you leave, check for missing data*. It is a good idea to check in with the ACT Team leader at the end of the visit to review and resolve any discrepancies if possible.

<u>After Your Fidelity Site Visit:</u>

- If necessary, *follow up on any missing data* (e.g., by phone calls or email to the ACT Team site). This would include a discussion with the team leader about any discrepancies between data sources that arise after the visit has been completed.

- 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.

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

- *Send a follow-up letter to the site*. In most cases, this letter will include a *fidelity report,* explaining to the ACT Team 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.

- If the fidelity assessment is given repeatedly, it is often useful to *provide a visual representation of an ACT Team'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.

Dartmouth Assertive Community Treatment Scale

Human Resources: Structure & Composition

H1. Small Caseload.
H2. Team Approach.
H3. ACT Team Meeting.
H4. Practicing Team Leader.
H5. Continuity of Staffing.
H6. Staff Capacity.
H7. Psychiatrist/Psychiatric Prescriber on Staff.
H8. Nurse (RN) on Staff.
H9. Substance Abuse Specialist on Staff.
H10. Vocational Specialist on Staff.
H11. ACT Team Size.

Organizational Boundaries

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 (Graduation Rate).

Nature of Services

S1. Community-Based Services.
S2. No Dropout Policy.
S3. Assertive Engagement Mechanisms.
S4. Intensity of Service.
S5. Frequency of Contact.
S6. Work with Informal Support System.
S7. Individualized Substance Abuse Treatment.
S8. Dual Disorder Treatment Groups.
S9. Dual Disorders (DD) Model.
S10. Role of Consumers on Treatment Team.

Global:

All items (unless specified) are based on whatever is current on the day of the review.

A note about rounding: look at the "units" in the anchors and round to that decimal. So for H1, since anchors have no decimal, round to nearest whole number then rate.

Reviewers will go over the staffing grid with the ACT team leader and ensure all people who are considered "team members" and their allotted time to the team (percentage or FTE) are represented on the staffing grid. If someone is on extended leave (3 months or more) as of the day of the review, they are not counted as a member of the team. At minimum, a "team member": provides direct services to consumers on the team; attends team meetings; and is considered to be a team member by the team leader. Anyone identified as a "team member" then gets rated across all items (e.g. attendance at team meetings, vacancies, ratio, etc.).

Persons temporarily assigned to the team do count towards team staffing if they meet the minimum requirements above, but do note that when they leave the temporary assignment, they also count as a staff turnover. Please be sure to note if a temporary assignment is part-time assignment to the team.

If the person is determined to not "count" by these criteria, they are not counted in any further DACTS items. For example, an excluded staff person's services would not be included in calculation of *S4* or *S5* – service intensity and frequency, nor would turnover or vacancies in these positions count against the team in calculating items *H5* and *H6*. Also, if a staff person is determined to NOT be part of the team, then their services would be considered a brokered service on item *O3, Full responsibility for treatment services*. These are just a few examples. It is important to balance advantages/disadvantages of including someone as a team member both by its impact on scoring *and* impact on client care.

In addition, for someone to get credit as a specialist/role, they have to have the title and function of that specialist role. For instance, a nurse who has the title and functions as the team leader, would NOT count as the nurse on the team. If someone has the qualifications of substance abuse specialist, but does not hold that role on the team (e.g., does not provide leadership on dual disorders issues), then the team does not receive credit for that specialty role.

ITEM DEFINITIONS, RATIONALES, AND SCORING

Human Resources: Structure and Composition

Item H1. Small Caseload.

Definition: Client/provider 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: TL interview; Agency documents

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. Reminder: this is based on current staffing on the day of the review, not positions allocated to the team. If someone is technically employed by the team as of the day of the review but has been on extended leave (3 months or more), they are not counted here.

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

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

H1. Small Caseload	**Rating**
50 clients/clinician or more	1
35 – 49	2
21 – 34	3
11 – 20	4
10 clients/clinician or fewer	5

Item H2. Team Approach.

Definition: Provider group functions as team rather than as individual practitioners; 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: Chart review, TL interview, clinician interview, client interview, other data sources.

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 >= 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.

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 (identified on the Staffing Grid) 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.

H2. Team Approach	**Rating**
Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period.	1
10% – 36%	2
37% – 63%	3
64% – 89%	4
90% or more clients have face-to-face contact with >1 staff member in 2 weeks.	5

Item H3. ACT Team Meeting.

Definition: ACT Team 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: TL interview, internal documentation

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 – for the entire team meeting). 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 any of these conditions are not met, team does not score above a 4.

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 ACT Team holds the expectation that all team members attend; however, poor attendance is something to note in the fidelity assessment report.

H3. ACT Team Meeting	**Rating**
ACT Team service-planning for each client usually occurs once/month or less frequently.	1
At least twice/month but less often than once/week	2
At least once/week but less often than twice/week	3
At least twice/week but less often than 4 times/week	4
ACT Team meets at least 4 days/week and reviews each client each time, even if only briefly	5

Item 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: TL interview, Productivity records

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."

NOTE: "50%" here is defined as 50% of direct service expectation of other ACT Team members. Direct Service is defined as face-to-face or phone with or on behalf of client; responding to crises; as crisis back-up; co-facilitating group; field mentoring of ACT team members. Note: Time with or on behalf of a client does not have to be billable to count here.

For this item to be coded a "5" ACT team leader needs to provide direct service at least 10 hours per week (50% of the ~20 hours/week expected of other FTE clinicians on ACT team). A "4" is given if the Team Leader provides more than 5 but less than 10 hours per week. There is no "maximum" number of hours, however reviewers should note in the report if it appears the Team Leader is not adequately providing supervision and/or other Team Leader activities.

H4. Practicing Team Leader	**Rating**
Supervisor provides no services	1
Supervisor provides services on rare occasions as backup	2
Supervisor provides services routinely as backup, or less than 25% of the time	3
Supervisor normally provides services between 25% and 49% of the time	4
Supervisor provides services at least 50% of the time	5

Item H5. Continuity of Staffing.

Definition: ACT Team maintains 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: Staffing Grid – reviewed/confirmed during TL interview.

a) Team leader interview

- In advance of the fidelity visit, request that the team leader complete the Staffing Grid: a list of all employees over past two years (or for the duration of the existence of the ACT team)
- *"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:

$$\frac{(\text{\# Staff who worked on the team in the last 2 years}) - (\text{Total \# of positions})}{(\text{Total \# of positions})} \times \frac{(12)}{(24)\ [\text{or \# months team has been in existence if less than 24 months}]}$$

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: [(20-9)/9 x 12/24] =61.1%
SOUTH: [(7-5)/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. "Total number of positions" is based on the number of positions currently on the team as of the day of the review. Note: do not include administrative staff here.

Count each position, regardless of FTE devoted to the team, as one full position in both numerator and denominator in calculating this item. For instance, turnover of a half-time vocational specialist still counts as one turnover of a staff position. From the consumer's perspective, turnover of any person on the team is worth noting.

Staff positions that have been eliminated from the team are also considered turnover. If a position has been eliminated in the last 24 months, the individual in that position still counts in the number of staff who have left (numerator) but does not count in the number of positions on the team (numerator and denominator).

H5. Continuity of Staffing	**Rating**
Greater than 80% turnover in 2 years	1
60% - 80% turnover in 2 years	2
40% - 59% turnover in 2 years	3
20% - 39% turnover in 2 years	4
Less than 20% turnover in 2 years	5

Item H6. Staff Capacity.

Definition: ACT Team operates at full staffing.

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

Sources of Information: Staffing Grid – reviewed/confirmed during TL interview.

Item Response Coding: For each month, calculate the vacancy rate. "Vacancy" is the number of unfilled positions each month for the last 12 months (or less if the ACT Team has been in existence less than 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.

Using the staffing grid information, calculate the total number of days each position was vacant. Divide that number by 30 (days) to get the number of months vacant. Include the psychiatrist, but exclude any administrative support staff when determining total staff positions. Calculate the mean monthly vacancy rate (given by the formula below) for the 12-month period. Subtract from 100%.

FORMULA:
100 – [100* {TOTAL MONTHS OF VACANCIES / (TOTAL # STAFF POSITIONS x 12 months) }]

EXAMPLE: There are a total of 10 staff positions on the ACT team. Bob left his position on the ACT team on April 12th; his position was filled May 16th. Sue left the team April 28th; her position was filled July 6th.

Bob's position was vacant for 33 days ("vacant" April 13th through May 15th); Sue's position was vacant for 68 days ("vacant" April 29th through July 5th). No other staff members have been on leave or left the team within the past 12 months, resulting in a total of 101 days of vacant positions.

Total months of vacancies: 101 days / 30 days = 3.4 months of vacancies

100 – [100* {3.4 months of vacancies / (10 staff positions x 12 months)}]

100 – [100* (0.0283)]

100 – 2.83 = 97.17% staffing capacity

If the ACT Team 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 3 months or more, this counts as a position vacancy.

Count each position, regardless of FTE devoted to the team, as one full position in both numerator and denominator in calculating this item. For instance, extended leave for three months or more of a half-time vocational specialist still counts as one position of vacancy. From the consumer's perspective, any extended staff absence is worth noting.

H6. Staff Capacity	**Rating**
ACT Team has operated at less than 50% of staffing in past 12 months	1
50% - 64%	2
65% - 79%	3
80% - 94%	4
ACT Team has operated at 95% or more of full staffing in past 12 months	5

Note for items H7-H11:
ACT Teams do not receive credit for having specialists on staff (e.g., psychiatrist/psychiatric prescriber, 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 90 days or more. If the individual in that position has been on leave for LESS than 90 days, the team can receive credit.

Item H7. Psychiatrist/Psychiatric prescriber on Staff.

Definition: There is at least one full-time psychiatrist/psychiatric prescriber on the ACT Team per 100 clients.

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

Sources of Information: TL interview, clinician interview, psychiatrist/psychiatric prescriber interview, client interview

a) Team leader and 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?"*

b) Client interview

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

Item Response Coding:
FORMULA:
[(FTE value x 100) / # clients served] = FTE per 100 clients

EXAMPLES:
West has .75 FTE psychiatrist for a 50-client ACT Team. South has .75 FTE for a 120-client ACT Team.

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 ACT Team. 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 he/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 ACT Team, the item is coded as a "5."

H7. Psychiatrist/Psychiatric prescriber on Staff	**Rating**
ACT Team for 100 clients has less than .10 FTE regular psychiatrist/psychiatric prescriber	1
.10 - .39 FTE per 100 clients	2
.40 - .69 FTE per 100 clients	3
.70 - .99 FTE per 100 clients	4
At least one full-time psychiatrist/psychiatric prescriber is assigned directly to a 100-client ACT Team	5

Item H8. Nurse on Staff.

Definition: There are at least two full-time nurses (RNs) assigned to work with a 100-client ACT Team.

Rationale: The full-time RN has been found to be a critical ingredient in successful ACT Teams. 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: TL interview, clinician interview, client interview

a) Team leader and 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?"*

b) Client interview

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

Item Response Coding:
FORMULA: [(FTE value X 100) / # clients served] = 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 ACT Team, the item is coded as a "5."

While LPN nurses do not get counted in this item, they do count in the overall staff to client ratio; may serve in one of the specialist roles (if they meet the qualifications outlined); and count in other items as members of the team.

H8. Nurse on Staff	**Rating**
ACT Team for 100 clients has less than .20 FTE regular nurse	1
.20 – .79 FTE per 100 clients	2
.80 – 1.39 FTE per 100 clients	3
1.40 – 1.99 FTE per 100 clients	4
Two full-time nurses or more are members of a 100-client ACT Team	5

Item H9. Substance Abuse Specialist on Staff.

Definition: A 100-client ACT Team includes at least two staff members with at least 1 year of training or clinical experience in substance abuse treatment.

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

Sources of Information: TL interview, SA Specialist interview

Item Response Coding:
FORMULA: [(FTE value X 100) / # clients served] = 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 ACT Team 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 lack one year of experience, then cannot score higher than a "2".

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

H9. Substance Abuse Specialist on Staff	**Rating**
ACT Team has less than .20 FTE S/A expertise per 100 clients	1
.20 - .79 per 100 clients	2
.80 - 1.39 FTE per 100 clients	3
1.40 - 1.99 FTE per 100 clients	4
Two FTEs or more with 1 year S/A training or supervised S/A experience	5

Item H10. Vocational Specialist on Staff.

Definition: The ACT Team includes at least two staff members with at least 1 year 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: TL interview, Vocational Specialist interview

Item Response Coding:
FORMULA: [(FTE value X 100) / # clients served] = 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 on this team; otherwise, give partial credit according to the percentage of time the vocational specialist works with ACT clients. Experience includes helping people find jobs or support them in community job settings.

If lack of one year of experience, then cannot score higher than a "2".

If, for a 100-client ACT Team, two FTEs or more with one year vocational rehabilitation training/supervised experience were assigned, the item is coded as a "5."

H10. Vocational Specialist on Staff	**Rating**
ACT Team has less than .20 FTE vocational expertise per 100 clients	1
.20 - .79 FTE per 100 clients	2
.80 - 1.39 FTE per 100 clients	3
1.40 - 1.99 FTE per 100 clients	4
Two FTEs or more with 1 year vocational rehabilitation training or supervised VR experience	5

Item H11. ACT Team Size.

Definition: ACT Team is of sufficient absolute size to consistently provide the necessary staffing diversity and coverage.

Note: this item does not get pro-rate based on the number of clients served by the team. It is based on the total number of FTEs allocated to the team.

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 and adequate access/coverage to each client.

Sources of Information: Staffing Grid confirmed during TL interview

Item Response Coding: If the ACT Team has at least 10 FTE staff, the item is coded as a "5." Count all staff, including psychiatrist (exclude administrative support staff). A member of the team on extended leave for 3 months or more does not count for this item.

H11. ACT Team Size	**Rating**
ACT Team has fewer than 2.5 FTE staff	1
2.5 – 4.9 FTE	2
5.0 – 7.4 FTE	3
7.5 – 9.9 FTE	4
ACT Team has at least 10 FTE staff	5

Organizational Boundaries

Item O1. Explicit Admission Criteria.

Definition: The ACT Team 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: TL interview is primary source, clinician interview, internal records (e.g. Admission forms, Admission criteria and/or policy)

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. Are admission criteria consistent with ACT target population?
- Review Admission forms – are they filled out well/completely?
- Do ACT clients currently on the team meet the stated admission/eligibility criteria?

Item Response Coding: If the ACT Team serves a well-defined population and all clients meet explicit ACT–appropriate admission criteria, the item is coded as a "5."

O1. Explicit Admission Criteria	**Rating**
ACT Team has no set criteria and takes all types of cases as determined outside the ACT Team	1
ACT Team has a generally defined mission but the admission process is dominated by organizational convenience.	2
The ACT Team makes an effort to seek and select a defined set of clients but accepts most referrals.	3
ACT Team typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	4
The ACT Team actively recruits a defined population and all cases comply with explicit admission criteria.	5

Item O2. Intake Rate.

Definition: ACT Team 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: Responses to fidelity review prep survey reviewed during TL interview

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.

O2. Intake Rate	**Rating**
Highest monthly intake rate in the last 6 months is greater than 15 clients/month	1
13 – 15	2
10 – 12	3
7 – 9	4
Highest monthly intake rate in the last 6 months is no greater than 6 clients/month	5

Item O3. Full Responsibility for Treatment Services.

Definition: In addition to case management, the ACT team directly provides:

1) Psychiatric services (medication prescription, administration, monitoring, and documentation),
2) Counseling/psychotherapy,
3) Housing support (e.g. finding and keeping safe affordable housing, help with ADLs, independent living skills, meal preparation),
4) Substance abuse treatment – group and/or individual,
5) Employment (e.g. vocational counseling/support) ***and*** rehabilitative services (e.g. ADLs, skills/activities to live independently in the community).

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: TL interview, clinician interview, client interview

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 from another agency), and which do your team provide directly?"* (Query for details on particular services as necessary)
    - *medication prescription, administration, monitoring, and documentation*
    - *counseling/individual supportive therapy*
    - *housing support*
    - *substance abuse treatment*
    - *employment or other rehabilitative services (e.g., ADLs, vocational counseling/support)*

b) Clinician interview:

- Ask similar questions as for team leader

c) Client interview.

- *"Who helps you with your medication (e.g., prescribing it, getting it from the pharmacy, organizing it into med boxes, understanding what they are/what they're for, when and how to take them)?"*
- *"Who helps you get your services for housing? For employment?"*
- *"Who helps you besides the ACT team?"*

Item Response Coding: From all sources of information, 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. For each of the five (5) service categories, first determine if any of the clients on the team is receiving the service from the team or from another provider. Second, 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." If either of these is not accurate (the team does not provide the service *or* the team is responsible for less than 90%), the team does not get credit for that service type. Please note for the fifth service on the list ("*5. Employment or other rehabilitative services (e.g., ADLs, vocational counseling/support)"*, brokering EITHER employment or rehabilitation services counts the whole element as brokered. If more than 10% of caseload is living in a group home, the team likely does not get credit for "housing support."

If no one on the team is receiving a service as of the day of the review, assessors need to (a) assess capacity – do they have staff who can do this? (b) do they routinely assess if someone wants/would benefit? (c) has this service type ever been provided to anyone ever on the team? More importantly – has anyone ever been referred out for this service type in the past year?

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.

O3. Full Responsibility for Treatment Services	**Rating**
ACT Team provides no more than case management services	1
ACT Team provides one of five additional services and refers externally for others	2
ACT Team provides two of five additional services and refers externally for others	3
ACT Team provides three or four of five additional services and refers externally for others	4
ACT Team provides all five of these services to clients	5

Item O4. Responsibility for Crisis Services.

Definition: ACT Team 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: TL interview, ACT team member interview, client and family interviews

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?"*
- *"What information is provided to clients regarding crisis services?"*

b) ACT team member interview

- "What 24 hour emergency services are available for ACT clients?"
- "What is your role in providing 24-hour emergency services?"

c) Client and family interviews

- "Who would you contact if you had an emergency in the evening or on the weekend and needed to talk with someone?"

Item Response Coding: If the ACT Team provides 24-hour coverage directly (i.e., an ACT team member is on-call at all times, typically by carrying a beeper), the item is coded as a "5."

This next sentence is key to determine difference between "4" and "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 the ACT team for any situation beyond routine.

Rating of "3":

- There is another entity that is responsible for responding to crisis calls (e.g. an answering service specific to the organization; a rotating phone number – not exclusive to the ACT Team; or a separate crisis service provider) and
- ACT Team members are available 24/7 to this other entity, however
- The ACT Team predominantly consults with the crisis service provider, not directly with the ACT client – this is rated a "3."

Rating of "2":

- There is another entity that is responsible for responding to crisis calls (e.g. an answering service specific to the organization; a rotating phone number – not exclusive to the ACT Team; a separate crisis service provider) and
- The ACT Team either has generic procedures, protocols, and/or instructions re: how to handle ACT Team clients or
- The ACT Team provides client-specific procedures, protocols, and/or instructions re: how to handle ACT Team clients to this entity – this is rated a "2."
- ACT Team typically (though not always) is notified after the fact of the crisis encounter and the results of the encounter.

Note: This item is rating the availability, policies and procedures of the ACT team. If the team is available to provide crisis services but clients and/or supports choose to utilize other community resources for crisis services, this should be noted in the report but should not be reflected in the rating.

O4. Responsibility for Crisis Services	**Rating**
ACT Team has no responsibility for handling crises after hours	1
Emergency service has ACT Team-generated protocol for ACT Team clients	2
ACT Team is available by telephone, predominantly in consulting role	3
ACT Team provides emergency service backup; e.g., ACT Team is called, makes decision about need for direct ACT Team involvement	4
ACT Team provides 24-hour coverage	5

Item O5. Responsibility for Hospital Admissions.

Definition: ACT team is closely involved in hospital admissions. (One example of ACT Team involvement: the team was aware before the admission and gave input into the decision whether or not to hospitalize – whether or not their input was followed.)

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: TL interview, clinician interview

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?"* [Listen for ACT team input into the decision to hospitalize. Their input does not have to be followed to get credit.]
- *"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. If 95% or more of all admissions involved the ACT team, the item is coded as a "5." While not required, ACT Teams are encouraged to develop and follow a policy outlining expectation of contact as soon as the client is admitted (e.g. within 48 hours).

O5. Responsibility for Hospital Admissions	**Rating**
ACT Team has involvement in fewer than 5% decisions to hospitalize.	1
ACT team is involved in 5% - 34% of admissions.	2
ACT team is involved in 35% - 64% of admissions.	3
ACT team is involved in 65% - 94% of admissions.	4
ACT team is involved in 95% or more admissions.	5

Item O6. Responsibility for Hospital Discharge Planning.

Definition: The ACT Team 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: TL interview, clinician interview

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 have a policy requiring an ACT team member being at the hospital within a certain amount of time within admission? If yes, what is the expectation (e.g. ACT team will go to the hospital and meet with the client within 48 hours of admission)?*
- *"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."

"Involvement in discharge" is more than just picking the client up at discharge. Examples of involvement include participation in inpatient treatment team meetings, providing input into the discharge decision-making/planning process, and advocating for the client.

O6. Responsibility for Hospital Discharge Planning	**Rating**
ACT Team has involvement in fewer than 5% of hospital discharges	1
5% - 34% of ACT Team client discharges are planned jointly with the ACT Team	2
35% - 64% of ACT Team client discharges are planned jointly with the ACT Team	3
65% - 94% of ACT Team client discharges are planned jointly with the ACT Team	4
95% or more discharges are planned jointly with the ACT Team	5

Item O7. Time-Unlimited Services (Graduation Rate).

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

Rationale: Clients often regress when they are terminated from short-term ACT Teams. 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., proactive transition to less intensive services because the team assesses that the client no longer needed ACT-level intensity of services—omit from the count any clients who left due to relocation or dropping out of treatment – these are counted in Item S2). If all clients are served on a time- unlimited basis, with fewer than 5% graduating from the ACT Team annually, the item is coded as a "5".

- Proactive transition to less intensive services because the team believes the consumer no longer needs ACT level services = graduation

- If client moves out of service area BUT team anticipated and was involved in transition to new provider prior to the move, then not considered a graduation (nor a drop-out).

- Deceased clients do not count as either a graduation, nor as a drop-out.

Use total number of clients served by team over 12 months as denominator.

FORMULA:

100 * [(# ACT clients successfully graduated in past 12 months)
(Total # ACT clients served by team over past 12 months)]

Where

"Total # ACT clients served by team over past 12 months" = # current ACT clients + # ACT clients discharged for any reason in past 12 months.

O7. Time-Unlimited Services (Graduation Rate)	**Rating**
More than 90% of clients are discharged within 1 year.	1
From 38% - 90% of clients are discharged within 1 year.	2
From 18% - 37% of clients are discharged within 1 year.	3
From 5% - 17% of clients are discharged within 1 year.	4
All clients are served on a time-unlimited basis, with fewer than 5% graduating annually.	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.

Item S1. Community-Based Services.

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

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: Chart review, review of internal reports/documentation, clinician interview, client interview

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* Nature of Services *Section*. **In scoring this item, count face-to-face contacts between ACT team members and ACT clients. Do not count phone calls and do not count contacts with collaterals or family members.** When multiple "contacts" take place on the same day, determine if the contacts are for specific skill-building or support activities versus simply for transportation. Skill-building/support activities count as "contacts," simple transportation does not.

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."

S1. Community-Based Services	**Rating**
Less than 20% of face-to-face contacts in community	1
20% - 39%	2
40% - 59%	3
60% - 79%	4
80% or more of total face-to-face contacts in community	5

Item S2. No Dropout Policy.

Definition: ACT team engages and retains clients at a mutually satisfactory level (ACT Team retains a high percentage of its clients).

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: TL interview, clinician interview

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.]
- *"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?"*

The following ***are*** considered "drop out":

- 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 would count as "drop-out".
- A consumer who left the geographic area IF the ACT team did not provide referrals for services for continuing care in the new location.
- If the consumer was transferred to less intensive services as a result of non-compliance with ACT services (rather than the team determining lack of need for ACT services), then this consumer would count as a drop-out.
- If consumer went into any of the following "facilities" and the team is no longer working with them (discharged from the ACT team), then it counts as a drop out: Group Homes, nursing home based on psychiatric decompensation, Jail

The following ***are not*** considered "drop-out":

- Death doesn't count as a dropout.
- If team helped with transfer to new provider proactively – doesn't count as a drop-out.
- Individuals who graduated the program – successfully transitioned to a lesser intensive level of care (see Item O7)

Item Response Coding:

FORMULA:

$$\frac{\text{(TOTAL \# ACT CLIENTS served by the team over the past 12 months)} \quad \text{MINUS} \quad \text{(\# CLIENTS DISCHARGED, DROPPED, MOVED WITHOUT REFERRAL)}}{\text{(TOTAL \# ACT CLIENTS served by the team over the past 12 months)}} \times 100$$

Where:

"Total # ACT clients served by team over past 12 months" = # current ACT clients + # ACT clients discharged for any reason in past 12 months.

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

S2. No Dropout Policy	**Rating**
Less than 50% of the caseload is retained over a 12-month period	1
50% - 64%	2
65% - 79%	3
80% - 94%	4
95% or more of caseload is retained over a 12-month period	5

Item S3. Assertive Engagement Mechanisms.

Definition: ACT team uses street outreach, motivational/engagement techniques, as well as legal mechanisms (e.g., probation/parole, outpatient commitment, representative payee, guardianship) or other techniques to ensure ongoing engagement.

Rationale: Clients are not immediately discharged from the ACT Team 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: TL interview, clinician interview, client interview, Assertive Engagement protocol/document

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?"*
- *Do you have a formal written Assertive Engagement Strategy Protocol? [request copy]*
- *If yes, how and when does it get used?*
- *Where do you get your clients from?*
- *Does your team have a relationship with a local jail?*
- *Describe what you do to help transition off payeeship/OP commitment.*

b) Clinician interview

- *"What happens if a client says he or she doesn't want your services?"*
- *Do you have a formal written Assertive Engagement Strategy Protocol?*
- *If yes, how and when does it get used?*

c) Client interview

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

Item Response Coding: A formal written Assertive Engagement Strategy Protocol includes strategies for working with individuals who are: 1) unengaged, 2) tentatively engaged (talking with staff but not interested in services, 3) missing or otherwise unable to be located, or 4) not responding to attempts to contact. The protocol should address specific engagement and motivational strategies; use of street outreach; and the appropriate use of legal mechanisms (e.g. payeeship, guardianship, assisted outpatient treatment (AOT) or outpatient commitment). The Protocol also delineates when and how the strategies are to be considered and implemented.

- Ideally, there are no more than 30% commitments & 50% payeeship on ACT teams.
  - Note: these percentages are prompts to understand the high rate (not scoring guidelines).
  - Note: for teams whose specific focus (admission criteria) is for those people on Outpatient Commitment, the expectation of "no more than 30%" does not apply.
- Look for evidence of creativity and individualization

If the ACT Team has a formal written Assertive Engagement Strategy Protocol, and there is evidence that it is consistently applied, score is a "5". If a formal written Protocol exists and there is evidence it is not consistently applied (or, for example, team members are not aware of it), or the protocol is missing key elements, score no higher than a "4". If there is no formal written Protocol, score no higher than a "3."

S3. Assertive Engagement Mechanisms	**Rating**
ACT Team passive in recruitment and re-engagement; almost never uses street outreach or legal mechanisms	1
ACT Team makes initial attempts to engage but generally focuses efforts on most motivated clients	2
ACT Team attempts outreach and uses legal mechanisms only as convenient	3
ACT Team usually has plan for engagement and uses most of the mechanisms that are available	4
ACT Team demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate	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: Chart review, management information reports

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.) This tally includes only face-to-face contacts with ACT Team members who are identified on the staffing grid. From the per-client 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.

- Would like to see 1 quarter's worth of data if using these reports to score item

Item Response Coding: *See general instructions at beginning of* Nature of Services *Section.* **In scoring this item, count face-to-face contacts between ACT Team members and ACT 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."

S4. Intensity of Service	**Rating**
Average of less than 15 min/week or less of face-to-face contact per client	1
15 – 49 minutes/week	2
50 – 84 minutes/week	3
85 – 119 minutes/week	4
Average of 2 hours/week or more of face-to-face contact per client	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: Chart review, client interview, internal reports/documentation

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. This tally includes only face-to-face contacts with ACT Team members who are identified on the staffing grid. From the calculated per-client 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.

- Would like to see 1 quarter's worth of data if using these reports to score item

c) Client interview

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

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

S5. Frequency of Contact	**Rating**
Average of less than 1 face-to-face contact/week or fewer per client	1
1.00 – 1.99 / week	2
2.00 – 2.99 / week	3
3.00 – 3.99 / week	4
Average of 4 or more face-to-face contacts per week per client	5

S6. Work with Informal Support System.

Definition: With or without the client present, the ACT team 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: TL interview, clinician interview, client interview, internal reports/documentation

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. Note: guardians may or may not be considered "informal supports" (e.g. when a family member is also the legal guardian). The rule of thumb in determining this is whether or not the person is operating in the context of his/her responsibility/role or going above and beyond the role s/he is paid to perform. When determining who to count as an informal support, reviewers need to prompt for details about what the person does that is within or outside of the defined role and function.

One method to capture this is to ask the team (or just the team leader) to go through the entire caseload and ask, for each client "in the last month, who had contact with an informal support?" For the subgroup (those clients for whom the team had contact with an informal support), ask how often the team had such contact. Tabulate the rate for the subgroup for which the team has at least some contact in the last month. From this, calculate the rate for the entire caseload.

FORMULA:

$$\frac{\text{(AVERAGE \# OF CONTACTS BETWEEN TEAM AND INFORMAL SUPPORT MEMBER PER MONTH)} \times \text{(\# CLIENTS FOR WHOM THE TEAM HAD CONTACT WITH AN INFORMAL SUPPORT MEMBER)}}{\text{(TOTAL \# ACT CLIENTS)}}$$

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

2 * 50/100 = 1 time per month

If the ACT Team makes four or more contacts per month, per client, the item is coded as a "5."

S6. Work with Informal Support System	**Rating**
Less than 0.50 contact per month per client with support system	1
0.50 – 0.99 contact per month per client with support system in the community	2

1.00 – 1.99 contacts per month per client with support system in the community	3
2.00 – 3.99 contacts per month per client with support system in the community	4
Four or more contacts per month per client with support system in the community	5

S7. Individualized Substance Abuse Treatment.

Definition: One or more members of the ACT 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: SA Specialist interview, TL interview

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 specialist on the team or another ACT team member this last month?"*
- Ask the nature of the counseling.
- *"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 specialist interview is the primary data source. Obtain the total number of clients receiving substance abuse treatment in the last month. Obtain the total number of minutes in the last month for each of these clients. Multiply the number of clients receiving substance abuse treatment by the total number of minutes per month. Divide this product by the number of clients with substance use problems. Divide by 4 (weeks/month).

FORMULA:

$$\frac{[(\#\text{ clients who receive SA tx}) * (\text{Total \# minutes SA tx per month})] / (\text{Total \# clients with DD})}{4 \text{ weeks/month}}$$

Example: 20 clients with DD. 10 receive 60-minute counseling sessions every other week.

(10 clients * 120 minutes /20 clients)/4 = 15 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.

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.

S7. Individualized Substance Abuse Treatment	**Rating**
No direct, individualized substance abuse treatment is provided by the team	1
The team variably addresses SA concerns with clients; no formal, individualized SA treatment provided	2
While the team integrates some substance abuse treatment into regular client contact, they provide no formal, individualized SA treatment	3
Some formal individualized SA treatment is offered; clients with substance use disorders spend less than 24 minutes/week in such treatment	4
Clients with substance use disorders spend, on average, 24 minutes/week or more in formal substance abuse treatment	5

Item S8. Dual Disorder Treatment Groups.

Definition: ACT Team 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: TL interview, SA Specialist interview

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?"*
- *"How many clients attend these groups?"*

b) Substance abuse specialist interview

Repeat same questions as above.

Item Response Coding: Use substance abuse specialist 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 in the last month, the item is coded as a "5."

FORMULA:

(# clients who attended at least 1 SA tx group in the last month) / (Total # clients with DD)

Do not count groups offered by organizations that have no connection to the ACT team. Only count groups facilitated or co-facilitated by ACT staff. Groups does not have to be exclusively for ACT clients, however, they are the primary participants.

S8. Dual Disorder Treatment Groups	**Rating**
Fewer than 5% of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month	1
5% - 19%	2
20% - 34%	3
35% - 49%	4
50% or more of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month	5

Item S9. Dual Disorders (DD) Model.

Definition: ACT Team 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: TL interview, SA Specialist interview, clinician interview

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 AND Substance Abuse Specialist interview

- Repeat same questions as above.

Item Response Coding: Use Team leader interview as primary data source.

- The team MUST offer dual disorder groups within the team in order to score a 4 or 5 on this item. If no dual groups are offered, the maximum score is a 3.
- If the team offers individual SA treatment and no SA groups, then the maximum score is a 3.
- If the team offers no individual SA treatment and no SA groups, then the maximum score is a 2.
- Use of detox does not count against the team on this item if it is for medical necessity.
- An ACT Team 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.
- If the ACT Team is fully based in DD treatment principles (stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence), with the team providing treatment, the item is coded as a "5."

S9. Dual Disorders (DD) Model	**Rating**
ACT Team fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	1
ACT Team uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for motivation of clients in denial or who don't fit AA	2
ACT Team uses mixed model: e.g., DD principles in treatment plans; refers clients to motivation groups; uses hospitalization for rehab.; refers to AA, NA	3
ACT Team uses primarily DD model: e.g., DD principles in treatment plans; motivation and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some s/a treatment	4
ACT Team fully based in DD treatment principles (stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence), with treatment provided by ACT Team staff	5

Item 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: TL interview, Clinician interview, client interview, Peer Specialist interview

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?*
- *Describe what Peer Specialist does. [Probe for activities they do or do not do compared to other ACT team staff (e.g. interactions with clients, treatment planning, documentation in medical record).]*
- *Are they considered full-fledged clinicians? (Alternatively, are they considered aides?)*
- *How often do they attend team meetings?*

b) Clinician interview

- Ask similar questions as for team leader.

c) Peer Specialist interview

- *How much of your time is allocated specifically to the ACT team? (FTE and # HRS/WEEK)*
- *Is this the amount of time you want to work? (Alternatively, do they want to work more? Less?)*
- *Tell me about your role on the team.*
- *What kinds of services do you provide?*
- *Any tasks or responsibilities unique to your position?*
- *Any tasks or responsibilities other team members have that you don't have? (i.e. med drops, etc.)*
  - *IF YES, probe for whether this is due to organization rules/restrictions vs. choice*
- *Describe your access to charts. Do you write progress notes? Are you able to see all parts of the chart?*
- *Any tasks or responsibilities you don't currently have that you would like to have?*
- *How is it decided / do you decide which clients you work with?*
- *How many clients are you currently working with?*

d) 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 superficial 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. "Full time" equates to one FTE (does not need to be *one person* employed 40 hours per week).

Full professional responsibility means that the consumer specialist has access to medical records and the ability to chart consumer progress like other staff members, participates in clinical and treatment planning meetings like other staff, and has autonomous scope of action to same extent as others on team in interactions with and responsibilities to clients.

S10. Role of Consumers on Treatment Team	**Rating**
Consumers have no involvement in service provision in relation to the ACT Team.	1
Consumer(s) fill consumer-specific service roles with respect to the ACT Team (e.g., self-help)	2
Consumer(s) work part-time (less than 1 FTE total) in case-management roles with reduced responsibilities.	3
Consumer(s) work full-time (at least 1 FTE) in case management roles with reduced responsibilities.	4
Consumer(s) are employed full-time as clinicians (e.g., case managers) with full professional status	5