Mid-America (HHS Region 7)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

ACT Fidelity Assessment KDADS 2022

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UNMC MUNROE-MEYER INSTITUTE
SAMHSA Substance Abuse and Mental Health Services Administration

Disclaimer

At the time of this publication, Miriam Delphin-Rittmon served as Assistant Secretary for Mental Health and Substance Use and Administrator of SAMHSA. The opinions expressed herein are the views of the speakers and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

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The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

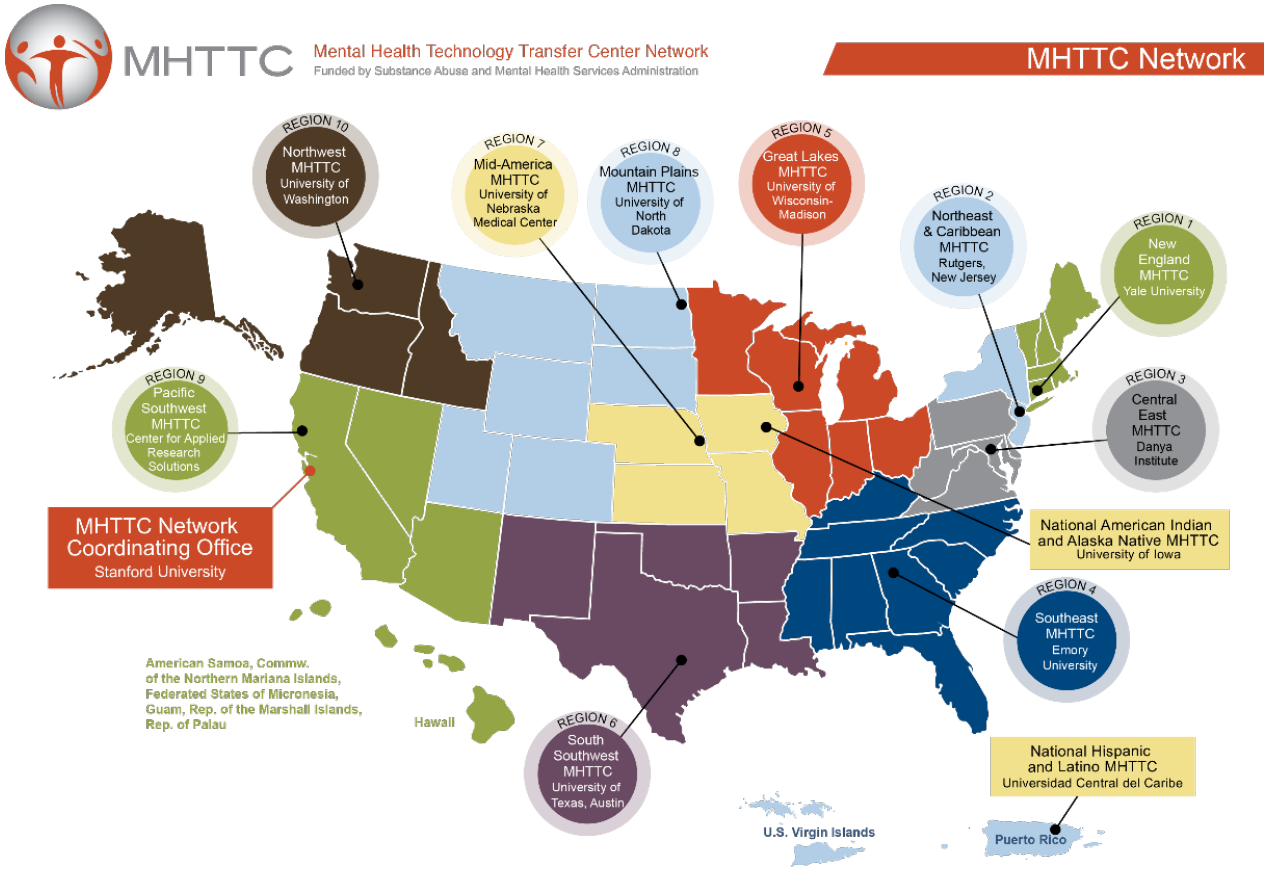
- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered/ trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Mid-America Mental Health Technology Transfer Center

Established to increase utilization of evidence-based mental health practices.

- Missouri, Iowa, Nebraska, and Kansas.
- Free training and technical assistance.
- SAMHSA grant awarded to the Behavioral Health Education Center of Nebraska at University of Nebraska Medical Center.
  (5 years, $3.7 million, grant number: H79SM081769)



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I, Mogens Bill Baerentzen attest that I have no financial, personal, or professional conflicts of interest in this training titled Implementing Assertive Community Treatment in Kansas: Orientation to ACT.

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Deinstitutionalization

Since the deinstitutionalization of persons with mental illness, beginning in the 1950's fewer people with serious mental illness are living in hospitals, nursing homes and assisted living facilities; in fact, most are living in the community independently or with formal supports. The role of families has increased as access to long-term inpatient care has reduced.

- From 1955 to 1983 there was a 75.3% reduction in the state-hospital population (Goldman, Adams, & Taube, 1983).
- 558,239 inpatient psychiatric beds in 1955 for a population of 164.3 million (Bureau of the Census, 1956).
- 51,413 inpatient psychiatric beds in 2004 for a population of 269.4 million (Torrey, Entsminger, Geller, Stanley, & Jaffe, 2007).

Serious Mental Illness and QOL

Persons with severe and persistent mental illness are at risk of not living a fully satisfying life.

- Difficulties forming social connections (Bellack, Morison, Wixted & Mueser, 1990),
- sexual dysfunction (Bobes et al., 2003; Wesby, Bullmore, Earle, & Heavey, 1996),
- impaired functioning (Bellack & Mueser, 1993),
- lower work readiness skills (Lysaker, Bell, Milstein, Bryson, Shestopal, & Goutlet, 1993), and
- impaired cognitive abilities (Braff, 1993) contribute to lower life satisfaction among persons with severe mental illness.

Low life satisfaction for persons with severe and persistent mental illness are directly related to

- poverty (Cohen, 1993),
- homelessness (Lehman, Kernen, DeForge, & Dixon, 1995),
- mental health stigma (Corrigan, 2004),
- impaired family relations, friendships,
- access to health care and community services (Brown, Cosgrove, & DeSelm, 1997) are associated with.

SMI and Health

Serious mental illness is associated with 20-year lower life expectancy (Thornicroft, 2011) and increased rates of many chronic life style related illnesses (Jones et al., 2014). Persons with a severe and persistent mental illness are more likely to be
obese (Cook et al., 2016),

to smoke cigarettes (Bartlem et al., 2015),

to use alcohol and illicit drugs (Regier et al., 1990),

to eat unhealthy (Christensen & Somers, 1996; Kilbourne et al, 2007),

to be physically inactive (Bartlem et al., 2015),

have other negative health practices, such as

poor adherence with treatment (Lehner et al., 2007), and

adverse health related side effects from psychotropic medication (Blanchard and Samaras, 2014; Dipasquale et al., 2013; Jerome et al., 2009; Cooper et al., 2012).

In a multi-national study, Parletta, Aljeesh, & Baune (2016) found that persons with mental illness compared to a normative sample eat less healthy food, more unhealthy foods, have more sleep problems and higher alcohol consumption.

Support for Recovery

- The transition from hospital to community created a significant concern about how to help persons with serious mental illness live meaningful lives (Gudeman, Miles, & Shore, 1984).
  - how to support people in housing, and
  - how to improve the quality of their lives.

History of Assertive Community Treatment

Alternative to Mental Hospital Treatment 1/2 (Stein & Test, 1980)

Stein and Test publish a study on a conceptual model of community-based treatment – An alternative to years or a lifetime in a psychiatric hospital.

A supportive system that assertively helps the patient with:

1. Material resources such as food, shelter, clothing, and medical care.
2. Coping skills to meet the demands of community life.
3. Motivation to persevere and remain involved with life.
4. Freedom from pathologically dependent relationships.
5. Support and education of community members who are involved with patients.

Alternative to Mental Hospital Treatment 2/2 (Stein & Test, 1980)

Control Condition: ***Hospital Admission***
Experiential Condition: ***Training in Community Living (Pre-ACT)***

	Control	Experiential
Re-Hospitalization	58%	6%
Unemployment	57%	30%
Income	$419	$760
Life Satisfaction		↑
Self Esteem		↑
Psychiatric Symptoms	↑	

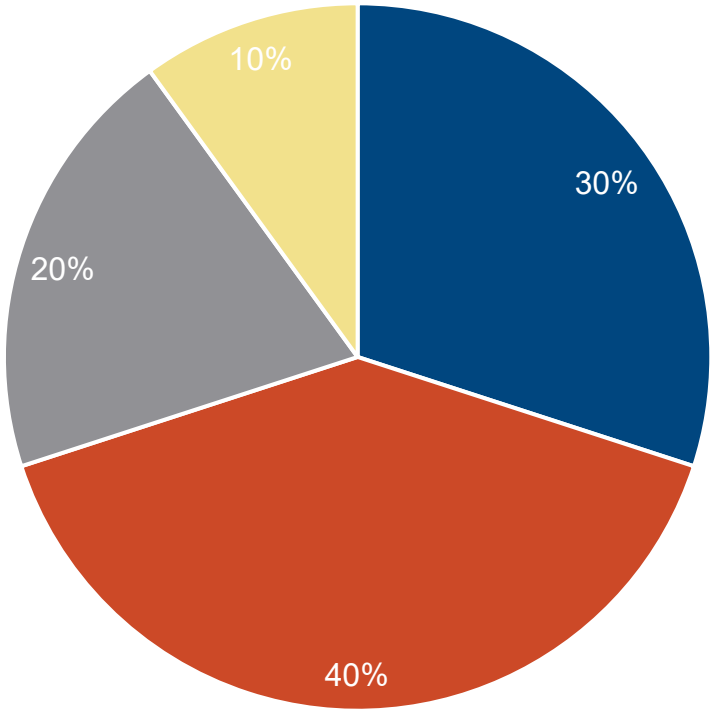
Social Determinants Of Health

Social Determinants of Health (SDOH)

"Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes."

-Center for Disease Control (CDC)

Determinants of Health and Their Contribution to Premature Death



Source: Beyond Healthcare: The Role of Social Determinants in Promoting Health and Healthy Equity. Kaiser Family Foundation, 2015.

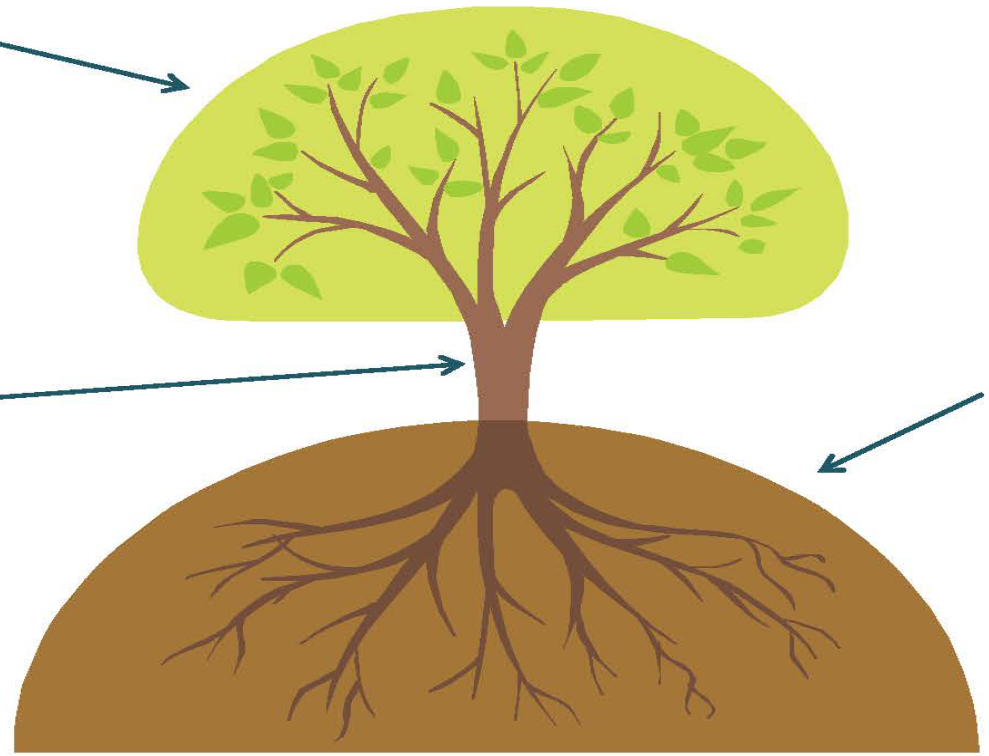
Social Determinants of Health

Health outcomes:

- cancer
- diabetes
- asthma
- depression

Health choices:

- diet
- exercise
- drinking
- smoking



Social, economic & environmental factors :

- education
- child care
- healthy food
- housing
- health care
- work environment
- wages & benefits
- transportation
- air & water quality
- A.C.E.s

Social Determinants of Health in Assertive Community treatment

ACT Builds Resilience

Risk Factors

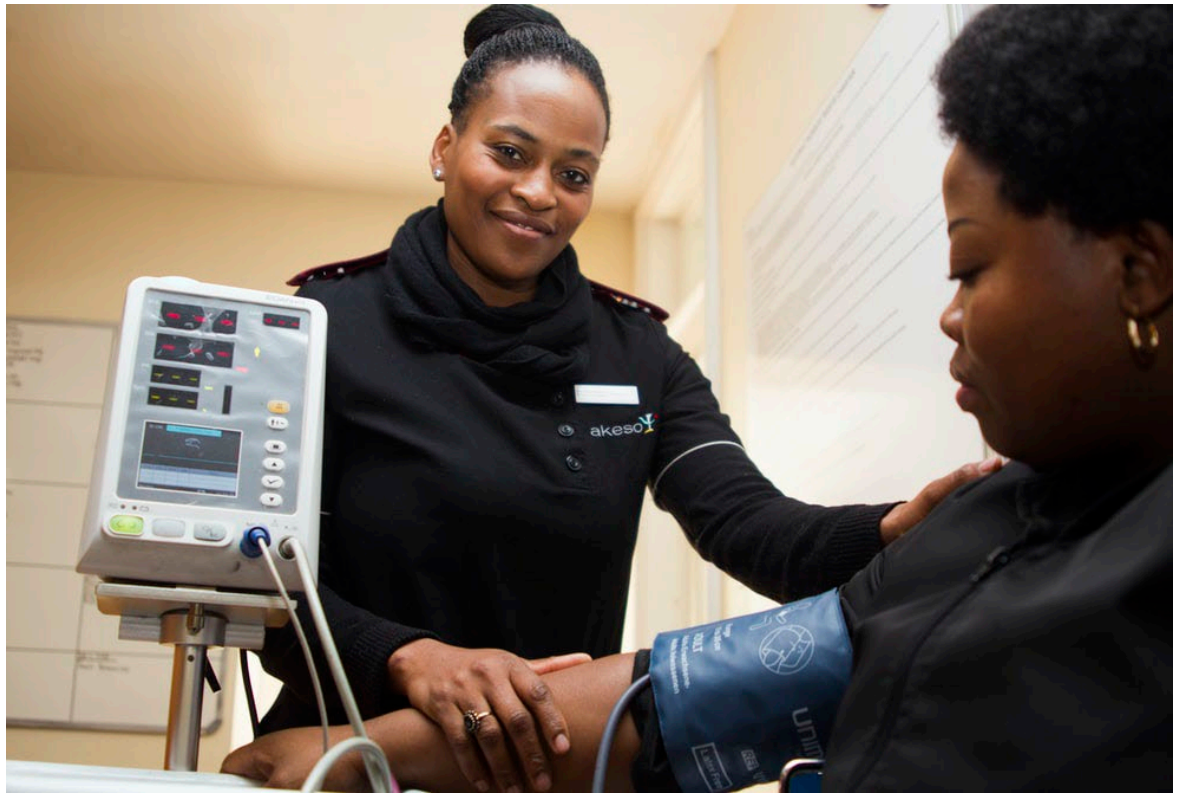
- Behavioral risks
- Physiological and genetic risks
- Environmental and cultural risks

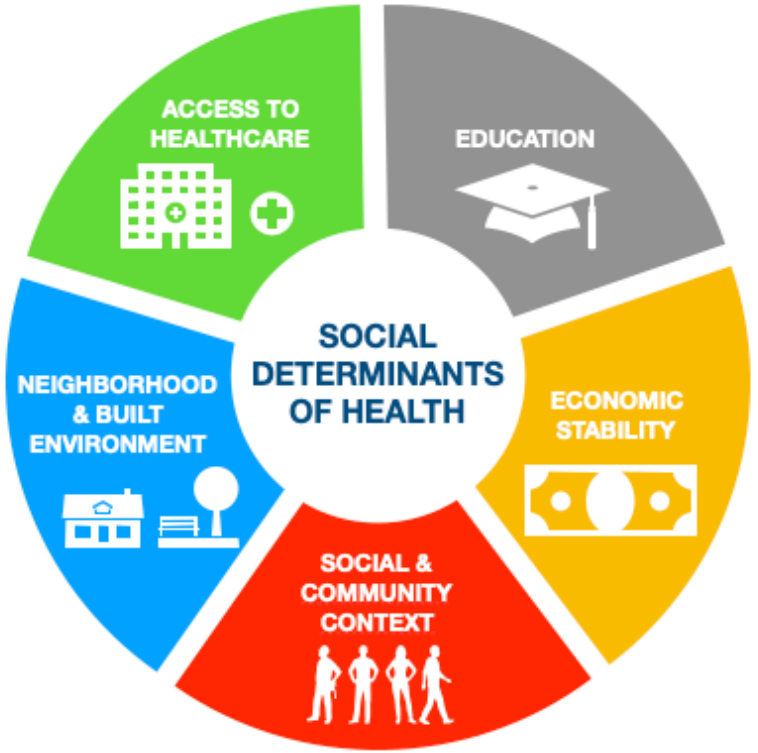
Protective Factors

- Supportive relationships
- Healthy coping strategies
- A sense of purpose
- Positive parenting by caring adults
- Emotional self-awareness
- Socioeconomic stability
- The willingness to seek help
- Problem-solving skills

Access to HealthCare

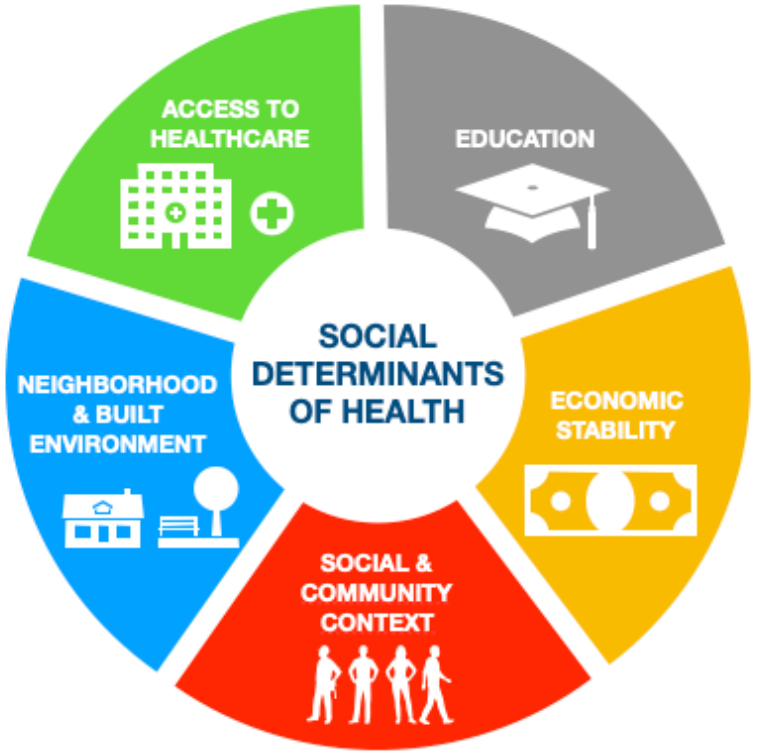
Assertive Community Treatment takes responsibility for behavioral healthcare by providing services in the community. Primary care, specialty care and dentistry are made by referral.





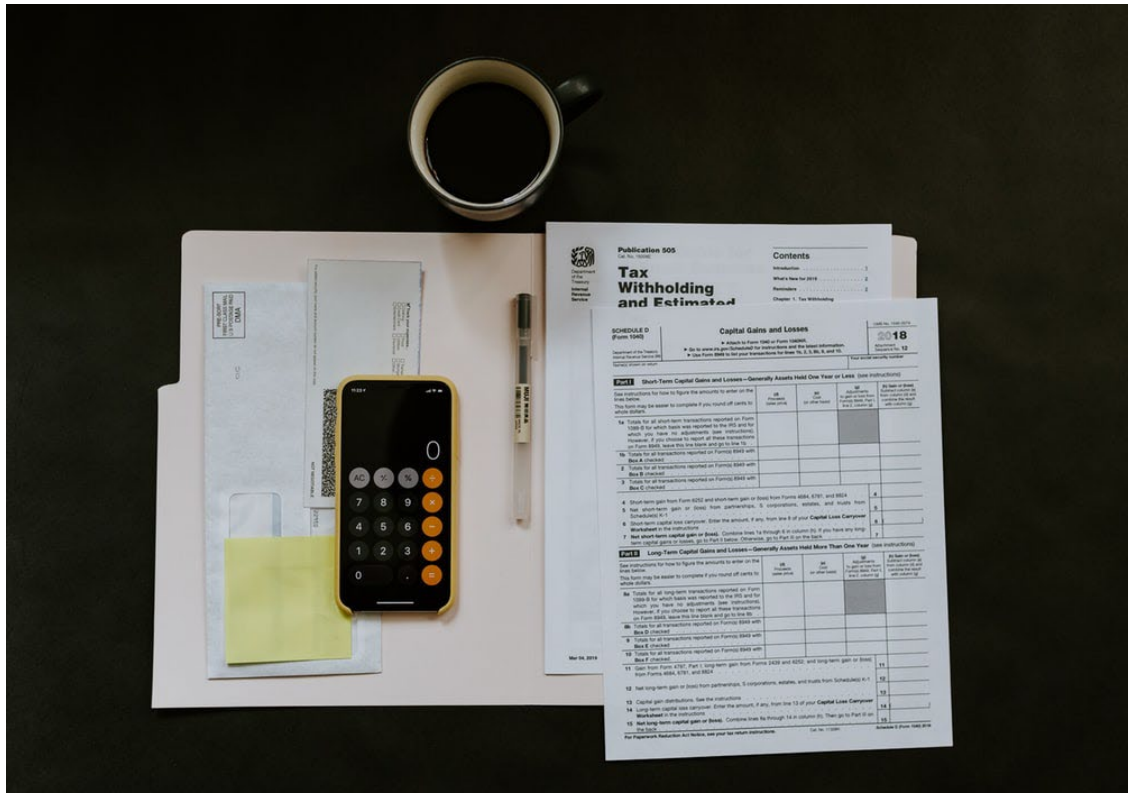
Education Access & Quality

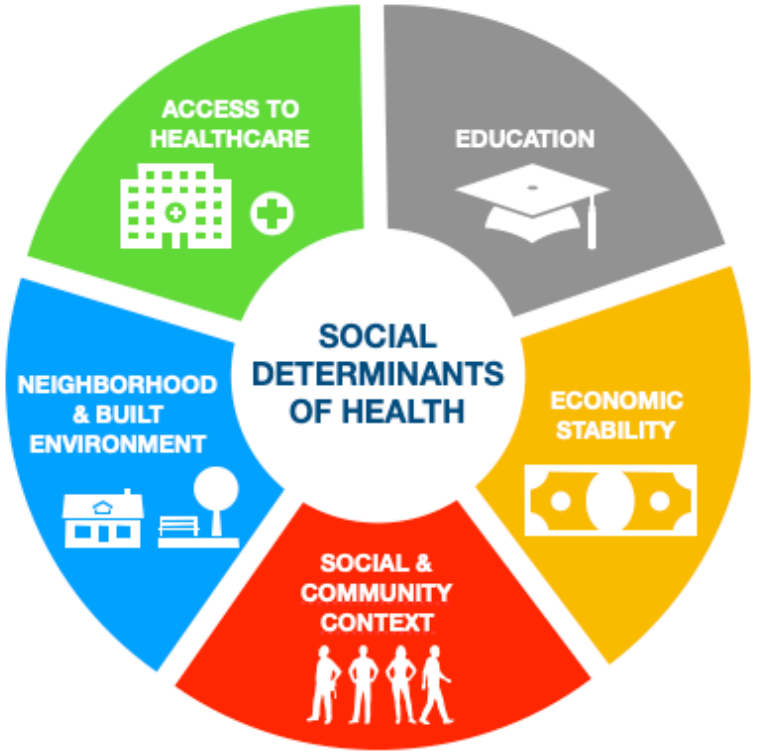
Employment services are included on an ACT team. Support for education is considered based on client preferences.



Economic Stability

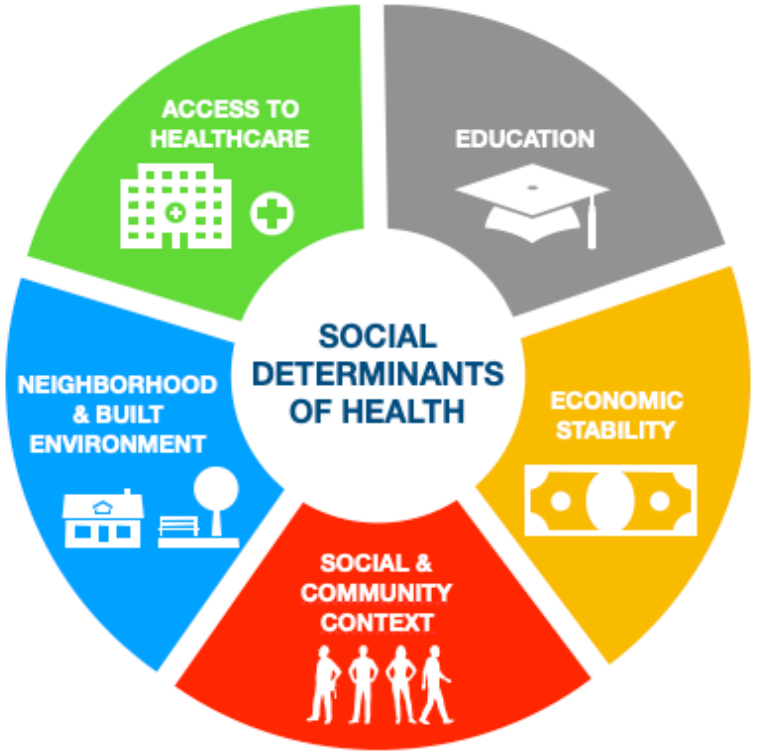
Benefits and entitlements are important for persons with serious mental illness. Support and benefits planning are provided by ACT.





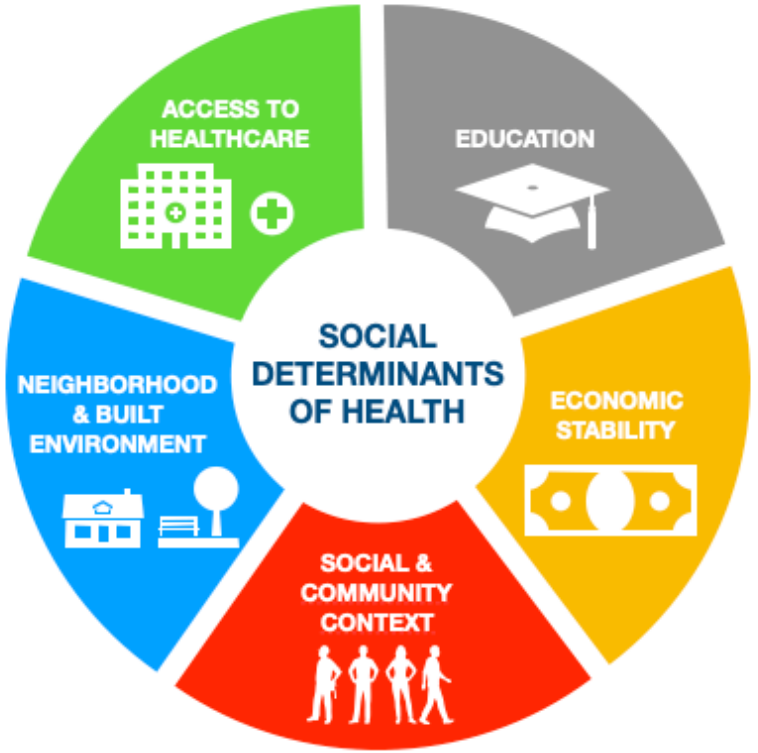
Social & Community Context

Assertive Community treatment is grounded in community inclusion. An effective team helps clients build natural supports.



Neighborhood & Built Environment

Housing and neighborhood is based on individuals' choice and availability. ACT works closely with landlords and often meet clients in the community.



ACT
Fidelity Scale

Adherence to the model - Fidelity

- Well defined
- Reflect client goals
- Be consistent with societal goals
- Demonstrate effectiveness
- Yield durable outcomes
- Produce minimal side effects
- Have reasonable costs
- Be adaptable to diverse communities and client subgroups
- Be relatively easy to implement

Fidelity Assessment – Process measures

- An objective way to determine fidelity to an evidence-based practice
- These measures are associated with consumer outcome measures – Predictive Validity
  - In other words consumers on teams with high fidelity have better outcomes than consumers on teams with low fidelity
- Sets the stage for ongoing quality improvement
  - Identify training needs, policy changes, leadership needs etc

Predictive Validity

Fidelity assessment scores are predictive of client outcomes. The higher the score the better the outcomes.

Positive outcomes can be expected once fidelity is established. This is discouraging for programs as they work hard for little initial gain.

What can a fidelity assessor do to mitigate fatigue during the program implementation phase?

Fidelity to Assertive Community Treatment and Client Outcomes

(McHugo et al., 1999)

	High Fidelity	Low Fidelity
N days of alcohol use	35	80
N days of drug use	28	60
N hospital admissions	2.87	4.69
SATS	5.48	4.12

Human Resources

- Small caseload
- Team approach
- Program meeting
- Practicing ACT leader
- Continuity of staffing
- Staff capacity
- Psychiatrist on team
- Nurse on team
- Substance use specialist on team
- Vocational specialist on team
- Program size

Organizational Boundaries

- Explicit admission criteria
- Intake rate
- Responsibility of tx services
- Crisis services
- Hospital admission
- Hospital discharge
- Time unlimited service

Nature of Services

- Community based services
- No dropout policy
- Assertive engagement
- Intensity of service
- Frequency of contact
- Work with informal support
- Individualized substance use treatment
- Co-occurring disorders group
- Dual Disorders model
- Role of consumer

Kansas
Department for Aging and Disability Services

Assertive Community Treatment Fidelity Scale

Criterion		Ratings 1	2	3	4	5
Human Resources: Structure and composition						
H1	**Small caseload**: Individual to team member ratio 10:1	50 individuals/staff or more	35-49	21-34	11-20	10 individuals/staff or fewer
H2	**Team approach**: Team shares caseload. Each member knows and works with every individual.	Fewer than 10% of individuals have face-to-face contact with multiple team members	10-36%	37-63%	64-89%	90% or more individuals have face-to-face contacts with multiple team members in 2 weeks
H3	**ACT Team Meeting**: ACT Team meets frequently to plan and review services for individuals.	ACT Team service-planning for individuals usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least twice/week but less often than 4 times/week.	ACT Team meets at least 4 days/week and reviews every individual each time, even if only briefly.
H4	**Practicing ACT team leader**: Supervisor of frontline ACT team members provides direct services.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25% and 50% time.	Supervisor provides services at least 50% time.
H5	**Continuity of staffing:** Keeps same staffing over time.	Greater than 80% turnover in 2 years	60-80% turnover in 2 years.	40-59% turnover in 2 years	20-39% turnover in 2 years.	Less than 20% turnover in 2 years
H6	**Staff capacity**: Operates at full staffing.	Operated at less than 50% staffing in past 12 months	50-64%	65-79%	80-94%	95% or more of full staffing in past 12 months

Criterion		Ratings				
		1	2	3	4	5
H7	**Psychiatrist/ Psychiatric Prescriber on staff:** there is at least 1 FTE psychiatrist/ psychiatric prescriber per 100 individuals assigned to work with the ACT Team.	Less than .10 FTE regular psychiatrist/ psychiatric prescriber per 100 individuals.	.10-.39 FTE per 100 individuals.	.40-.69 FTE per 100 individuals	.70-.99 FTE per 100 individuals	At least 1 FTE psychiatrist/psychiatric prescriber is assigned directly to a 100-individual ACT Team.
H8	**Nurse (RN) on staff**: there is at least one full-time nurse (RN) assigned to work with the ACT Team.	Less than .10 FTE regular nurse.	.10-.39 FTE	.40-.69 FTE	.70-.99 FTE	One full-time nurse or more
H9	**Substance Abuse Specialist on staff**: ACT Team includes at least one staff member with 1 year of training or clinical experience in substance abuse treatment.	ACT Team has less than .25 FTE S/A expertise	.25-.49 FTE	.50-.74 FTE	.75-.99 FTE	1 FTE or more with 1 year S/A training or supervised S/A experience.
H10	**Employment Specialist on staff**: at least 1 staff member with at least one year of training/experience providing employment services.	ACT Team has less than .25 FTE	.25-.49 FTE	.50-.74 FTE	.75-.99 FTE	1 FTE or more with 1-year training/experience
H11	**Program size**: The team is of a sufficient size to consistently provide for necessary staffing diversity and coverage. NOTE: This item includes separate parameters for minimal coverage for smaller teams to allow for enough staff to be available 24 hours a day, seven days a week.	**100-Client Team:** Includes fewer than 5.5 FTE direct clinical staff.	5.5-6.9 FTE	7.0-8.4 FTE	8.5-9.9 FTE	Includes at least 10.0 FTE direct clinical staff.
		50-Client Team: Includes fewer than 5.5 FTE direct clinical staff.	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	Includes at least 7.0 FTE direct clinical staff.
H12	**Housing Specialist on staff:** at least 1 staff member with at least one year of training/experience providing housing services.	ACT Team has less than .25 FTE	.25-.49 FTE	.50-.74 FTE	.75-.99 FTE	1 FTEs or more with 1-year training/experience

Criterion		Ratings				
		1	2	3	4	5
H13	**SOAR Certified Staff:** at least two staff members who are SSI/SSDI Outreach, Access, and Recovery (SOAR) certified NOTE: Online Application Tracking (OAT) registration and participation are required. **This is not a separate position. Any ACT staff member can fulfill this requirement.**	ACT Team has less than .20 SOAR certified FTE per 100 individuals.	.20-.79 FTE per 100 individuals.	.80-1.39 FTE per 100 individuals.	1.40-1.99 FTE per 100 individuals.	Two FTEs or more SOAR certified team members per 100 individuals.
Organizational Boundaries						
O1	**Explicit admission criteria**: Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Has no set criteria and takes all types of referrals	Has a generally defined mission, but the admission process is dominated by organizational convenience	Tries to seek and select a defined set of clients but accepts most referrals.	Typically, actively seeks, and screens referrals carefully but occasionally bows to organizational pressure	Actively recruits a defined population, and all cases comply with explicit admission criteria
O2	**Intake rate**: Team takes individuals in at a low rate to maintain a stable service environment.	Highest monthly intake rate in the last 6 months = greater than 15 individuals/month	13 -15	10 - 12	7 - 9	Highest monthly intake rate in the last 6 months no greater than 6 individuals/month.
O3	**Full responsibility for treatment services**: in addition to case management, the ACT team directly provides psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment, and rehabilitative services.	ACT Team provides no more than case management services.	ACT Team provides one of five additional services and refers externally for others.	ACT Team provides two of five additional services and refers externally for others.	ACT Team provides three or four of five additional services and refers externally for others.	ACT Team provides all five of these services to individuals.
O4	**Responsibility for crisis services**: ACT Team has 24-hour responsibility for covering psychiatric crises.	Has no responsibility for handling crises after hours	Emergency service has ACT Team-generated protocol for ACT individuals	Is available by telephone, predominantly in consulting role	Provides emergency service backup, e.g., ACT Team is called, makes decision about need for direct ACT Team involvement	Provides 24-hour coverage
O5	**Responsibility for hospital admissions**: ACT Team is involved in hospital admissions.	Involved in fewer than 5% decisions to hospitalize.	ACT team is involved in 5% -34% of admissions.	ACT team is involved in 35% - 64% of admissions.	ACT team is involved in 65% - 94% of admissions.	ACT team is involved in 95% or more admissions.

Criterion		Ratings				
		1	2	3	4	5
O6	**Responsibility for hospital discharge planning**: ACT Team is involved in planning for hospital discharges.	ACT Team is involved in fewer than 5% of hospital discharges.	5% - 34% of ACT Team client discharges are planned jointly with the ACT Team.	35 - 64% of ACT Team client discharges are planned jointly with the ACT Team.	65 - 94% of ACT Team client discharges are planned jointly with the ACT Team.	95% or more discharges are planned jointly with the ACT Team.
O7	**Transition to less intensive services:** 1) Conducts a regular assessment of the need for ACT services; 2) Uses explicit criteria to assess need to transfer to less intensive service option; 3) Transition is gradual & individualized, with assured continuity of care; 4) Status is monitored following transition, per individual need; and 5) The team expedites re admission to the team if necessary.	Team does not actively facilitate individual transition to less intensive services OR 1 to 2 criteria met, at least PARTIALLY	2 criteria FULLY met OR 3 criteria met, at least PARTIALLY	3 criteria FULLY met OR 4 criteria met, at least PARTIALLY	4 criteria FULLY met	ALL 5 criteria FULLY met
Nature of Services						
S1	**Community-based services:** Works to monitor status, develop community living skills in community rather than in office.	Less than 20% of face-to-face contacts in community	20 - 39%	40 - 59%	60 - 79%	80% of total face-to-face contacts in community
S2	**No dropout policy:** Retains high percentage of individuals.	Less than 50% of caseload retained over 12-month period	50 - 64%	65 - 79%	80 - 94%	95% or more of caseload is retained over a 12-month period
S3	**Assertive engagement mechanisms**: ACT Team uses street outreach, motivational/ engagement techniques, as well as legal mechanisms (e.g., probation/parole, outpatient commitment, payeeship, guardianship) or other techniques to ensure ongoing engagement.	ACT Team passive in recruitment and re-engagement; almost never uses street outreach, legal mechanisms.	ACT Team makes initial attempts to engage but generally focuses efforts on most motivated individuals.	ACT Team attempts outreach and uses legal mechanisms only as convenient.	ACT Team usually has plan for engagement and uses most of the mechanisms that are available.	ACT Team demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.

Criterion		Ratings				
		1	2	3	4	5
S4	**Intensity of service**: high amount of face-to-face service time as needed.	Average of less than 15 min/week or less of face-to-face contact per individual.	15 - 49 minutes / week.	50 - 84 minutes / week.	85 - 119 minutes / week.	Average of 2 hours/week or more of face-to-face contact per individual.
S5	**Frequency of contact**: high number of face-to-face service contacts as needed.	Average of less than 1 face-to-face contact / week or fewer per individual.	1.00 - 1.99 / week.	2.00 - 2.99 / week.	3.00 - 3.99 / week.	Average of 4.00 or more face-to-face contacts / week per individual.
S6	**Work with informal support system**: with or without individual present, ACT Team provides support and skills for individual's support network: family, landlords, employers etc.	Less than .50 contact per month per individual with support system.	.50-.99 contact per month per individual with support system in the community.	1.00-1.99 contact per month per individual with support system in the community.	2.00-3.99 contacts per months per individual with support system in the community.	4.00 or more contacts per month per individual with support system in the community.
S7	**Individualized substance abuse treatment**: one or more members of the ACT Team provide direct treatment and substance abuse treatment for individuals with substance use disorders.	No direct, individualized substance abuse treatment is provided by the team.	The team variably addresses SA concerns with individuals; no formal, individualized SA treatment provided.	While the team integrates some substance abuse treatment into regular individual contact, they provide no formal, individualized SA treatment.	Some formal individualized SA treatment is offered; individuals with substance use disorders spend less than 24 minutes/week in such treatment.	Individuals with substance use disorders spend, on average, 24 minutes / week or more in formal substance abuse treatment.
S8	**Dual Disorder treatment groups:** ACT Team uses group modalities as a treatment strategy for individuals with substance use disorders.	Fewer than 5% of the individuals with substance use disorders attend at least one substance abuse treatment group meeting during a month.	5 - 19%	20 - 34%	35 - 49%	50% or more of the individuals with substance use disorders attend at least one substance abuse treatment group meeting during a month.
S9	**Dual Disorders (DD) model**: ACT Team uses a 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.	ACT Team fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	ACT Team uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for motivation of individuals in denial or who don't fit AA.	ACT Team uses mixed model: e.g., DD principles in treatment plans; refers individuals to motivation groups; uses hospitalization for rehab.; refers to AA, NA.	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.	ACT Team fully based in DD treatment principles, with treatment provided by ACT Team staff.

Criterion		Ratings				
		1	2	3	4	5
S10	**Role of Peer Specialist:** Peer Specialists are involved as members of the team providing direct services.	Peer Specialists are not involved in service provision in relation to the ACT Team.	Peer Specialist(s) fill individualized service roles with respect to ACT Team (e.g., self-help).	Peer Specialist(s) work part-time in case-management roles with reduced responsibilities.	Peer Specialist(s) work full-time in case management roles with reduced responsibilities.	Peer Specialist(s) are employed full-time as clinicians (e.g., case managers) with full professional status.
S11	**Peer Specialist on staff:** at least 1 staff member with serious mental illness who functions as a fully integrated team member	ACT Team has less than .25 FTE	.25-.49 FTE	.50-.74 FTE	.75-.99 FTE	1 FTE or more

Notes:

- The term "individual" is used throughout to replace terms like "consumer", "client", or "patient".
- This scale was created in conjunction with and based upon Dartmouth Assertive Community Treatment Scale (DACTS), Oregon Center of Excellence for Assertive Community Treatment (OCEACT) Fidelity Scale, and Tools for Measurement of Assertive Community Treatment (TMACT) Summary Scale, as well as SAMHSA's Assertive Community Treatment (ACT) Evidenced-Based Practices (EBP) KIT.

Highlight changes

The reduction of minimum staffing requirements leads to a direct match in the minimum program size (7 FTEs)

1. Team Leader
2. Psychiatrist
3. Nurse
4. Substance Abuse Specialist
5. Employment Specialist
6. Housing Specialist
7. Peer Specialist

Contemporary Mental Health Principles to Convey During Fidelity Assessment

Contemporary Principles of Psychiatric Rehabiltation

- Convey hope and respect and believe that all individuals have the capacity for learning and growth.
- Recognize that culture is central to recovery and strive to ensure that all services are culturally relevant to individuals receiving services.
- Engage in the processes of informed and shared decision-making and facilitate partnerships with other persons identified by the individual receiving services.

Contemporary Principles of Psychiatric Rehabilitation

- Build on the strengths and capabilities of individuals.
- Are person-centered and designed to address the unique needs of individuals
- Support full integration of people in recovery into their communities

Contemporary Principles of Psychiatric Rehabilitation

- Promote self-determination and empowerment.
- Facilitate the development of personal support networks by utilizing natural supports within communities, peer support initiatives, and self- and mutual-help groups.
- Help individuals improve the quality of all aspects of their lives; including social, occupational, educational, residential, intellectual, spiritual and financial.

Contemporary Principles of Psychiatric Rehabilitation

- Promote health and wellness, encouraging individuals to develop and use individualized wellness plans.
- Emphasize evidence-based, promising, and emerging best practices that produce outcomes congruent with personal recovery.
- Must be readily accessible to all individuals whenever they need them. These services also should be well coordinated and integrated with other psychiatric, medical, and holistic treatments and practices.

Fidelity Assessment to Improve Adherence to ACT

Fidelity Assessment as a Tool for Improving Outcomes

- To measure adherence to Assertive Community Treatment (ACT)
- To identify strengths and weaknesses of an Assertive Community Treatment program
- To develop a quality improvement plan
  - Use a written summary to highlight positive scores and make reasonable suggestions for improvements

Storming

Early in the process of working with people a sense of discomfort occurs. People are fearful of being (mis)judged and exposed:

- Initial discomfort with unknown
- Fear of bad assessment
- Who are you to grade me
- Conflict and anxiety
- Withdrawal
- Sugar coating

Don’t fear that. You can establish norms.

Norming

To prevent and work through initial negative experiences we can establish norms. These norms sets the stage for a productive working phase.

- Clarity about process
- Clarity about your role
- Negotiating a plan
- Give a sense of control
- Offering options

Roles and Functions when collecting data

Role and functions of Psychiatrist/Psychiatric Prescriber

- Provide clinical oversight for the team with the Team Lead
- Provide medication management services to the clients of ACT

Team Lead

- Provide clinical supervision to the team members with the Psychiatric prescriber
- Responsible for hiring and training new staff

Roles and Functions when collecting data

Psychiatric nurse (RN)

- Provides basic medical treatment
- Assists with medication management

Peer Support Specialist

- Serves as a model for recovery and healing
- Helps establish safety and trust

Roles and Functions when collecting data

Employment Specialist

- Assists clients with vocational training as needed
- Serves as a liaison between employers and clients

Housing Specialist

- Serves as a liaison between landlords and clients
- Assists clients with housing options as needed

Roles and Functions when collecting data

Substance Use specialist

- Provide and implement substance use interventions for clients that struggle with substance use

Stages of a Fidelity Assessment

Fidelity Assessment - Purpose

1. To measure adherence to the ACT model
2. To track implementation over time (3-months)
3. To identify strength and weaknesses of an ACT program
4. To develop a quality improvement plan

Fidelity Assessment – small things

- Be prepared
- Announce what you need from team lead and administration prior to assessment
- Announce what you need the day of the assessment
  - Consumer chart
  - Site visit
  - Team lead interview
  - Staff member interview
  - Consumer interview
  - Observe services and team meeting
  - Etc.
- Use local terminology

DATA, DATA, DATA – Quality Improvement

- Get used to it
- Healthcare is going in this direction
- Value based care puts focus on quality improvement
- Professionals do not get education on ACT and many of its principles

Follow-Up with team

Stages of an ACT Fidelity Assessment

1. Introduction
2. Preparation
3. Data collection
4. Data analysis
5. Report writing
6. Disseminating results
7. Follow-up meeting

Stages of an ACT Fidelity Assessment

Introduction

1. First contact with agency
2. Set the stage for quality improvement
3. Establish norms
4. Ask for ACT data/forms/policies
5. Engage in dialogue and offer choice (time and place for FA and follow up meeting, etc)

Stages of an ACT Fidelity Assessment

Preparation

1. Review previous assessments
2. Review data/forms/policies
3. Develop interview guides for
    1. Admin
    2. Team lead
    3. Staff
    4. Clients
4. Develop forms to take notes during meetings and after site visits
5. Divide the work among fidelity assessment team

Stages of an ACT Fidelity Assessment

Data collection

1. Take lots of notes
    1. Review charts
    2. Interview staff and clients
    3. Observe meetings (morning meeting, treatment planning, groups, etc)
    4. Observe client/staff interaction
2. Meet with Fidelity Assessment team during lunch and after each day to share notes
3. Let it flow – do not be too assertive
4. Do not score – keep an open mind

Stages of an ACT Fidelity Assessment

Data analysis

1. Each Fidelity Assessor review own notes
    1. Articulate strength and weaknesses of the program
    2. Give tentative score
2. Scores are shared among the Fidelity Assessment team
3. Team reaches consensus
4. When in doubt – score low

Stages of an ACT Fidelity Assessment

Report writing

1. Include quantitative and qualitative data
    1. Use qualitative data to strengthen qualitative data
    2. I.e. “We observed a consistent warm and engaging attitude among staff and suggest that might be the cause of the program’s high staff retention”
2. Be accurate in observations on positive and negative findings
3. Suggest things to improve before next fidelity assessment
4. Suggest incremental quality improvement
5. Note in report that fidelity to ACT is a process that is never ending
6. All ACT programs have things to improve upon

Stages of an ACT Fidelity Assessment

Disseminating results

1. I prefer to give a verbal report first
    1. Start with strengths
    2. Normalize fidelity assessment
    3. Review data
    4. Review suggestions for quality improvement for next fidelity assessment
2. Send the Fidelity Assessment report
3. Allow time for feedback – listen

Stages of an ACT Fidelity Assessment

Follow-up meeting

1. Be prepared to share resources
    1. Training
    2. Technical assistance
    3. Peers
2. Discus the strengths to build on
3. Negotiate a plan to improve services
    1. Start with the low hanging fruit

Questions?

Mid-America (HHS Region 7)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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